HEYOKA[1]*:* THE SHIFTING SHAPE OF DISPUTE RESOLUTION IN HEALTH CARE

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INTRODUCTION

Contributors to health care conflict are well-chronicled. The volume and complexity of regulations threatens to obscure their value in protecting patients and exacerbates pressures.[2] Financial pressures combine with employee shortages within some disciplines—most acutely, nurses, which threatens to get exponentially worse—creating dangerous instability.[3] These shortages, along with chronic time pressures arising out of cost constraints, immerse professionals in a sense of constant want and, potentially, hopelessness.

Many professionals experience profound disappointment when they find themselves in a practice entirely mismatched to their original vision of the profession. Their anger mounts until its inappropriate expression is labeled "disruptive."[4] Through natural ability and reinforcement through socialization, professionals tend to be autonomous problem-solvers, but the complex nature of health care delivery requires interdependence and creates tremendous

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1. The "*heyoka*" is a Lakota medicine man with features of the Trickster archetype. "Whenever an ugly situation developed resulting from misunderstandings and misapprehensions among the people, the *heyoka* would burst upon the scene with his clowning and cavorting. Seeing this strange performance was usually enough to restore good humor and restraint to those embroiled in the matter, allowing a more humane solution to be reached and protecting the community from itself." Blair A. Moffett, *Mind: Trickster, Transformer*, SUNRISE, Nov. 1979, *available at* http://www.theosociety.org/pasadena/sunrise/29-79-80/my-moff2.htm.

2. Dale C. Hetzler et al., *Curing Conflict: A Prescription for ADR in Health Care*, DISP. RESOL. MAG., Fall 2004, at 5.

3. *See Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern: Testimony Before the United States Senate Committee on Health, Education, Labor and Pensions*, 107th Cong. 4-6 (2001) (statement of William J. Scanlon, Director of Health Issues, United States General Accounting Office) (average age of nurses is increasing, nursing program enrollment has declined, and the number of aged in the general population is expected to grow dramatically).

4. David O. Weber, *Poll Results: Doctors' Disruptive Behavior Disturbs Physician Leaders*, PHYSICIAN EXECUTIVE, Sept.-Oct. 2004, at 6, 9.

barriers to solving anything.[5] Trends show that health care workers either avoid managing conflict, or are competitive, setting up a damaging cycle when their behaviors swing between poles.[6] There is a breakdown in trust at all levels between patients, clinicians, administration, payors, and agencies.[7] Indeed, often these same factors that generate the need for conflict management serve as obstacles to making use of it. Still, an estimated fifty percent of physicians' time is spent on conflict, and it similarly consumes time for executives.[8]

Traditional conflict resolution methods in health care—for example, using the chain of command, risk management, peer review, or licensing board action—are power-based. Those methods result in unilateral decisions, sometimes to the exclusion of those affected, neither seeking their input beyond an initial complaint nor informing them of decisions or remedies. Initial "alternatives" retained an adversarial nature as the first steps focused on settling medical malpractice claims in arbitration and evaluative mediation. Since then, an increasing number of interest-based resolution options have developed because of the intolerability of daily pressures; the years of groundwork laid by dispute resolution professionals; and attention in the health care literature to collaboration, "healthy work environments," and "patient-centered care."[9] These approaches, which developed recently and appear in small pockets of many professional disciplines and geographic regions, could presage a major cultural shift to come.

As the application of dispute resolution to health care evolves, there are observable trends in the forms it takes. The first involves

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5. Hetzler, *supra* note 2, at 5.

6. *See, e.g.*, Debra Gerardi, *The Culture of Healthcare: How Professional and Organizational Cultures Impact Conflict Management*, 21 GA. ST. U. L. REV. 857 (2005).

7. Marc Roberts & David A. Shore, *The State of Trust and the Public's Health: How Can We Do Better?*, Harvard School of Public Health, *at* http://www.hsph.harvard.edu/ccpe/Trust/whiute_paper_phtm (2002).

8. Coby Anderson & Linda L. D'Antonio, *Empirical Insights: Understanding the Unique Culture of Health Care Conflict*, DISP. RESOL. MAG., Fall 2004, at 15, 16; s*ee generally* Weber, *supra* note 4.

9. *See, e.g.*, AM. ASSOC. OF CRITICAL-CARE NURSES, AACN STANDARDS FOR ESTABLISHING AND SUSTAINING HEALTHY WORK ENVIRONMENTS (2005), *available at* http://www.aacn.org/aacn/pubpolcy.nsf/Files/HWEStandards/$file/HWEStandards.pdf.

direct efforts to shift culture in favor of interest-based thinking and collaborative practices. A second trend is for health care professionals to infuse conflict management techniques into their responses to existing operational, legal, or regulatory demands. Finally, traditional conflict resolution methods are being applied in a variety of health care settings, often as hybrids adapted to accommodate the needs of both organizations and individuals.[10] This Article will briefly examine those trends and various models employed or envisioned to advance them.

I. CHANGING HEALTH CARE'S CULTURE IN FAVOR OF COLLABORATION

A growing body of health care research demonstrates the risks and failures inherent in the health care system being structured for delivery by individuals without regard to mechanisms that prepare and permit them to act in concert. Consequences include patient injuries, forwarding known or suspected errors rather than speaking with an intimidating colleague about them, and the loss of needed professionals.[11] Various respected bodies are calling for deliberate action to foster collaboration, including promoting interdisciplinary practice; interdisciplinary rounds; regularly scheduled education in collaboration for all health care providers; team training; establishing

10. While these traditional approaches include arbitration, its adversarial nature raises sufficiently different considerations that it is outside the scope of this paper. Medical malpractice litigation also uses mediators to reach settlement before trial. Because this application is more widely understood, this Article will include only limited treatment of it and will focus principally on interventions where there is no court involvement.

11. *Sentinel Event Statistics: Root Causes of Sentinel Events (All Categories; 1995-2004)*, Joint Commission on Accreditation of Healthcare Organizations, *at* http://www.jcaho.com/accredited+organizations/ambulatory+care/sentinel+events/root+causes+of+sentinel+event.htm (last visited Apr. 16, 2005) (60% of all sentinel events—serious injury, death, or risk of same—are caused by communication breakdowns); *Preventing Infant Death and Injury During Delivery*, Joint Comm'n on Accreditation of Healthcare Orgs., Oakbrook Terrace, Ill.), *available at* http://www.jcaho.org/about+us/news+letters/sentinel+event+alert/print/sea_30.htm. (stating that in a recent examination of perinatal deaths and injuries, communication failures were the top cause) [hereinafter SENTINEL EVENT ALERT]; *Intimidation: Practitioners Speak Up About This Unresolved Problem (Part I)*, ISMP MEDICAL SAFETY ALERT (Inst. for Safe Medication Practices, Huntingdon Valley, Pa.), Mar. 11, 2004 [hereinafter *Practitioners Speak Up*], *available at* http://www.ismp.org/MSAarticles/IntimidationPrint.htm.

a conflict resolution process and norms for assertive, respectful communication; and providing incentives for collaborative behavior.[12]

A. Dialogue Identifying and Building on Common Ground

As a means to achieve these goals, conflict resolution professionals and universities have convened structured dialogues in Vancouver and Atlanta for health care professionals, government and union representatives, patients, conflict resolution professionals, attorneys, spiritual leaders, educators, and risk managers.[13] The goals were to initiate overcoming the isolation within which each discipline practices, with attendant misconceptions and assumptions about others; to increase awareness of common values and goals; to form the foundation for community; and to think together about creative options for restoring meaning and reducing the impact of conflict in daily practice.

B. Culture Change Through Future Professional Generations

In recognition of the damaging effects of developing subcultures in silos—reinforcing group identity in opposition to the "other"—some innovative professional schools are developing interdisciplinary coursework.[14] Extraordinary among them are two graduate courses

12. INSTITUTE OF MEDICINE, KEEPING PATIENTS SAFE: TRANSFORMING THE WORK ENVIRONMENT OF NURSES 341-83 (2004), *available at* http://www.nap.edu/openbook/0309090679/html; JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS, HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR IMPROVING THE MEDICAL LIABILITY SYSTEM AND PREVENTING PATIENT INJURY (2005) [hereinafter HEALTH CARE AT THE CROSSROADS], *available at* http://www.jcaho.org/news+room/press+kits/tort+reform/medical_liability.pdf; *Practitioners Speak Up*, *supra* note 11;

13. The Vancouver dialogue took place March 24-26, 2004 and was organized by the Morris J. Wosk Centre for Dialogue, Simon Fraser University; Health Care Mediations, Inc.; and mediate.*calm*. *Dialogue: An Opportunity to Think Together*, Creative Conflict Management in Healthcare, *at* http://www.healthdialogue.org (last visited Feb. 27, 2005). The Atlanta dialogue was organized by the Health Care Ethics Consortium of Georgia; Georgia State University Center for Law, Health & Society; Health Care Mediations, Inc.; and Kennesaw State University Center for Conflict Management. *See Managing Conflict Ethically: Collaboration in Bioethics and Health Law*, Health Care Ethics Consortium of Georgia, *at* http://www.hcecg.org/events/EventDetail.cfm?eventcode=2005Annual (last visited June 16, 2005).

14. *See* Gerardi, *supra* note 6.

offered at the University of Wisconsin-Madison; one features consumer issues in health care and the other focuses on practitioner self-reflection, communication skills, and the ethical considerations in providing patient-centered care.[15] Students are typically drawn from the fields of medicine, nursing, public policy, law, social work, pharmacy, psychology, industrial engineering, and business. Many also work collaboratively in practical placements in a health advocacy center.

Harvard Medical School offers a course to both medical and nursing students.[16] Similar programs are under consideration at northern California and Midwestern medical centers, and may also involve law and dispute resolution students. Georgia State University joins medical and law students in a medical ethics course.[17] California Western School of Law takes the approach of problem-based learning for law students—and potentially multiple disciplines in the future—in a public health setting.[18]

Additionally, a growing number of bodies recognize the need to include instruction in collaborative methods. The Commission on Accreditation of Healthcare Management Education now includes communication and management of conflict and change in its criteria.[19] The National Board of Medical Examiners examines all medical students on communication skills, and the Accreditation Council for Graduate Medical Education recently began to require all residency programs to provide like instruction.[20]

Responding to this need, beneficial models formally develop faculty and use experiential learning. Expected skills include maintaining the relationship; eliciting and understanding the patient's

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15. Telephone interview with Martha Gaines, Director, Center for Patient Partnerships, University of Wisconsin-Madison (Feb. 2005).

16. Interview with Lucian Leape, M.D., Adjunct Professor of Health Policy, Harvard Department of Health Policy and Management, in Alexandria, Va. (Nov. 2004).

17. Linda Morton, *A New Approach to Healthcare ADR: Training Law Students to Be Problem Solvers in the Healthcare Context*, 21 GA. ST. U. L. REV. 965 (2005).

18. *Id.*

19. Michael Romano, *A Good Education: Modern Healthcare Survey Finds Basic Satisfaction with Health-Management Programs—And a Few Suggestions*, MOD. HEALTHCARE, Mar. 1, 2004, at 6.

20. Stephen J. Lurie, *Raising the Passing Grade for Studies of Medical Education*, 290 J. AM. MED. ASS'N 1210, 1210-12 (2003).

perspective and feelings, and verifying one's understanding of them; allowing the patient to speak without interruption; acknowledging emotion; nonjudgmental expression; and mutuality in negotiation.[21] New York University, the University of Massachusetts, and Case Western Reserve University used this approach, applying it to varied substantive third-year curriculum, and researchers found significant skills improvement in ways that affect clinical care.[22] Another model, proposed by Medical Dispute Professionals and under consideration by West Coast universities, infuses conflict resolution skills and communication theory for medical students and residents throughout a four-year program, applying the skills to a variety of practical and ethical issues doctors will face.[23] For instructors, the model draws on a combination of methods used by conflict resolution professionals, faculty, and peer group mentors.

C. Widespread Adoption of Interest-Based Skills

Some health systems are working toward a collaborative culture through widespread training in interest-based process skills with the expectation that it will transform interactions between professionals as well as with patients and families. Lutheran Medical Center in Brooklyn, New York, trained every employee, along with some physicians.[24] Lutheran and other New York community hospitals worked with Pact Training; one joined with a major union to obtain federal training funds for this effort.[25] Using a "structured improvisation" method, Pact enacts and incorporates trainees into simulations, while other trainees offer advice, try different approaches, and debrief.[26] The model reinforces the training through

21. Michael J. Yedidia et al., *Effect of Communications Training on Medical Student Performance*, 290 J. AM. MED. ASS'N 1157, 1159 (2003).

22. *Id.* at 1162.

23. Telephone interview with Marc R. Lebed, M.D., M.D.R., Co-Director, Medical Dispute Professionals (Feb. 2005).

24. Telephone interview with Steven Hitt, Pact Training (Jan. 2005).

25. As many hospitals and other users of conflict resolution services prefer to keep that fact confidential, some will be referred to in this more general way. All organizations named in this Article have granted their permission.

26. Telephone interview with Steven Hitt, *supra* note 24.

champions in each service area, written materials, follow-up phone assessments, and attention to these skills as part of performance evaluations. After two years, these hospitals report significant improvements in employee and patient satisfaction measures.[27]

Similarly, Community Hospital of Monterey Peninsula developed interest-based skills in a wide variety of staff and leaders, including entire clinical units and physician and administrative leaders. Using an education model based on training for improvisational comedians, Health Care Mediations has participants practice discrete skills and techniques, engage in coached simulations, use appreciative inquiry, and otherwise apply interest-based ideas to their actual conflict situations.

Union contract negotiations provided the impetus for Tahoe Forest Hospital District to shift to a conflict management ethic.[28] The Center for Collaborative Solutions trained all department directors and bargaining unit officers in joint sessions focusing on interest-based skills before bargaining. The human resources department and directors have since adopted this approach in operations, it is incorporated into the organization's Communications Principles, and every employee is trained. The hospital also draws on independent facilitators when it is beneficial.[29]

Other organizations have trained a cadre of people likely to have a large impact on others, using their influence to affect a culture change. Baptist Health System, a San Antonio, Texas community health system, trained 400 of its senior leaders, directors, and managers from all departments in interest-based skills, and also offered sessions tailored to physician interests.[30] At the University of California at Los Angeles Medical Center (UCLA), the departments of nursing and international relations jointly developed a program to address patient care conflicts that have both clinical and cultural

27. *Id.*

28. E-mail from Gaile Holloway, Tahoe Forest Hospital District (Oct. 14, 2003, 10:53 PST) (on file with the author).

29. *Id.*

30. Baptist Health System employed the Health Care Mediations model described above.

components.[31] The model places "Cultural Liaisons" in every nursing unit to act as facilitators, and to mentor and teach conflict management and cross-cultural communication skills. Additionally, the Liaisons may consult with "Cultural Advisors" for culture-specific information helpful in resolving a particular conflict. Creators contemplated ongoing reinforcement training in that model.[32]

D. The Culture Change Necessary for Patient Safety

"Patient Safety," as a movement, is prominent in health care and requires a distinct culture change of its own; collaborative methods will be key in accomplishing it. While clinicians have long been troubled by patient injuries during treatment, an Institute of Medicine report starkly brought the issue to public attention with its estimates of tens of thousands of annual preventable inpatient care deaths, let alone the injuries in both inpatient and outpatient settings.[33] Patient safety adherents believe that the greatest number of injuries can be prevented by identifying and remedying breakdowns in health care's complex systems.[34] This practice relies heavily on widespread reporting of actual errors, injuries, and "near misses." In contrast, health care cultures value strength, autonomy, infallibility, and reputation; thus, traditionally, mechanisms for self-protection and societal expectations have combined to lead to the current culture of blaming and shunning the individuals involved, which threatens their livelihood, community, and identity.[35] To generate meaningful reporting, the health care community will need to demonstrate that the culture will now receive and use such reports consistent with its

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31. Mark Gelhaus, *UCLA Medical Center Cultural Liaisons Program: Managing Cultural Conflicts in the Clinical Setting*, *at* http://www.mediate.com/articles/gelhaus.cfm (May 2002).

32. *Id.* UCLA worked with a Health Care Mediations founder to implement this program.

33. INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (2000).

34. Ansley Boyd Barton, *Recent Remedies for Health Care Ills*, 21 GA. ST. U. L. REV. 831, 831 (2005) (citing TO ERR IS HUMAN, *supra* note 33); Charles Vincent, *Understanding and Responding to Adverse Events*, 348 NEW ENG. J. MED. 1051, 1051 (2003).

35. HEALTH CARE AT THE CROSSROADS, *supra* note 12, 27; Vincent, *supra* note 34, at 1055; *See* David Hilfiker, *Facing Our Mistakes*, 310 NEW ENG. J. OF MED. 118-22 (1984); Wendy Levinson, et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 J. AM. MED. ASS'N 553-58 (1997).

principles—for learning and improvement—while supporting those who report, to counteract professionals' years of experience to the contrary.[36] This approach requires establishing a widespread sense of trust that colleagues will preserve one's interests, inviting collaboration in examining very sensitive problems, balancing interests in service of the common goal of systems learning, and upholding accountability rather than applying blame. In short, it requires interest-based skills and techniques of the highest order. Indeed, one of the movement's leaders, Lucian Leape, M.D., speaks of teamwork and developing shared values as key components of safety-related cultural change, and as the characteristics of two of the more advanced stages in the movement's evolution.[37]

Projects demonstrating initial steps in this direction are very promising. While each project adopts a finite collaborative practice, rather than undertaking a global change, improvements in patient health and in operations are dramatic.

In Atlanta, Kaiser Permanente's primary care clinics reconfigured their leadership structure to feature collaborative, self-directed, autonomous teams, each led jointly by a physician and nurse who were authorized to design their own division of labor and workflow.[38] In the two years measured, staff saw concurrent improvements in the health of diabetic and asthma patients, some aspects of prescription practices that can harm patients, and patient and staff satisfaction measures.[39]

Concord Hospital's cardiac surgery unit instituted interdisciplinary rounds involving all disciplines and the patient, an anomaly in inpatient treatment. Staff and physicians used a set communication protocol to ensure universal input and topic coverage, focus on

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36. *See* HEALTH CARE AT THE CROSSROADS, *supra* note 12, at 28; Gerardi, *supra* note 6; *Leadership and System Thinking Learning Module*, National Patient Safety Foundation, *at* http://www.npsf.org/html/mcw/physicians.html (March 24, 2005).

37. Lucian L. Leape, M.D., *Talking About Medical Errors*, Remarks at the Conference on Medical Error Communication and Dispute Resolution (April 29, 2004) (PowerPoint slides *available at*: http://medliabilitypa.org/news/files/Leape.ppt).

38. Douglas Roblin, Measuring Culture Change in Outpatient Settings, Remarks at the 6th Annual National Patient Safety Foundation Patient Safety Congress (May 5, 2004) (PowerPoint slides on file with the Georgia State University Law Review).

39. *Id.*

patient strengths rather than illness, and capture potential patient safety pitfalls.[40] During the three years this practice was measured, there were *half* as many deaths as expected based on previous experience.[41]

In another project, each of seventy-two hospitals' intensive care units (ICUs) formed a multidisciplinary team that underwent teamwork and communication training, and also employed joint rounds and an inclusive communication protocol.[42] This formed the foundation for adopting new practices that, in less than one year, dropped bloodstream infections to less than the tenth percentile nationally—it actually eradicated them in twenty-two ICUs—and produced similar results for ventilator-associated pneumonia.[43]

By promoting the conflict resolution principles of better information exchange and mutuality among treatment providers, interdisciplinary practice has also been shown to reduce from one-fourth to one-third the amount of time patients need to be on ventilators.[44] Similarly, researchers believe gains would be evident even with simple measures such as introducing a common space where practitioners could daily record and easily access the patient's plan of care and current clinical information.[45]

UCLA more comprehensively addressed the conflicts that hampered a medical-surgical nursing unit's functioning. At the time a conflict resolution intervention began, there were severely entrenched alliances among the nursing staff.[46] Some nurses would tape-record clinical information to avoid having direct contact, and there was an incident of violence between clerical staff.[47] The three-year

40. Paul N. Uhlig, M.D., M.P.A. et al., Collaborative Communication Cycle: A System Innovation for Improved Patient Safety, Remarks at the Risk Management and Patient Safety Institute Audio Conference (April 28, 2004).

41. *Id.*

42. Peter Pronovost & Chris Goeschel, *Improving ICU Care: It Takes a Team*, HEALTHCARE EXECUTIVE, Mar./Apr. 2005, at 15, 18.

43. *Id.* at 22.

44. Elizabeth A. Henneman, *Liberating Patients from Mechanical Ventilation: A Team Approach*, CRITICAL CARE NURSE, June 2001, at 25, 27.

45. *Id.* at 29-30.

46. Telephone interview with Debra Gerardi, R.N., M.P.H., J.D., President & CEO, Health Care Mediations, Inc. (Dec. 2004).

47. *Id.*

intervention employed facilitated meetings, skills training, and consistent application of communication protocols requiring early and direct communication about differences using interest-based techniques.[48]

Thus, varied and rich efforts are underway to shift the culture of health care toward collaboration, creating mechanisms that reduce silos and the sense of "other" while directly teaching conflict resolution skills. Professionals are implementing discrete collaborative practices and measuring their benefits to patient health, patient safety, and environment of care, and the principles are clearly applicable to creating a culture of safety.

II. INTEGRATING CONFLICT RESOLUTION TECHNIQUES INTO OPERATIONS AND MANDATES

Given the regulatory environment and the rapid pace of technological, financial, and clinical change, health care professionals are constantly called upon to implement new regulatory mandates as well as clinical and business projects. This often requires balancing competing interests, joint planning, and execution. In some arenas, professionals are integrating conflict resolution techniques to improve handling the existing challenges, rather than resorting to a separate conflict resolution process.

A. Bioethics Concerns

Many hospitals support a multidisciplinary bioethics committee that consults because there are layers of both genuine dilemma—where multiple courses of action are ethically appropriate—and conflict within or between the treatment team, the administration, and family. In most cases, people are faced with wrenching questions about whether further treatment helps or harms a patient, whether treatment choices prevent others from accessing needed treatment,

48. *Id.*

what it means to be a professional, and all manner of values issues grounded in respect, justice, autonomy, dignity, and relationship.

Given this context, it is not surprising that a noted task force identified the core competencies for bioethics committee members as including "ethical assessment skills," "process skills," and "interpersonal skills."[49] The task force called for proficiency in identifying the conflict; assessing interpersonal dynamics, power relationships, and cultural differences; facilitating informal meetings; identifying key decisionmakers and concerned people; setting ground rules; defining roles; creating an atmosphere of trust that respects confidentiality and encourages discussion; building moral consensus; helping individuals analyze values underlying assumptions and possible consequences of decisions; negotiating between competing moral views; enabling effective communication; and recognizing and resolving relational communication barriers.[50]

While a traditional committee might function as a consulting doctor would by making a recommendation to be followed, there are a variety of styles that advance the task force's recommendations. A northern California community hospital developed a consultation protocol whose structure ensured that participants' opinions, interests, and emotions were elicited, acknowledged, and summarized.[51] The committee offered advice solely about which actions were ethical, rather than which to choose. Baystate Health System, in Massachusetts, requires full mediation training and ongoing education for all committee members; there, a committee employs a transformative mediation approach in its consultations and an ethicist acts as the patient's advocate.[52] Montefiore Medical Center has made mediation an integral part of its Bioethics Consultation Service for more than a decade.[53] Bioethics team

49. Mark P. Aulisio, et al., *Health Care Ethics Consultation: Nature, Goals, and Competencies: A Position Paper from the Society for Health and Human Values–Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation*, 133 ANNALS INTERNAL MED. 59, 61 (2000).

50. *Id*. at 62.

51. The author has personal experience on this committee.

52. Telephone interview with Betsy Johnson, Consultant, Baystate Health System (Mar. 2004).

53. NANCY NEVELOFF DUBLER & CAROL B. LIEBMAN, BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS, at xvi (2004).

members and risk managers have been trained in mediation.[54] In this model, a hospital employee typically does fact-finding and clarifying with the care team, then meets with a subset of them and the family.[55] The mediator is expected to provide information and educate on and enforce ethical norms, in addition to applying mediation process.[56] Other writers call for independent mediators to become familiar with bioethical issues and context, and to mediate such conflicts; some northern and central California hospitals have used this approach.[57]

B. Patient Safety Implementations

As organizations respond to calls for enhancing patient safety, practical and relationship barriers surface. "Root cause analysis" is a widely adopted tool to identify actions and processes that contributed to an incident.[58] "Failure mode and effects analysis" serves similar aims proactively, examining processes that pose high risks for error and harm. Both rely on bringing together multiple disciplines for self-examination and the potential for open discussion of personal failure, extremely unusual concepts in health care. Leading organizations recognize that facilitation skills are critical to the negotiation necessary to convene such groups, creating an atmosphere of trust sufficient to surface important facts, leading the group through brainstorming potential solutions, and marshaling support for writing and carrying out corrective action plans.[59]

Technology's role as a centerpiece in patient safety initiatives is founded on the belief that it can minimize many human errors grounded in memory failures, as well as written and oral misunderstandings. Physician order entry systems, electronic health records, and related projects hold real promise.[60] However, because

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54. *Id.* at xiv-xv.
55. *Id.* at 4.
56. *Id.* at 21.
57. Douglas Noll, *Bioethical Mediation: Peacemaking and End of Life Conflicts*, *at* www.mediate.com/articles/noll13.cfm (Aug. 2004); E-mail from Douglas Noll, Noll Associates (Feb. 7, 2005, 13:00 PST) (on file with the author).
58. HEALTH CARE AT THE CROSSROADS, *supra* note 12 at 22, 28; Vincent, *supra* note 34, at 1053.
59. A Health Care Mediations founder is among those with experience in this area.
60. *See* HEALTH CARE AT THE CROSSROADS, *supra* note 12, at 23.

they create major shifts in practice and communication patterns, and require massive capital outlays, these changes have emotional implications as well as practical ones. Several hospitals have experienced substantial implementation barriers, or have had to take down operating systems in a unit or entire facility, likely because of both design issues and this clash of strongly held interests.[61]

These initiatives greatly benefit from conflict resolution techniques in the earliest design phases by incorporating information and interests from a wide variety of affected disciplines. Some organizations, such as Stanford Hospital and Clinics, have brought in conflict resolution professionals to facilitate restoring relationships between information technology and clinical professionals, and to plan future action after serious rifts and shutdown during implementation.[62]

C. Legal and Regulatory Mandates and Functions

1. Direct Oversight

Several authorities with oversight powers are creating opportunities for a conflict management approach in their review of health care concerns. The California prison system is under court order to implement a mental health system to screen for and treat seriously mentally disordered prisoners.[63] The Special Master appointed to oversee the remedy, and most members of his monitoring team, are mediators, psychiatrists, or psychologists.[64] Instead of holding adversarial hearings, the Special Master frequently conducts negotiations and uses other interest-based methods as the parties interpret the scope and practicalities of implementing the orders. When the team conducts site visits, it helps staff identify

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61. Tyler Chin, *Doctors Pull Plug on Paperless System*, AM. MED. NEWS, Feb. 17, 2003, *available at* http://www.ama-assn.org/amednews/2003/02/17/bil20217.htm; *see also* HEALTH CARE AT THE CROSSROADS, *supra* note 12, at 23.

62. Telephone interview with Debra Gerardi, R.N., M.P.H., J.D., President & CEO, Health Care Mediations, Inc. (Dec. 2001).

63. Coleman v. Schwarzenegger, 912 F. Supp 1282, 1297, 1323 (E.D. Cal. 1995).

64. The author has personal experience on this team.

compliance obstacles and design their own remedies, as well as designing a quality improvement system to sustain gains. Emphasis is on facilitating interactions between medical, mental health, and custody staff to help surface their assumptions and interests, establish common ground, and plan means to align their missions.

As the offices responsible for much of Medicare's daily operations, each state's Quality Improvement Organization (QIO) has tremendous influence over physicians and organizations.[65] In 2003, as part of their response to patient complaints, QIOs began offering a mediation option to patients and families concerned about the care experience.[66] California's QIO, Lumetra, was a leader in designing and coordinating these services.[67] Its employees administer the program and do case development while drawing on a panel of independent mediators.[68] Some cases are co-mediated with a clinician, and lay mediation advisors support patients.[69] The QIO retains enforcement authority over agreements.[70] QIOs are also currently exploring a variety of expeditious conflict resolution methods.[71]

The Massachusetts Board of Registration in Medicine has also offered, through a panel of independent mediators, the option of mediation for patient complaints against their physicians.[72]

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65. *See Quality Improvement Organizations*, Centers for Medicare & Medicaid Services, *at* http://www.cms.hhs.gov/qio/ (last modified Sept. 16, 2004) ("QIOs work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly among underserved populations. The program also safeguards the integrity of the Medicare trust fund by ensuring payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care."). *Id.*

66. *Mediation*, Lumetra, *at* http://www.lumetra.com/mediation/index.asp (Feb. 27, 2005).

67. *QIO Listings*, Medicare Quality Improvement Community, *at* http://www.medqic.org/dcs/ContentServer?pagename=Medqic/MQGeneralPage/GeneralPageTemplate&name=QIO%20Listings; *see id.*

68. LUMETRA, MEDIATION RESOURCE PACKET FOR PHYSICIANS/PROVIDERS 6 (2004), *at* http://www.lumetra.com/mediation/doc/Mediation_ResourcePacket_0504.pdf

69. *Id.*

70. *Id.* at 7.

71. *Id.*; E-mail from Pat Shanahan, Mediation Project Manager, Lumetra (Jan. 15, 2005, 15:47 PST) (on file with the author).

72. Leonard J. Marcus & Barry C. Dorn, *Mediation Can Avert Malpractice Suits*, AM. MED. NEWS, June 17, 2002, *available at* http://ww.ama-assn.org/amednews/2005/06/17/prca0617.htm.

The Minnesota Department of Labor and Industry holds authority over workers' compensation benefits and disputes, but has offered a range of resolution processes since 1983.[73] The Customer Assistance Unit is staffed by 15 mediators trained according to court panel standards. The staff handles thousands of informal resolutions and mediates hundreds of cases annually by phone or in person, and more are handled by independent mediators.[74] Methods are individualized, though an evaluative approach is often thought appropriate. Any mediation agreement must be approved by the mediator or a hearing officer and becomes enforceable by other divisions' staff members. Mediators may make a referral if they learn of rare enforcement problems. The mediators also conduct arbitrations where desired or if mediation does not reach agreement, and they work closely with other divisions' staff who conduct administrative hearings.

Although some features are inconsistent with traditional conceptions of neutral services, these models allow these authorities to modify a strict enforcement role and incorporate interest-based principles into their oversight.

2. Patient Harm "Disclosure"

A predominant ethical and legal concern in patient safety is informing patients about errors and other adverse events. The main hospital accreditation body, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and at least four states now mandate "disclosure."[75] They define differently what triggers the obligation, sometimes with distinctions based on severity or fault, and they often leave open the interpretation of what must be included. The JCAHO policy, the most widely influential, contains the broadest

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73. *See Alternative Dispute Resolution Services*, Minnesota Department of Labor and Industry, *at* http://www.doli.state.mn.us/irdspres.html (last visited Feb. 27, 2005).

74. Telephone interview with Mark McCrea, Supervisor, Customer Assistance Unit, Minnesota Department of Labor and Industry and Minnesota Workplace Mediation Program Advisory Committee Member (Feb. 2005).

75. FLA. STAT. ANN. § 395.1051 (West 2005); N.J. STAT ANN. § 26:2H-12.25(d) (2004); NEV. REV. STAT. 439.835 (2003); PA. STAT. ANN. tit. 40, § 1303.308 (2004); HEALTH CARE AT THE CROSSROADS, *supra* note 12, at 5.

obligation—to discuss outcomes that differ from what was expected, regardless of whether there was fault or harm.[76]

There has been a range of responses to carrying out these directives. Although the temptation is to meet the obligation as precisely as possible and go no further, the most interesting approaches use conflict resolution methods to serve the intended goals, and, perhaps counterintuitively, to reduce the inherent liability risk.

Generally, patients who have been harmed want a detailed explanation; an acknowledgement of the impact of the event on the patient, often including an apology; a description of the measures taken to prevent recurrence; and coverage of expenses they would not have otherwise incurred.[77] Studies document that the failure to meet these expectations, or poor communication in meeting them, can be perceived as measures of disrespect and may inflict as much or more pain than the injury, serving as the catalyst for taking legal action.[78] Practices such as managing expectations, eliciting patient opinion and understanding, expressing empathy, spending slightly more time on the issue, listening, and providing direct answers are critical in meeting patients' and families' need for information, emotional and physical healing, and restored trust.[79]

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76. *See* HEALTH CARE AT THE CROSSROADS, *supra* note 12, at 5.

77. Thomas H. Gallagher, et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 J. AM. MED. ASS'N, 1001, 1004 (2003); HEALTH CARE AT THE CROSSROADS, *supra* note 12, at 27. The American Society for Healthcare Risk Management was among the first to endorse the conversation having these components. *See* AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT, DISCLOSURE: WHAT WORKS NOW AND WHAT CAN WORK EVEN BETTER (2004), *available at* http://www.hospitalconnect.com/ashrm/resources/files/Disclosure.Part3.0204.pdf.

78. Charles Vincent, et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609 (1994); Berkeley Rice, *How Plaintiffs' Lawyers Pick Their Targets*, MED. ECON., Apr. 24, 2000 (interviewed attorneys cite multiple examples of patients overlooking liability when there is a solid relationship with the physician and inaccurately projecting liability on other health care providers because of how they were treated, particularly where there has been a failure to listen to the patient); HEALTH CARE AT THE CROSSROADS, *supra* note 12, at 10.

79. *See* Levinson, *supra* note 35, at 557-59 (discussing results of study indicating that primary care physicians who had had no legal claims against them by patients used facilitative comments, oriented their patients, showed empathy, elicited patient's views, and spent slightly more time); Gerald Hickson, et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 J. AM. MED. ASS'N, 1359, 1363 (1992).

Health care organizations, liability carriers, and policy groups, sometimes in conjunction with conflict resolution professionals, have developed a number of interesting models to carry out these principles. We see them in an academic medical center, a community health system, government providers of health services, a staff model HMO, physician-owned insurance carriers, and a liability carrier.[80] Each model calls for an early conversation covering the above-described points, preferably within hours and certainly within a week.[81] This practice is applied to any disappointment with outcome, regardless of severity, harm, or fault.[82] Most models include early

80. Sheri Hall, *U-M Docs Say Sorry, Avert Suits*, THE DETROIT NEWS, May 12, 2004, *available at* http://www.detnews.com/2004/business/0405/12/c01-150576.htm (discussing the disclosure and apology policy within the University of Michigan Health System); Children's Healthcare of Atlanta, *For Professionals: CME Online: Disclosure of Unanticipated Events Online Module*, *at* http://www.choa.org/default.aspx?id=1656 (explaining the disclosure policy at Children's Healthcare of Atlanta in a continuing medical education course) [hereinafter Children's]; Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANNALS OF INTERNAL MED. 963 (1999) (discussing the approach taken at the Lexington, Kentucky Veteran's Administration Hospital); Carole Houk, *The Internal Neutral: Why Doesn't Your Hospital Have One?*, MEDIATE.COM, June 2002, *at* http://www.mediate.com/articles/houk.cfm (Feb. 27, 2005) (discussing the use of an internal neutral at the National Naval Medical Center in Bethesda, Maryland); Telephone interview with Carole Houk, Carole Houk and Associates (June 2003) (discussing the internal ombudsperson/mediator model at Kaiser Permanente); June Riley, *Code Green: What Is It and How Can It Help You?*, PRF NEWS (Physicians Reimbursement Fund, Inc., San Francisco, Cal.), Dec. 2004, at 7 (discussing the model employed by Physicians Reimbursement Fund); *Success Stories*, COPIC'S 3RS PROGRAM (COPIC Insurance Company, Denver, CO), Oct. 2004, at 2, *available at* http://callcopic.com/publications/3rs/vol_1_issue_2_oct_2004.pdf (explaining the parameters of COPIC Insurance Company's "3Rs" program to help physicians to "recognize," "respond" to, and "resolve" incidents) [hereinafter COPIC 3RS PROGRAM]; *Responding to Unanticipated Outcomes: A Vital Component of Patient Care*, CLAIMSRX (NORCAL Mutual Insurance Company, Risk Management Department, San Francisco, CA), July 2004, at 1-2, *available at* http://www.norcalmutual.com/information_center/claimsrx/jul_04.pdf (advising physicians to communicate with patients following an unanticipated outcome) [hereinafter CLAIMSRX, *Responding to Unanticipated Outcomes*]; *Responding to Medical Errors: Disclosure Is the Best Medicine*, CLAIMSRX (NORCAL Mutual Insurance Company, Risk Management Department, San Francisco, CA), Feb. 2001, at 1, *available at* http://www.norcalmutual.com/information_center/claimsrx/feb_01.pdf (discussing the benefits of disclosure and outlining recommended steps for physicians to take in disclosing adverse events) [hereinafter CLAIMSRX, *Responding to Medical Errors*].

81. *See* sources cited *supra* note 80; COPIC INSURANCE COMPANY, PARTICIPATION MANUAL FOR PHYSICIANS AND OTHER PROVIDERS VERSION 1.2 (2002) [hereinafter COPIC MANUAL V. 1.2]; Interview with George Lee, CEO, Physicians Reimbursement Fund, in San Francisco, Cal. (Jan. 2005). There are some exceptions; for example, the policy at the VA Hospital in Lexington calls for an event investigation before contacting the patient. Kraman & Hamm, *supra* note 80, at 967.

82. *See* sources cited *supra* notes 80 and 81. Some programs, however, handle differently any complaint where legal or licensing board processes have been initiated, or where the patient died.

discussions of payment for costs and none requires a waiver of the right to sue.[83]

Some treat this conversation as a team effort, while others consider it primarily the physician's responsibility. At some Kaiser facilities, the internal ombudsperson/mediator generally holds the conversations.[84] The model applied at the VA Hospital in Lexington, Kentucky also moves the task away from the treating clinicians by convening a meeting of the Chief of Staff and members of the risk management, legal, and quality management departments.[85]

Children's Healthcare of Atlanta's administration, risk management, nursing and physician leaders, and the attending physician plan the conversation and follow-up, and the attending physician generally speaks with the family alone.[86] NORCAL advises physicians to conduct the conversations and to consider when it would be helpful to draw on a team for preparation, as in the Children's model, or for the conversation itself.[87] COPIC and the Physicians Reimbursement Fund coach physicians; COPIC bifurcates the discussions so that the physician manages many aspects, and the carrier speaks about reimbursement.[88]

The program of longest standing is the most comprehensive, least cautious, and most true to conflict resolution principles. Physicians Reimbursement Fund, a San Francisco physician-owned carrier, was formed in response to malpractice insurance market pressures in 1976 and, from its inception, encouraged its insured physicians to act as patient advocates when harm occurs, building on their natural talents

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83. *See* sources cited *supra* notes 80 and 81.

84. Telephone interview with Carole Houk, *supra* note 80.

85. Kraman & Hamm, *supra* note 80, at 967.

86. Children's, *supra* note 80.

87. CLAIMSRX, *Responding to Medical Errors*, *supra* note 80, at 3, 7. NORCAL's educational materials also feature a number of conflict resolution techniques, including managing expectations; eliciting patients' understanding, questions, and reactions; acknowledging each person's emotion; restoring trust; and reliable continued contact. *See, e.g.*, CLAIMSRX, *Responding to Unanticipated Outcomes*, *supra* note 80.

88. COPIC 3Rs Program, *supra* note 80 (stating that COPIC reimburses future medical care and lost work time subject to limits, and claims representatives may assist in related tasks such as arranging for treatment or having medical charges written off); Interview with George Lee, *supra* note 81. Dr. Lee also joins or assumes responsibility for the conversation on request. *Id. See also* COPIC INSURANCE COMPANY, PARTICIPATION MANUAL FOR PHYSICIANS AND OTHER PROVIDERS VERSION 1.6, at 2 (2004).

as problem-solvers.[89] Physicians are asked to be forthcoming and to discover patients' interests, identifying the impact of the event and what would meet the interests, including paying costs incurred because of the harm, such as additional help to meet usual responsibilities.[90] Physicians are asked to give a full apology, including admitting error if accurate, for everyone involved in the care; they are counseled that sincerity is much more important than particular language.[91] The physician remains the primary contact, with the carrier consulting on financial decisions, and attorneys consulted even more rarely for discrete issues.[92]

In health care, the issue of apology and admitting fault is highly contested since admissibility is an open question. Skepticism about how patients will receive and use it abounds.[93] Laws protecting expressions of sympathy expressly continue to allow statements of fault into evidence, or are silent on the point, leaving that risk open.[94] A few recent laws protect apologies more broadly; Colorado and Georgia expressly protect admissions of error or fault in this context, while four other states protect "apology" but stop short of defining whether apology includes a statement of fault. [95]

In the world outside the courtroom, of course, it does. Scholars have stated, "[i]n order for an apology to be performed, the speaker must acknowledge responsibility for having committed some offending act, and he or she must express regret about the offense."[96]

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89. Interview with George Lee, *supra* note 81.

90. *Id.*

91. *Id.*

92. *Id.*

93. Gallagher, *supra* note 77, at 1004.

94. *See, e.g.*, CAL. EVID. CODE § 1160 (West 2004); MASS. GEN. LAWS ANN. ch. 233, § 23D (2004); TEX. CIV. PRAC. & REM. CODE § 18.061 (Vernon 2004).

95. COLO. REV. STAT. § 13-25-135 (2004); S.B. 3, 150th Gen. Assem., Reg. Sess. (Ga. 2005), *available at* http://www.legis.state.ga.us/legis/2005_06/fulltext/sb3.htm (last visited Apr. 1, 2005). This bill was signed into law by the Governor of Georgia on February 21, 2005. *SB 3 Bill History*, Georgia General Assembly, *at* http://www.legis.state.ga.us/legis/2005_06/sum/sb3.htm (last visited Apr. 1, 2005). The four states are Ohio, Oklahoma, Oregon, and Wyoming. OHIO REV. CODE ANN. § 2317.43 (Anderson 2005); OKLA. STAT. ANN. tit. 63, § 1-1708.1H (West 2004); OR. REV. STAT. § 677.082 (2003); WYO. STAT. ANN. § 1-1-130 (Michie 2004).

96. Steven J. Scher & John M. Darley, *How Effective Are the Things People Say to Apologize?: Effects of the Realization of the Apology Speech Act*, 26 J. PSYCHOLINGUISTIC RES. 127, 129 (1997). An apology includes an "illocutionary force indicating device" (e.g., "I'm sorry"), an "expression of

In studies comparing apologies of sympathy to apologies acknowledging fault, subjects attributed a range of positive qualities to the complete apology and they were more willing to accept a settlement offer.[97] Indeed, where injury was severe, the expression of sympathy was rated no better than saying nothing at all.[98] Further, some believe that the failure to combine remorse with an expression of empathy "exacerbates the very injury that prompted the disclosure."[99]

Given how extraordinarily few complaints actually reach a trial, it is more appropriate to focus on preventing claims or influencing settlement. These studies and others demonstrate or are consistent with arguments that the motive to sue is diminished when professionals take responsibility and attempt to put things right, both because anger is defused and because, absent a taking of responsibility, people tend to believe the bad act was the result of a character flaw and is likely to be repeated.[100]

The two disclosure programs with sufficient longevity to measure results both call for admitting any errors and both support the propositions that disclosure reduces the likelihood of litigation and leads to lower settlement costs:

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responsibility," an "offer of repair," and a "promise of forbearance." *Id.* at 129-31. Researchers found that offering any apology was most important, and that as each of these elements was added, people rated the apology more effective and the apologizer less worthy of condemnation. *Id.* at 137. *See also* Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55, 71 (2004) (stating that the "expression of sorrow and the admission of wrongdoing ... are essential, so that the absence of either renders the apology incomplete and interrupts its moral dimension.").

97. Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460, 479-80, 482-89 (2003). Subjects viewed the full apologizer "as experiencing more regret, as more moral, and as more likely to be careful in the future." *Id.* at 487. Subjects "expressed greater sympathy and less anger" and "indicated more willingness to forgive." *Id.* at 488. With a partial apology, subjects believed their own injuries to be worse. *Id.* at 497.

98. *Id.* at 495 ("[P]artial apology is (often) not different than no apology.").

99. Taft, *supra* note 96 at 72.

100. *See, e.g.*, Scher, *supra* note 96, at 128-30 ("When subjects rated a [person] who neither expressed responsibility nor made an offer of repair, they rated [the] apology as less appropriate, and they wanted to blame and punish [that person]."). *Id.* at 136. *See* Robbennolt, *supra* note 97, at 478, 498 (concluding that "observers may infer from an apology that the cause of the incident is less stable and, therefore, less likely to be repeated" and "an offender who failed to take responsibility in the apology (*i.e.*, offered a partial apology) in the face of strong evidence of responsibility was seen as less likely to be careful in the future"). *Id.* There are mixed results, however, in other studies of whether an apology reduces blame. Scher, *supra* note 96, at 139.

- In nearly all of Physicians Reimbursement Fund's concerns handled in this way, the average payment was just over $3,000. Only eight proceeded to a legal process, with one complainant having accepted a payment.[101]

- The Veterans' Administration in Lexington, Kentucky found that its average payout per claim dropped drastically after implementing this practice, so that it was in the lowest one-sixth of VA hospitals, and only eight claims proceeded to court.[102]

- COPIC and the National Naval Medical Center also report that none of the patients who participated in early intervention went on to sue or make a claim.[103]

Particularly when there is no apparent error or the harm is minor, an expression of sympathy may be appropriate, and studies show patients are receptive to such gestures in some circumstances:[104]

- COPIC, whose public documents advocate this type of apology, found that 592 concerns were handled by early and direct

101. Interview with George Lee, *supra* note 81. Physicians Reimbursement Fund handled about 32% of its completed cases in this manner. *Id.* The cases described were typical, and the average was $3,058; there were an additional eight such cases that settled for a much higher amount. *Id.* Since information about cases' severity is not readily obtainable, this Article will not include a comparison of the average settlement amounts. None of the dollar amounts in this Article are adjusted for inflation.

102. Kraman & Hamm, *supra* note 80, at 964; Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1453 (2000). The authors publish the numbers of claims and average claim payment before and after this approach, and correctly point out differences in the settlement values because of federal immunity and other factors. Kraman & Hamm, *supra*; Cohen, *supra*, at 1453-54. For those reasons, the per-claim amounts may not be relevant to the private sector, but the percentage drops certainly are. The experience reported in these articles spanned seven years; reportedly, subsequent experience has been consistent with these reports.

103. Telephone interview with Carole Houk, *supra* note 80; COPIC 3RS PROGRAM, *supra* note 80. These programs have been in operation for less than five years. Since the statute of limitations has not run in many instances, information about cases converting to legal claims and final settlement amounts can give a good indication but are not definitive.

104. Robbennolt, *supra* note 97, at 493; Scher, *supra* note 96, at 137 ("[T]he greatest improvement in perceptions came from…the offering of an apology, compared to no apology."). *Id.*

intervention; 232 of them concluded with no payment needed, and the average payout was $2,029.[105]

- The University of Michigan saw its number of annual lawsuits cut in half.[106]

- The most dramatic example comes from another industry. The Toro Company's practice of being forthcoming with injured customers and expressing sympathy for the injury led to its average payout dropping from $68,368 to $18,594.[107]

Regardless of approach, each of these programs saw major savings in legal costs and the time a claim is open:

- The University of Michigan's legal costs dropped from $3 million to $1 million per year.[108] Its average time to close a case dropped from three years to less than one year.[109]

- Physicians Reimbursement Fund paid an average of $586 for the usual early resolution case as opposed to an average of $19,541 for events that used any legal process.[110]

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105. COPIC 3RS PROGRAM, *supra* note 80. The claims numbers and dollar figures are from the program's inception in October 2000 through June 30, 2004. *Id.* The average payout figure indicated above is an average among all 592 qualifying incidents; among the incidents where a payout was made, the average payout was $5,177. *Id.* COPIC also publishes an average amount for all claims settled, an amount dramatically higher. Because injury severity is not identified in either category, these numbers are not compared here. Since Colorado passed its law protecting statements of fault, it may be that COPIC has adjusted its guidance about what type of apology to offer.

106. Hall, *supra* note 80. In 2001, the University had 260 pending complaints and lawsuits. Since instituting its policy of disclosure and apology in 2002, the number has fallen, with only 125 pending in 2004. *Id.*

107. Cohen, *supra* note 102, at 1461. Toro's program involves mediation, at which confidentiality agreements are signed to exclude statements from potential litigation, information is exchanged, an expression of sympathy is offered, and an offer of settlement is made. *Id.* at 1460-61. However, "while Toro commonly expressed sympathetic words, it appears that Toro typically did not apologize in the sense of admitting its own fault." *Id.* at 1460.

108. Hall, *supra* note 80.

109. *Id.*

- Toro's average legal costs dropped from $47,252 to $12,023 per claim.[111] Its average time to close a case dropped from two years to four months.[112]

Insurance premiums also dropped after adopting these practices. Toro indicates its insurance premiums were reduced by $1.8 million per year.[113] Physicians Reimbursement Fund says it is able to offer physicians—even those practicing in high-risk specialties such as obstetrics and gynecology, orthopedic surgery, and general surgery—premiums at an estimated 60% of market price.[114]

This data, of course, is an initial step in the robust examination needed for these practices. There can be reasonable questions about whether results would be equivalent in other markets and treatment settings, the comparability in situations of severe injury or blatant negligence, and the possibility of confounding factors.

Nevertheless, this much is clear: patients look to clinicians for this type of treatment as a part of their relationship and the creation of these programs is evidence that some clinicians, organizations, and carriers agree. Conflict resolution skills are key in effectively surfacing and aligning these interests in an emotion-laden situation.[115] These principles may be applied directly by the health care professionals, as in these examples, or in the context of mediation, which likely extends the time but adds the benefit of an impartial influence and heightened evidentiary protections that may

110. Interview with George Lee, *supra* note 81. The latter figure includes cases that went to mediation or arbitration. Even with eight cases handled by the early and direct method but settled at higher amounts, the average legal fee was $13,217, still well below the usual. *Id.*

111. Cohen, *supra* note 102, at 1461.

112. *Id.* at 1460-61.

113. *Id.* at 1461.

114. Interview with George Lee, *supra* note 81. An informal comparison appears consistent with this estimate. Other than newsletter education, there are no other specific programs aimed at lowering risk that would confound these numbers.

115. This often applies to clinicians as well as patients. Taft, *supra* note 96, at 89 & n.228 (quoting Martin L. Smith & Heidi P. Forster, *Morally Managing Medical Mistakes*, 9 CAMBRIDGE Q. HEALTHCARE ETHICS 38, 42 (2000) ("[I]n the aftermath of error, 'professionals often feel shame, humiliation, agony, anguish, devastation, panic, guilt, remorse, sadness, anger, self-doubt, and self-blame.'")).

give participants enough comfort to be forthcoming.[116] Demonstrated progress in a variety of measures, and the range of treatment settings and business models in which they are found, speaks to the likelihood that conventional wisdom is correct—that many people do not seek legal redress when the needs for doing so have already been met, and they settle for moderate amounts consistent with their injuries rather than seeking punishment.[117]

Other models, such as one developed as a component of The Project on Medical Liability in Pennsylvania, seek to integrate the disclosure conversation into a wider context.[118] It calls for widespread introductory training in conflict resolution skills, as well as developing a core group of staff—likely drawn from those known to be skilled problem-solvers and *de facto* and recognized leaders—to help others prepare for disclosure conversations, and to sometimes participate.[119] It encourages mediation before discovery, debriefing disclosure conversations, support for involved clinicians, and using information learned in these settings to improve patient safety.[120] Health Care Mediations has also designed a program that aligns physician, organization, carrier, and family interests, and integrates

116. *See, e.g.,* CAL. EVID. CODE § 1119 (West 2005) (making inadmissible any statements or admissions made in the course of mediation, or any writings prepared for mediation). *See also* admissibility protections in FED. R. EVID. 408 (excluding conduct or statements made in compromise negotiations as evidence of liability); FED. R. EVID. 407 (excluding subsequent remedial measures taken to mitigate harm caused by an injury as evidence of fault); FED. R. EVID. 409 (excluding payment or offer of payment of medical and other expenses related to an injury as evidence of fault).

117. Further support can be found in two mock trials conducted before two juries. The trials were identical except for the addition of evidence of a disclosure. The mock jury in the case with disclosure awarded millions less than the other jury. In contrast to the non-disclosure jury, which wanted to punish the organization for conspiring to hide information, the jury that heard about disclosure felt its duty was to compensate for actual losses. AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT, *supra* note 77, at 6. In another study, subjects wanted to seek legal advice under most scenarios (though it was least likely with a slight injury and full disclosure). Kathleen M. Mazor, et al., *Health Plan Members' Views About Disclosure of Medical Errors*, 140 ANNALS INTERNAL MED. 409, 413 (2004). This, of course, is distinguishable from whether they would proceed after this initial reaction, and whether they would seek compensation that matched or exceeded actual expenses, questions not answered in this study. *See id.* at 416-17.

118. Carol B. Liebman & Chris Stern Hyman**,** *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients*, 23 HEALTH AFF. 22 (2004).

119. *Id.*

120. *Id.*

patient safety operations.[121] It uses a collaborative process to design and implement organization policy. The program utilizes multiple methods and formats for physician skill development, emphasizing experiential learning, mentoring methods, and just-in-time materials. Likewise, nursing staff and administration workshops develop a team approach. Structures, including peer forums, tools for use in Morbidity and Mortality conferences, and debriefing difficult incidents, reinforce and deepen initial skills and provide much needed support for clinicians struggling with the experience.

In these examples, health care professionals are integrating conflict resolution techniques into these highly-charged legal and regulatory requirements to the benefit of restoring trust in health care and enhancing the patient-physician relationship.

III. USING AND ADAPTING TRADITIONAL DISPUTE RESOLUTION MECHANISMS

Health care has begun to adopt a range of dispute resolution methods to supplement its traditional power-based options. Innovative uses and proposals can be found in community hospitals, academic medical centers, pharmacies, medical practices, long-term care facilities, and government agencies delivering or overseeing health care. Several models combine features of different conflict resolution methods, and some incorporate practices thought to be outside a neutral's traditional role. Many approaches are designed as early intervention to preserve relationships among health care professionals or between them and their patients, and some address patient-provider litigated claims in a more balanced and individual-centered way.

A. Multiple Methods to Reach Agreements

Several hospitals use independent mediators in long-term projects and as an ongoing resource. A Southeastern academic medical center

121. Children's Healthcare of Atlanta has partially adopted this model. Telephone interview with Dale C. Hetzler, M.C.S.M., J.D., General Counsel, Children's Healthcare of Atlanta (Mar. 2004).

worked with Health Care Mediations to restore working relationships among physicians and nurses in four interrelated departments. The dispute resolution model involved pairing a nurse-mediator and attorney-mediator throughout, and employing facilitative mediation, conflict coaching, facilitation, training, and evaluative mediation at different points in the year-long intervention. Participants made collaborative decisions about resident training, implemented a multidisciplinary quality improvement committee to examine trends in outcomes, initiated a multidisciplinary mechanism to quickly review disagreements about individual patients, shared research resources, developed a consultation protocol, enhanced nurses' conflict resolution skills, set up structures for better information-sharing and collaborative problem-solving of operational issues, and laid the foundation for a culture emphasizing early and direct conflict resolution.

Ministry Health Care-St. Michael's Hospital, a non-union community hospital in Stevens Point, Wisconsin, employs another model in collaboration with Alternative Resolutions, Inc.[122] The hospital contracts with the group to provide conflict coaching or mediation for any employee on request or by referral.[123] Conflicts are typically among nurses or other staff within a work unit, or between an employee and a supervisor. Coaching can occur by phone and anonymously, if desired.[124] Several mediations are convened each month, and mediators often follow up to gauge effectiveness.[125] An agreement produced after an official referral is generally shared with human resources staff; otherwise, only statistical information is released.[126] The effort was a response to low employee satisfaction scores regarding the hospital's handling of conflict.[127] After one and

122. Telephone interview with Cheryl Stinski, President, and Karen Dorn, Vice President, Alternative Resolutions, Inc. (Jan. 2005).
123. *Id.*
124. *Id.*
125. *Id.*
126. *Id.*
127. *Id.*

a half years of the program's implementation, scores jumped from 25% to 47% satisfaction.[128]

A northern California community clinic used an independent mediator for a series of interventions combining mediation and facilitation, which targeted repairing rifts between different cultures and disciplines, including nurses, office staff, physicians, and management.[129] Wisconsin physician practices also worked with Alternative Resolutions to mediate disputes arising out of business and practice differences, the type of conflict research suggests is most prevalent and most troubling for physicians.[130] An intervention typically begins with an interview-based needs assessment, and might include a combination of mediation, facilitation, and conflict coaching, as well as subsequent evaluation of effectiveness through survey tools or a reconvened session.[131]

The District of Columbia Department of Mental Health provides direct client services and maintains a panel of independent "external reviewers" who offer mediation as an option for clients' treatment complaints.[132] In this model, an administrator receives a copy of the mediated agreement. If none is reached, a party may ask the external reviewer to issue an advisory opinion as a basis for a director's decision.[133]

B. Staff Models

The University of California at San Francisco employs various methods, including a peer mediation model.[134] Serving the medical center and the campus, the program is staffed full-time with an attorney-mediator who offers conflict coaching, team-building, and

128. Telephone interview with Cheryl Stinski and Karen Dorn, *supra* note 122.

129. Interview with Debra Gerardi, R.N., M.P.H., J.D., President & CEO, Health Care Mediations, Inc., in San Francisco, Cal. (Nov. 2004).

130. Telephone interview with Cheryl Stinski and Karen Dorn, *supra* note 122; Anderson & D'Antonio, *supra* note 8, at 16.

131. Telephone interview with Cheryl Stinski and Karen Dorn, *supra* note 122.

132. E-mail from Charles Bethel, Consultant, District of Columbia Department of Mental Health (Apr. 21, 2004, 19:53 PST) (on file with the author).

133. *Id.*

134. Telephone interview with Ellen Beilock, Mediation Officer, University of California, San Francisco (Jan. 2005).

facilitation for retreats or to reintegrate staff after difficult events polarize them.[135] The attorney-mediator also coordinates clinicians, administrators, and others who co-mediate intra-professional issues raised by any faculty, staff, or student.[136] The program also occasionally makes use of independent mediators.[137] Often disputes arise between different levels of power, or among faculty, and can focus on access to resources, research, and varied relationship issues.[138] Parties may opt to toll disciplinary and grievance processes during mediation.[139]

A different in-house model is found in a government hospital and a staff-model HMO—the National Naval Medical Center and some Kaiser Permanente facilities.[140] Each employs a clinician to respond within hours to patient complaints or indications of harm during treatment.[141] The clinician performs ombuds/investigatory work, acts as a liaison in solving problems, and conducts mediations on request.[142] When patients have been harmed, the clinician follows the principles of early intervention and full disclosure, and none of these patients filed suit.[143] This position is also intended to serve as a link between legal, patient safety, and clinical departments, so that information developed during conflict resolution can be used for systems learning.[144]

C. More Variations on Mediation

Some models combine in-house and external conflict resolution experts. The Center for Patient Partnerships, a patient advocacy center at the University of Wisconsin-Madison, uses interest-based principles in several patient advocacy practices, including the use of

135. *Id.*
136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.*
140. Telephone interview with Carole Houk, *supra* note 80.
141. *Id.*
142. *Id.*
143. *Id.*
144. *Id.*

interdisciplinary faculty and students to coach patients in conflict management principles to get their needs met through respect and mutuality, and accompanying patients to appointments to help with reframing the conversation.[145] When a facilitated meeting is called for, the Center's director and a director from the University of Wisconsin Hospital and Clinics work together to arrange and manage it.[146] In this model, their roles are both as advocates—one for the patient and one for the professional—and as process managers responsible for keeping the group faithful to interest-based principles.[147] They coach the participants in preparing to be effective, and they facilitate the meeting.[148] In another setting, Creative Mediation, a community mediation center, and Medical Dispute Professionals propose a model drawing on community mediators, attorney- and physician-mediators, and trained hospital staff to mediate patient-provider conflict both early and after legal or licensing board complaints have been filed.[149]

D. Early Mediations With Independent Mediators

California physician practices have called on a physician-mediator to mediate patient-physician conflicts concerning treatment and the care experience before any of the patients initiated litigation.[150] One advantage of such early intervention is that there must be a written demand for money before a National Practitioner Data Bank report is required, so agreements achieved absent any written demand preserve physicians' strong interest in reducing such reports.[151] The conflicts involved missed diagnosis, treatment failures, inadequate or untimely provision of information, failure to transfer a patient, and

145. Telephone interview with Martha Gaines, *supra* note 15.

146. *See* Martha E. Gaines & Sue Sanford-Ring, *Alchemy: Medical Mediation at its Best*, FOCUS ON PATIENT SAFETY (National Patient Safety Foundation, North Adams, MA), 2004, at 1, 3.

147. Telephone interview with Martha Gaines, *supra* note 15

148. *Id.*

149. Telephone interview with Marc Lebed, *supra* note 23.

150. *Id*.

151. Cynthia Grubbs, Strategies in Reporting to the Data Banks, Remarks at American Health Lawyers Association teleconference (May 1, 2003).

abandonment of the relationship.[152] In several cases, the patient continued to receive the physician's care after reaching resolution in mediation.[153]

Independent mediators have been used or proposed for disputes as diverse as safety and health issues for seniors, pharmacy errors, reintegrating nursing staff after a damaging strike, pharmaceutical intra-team issues, ethics and compliance issues in clinical research, coordinating bioterrorism response, and differences between medical staff and governing boards.[154]

E. Novel Approaches With Litigated Claims

Several innovative approaches to managing and settling litigated claims have also been taken. At Children's Healthcare of Atlanta, a community health system with teaching as part of its mission, the legal department promotes early, respectful contact and emphasizes continued relationships, openness with discovery, and frequent use of mediation or other non-adversarial methods.[155]

In cooperation with a physician carrier, CHORDA Conflict Management is implementing a model in Texas hospitals that is structured with a series of interest-based options.[156] Independent mediators coordinate the program, including providing patient ombuds services, conflict coaching, and facilitation.[157] Risk

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152. Telephone interview with Marc Lebed, *supra* note 23.

153. *Id.*

154. John Bertschler, Remarks at the 2005 Georgia State University Law Review Symposium (Feb. 15, 2005); Interview with Debra Gerardi, R.N., M.P.H., J.D., President & CEO, Health Care Mediations, Inc., in San Francisco, Cal. (Mar. 2003); Telephone interview with Debra Gerardi, *supra* note 62; Leo Hura, *Mediation of an Internal Corporate Pharmaceutical Construction Project Dispute During Software Qualification*, *at* http://www.mediate.com/articles/huraL1.cfm (Mar. 2004); Leonard J. Marcus, *Bioterrorism Preparedness and Conflict Resolution: Adapting What We Know to What We Learn*, ACRESOLUTION, Spring 2003, at 23, 25; American Medical Association, *Policy H-225.979: Hospital Medical Staff Relationships-Dispute Resolution*, *at* http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/ HnE/H-225.979.HTM] (last visited Feb. 27, 2005).

155. Dale C. Hetzler, *Superordinate Claims Management: Resolution Focus From Day One*, 21 GA. ST. U. L. REV. 891 (2005).

156. Telephone interview with Karl Slaikeu, CEO, Chorda Conflict Management Services (Nov. 2004).

157. *Id. See Products and Services*, CHORDA Conflict Management Services, *at* http://www.chorda.com/ProductsServices.htm (Feb. 27, 2005).

management staff members who are trained in conflict resolution skills negotiate with patients.[158] The next option is a panel of attorneys, paid by the hospital, who agree to represent the patient only in mediation or interest-based negotiation.[159] Discovery is either postponed or limited and conducted cooperatively.[160] Parties retain their rights to litigation using attorneys other than the advocates in mediation and negotiation.[161] There are consultations between these attorneys at an early stage, but the general tenor is encouraging collaboration and settlement.[162]

At Rush-Presbyterian-St. Luke's Medical Center, a Chicago academic medical center, after much discovery has been completed and exposure is determined, hospital and patients' counsel choose two persons from a panel of trial attorneys and judges to serve as a co-mediator team.[163] One of the individuals is from the plaintiff's bar while the other is drawn from the defense bar.[164] Sometimes the Center uses a single mediator.[165] They use an evaluative, caucus-based method to facilitate negotiations of financial aspects.[166] If settlement is reached, the hospital often apologizes.[167] There are substantial benefits to the organization, with estimates that defense costs have been reduced by half.[168]

CONCLUSION

With the realities of complex organizational structures, the marketplace, technological advances, and biological variability, health care is a field characterized by constant adaptation to change,

158. Telephone interview with Karl Slaikeu, *supra* note 156.
159. *Id.*
160. *Id.*
161. *Id.; see generally About Two-Track*, CHORDA Conflict Management Services, *at* http://www.twotracklawyers.com (last visited Feb. 27, 2005).
162. Telephone interview with Karl Slaikeu, *supra* note 156.
163. Max D. Brown, *Rush Hospital's Medical Malpractice Mediation Program: An ADR Success Story*, 86 ILL. B.J. 432, 432-40 (1998).
164. *Id.*
165. *Id.*
166. *Id.*
167. *Id.*
168. *Id.*

and dispute resolution mechanisms must adopt this characteristic if they are to fulfill their value for the field. Creativity has generated contributions to culture change. It has led to the integration of conflict resolution techniques and values into operations and legal and regulatory mandates. Traditional and hybrid applications can be found in a host of health care delivery and oversight settings and creativity has spurred a number of unique partnerships in designing and accomplishing this work.

The projects and models described are merely representative of the variety of innovative work taking place in the field. This Article is meant to stimulate thinking about the synergy between health care organizations and dispute resolution professionals, and to prompt further discussion about successful projects and greater possibilities.