FEATURE

CONFLICT RESOLUTION IN HEALTHCARE

by Pam Marshall, RN, LLB, LLM (ADR), Rob Robson, MDCM, FRCP(C)

Mankind always sets itself only such problems as it can solve; since, looking at the matter more closely, it will always be found that the task arises only when the material conditions for its solutions already exist or at least are in the process of formation.

– Karl Marx

Karl Marx was an astute social critic: he suggested that problems do not tend to be noticed or taken seriously until the possibility for their resolution is also available. Now, while it may be true that a variety of solutions exist for the resolution of a whole range of disputes, many people need help in fitting and fashioning those solutions to the disputes in hand.

Traditionally, people have turned to the law as the favoured forum and lawyers as the preferred players. However, participants often become disillusioned with lawyers and the cost of legal services and have sought alternatives. The use of more appropriate methods of dispute resolution (mediation facilitation) has been well received in many fields such as family law, commercial disputes and even criminal law.

In healthcare, the use of appropriate dispute resolution (ADR) has been slow to take hold; however, there are some positive signs on the horizon. A number of programs and processes are in place and others will surely follow. This article outlines why ADR is well suited to resolve healthcare disputes, identify some of the unique characteristics of healthcare and review some of the current uses of ADR, emphasizing the Canadian context.

Why ADR in Healthcare?

The simple answer is found in the recognition that the conflict resolution methods used to date have largely failed. By and large, these methods have been variations on an adversarial theme, with the result that many parties, including patients, have been left out of the process.

Most healthcare facility risk management efforts adopt the classical "self-protective" stance encouraged by the insurance industry. While concern with the institution's "bottom line" is not unreasonable, in most cases this approach results in practices that alienate patients and their families, creating major barriers to effective communication.

Multiple avenues to make formal complaints exist for those unhappy with their experiences in the healthcare system. These processes are often agonizingly slow, generating more distrust and skepticism. It is cold comfort to a patient to learn many months or years after the fact that a regulatory body finds some credence in their complaint.

Finally, there has never been evidence to support the concept that medical malpractice litigation can serve as a positive force to improve care. On the other hand, there has been ample documentation of the slow, costly and uneven nature of justice at the end of a lawsuit relating to healthcare outcomes.

All is not lost! Some hospitals have consciously adopted the so-called "humanistic" approach to risk management, and others have given real power to in-hospital ombud positions. Gradually, healthcare facilities are learning about the advantages of using trained mediators. Some liability

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providers have even "experimented" with "early intervention ADR" in potential litigation situations.

The problem with most adversarial methods for dealing with conflict in healthcare is that they ruin relationships. In order for the healthcare system to work effectively, strong and respectful relationships must be developed and nurtured between providers and patients and their families. As well, most care is now provided by multidisciplinary teams, whose optimal functioning requires fair treatment of all team members and solid relationships based on mutual respect.

What's Special About Healthcare?

There are several characteristics specific to healthcare that help to generate misunderstandings and conflict.

Healthcare is a classic example of a complex adaptive system (CAS). Such systems are prone to generate errors on a regular basis; they are also capable of achieving innovation if the correct conditions are created. Since the type of service that healthcare systems provide involves the health/sickness of individuals, it is essential to understand the systemic causes of error to prevent and respond to it whenever possible.

Secondly, the complexity of the healthcare system means that misunderstandings and conflict usually occur at multiple levels at the same time. Mediators may easily overlook some of the important parties in a given dispute. For example, the physician who treats the patient may also have defined administrative duties, additional academic/teaching duties in the broader community and a political involvement in the healthcare system. It would be very surprising if all of these activities were perfectly aligned; indeed, competing priorities will frequently be experienced by virtually each member of a team that provides care.

An additional characteristic of the healthcare system involves the wide disparity of knowledge, power and control experienced by the various players. This is a good example of "negotiating at an uneven table." While most conflicts involve some disparity between parties, it is unusual for this to be as markedly institutionalized as is the case in healthcare. A neutral involved in assisting parties to resolve a healthcare dispute must understand and address these dynamics to enhance the potential for a fair and enduring outcome.

Healthcare typically presents as a fascinating cultural mosaic in several ways. The ethnic diversity of both consumers and providers of healthcare services in many communities is striking and can generate potential barriers to neutrals seeking to help parties create solutions. As well, there remain strong gender inequities in terms of the services offered, the research done and the treatment of many providers. However, the ultimate cultural challenge in healthcare often goes unrecognized. This is manifested in the widely divergent professional culture of many of the providers who look at patients and their problems in often contradictory ways. The influence of this level of cultural diversity is often overlooked.

Finally, healthcare involves people interacting with other people to repair and preserve the health and personal integrity of patients. Often this involves issues about which people may have strongly held personal or religious values that may seem to be, and often are, irreconcilable.

Why ADR Can Help in Healthcare Disputes

It may be obvious to say that courts are not the place to try to resolve healthcare disputes. Anyone who has been involved in trying to resolve a dispute using the court system would attest to this fact. However, it is useful to identify the particular reasons why dispute resolution techniques are well suited to resolving healthcare conflicts. We will briefly outline four general principles that underlie ADR practice that we believe provide particular benefits in a healthcare setting.

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1. Timely and cost-effective resolution

Examples of costly, drawn-out legal battles are common. The only winners in these protracted situations are the lawyers. Using an interest-based collaborative approach allows parties to get to the points at issue and focus on moving forward rather than finding fault. In a recently mediated situation, the four-year dispute had generated legal bills in excess of $350,000. The matter was brought to resolution after a two-day mediation, and the cost to the facility was roughly $10,000.

2. Interests, not positions

When parties are in conflict, each focuses on its own position and is unable to see a clear solution that will allow everyone to get what they want. People naturally focus on their own needs and fears and are unable to recognize that it is possible for each person to be satisfied by the outcome. CR techniques allow all parties to express their issues and collaborate towards positive outcomes.

3. Maintains relationships

In the language of conflict resolution, the notion of maintaining relationships is captured by the well-known phrase "separate the people from the problem." It is an apt description and a valid approach that works for most conflicts but is particularly useful in a healthcare situation in which people may be dealing with deeply rooted ethical issues such as end-of-life decision-making or abortion.

4. Confidentiality

Healthcare situations are filled with highly personal and traumatic issues that most people do not want to display publicly. Litigation is by its nature a highly public forum, and healthcare disputes often provide interesting fodder for TV and print media (i.e., the case of Sue Rodriguez, who fought to end her own life) Using ADR to resolve such conflicts would allow the parties to work together towards a resolution while maintaining the dignity and privacy of such sensitive issues.[1]

Examples of the Application of ADR in Healthcare Conflict

ADR efforts to resolve conflict – by involving providers, consumers, facilities and governments outside of a contractual bargaining sphere – have mostly been limited to the last several years. Below is a brief overview of some of the activities that reflect the introduction of ADR activities in the healthcare field. We have organized each ADR activity according to when it occurs chronologically with respect to the conflict or dispute and suggest four rough categories:

1. Pre-conflict

This stage refers to efforts at prevention as typified by organizational conflict management (OCM) system design activities. This is truly the "new frontier," with relatively little reported activity.[2]

In the United States, some efforts at including elements of system design have been attempted, but they remain very elemental compared to the elaborate integrated systems that have been designed for, and embraced by, major industries.

In Canada, an effort at OCM systems design is underway at Humber River Regional Hospital in Toronto. A system design for a large urgent care clinic in Ottawa is presently confronting the issue of how to involve patients directly in the design and implementation piece.

2. Post-conflict – Early phase (within 1–2 months of incident)

This approach refers to very early interventions, within days or weeks of a specific incident's occurrence. We are not aware of any examples within Canada at the present time. In the United States there are three interesting examples, all of which show encouraging results.

The VA Hospital in Lexington, Kentucky, decided to change its risk management policy to a proactive, "humanistic" approach. This involved the hospital's contacting patients or their families *as soon as* it realized that a medical error had occurred. This usually happens within a few weeks of the incident. Typically, patients are astonished and grateful. The result of 10 years of experience shows an increase in the total number of claims brought against the hospital, but a significant decrease in total costs when compared to 35 other similar VA hospitals that continue to function in the more traditional "self-protective" risk management mode.

The main physician liability provider in Colorado undertook an experiment in *early intervention ADR* over a two-year period. In order to remain eligible for assistance, the 5,000 insured physicians must report any incident that may lead to a claim as soon as it is recognized. During the study, this led to direct face-to-face meetings between physician and patient (with an ADR-trained claims manager in attendance), usually within two weeks of the incident. More than 400 claims were processed with projected savings in excess of US$2.5 million. More importantly, physicians reported that previously unhappy patients were continuing in their practice and referring other family members once the problem was resolved.

Active efforts in the ICU at Stanford Medical Center to recognize conflict and to intervene early has led to many successful resolutions of problems ranging from disputes about visiting hours (rights-based disputes) to disagreements about end-of-life decision-making processes (value-based disputes). Often the resolutions occur "in the field," with the healthcare providers using skills learned through training sessions. Occasionally, third-party neutrals are required to help with more complex issues, although coaching is often sufficient.

3. Post-conflict – Mid phase (2–6 months post-incident)

An innovative program at the College of Nurses of Ontario (PRP – Participative Resolution Program) was devised in 1994 and refined by one of the authors over the next few years. The

PRP has operated successfully for more than eight years and has resolved more than 300 complaints concerning nursing care brought by patients, families, co-workers or facilities. The process can be relatively informal for minor issues or may involve a traditional mediation or shuttle diplomacy approach. The PRP does not mandate that the parties have an in-person meeting, nor is the nurse required to admit liability or fault for the process to proceed.

Two large teaching hospitals have recently established CR programs, primarily involving efforts to resolve conflicts between providers within the institutions. At the Hospital for Sick Children in Toronto, a full-time staff member coordinates the program. In Winnipeg, the Health Sciences Centre program is coordinated by senior staff in the facility, with mediation and training services contracted to a private CR services provider. In the three-year period covered by the program, more than 250 cases were accepted, with full resolution of 80 per cent. There is an effort to provide training and education services to physicians, and some of the conflicts have included disagreements between physicians and other staff.

4. Post-conflict – Late phase (more than 6 months post-incident)

Some interesting US examples have been reported. An active program to resolve complaints about physicians in Massachusetts has been underway for several years. While there are significant statutory constraints on the program, it has involved face-to-face meetings between physicians and patients, with positive results.

A malpractice mediation program has been underway for several years at Rush–Presbyterian–St. Luke's Medical Center in Chicago. The program focuses on indefensible malpractice litigation cases and routinely involves face-to-face mediations with patients and providers/facilities. Co-mediation is common. More than 50 cases have been processed, with the largest settlement in excess of US$5 million. The mediation may result in apologies and changes in programs to respond to patients' concerns. At the time of the program's inception, this was an unusual and arguably courageous approach for a large hospital system.

In Canada, there has been reluctance to use CR techniques in the field of malpractice litigation. Physicians are represented by the CMPA, which participates in very late-stage settlement conferences (usually pre-trial). These do not involve plaintiffs and deal only with monetary considerations.

A survey in 2001 indicated that 15 out of 20 medical and nursing licensing/regulatory bodies were using some form of ADR to address complaints against their members. In most cases this was done informally, through telephone or correspondence "shuttle" discussions, and usually occurred in the late phase (more than six months post-incident). In the case of large provinces, informal approaches such as these involved several hundred complaints a year. With one exception, in-house staff provided the services. It was generally unusual for patients or complainants to be active participants in the process.

In the mid-1990s, the College of Physicians and Surgeons of Ontario (CPSO) developed a formal ADR program that dealt with more than 200 cases. The program encountered some significant problems, and changing priorities within the CPSO led to its cancellation in 1998, effectively removing patients from the resolution process.

Conclusion

There is undoubtedly more conflict resolution work being done in the healthcare realm, but it is rarely reported in a form that is accessible to other CR practitioners. While confidentiality concerns provide one valid reason for this hesitation, there are clearly ways of describing processes and experiences to allow others to learn from our activities. This shared learning is crucial if we are to move forward.

As we have discussed throughout this article, while healthcare disputes have certain characteristics that are unique and challenging, the methods used to resolve them can be adapted from the tried and true approaches that ADR provides. Using collaborative and facilitative approaches, focusing on interests and remembering the importance of maintaining relationships will allow for positive, cooperative and long-lasting solutions.

Our treatment recommendation is a prescription that, if taken as directed, will ensure healthy outcomes for healthcare problems.

Notes

1 We recognize that all resolutions must be made in accordance with all applicable legal requirements and provisions. However, ADR solutions can be both confidential and within legal parameters. Some critics of ADR have questioned the private nature of DR outcomes and favour the public nature of legal processes; this debate is outside the scope of this article.

2 Much importance is attached to the qualifier *"reported,"* since there is undoubtedly more happening than we are able to uncover – reflecting a major failure of CR practitioners not to share their experiences in a written or otherwise accessible form.

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After quoting extensively in its judgement from Furrow's article, the trial court in *Halkyard* stated:

> I am satisfied on the basis of the evidence I have heard and the cases and articles I have read that Dr. Mathew was not obligated to disclose to Mrs. Halkyard his personal medical history. According to Dr. Mathew and his own doctors, by reason of the letters put in evidence, the medication he was on kept his epilepsy under control. There was no epileptic seizure in the operating room at the time of the surgery he performed on Mrs. Halkyard. *It is the duty of Dr. Mathew's personal physician to determine whether Dr. Mathew can continue doing surgery. It is also the duty of the hospital to determine whether Dr. Mathew or any other doctor performing surgery in its hospital can continue his or her practice in that hospital if the doctor, for whatever reason, is not capable of performing surgery. It is also the duty of any doctor to determine if he or she can continue their medical responsibilities when a physical or mental incapacity exists.* [Emphasis added][14]

Another commentator argues: "[t]he privacy rights of the physician about his or her own health must also be considered along with the potential for discrimination against persons with illnesses or disabilities that do not, in reality, pose a risk to the patients' health.[15] She proposes that

> [t]he most satisfactory resolution is to continue to require disclosure of "material" and "special risks" that are referable to the treatment itself. A patient is entitled to assume his or her physician is competent and skilled and will perform to the standards of the profession. Only if a physician's personal factors actually intervene in the treatment and cause injury to the patient, is an action in negligence an appropriate avenue for addressing liability.[16]

… there is currently no duty on a physician to disclose his or her medical condition where such medical condition does not pose a material risk to the treatment being provided by the physician. A duty may be imposed and liability in negligence may arise where there is a causal connection between the medical condition of the physician and the harm caused to the patient.

It appears that a proper application of basic negligence principles dictates the same results favoured by the policy commentators above. Negligence requires a duty, a breach of that duty and a causal link between the breach and the ensuing harm. If these criteria are applied to informed consent cases involving medical risk factors of healthcare providers, then there will be a basis for liability only where the risk of harm is objectively reasonable and where that risk materializes into actual harm. This approach appears to satisfy policy considerations by providing an appropriate balance between the privacy rights of healthcare providers and the patients' right-to-know.

Notes

1 *Halkyard v. Mathew* (1998), 231 AR 281 (QB), aff'd (2001), 277 AR 373 (CA) [hereinafter *Halkyard*].

2 *Ibid.*, at para. 9.

3 *Reibl v. Hughes*, [1980] 2 SCR 880 at 890 [hereinafter *Reibl*].

4 *Ibid.*

5 *Hopp v. Lepp*, [1980] 2 SCR 192 at 210 [hereinafter *Hopp*].

6 *Ibid.*

7 *Halkyard*, *supra* note 1, at para 18.

8 *Arndt v. Smith*, [1997] 2 SCR 539 [hereinafter *Arndt*].

9 *Ibid.*, at 554.

10 *Reibl*, *supra* note 3, at 900; as affirmed in *Arndt*, *ibid.*, at 547.

11 *Halkyard*, *supra* note 1, at para. 11.

12 *Halkyard*, *supra* note 1, at para. 9.

13 Barry R. Furrow, "Must Physicians Review Their Wounds" (1996), 5 *Cambridge Quarterly of Health Care Ethics*, at p. 211.

14 *Halkyard*, *supra* note 1, at para. 18.

15 Brenda Johnson, "Recent Decisions: Must Doctors Disclose Their Own Personal Risk Factors: Halkyard v. Matthew" (2001), 10 *Health L. Rev.* No. 1, at para. 16.

16 *Ibid*., at para 18.

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