

2007 SYMPOSIUM REPORT

**An Intentional Conversation About
Conflict Resolution in Health Care**

Held November 8–10, 2007 in Saint Paul, Minnesota

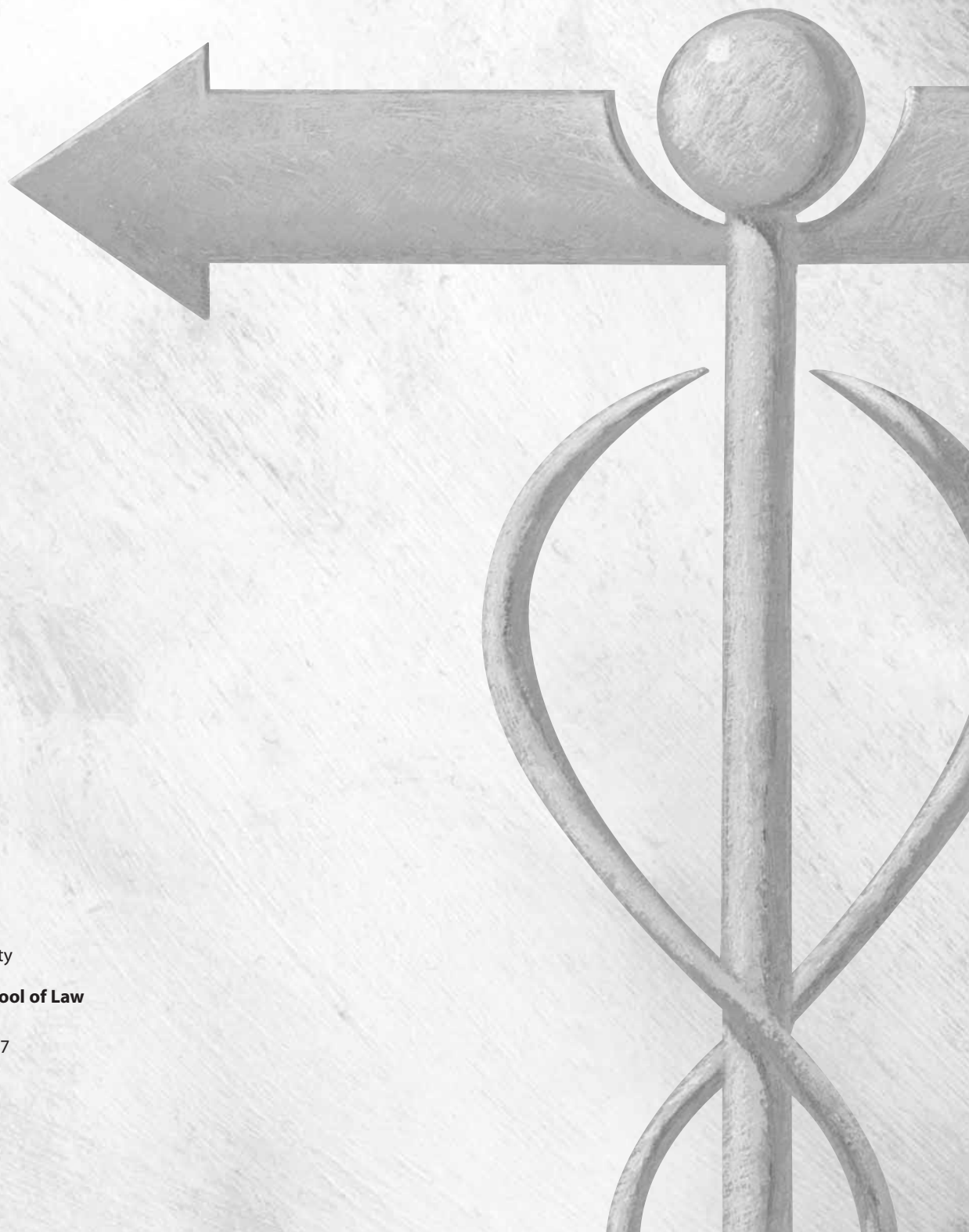
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An Intentional Conversation About Conflict Resolution in Health Care

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Hamline University School of Law

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PREFACE

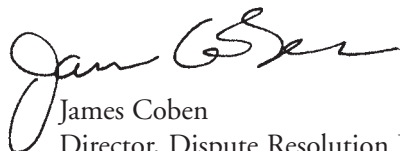
This report summarizes the conversation that occurred and the principles that evolved from the symposium, *An Intentional Conversation about Conflict Resolution in Health Care*, held on November 9–10, 2007 at Hamline University in St. Paul, Minnesota. The Symposium on Advanced Issues in Dispute Resolution was inaugurated in 1999. Its purpose is to bring together scholars and professionals to engage in purposeful conversation around critical issues in the field of conflict studies and dispute resolution.

Symposium sessions are facilitated by carefully selected theme leaders who provide expertise and promote participative dialogue of all attendees. Proceedings are published in the *Hamline Journal of Public Law & Policy*.

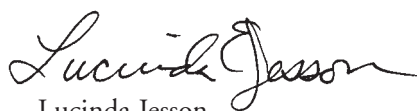
The symposium began with an introductory session, *Building a Context for Conversation: What Makes Health Care Conflicts Different?* Next, recognizing the wide variety of health care disputes, the conversation turned to separate sessions on three types of health care disputes. Each session opened with remarks by leading academic and health care professionals (our “theme leaders”), then turned either to a discussion by the full group or to small group discussions. Session two addressed patient care disputes, particularly disputes related to medical errors and end-of-life decision making. Session three focused on payor disputes and the challenges involved in navigating the health coverage maze while session four addressed provider competency. The final session was a first attempt at synthesis and naming the common themes that reverberated throughout the symposium.

In this report, we first reflect the conversation, specifically addressing the points of consensus and sources of tension in each session. These are complex issues. Understanding the conversation is instrumental to understanding the principles that, after several months of reflection and fine-tuning, evolved. Those Guiding Principles for Creation of Dispute Resolution Systems in Health Care are summarized at the end of this report.

But continued conversation, not just a laminated one page list of principles, is the key to developing an improved dispute resolution system in health care. The symposium participants—composed of health care providers, payors, regulators, recognized patient representatives, attorneys, and experienced conflict resolution professionals—made this event an important part of that continued conversation. We thank them for their participation. We also thank Rob Routhieaux, associate professor at the Graduate School of Management and Barbara Colombo for their writing and editing assistance. We welcome you to read and learn from our collective experiences.



James Coben
Director, Dispute Resolution Institute,
Hamline University School of Law



Lucinda Jesson
Director, Health Law Institute,
Hamline University School of Law

SYMPOSIUM BACKGROUND AND OBJECTIVES

The American health care system affects every man, woman, and child in our country. It encompasses over 16% of our Gross Domestic Product. Costs of care continue to rise and insurance premiums routinely increase at double-digit rates. Regulators and health care managers impose policies that affect medical decisions and access to treatment. Advertising and Internet research drive patient medical requests while the threat of malpractice claims impacts physician judgment and decision making. Ultimately, fewer Americans can afford the high price of health services and many feel disengaged from crucial health and life decisions.

At the same time, we hold on to important myths about our system: that doctors and patients are still in charge of our medical decisions; that the American system promotes egalitarian principles of fairness and open access to the finest care in the world; that individual citizens have real choices about the management of their health; and that health care professionals work collaboratively. This intractable clash between myth and reality has consumed policy-makers and fueled conflict at many levels for years.

This clash between myth and reality is even more complex in light of our rapidly changing society. Health care decisions are influenced by different and competing value systems: an increasingly diverse and aging population of patients; a growing universe of traditional and non-traditional health care providers; the ever-expanding role of third-party payors; suppliers promoting rapidly changing technologies and marketing directly to patients; policy-makers who promote increasingly divided ideologies and regulators caught in the middle. The result is an overwhelmingly complex set of challenges that provoke conflict at all levels.

How do we move forward? How can professionals from the conflict resolution field be constructive partners with health care professionals in working through these many difficult and complex conflicts? The 2007 Symposium on Advanced Issues in Dispute Resolution addressed these two questions.

Recognizing that the system cannot be easily “fixed” or the problem “solved,” the Symposium specifically focused on how health care professionals and conflict resolvers can work together to identify essential guiding principles for addressing conflicts across the health care field. The Symposium brought nationally recognized representatives of patients, health care providers, payors and regulators together with experienced conflict resolution professionals to identify and articulate a key set of principles for responsible decision-making in health care conflicts.

SYMPOSIUM THEME LEADERS



James Coben

James Coben is a professor of law and director of the Dispute Resolution Institute at Hamline University School of Law. He teaches civil procedure and a variety of law school dispute resolution courses and directs Hamline's international ADR programs in Rome, London, and Budapest. He has published numerous ADR related articles and currently is the domestic mediation editor for the *World Arbitration & Mediation Review*, and is co-authoring the third edition of *Mediation: Law Policy & Practice* (West Group, forthcoming late 2008). Together with Professor Peter N. Thompson, he has created the Mediation Case Law Project—a systematic attempt to catalogue litigation trends about mediation, as well as produce and distribute innovative teaching videos, and other resources to ADR academics, practitioners, and trainers. Between 1999 and 2005, Coben was a member of the Minnesota Supreme Court's ADR Review Board, charged with regulating the performance of court-appointed neutrals. He also is a past chair of the ADR Section of the Association of American Law Schools.

John Conbere

John Conbere, EdD, is associate professor and chair, Department of Organization Learning and Development at University of St. Thomas. His teaching and consulting interests include conflict management, cross-cultural conflict, integrated conflict management systems, mediation, and managing organizational change. His research has involved the design and implementation of governmental conflict management systems, studies of educational programs that create transformational learning for physician leaders, and the effects of culture on organizational conflict and change in Ukraine. With a variety of scholarly publications behind him, he is also a member of the Academy of Human Resource Development, the Academy of Management and the Organization Development Network, and he was on the Board of Directors of the Association for Conflict Resolution. Prior to his work in academia, he served as Deputy Director of the Conflict Prevention and Resolution Center at the U.S. Department of Agriculture. Each year he teaches a course on conflict management at National University Kyiv-Mohyla Academy in Kiev, Ukraine. He is on the Fulbright Senior Specialist roster.

Mary Foarde

Mary P. Foarde is the general counsel and corporate secretary of Allina Hospitals & Clinics. Prior to her appointment as general counsel in February 2003, Foarde served Allina as vice president and deputy general counsel for seven years. She has been with

Allina or one of its predecessors since 1989. Prior to her employment with Allina, she was a partner in the Minneapolis law firm of Maslon, Edelman, Borman & Brand. She is an active member of both the Health Law Section of the Minnesota State Bar Association and the American Health Lawyers Association, and has been a frequent lecturer at continuing legal education seminars on various health law topics. Foarde earned a JD cum laude from the University of Minnesota School of Law and a bachelor of arts from Creighton University, Omaha, Nebraska.

Ken Fox

Ken Fox is the university-wide director for conflict studies at Hamline University in St. Paul, Minnesota. Professor Fox teaches and works with Hamline's Graduate Schools of Public Administration, Management and Education, the Undergraduate College of Liberal Arts, and the School of Law, bringing an interdisciplinary approach to the study of conflict and constructive conflict response. He works closely with the School of Law's Dispute Resolution Institute and negotiation moot court program. Fox is a nationally known mediation teacher, trainer, and presenter. He is active in the dispute resolution professional community, serving on state, national and international boards, committees and grant-funded projects. He has designed dispute resolution programs and systems for electric utilities, state and federal agencies, courts, schools, and universities. He serves on a select national roster of trainers for the United States Postal Service's nation-wide REDRESS workplace mediation program.

Debra Gerardi

Debra Gerardi is chair of the Program on Healthcare Collaboration and Conflict Resolution in the Werner Institute for Negotiation and Dispute Resolution at Creighton University School of Law, where she also serves as an adjunct professor of law. Gerardi is a registered nurse with twenty-five years of experience in health care. She maintains a private consulting practice providing mediation/facilitation services, systems design and conflict management training programs for health care organizations internationally. Her mediation experience includes complex multi-party disputes, organizational mediation, civic dialogue facilitation, and community mediation. She has trained more than 5,000 professionals in conflict management, negotiation, creativity, and communication skills. Her clients include the World Health Organization, the American Medical Association, Kaiser Permanente, UCSF Medical Center, Stanford Hospital and Clinics, the Oregon Patient Safety Commission, the American Medical Group Management Association, and the Association

of Critical Care Nurses. As a professional improvisational comedienne, Gerardi has performed at various venues including the Comedy Store and the Upfront Comedy Club in Los Angeles and the Bay Front Comedy Theater in San Francisco. She has trained performers and non-performers in creativity, team-building, and conflict management.

Barbara Hartwick

Barbara Hartwick is director of health and welfare benefits for Xcel Energy. She brings 27 years of experience in human resources, which has largely been spent in health, welfare, retirement, and compensation programs. Among other accomplishments, she has put in place several nation-wide programs for more than 10,000 employees and more than 8,000 retirees across the company's 10-state territory. Before she joined Xcel Energy in 2002, Hartwick served as director of employee benefits at Minnesota-based Allina Health System.

Diane Hoffmann

Diane Hoffmann has been on the faculty at University of Maryland since 1987. Her research interests include issues at the intersection of law, health care, ethics, and public policy such as advance directives, pain treatment, termination of life support, genetics, regulation of research, and of managed care. She was a primary author of Maryland's Health Care Decisions Act dealing with advance directives, surrogate decision-making, and guardianship for individuals lacking health care decision-making capacity. She has served as a member of a number of ethics committees including those at University of Maryland Medical Systems, the National Institutes of Health in Bethesda, and the VA Medical Center in Baltimore and is author of *A Handbook for Nursing Home Ethics Committees* published by the American Association of Homes & Services for the Aging (AAHSA). Her current research includes a study of the use of health related genetic tests in the court room and an article on the criminal prosecution of physicians for prescription of opioids.

James Jacobson

James Jacobson is senior vice president and general counsel of Medica Health Plans with responsibility for Medica's legal affairs, compliance, government relations, and public policy. Before joining Medica, Jacobson served for two years as Chief Deputy County Attorney for Hennepin County Attorney Amy Klobuchar. He supervised all civil litigation and other civil matters in that office, including representation of the Hennepin County Board and the Hennepin County Medical Center. He also has an extensive regulatory background, having worked for 13 years at the Minnesota Attorney General's Office. Jacobson served as manager of the Health Licensing Division, where he represented the Board of Medical Practice and other health licensing boards,

and manager of the Commerce Division, supervising legal services provided to the Department of Commerce. Before joining the Attorney General's Office, Jacobson clerked for three years for a federal district judge in Cleveland. He earned his JD from the University of Michigan Law School in 1984 and his undergraduate degree from Northwestern University in 1980.

Lucinda Jesson

Lucinda Jesson joined Hamline University School of Law in 2006 as an associate professor of law and director of the Health Law Institute. She teaches health law organizations and finance, comparative health law, food and drug law, public health law, and health law quality and liability. In private practice, before joining Hamline University School of Law, Jesson represented hospitals, clinics, and health care professionals through her practice, Jesson & Pust, P.A. Jesson also served as a frequent arbitrator and hearing officer in health care disputes. Prior to the start of Jesson & Pust, Jesson served as Chief Deputy Hennepin County Attorney (1999–2000), Minnesota Deputy Attorney General responsible for health and licensing (1993–1998) and as a partner with the national law firm of Oppenheimer Wolff and Donnelly LLP (1983–1993). While Deputy Attorney General she represented health care agencies and directed health care public policy for the Attorney General's Office.

David Matz

David E. Matz is the founder and director of the Graduate Program in Dispute Resolution at the University of Massachusetts Boston. He is also an active dispute intervener. Matz has focused his work on the techniques of mediation and negotiation, and on their relationship to the workings of organizations and courts. He has done this primarily in the United States and Israel. In the United States, he has led in the development and use of assessment tools for court mediators, trained mediators, judges, and engineers. In Israel, he was central in developing policy and practice for the Israeli Ministry of Justice and Supreme Court in integrating mediation into the judicial system. He has also applied these approaches to the peace talks between the Israelis and the Palestinians and he has worked extensively with Arab and Jewish groups, here and abroad.

Charity Scott

Charity Scott is professor of law with a joint appointment in Georgia State University's College of Law and J. Mack Robinson College of Business, Institute of Health Administration. She is also the director of the Center for Law, Health & Society at the College of Law. Scott teaches various courses on health care law and policy, bioethics, and tort law. She is a Faculty Fellow in Health Law with Emory University's Center for Ethics. Scott serves on the Board of Directors of the Public Health Law Association

Symposium Theme Leaders

as well as on the American Bar Association's Special Committee on Bioethics and the Law. She has served as chair of the ABA Health Law Section's Interest Group on Medical Research, Biotechnology, and Clinical Ethics and as chair of the Health Law Section of the State Bar of Georgia. She has published on a variety of health law issues, including antitrust and the health care field, medical ethics and the law, medical privacy, dispute resolution, and health policy.

Martin Stillman

Martin Stillman, MD, JD, FCLM, is a national educator of medico-legal issues. He delivers continuing education programs for health care providers (CME), lawyers (CLE), and other organizations such as the American College of Healthcare Executives and American Society for Healthcare Risk Management. Stillman currently practices internal medicine at Hennepin County Medical Center and is Assistant Professor of Medicine at the University of Minnesota Medical School. He graduated from the University of Minnesota Law School in 1993 and the University of Minnesota Medical School in 1997. Stillman brings his knowledge and expertise to both local and national organizations. He currently serves as president of the Minnesota Medical Alumni Society and co-chairs the Health and Safety Committee for the Herzl Camp Board of Directors. As a Board member of the American College of Legal Medicine (ACLM), he serves as chair of both the Membership and Young Leadership Committees. In 2001, Stillman developed and implemented the annual professional development luncheon conference at the ACLM annual meeting to formally enhance the development of those with training in law and medicine. In 2005, he was honored with an annual ACLM award for outstanding service to the College.

James Thompson

James N. Thompson, MD, is the president and chief executive officer of the Federation of State Medical Boards (FSMB) and a clinical professor of otolaryngology at the University of Texas Southwestern Medical Center. Prior to joining FSMB he served as dean and university vice president at Wake Forest University School of Medicine. Thompson is a graduate of the Ohio State University College of Medicine and Public Health and is certified by the American Board of Otolaryngology.

Barbara Tretheway

Barbara Tretheway serves as senior vice president and general counsel for HealthPartners, Inc., where she is the chief legal advisor to HealthPartners, its related organizations and their Boards of Directors. Tretheway is also responsible for the management and operation of the HealthPartners' legal department. Prior to joining HealthPartners, Tretheway was a principal

of the Minneapolis-based law firm of Gray Plant Mooty and chair of that firm's Health, Human Services and Nonprofit Organizations Practice Group.

Ellen Waldman

Ellen Waldman is a professor of law at the Thomas Jefferson School of Law. Waldman founded and supervises the school's mediation program, which affords students an opportunity to mediate disputes in small claims court. Additionally, she directs a government-sponsored grant that provides for student exposure to alternative dispute resolution techniques and mentoring within the ADR community. She is a former fellow at the Institute of Law, Psychiatry, and Public Policy in Charlottesville, Virginia and a fellow in the medical ethics department at the University of Virginia Medical School where she directed a grant awarded by the Virginia Institute for the Humanities to educate hospital staff and patients about patient rights and principles of biomedical ethics. Waldman speaks, trains, and publishes in the areas of mediation and medical ethics.

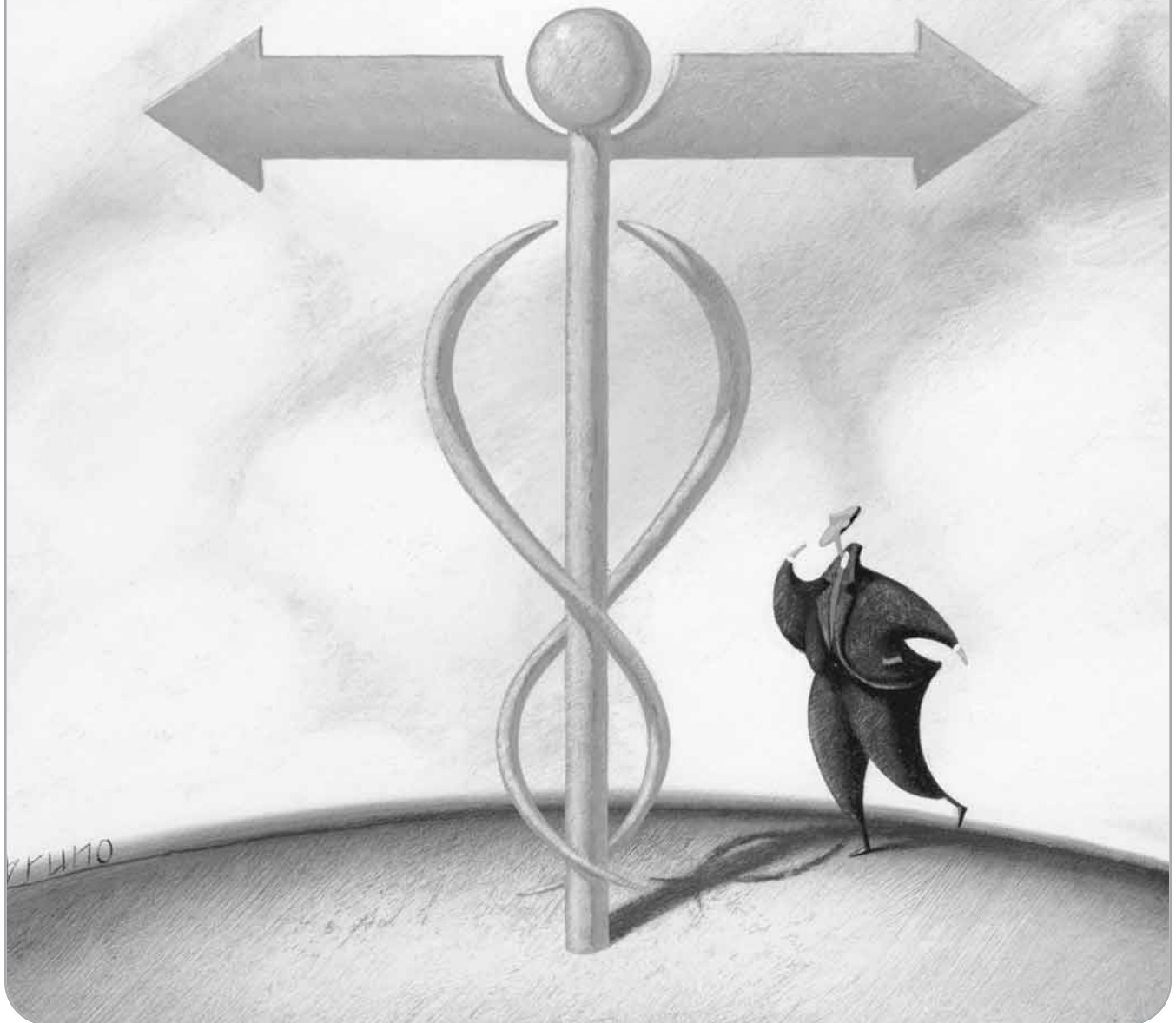
Eben Weitzman

Eben Weitzman is an associate professor in the Graduate Program in Dispute Resolution and an adjunct faculty member in its sister program, the Master of Science in Public Affairs (MSPA) at the University of Massachusetts Boston. Weitzman is a social and organizational psychologist specializing in the study of conflict. His work focuses on conflict within and between groups, with emphases on organizational conflict, cross-cultural conflict, and inter-group relations. He works with a wide variety of organizations in both the public and private sectors, including organizations in education, government, law enforcement, social services, business, and the courts. Weitzman also does extensive work on research methodology, and is reviews editor for the journal, *Field Methods*.

William Winslade

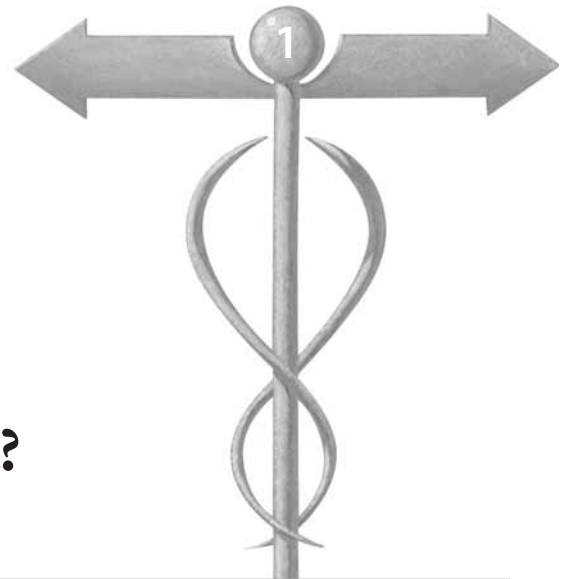
William Winslade, MD, is the James Wade Rockwell Professor of Philosophy of Medicine in the Institute for the Medical Humanities at the University of Texas Medical Branch. He holds a PhD in philosophy from Northwestern University, a JD from the University of California at Los Angeles, and a PhD in psychoanalysis from the Southern California Psychoanalytic Institute. His special interests and expertise include brain injury, health care policy, medical ethics, medical law, and neuro-ethics.

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Session One:

Building a Context for Conversation—What Makes Health Care Conflicts Different?



The Symposium began with a general discussion about whether conflicts in health care truly are unique and if so, why. Ken Fox, the Symposium facilitator, challenged the opening-session panelists, as well as all Symposium participants, to specifically articulate the unique challenges presented by health care conflicts. The following summarizes the panel's observations as well as those of the Symposium participants.

The Culture of Health Care

- The culture of health care is dominated by society's general expectations of perfection, where practitioners are not expected to make mistakes and are reluctant to openly address competency issues.
- While health care consumers often demand perfection, in reality health care delivery is filled with uncertainty and stress, with ever-increasing pressures to be more productive and contain costs.
- Embedded hierarchies between and within the professions contribute to the complexity of health care. Each profession is trained separately, has different values, and speaks a different dialect, if not a different language.
- A provider noted that the hierarchal nature of health care oftentimes manifests itself in a lack of mutual respect. This lack of respect and extreme hierarchal culture can also create a reluctance to report substandard care or other inappropriate behavior for fear of retaliation.
- There is a dominant culture of silence and complicity. Several nurses described a situation in which they would "work around" a physician they did not trust. Rather than report or confront the physician, the nurses would try to make sure the most difficult cases were assigned to someone else.
- A health care provider further noted that concerns that are raised are often dismissed with no follow up. Moreover, a general fear of retaliation predominated over any incentive to report competency concerns.
- A physician panelist commented that physicians often have very different viewpoints from other providers. For example, in reviewing a surgical team's performance for a specific surgery, physicians rated the teamwork as "high" while nurses on the team rated it as "low." These highly variable perceptions underscore a lack of cohesiveness among health care professionals.
- One group of discussants estimated trust among health care professionals to be about 3–4 on a scale of 1–10.
- A health care mediator noted that communication dysfunction within health care teams accounts for the majority of health care disputes.

Advances in Science and Complexities of Decision Making

- With advances in medicine come unprecedented complexities. When a difficult decision is to be made—or a conflict over that decision arises—it is not just the patient and the physician in the room. Insurance providers, specialists, and readily available information through the Internet have made decision-making and the doctor-patient relationship much more complex.
- This complexity is heightened by technological advances, differential opinions of specialists, evidence-based medicine publications, insurance provider restrictions, experimental treatments available in other locations, and value differences among providers, payors, and patients. While there remains a common value among physicians of “do no harm,” one participant equated the value differences to a United Nations summit without translators.
- Part of the complexity in health care is driven by an explosion in scientific information. While advances in technology, including extensive use of electronic medical records, are sure to enhance the health care delivery system, they also lead to the unintended outcome of reducing continuity of care as parties move from one “expert” to another.
- Despite scientific and technological advances, uncertainty clouds clear diagnosis and treatment decisions. Optimal treatment modalities may not be readily apparent. One physician pointed out that it takes 17 years for a “best practice” to become imbedded as a “standard practice.”

The Information Gap, the Power Imbalance

The facilitator challenged the panel to consider the question, “If advances in science and payment complexities challenge the health care provider, how much more difficult is it for the patient?”

- Patients and family members typically enter the health-care system ill and afraid. Understanding the risks and benefits of alternative treatments is difficult, particularly if the patient is not well-versed in health care matters. This stress and information gaps often lead to a power imbalance and a relationship that, if not properly managed, can easily become strained and compromised.
- These information and power imbalances are not limited to the physician/patient relationship. They can also occur between the payor and the patient and/or the provider.

Prof. Debra Gerardi

Program on Health Care Collaboration and Conflict Resolution,
Werner Institute for Negotiation and Dispute Resolution,
Creighton University School of Law

In looking broadly at the culture of health care we have an environment that's very competitive, we have an environment with embedded hierarchies, we have an environment in which people who are clinicians are trained that you can never make mistakes—there's a myth of perfectionism that pervades the work that is done.

Working within Broken Systems

- According to the CEO of the Federation of State Medical Boards, we have an “antiquated” system of licensure and regulation, set up 100 years ago. This system could be more effective in protecting patients and represents one of the single greatest challenges to the delivery of health care. The regulatory structure is fragmented and highly complex, and has not kept pace with the tremendous changes in the health care delivery system. For instance, today physicians in India read our x-rays and teens can go online and order drugs.
- Participants overwhelmingly agreed that the tort system is broken and in desperate need of repair. One doctor described the system as doing little to truly compensate those who are injured. He noted that the current system actually precludes practitioners from even talking with or apologizing to patients, though some providers, regulators, and payors noted increasing efforts to instill apology into the system.
- The practice of prohibiting a provider (usually a physician) from talking with his/her patient following an unanticipated outcome only serves to inflame the situation. Patients develop feelings of betrayal, abandonment and bewilderment, often leading to more severe conflict and higher likelihood of legal action.
- What patients and families typically desire most after unanticipated outcomes is information (full disclosure), an apology, and some assurance that changes will be put in place so that the likelihood of the problem happening again diminishes substantially.
- Physician fears of the legal system cannot be overstated, according to a provider. He explained that the personal identity of the provider is inextricably linked to professional stature, noting that if professional judgments are questioned, personal self worth is also questioned. He urged the legal profession to take some responsibility for compromising the physician/patient relationship.
- The tort system encourages over-utilization of medical tests and procedures by providers. One physician noted that when accused of malpractice, he believed that the only thing that kept him out of a long and drawn out legal battle was that a CT-scan had been ordered and performed on a patient who presented with headaches of unknown etiology. The physician stated that he is far more likely to order CT-scans and other high-tech diagnostic procedures and tests as a direct result of the fear of being accused of malpractice.
- An attorney member of the panel noted that fear permeates many aspects of medicine. The mere suggestion of incompetency is devastating and involvement in a lawsuit, even without any finding of wrongdoing, translates into vulnerability.
- Despite provider fears of litigation, studies show that overwhelmingly, patients do not want to sue their caregivers.
- A health plan attorney stressed that while our liability system focuses on individual error—holding individuals accountable—most mistakes are system errors and that these system errors are often the result of teamwork failures.
- It was noted that the medical educational system is in need of repair. Panelists suggested that medical schools need to incorporate issues of communication, conflict management, and legal and regulatory matters into the curriculum. Medical academic leadership must embrace these issues in order for real change to occur. Physicians and other providers cannot be expected to perform well in these areas when they are not provided with training or encouraged on any level to seek out such training.
- While there are aspects of the system that are clearly broken, it should be noted and remembered that the health care system does work well most of the time, and that numerous disputes are resolved every day.

As a critical care nurse I can tell you that health care is different. We can't use the same model that we use for managing other disputes. The main reason is that it's just intensely personal.

Barbara Colombo, JD, RN

Payment Disconnects

- A complicating factor in the health care system is what the insurance industry refers to as “moral hazard”—where patients spend more than optimal amounts on medical care because they are not paying the bills. This is particularly true for the highest cost patients with chronic conditions, who incur costs far beyond a deductible after just one hospital stay. Most of the time the consumer making the choice is not directly responsible for the full cost of care.
- Payment disconnects are also evident with physicians. In a fee for service payment system, with the specter of litigation hovering, defensive medicine becomes almost second nature. “Additional” tests and services both increase revenues and decrease potential claims of malpractice.
- According to a study cited by one physician participant, 28 cents of every dollar is spent on unnecessary treatment. Of course, as the physician stated, “It’s not defensive medicine when it’s practiced on you.”
- In most industries, inefficiencies and ineffectiveness come with clear consequences in terms of lost business and declining revenues. In health care, reimbursement is typically received regardless of performance or outcomes. Thus, the health care industry is not as financially accountable as other industries.
- In an environment that should promote provider/patient communication, most payment systems do not pay providers for communication. It is hard to incentivize communication when there is “no code for talking to patients.”

In most cases the health plan member has little if any financial liability at all. They're perfectly willing to go along with more tests, more procedures, more services; it gives them a sense they are getting the best care possible. That may not be the case, but the system is designed to really generate utilization and services.

James Jacobson
Medica Health Plans

The Most Intimate Matters, the Immediacy of Decision Making

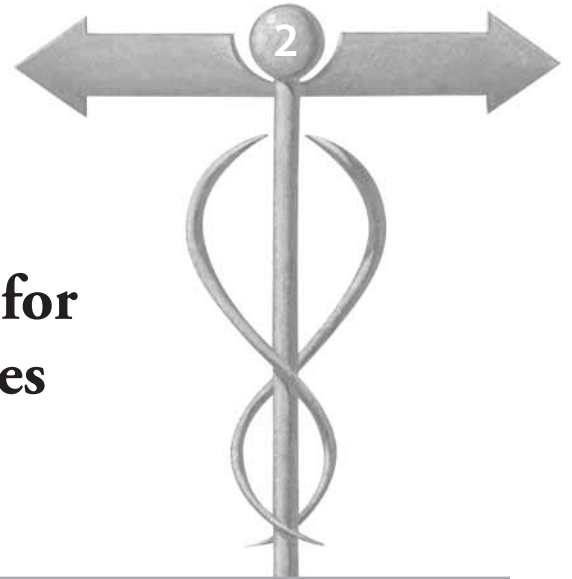
- Relationships in health care are intensely personal with unparalleled human vulnerability. In what other professional setting does the consumer come into an office, disclose their most personal secrets, and disrobe? Moreover, the fear and apprehension in health care disputes truly relates to matters of life and death.
- Vulnerability is further exacerbated by perceptions of lack of self-determination. As one participant stated, “I choose to get on a plane, I don’t choose to get sick and go to a hospital.” The lack of control over one’s own destiny clearly makes health care unique. As a result, conflicts take on a different flavor often steeped in issues of trust, confidence, and desperation.
- This vulnerability is further compounded by the immediacy of health care decisions, where quality of life and life/death decisions must often be made immediately or within a few hours or days.

Does Health Care Hide Behind the Differences?

- When the facilitator asked, “Is health care really so different?” one panelist contrasted health care disputes with environmental, international, family and legal disputes, and found many similarities. In the lawyer/client setting, clients, like patients, are vulnerable. There is a power and information imbalance in both settings. She acknowledged that physicians are subject to greater regulation, and more likely to be defendants in malpractice cases than lawyers, and that the life and death decisions common in health care often have more personal impact than the issues underlying lawyer/client disputes. But she cautioned that we “should not overstate the differences.”
- A former medical director for a large health plan followed up on this concern in the large group discussion. “In health care do we use the phrase ‘we’re different’ as a way to hide, to set us up so that we can’t solve the ongoing problems?”

Health care professionals are the only ones to whom someone will go in and reveal inner most thoughts, deepest emotions, some things they would not even reveal to their families. And similarly at the same time expose their bodies for care. Dealing with death and dying and life and illness, those are extraordinarily complicated issues for the public and conflicts that arise related to those tend to be more significant because of that unique relationship.

Dr. James Thompson
Federation of State Medical Boards



Session Two:

Developing Guiding Principles for Addressing Patient Care Disputes

As session two opened, the facilitator asked the panel to examine patient care disputes, and identify how patient care disputes might be unique. Panelists were encouraged to consider a system that balances the needs of patients and providers, and one that gathers and shares information to reduce errors and adverse outcomes. The facilitator further challenged the panel and Symposium participants to explore and identify guiding principles for addressing patient care disputes.

The following summarizes the panel's exploration of these issues, plus Symposium participant comments and suggestions.

Patient Expectations

- A physician member of the panel urged participants to recognize that physicians and patients should have similar goals of respect, honesty and meaningful communication in addressing patient care disputes. However, he noted that “good service does not always mean a good outcome” and that there are serious concerns about unrealistic patient expectations.
- The origins of inflated expectations were discussed, citing ineffective communication, information overload, the media, and the natural complexity of health decision-making and delivery. Patients often have direct access to unfiltered and sometimes questionable information via the Internet, media outlets or advertisements. This information can affect the physician/patient relationship by setting up unrealistic expectations regarding care and treatment.

- When conflicts do arise, these unrealistic expectations only serve to undermine the physician/patient relationship. This observation further suggests that communication skills and teamwork are both critical components to reducing liability exposure.

Health Care Team Dynamics

- A panelist noted that *invisible conflicts* exist among professionals in health care teams. These invisible conflicts, described as unspoken but very real struggles among providers, are often pervasive throughout health care systems. They create a veil of dysfunction among providers and clearly compromise patient care. These conflicts are invisible in that they are rarely addressed and typically ignored. He noted that these conflicts are exacerbated by the physicians' historic reluctance to engage as a collaborative member of the health care team.
- One participant observed that physicians often become defensive in the face of conflict, demonstrating lack of respect and blaming others. This culture of blame and limited respect undermines the teamwork necessary for good health care.

Patient Care Disputes—Are They Truly Unique?

- A mediator noted that when faced with the inherent uncertainty of medical decision making, providers tend to be risk averse; in contrast, patients, and more importantly, their families, are willing to “go to the mat” for a desired outcome. This divergence in approaches to managing risk makes joint problem solving much more difficult in patient care disputes than in other dispute contexts where uncertainty often sparks creativity and collaboration.
- In asking, “Who are the stakeholders in a patient care dispute?” the facilitator attempted to probe more deeply into the notion that patient care disputes are unique. Patients, family members, physicians, other caregivers, regulators, advocates, payors, and the media were all noted as stakeholders in patient care disputes.
- Unlike other disputes, patient care disputes are not “arm’s length transactions.” The physician stands in a fiduciary relationship and even if a dispute arises, that physician is obligated to act in the best interest of the patient.
- In examining patient care errors and associated conflicts, a panelist remarked that understanding what happened and sharing the “truth” is healing in and of itself for patients. She went on to stress that the “invisible conflict” (*see Health Care Team Dynamics from page 7*) often hinders the sharing of the truth in an open, honest and timely manner.
- Health care providers remain fearful of the notion of full disclosure. This fear is based on the perception that the tort-based legal system strives to attach blame and seeks to find winners and losers in disputes, rather than real solutions. There was agreement among the panelists that we need to move away from how lawyers typically frame disputes.

Prof. Charity Scott
Center for Law, Health and Society,
Georgia State University College of Law

One of the primary things that make patient care disputes so hard is that they frequently do involve issues of life and death and in either case issues around bodily security and bodily integrity. Whether we’re talking about end-of-life care or whether we’re talking about medical error, there’s a threat to personal security. And I think that those threats just change the dynamics emotionally, psychologically, even cognitively, for patients and bring the potential for conflict faster, quicker, and more deeply than other disputes.

Mary Foarde
Allina Health System

One of the things you hear a lot is that lawyers advise people in hospitals and physicians not to talk to patients when something's gone wrong—not to give them information because of liability concerns. I know that does happen, but in my opinion it's a mistake. I really believe that we have to bring forward information—that patients need to know when something goes wrong.

System Pressures Adversely Impact Communication

- When there is a breakdown in the physician/patient relationship due to a perceived or real conflict, patients often lose faith in the system and in their providers. To work past this constraint, there must be opportunities for open and honest conversation. The current system will remain “stuck” until physicians and attorneys are educated about and embrace the concept of an open exchange of information.
- A physician panelist noted that cost containment pressures are significant barriers to effective communication. Physicians must be provided ample time to communicate with and gather information from patients and other providers.
- Pressures from insurance providers must also be considered in examining patient care disputes and their resolution. Physicians feel increasing and unrelenting pressures from insurance providers to limit their time spent with patients in diagnostic and prevention-oriented communications.
- Legal pressures also play a role. Research clearly indicates that what patients want to understand after adverse outcomes is what really happened. Our current legal system frowns upon such conversations. This communication barrier leaves patients feeling betrayed and abandoned by the physician.
- Patients are not the only ones who suffer from a system that prohibits open communication. Physicians also experience lasting effects from patient

care conflicts, oftentimes manifested in compromised decision making, defensive medicine, and a lack of confidence in treating subsequent patients.

The facilitator observed that when the therapeutic relationship between the physician and the patient breaks down, for whatever reason, it seems extremely difficult to maintain a fiduciary duty. He challenged the panel to focus on exactly what is in the best interest of the patient when a dispute about care arises. The following summarizes the discussion.

Ongoing Obligation of Patient Care

- A physician panelist agreed with the facilitator, noting that there is a legal and ethical obligation to continue to treat and not abandon the patient even after a dispute has arisen. But when asked, “Does the duty of that particular physician actually continue?” the panelist stated that while it should, allowing there to be continuity of care, it typically does not in the current system. Oftentimes, the physician is prohibited from continuing to care for a patient after a conflict occurs.
- The tendency to discontinue care when a dispute arises violates central principles of fiduciary obligation, operationalized in health care as the necessity to act in the best interest of the patient, with loyalty and an obligation not to abandon the “do no harm” philosophy. Moreover, discontinuing care may pose adverse therapeutic implications for the patient, raising a healing dimension not captured by the traditional “legal” definition of fiduciary duty.

What physicians may not realize when a dispute arises is that that fiduciary obligation of care, and caring and concern lasts beyond the instigation of the conflict. Until such time as that relationship is terminated, either by the patient or by the doctor finding alternate care elsewhere, that relationship continues to exist.

Prof. Charity Scott
Center for Law, Health and Society,
Georgia State University College of Law

Effective Communication Strategies

- A number of participants endorsed the principle of immediate disclosure to patients and family members when adverse events occur. Immediate disclosure refers to accurate and timely communication regarding outcomes, their potential causes and their potential implications.
- A panelist noted that the longer the lag time between the adverse event and communication with the patient, the greater the likelihood that the patient will find the discussion to be disingenuous and become suspicious of intent. She noted that when medical errors occur, it is imperative that the patient has confidence that the medical team is doing what ever is necessary to “fix” the problem.
- A health plan lawyer emphasized that patients need to know the facts surrounding the error and what will be done in the future to make sure this does not happen to someone else. It was noted that an apology must be real and heartfelt, noting that a half-hearted apology is worse than no apology at all.
- Insurance providers and the legal system often present the most significant barriers to addressing disputes in this fashion. However, according to legal counsel for an insurance provider, there is a growing trend to provide protection for apologies and expressions of empathy as admissions of responsibility or fault.
- Participants were in general agreement that financial settlement talks should be separate from discussions involving apology and transparency surrounding adverse outcomes. Research clearly indicates that most patients are not looking for money, but other forms of remediation and the assurance that health care providers will do whatever necessary to “make things rights” and to prevent similar occurrences in the future.
- Discussions emphasized the need for a common understanding among providers regarding approaches to “conflict.” Members of the health care team speak different languages and do not describe “conflict” in the same way. Education and common understanding are key to effectively managing conflict.
- A health care provider emphasized the importance of listening as a means to develop trust and open communication. This trust and communication typically proves critical in resolving patient care disputes without legal action or prolonged involvement.
- A physician participant advocated for the L.E.A.P. (Listen-Explain-Apologize-Plan) strategy. He suggested that frequently the physician skips over “Listen” and moves directly to “Explain.” This mistake can be costly to the therapeutic relationship because the patient will likely feel dismissed.

Patient Centered Approach

- If we are to make meaningful changes to the manner in which patient care disputes are resolved, patients must be included as an integral member of the health care team. Without patient involvement there can be no meaningful communication especially on the critical issues of mutual respect, trust and honesty.
- Several participants stressed the importance of establishing a framework for resolving patient care disputes at the very beginning of the physician/patient relationship. Trying to establish this framework during or after an acute adverse event or error has occurred will leave both the patient and the provider feeling vulnerable.
- Cultural differences and religious and spiritual values must be considered in looking at what is in the best interest of the patient. This makes conflict resolution in patient care disputes even more challenging. Individual values and beliefs regarding appropriate care vary tremendously from patient to patient.
- Several nurses stressed the importance of treating the entire patient, including the family, and creating an environment where patients are not intimidated or overwhelmed. Making patients feel like a member of the team goes a long way in establishing a mutually respectful and trustworthy culture, with common expectations.

Barbara Colombo, JD, RN

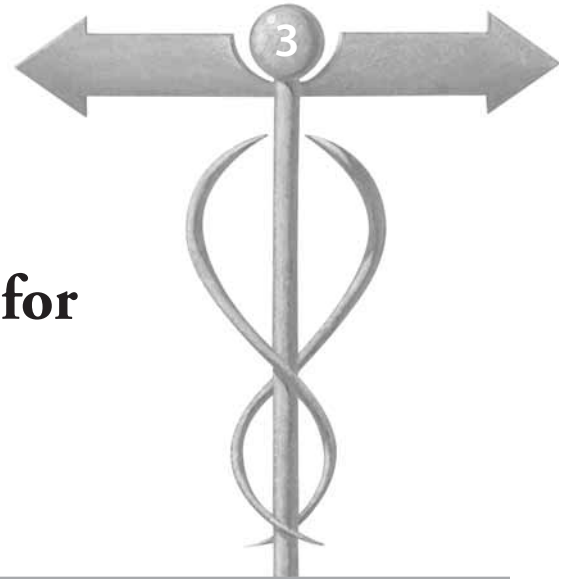
Prof. David Matz
Graduate Program in Dispute Resolution,
University of Massachusetts Boston

A Culture of Accountability, Responsibility and Transparency

- Participants endorsed a system that moves away from blame and secrecy to one that encourages responsibility and accountability, built on principles of integrity, trust and nurturing. The entire health care system, from senior management to direct care givers, must buy into an approach that stresses open communication.
- The tendency of each part of the health care system (physicians, other providers, payors, regulators, administration) to blame the others for adverse outcomes needs to be addressed. All parties need to be urged to get away from placing responsibility and blame on other members of the health care team, and understand that fault is multifunctional, diffuse and often systems-based.
- The legal infrastructure must adapt and change the manner in which patient care conflicts are managed. Without this, the entire discussion is irrelevant or at least seriously constrained.
- There was general consensus among participants that until the system feels safe, there will always be tension between transparency and potential liability.

It's not just that good guys apologize and the bad guys protect themselves—I think that's not a fair model. I think everybody tries to do some of both and it's perfectly normal that they should.

If the doctor had the opportunity to go in and maintain a very close relationship with that patient and just say 'I'm really sorry about what happened, I'm really sorry about where things are, this is not what we had intended or anticipated, let's talk about that, let's talk about how we're going to prevent it from ever happening again, and we also want to talk about how to make things right with you' that's going to go a long way.



Session Three:

Developing Guiding Principles for Health Coverage Disputes

Building on earlier discussions, the facilitator opened the second day by leading a new panel in exploring health care coverage disputes. He asked the panel to consider the fact that health care costs rose by 7.2 and 6.9 percent in 2004 and 2005 respectively. While this growth is slower than the annual average increases between 2000 and 2005, it is significantly faster growth than the economy as a whole. The facilitator challenged the panel to consider what drives these cost increases, and also how payors attempt to contain costs. He urged panelists and participants to express their views on how to improve our system of resolving health coverage disputes.

I think the most interesting thing I've found in this two-day process is that sometimes we become hardened to people's needs. We're looking at what the law tells us we can do within the plan document. Sometimes the human element is way down on the list of needs.

Barbara Hartwick
Health & Welfare Benefits, Xcel Energy

Realities of Our Current System

- A benefits manager of a large employer pointed out that health care costs are a major expenditure for the company and that a lot of time is spent on strategies to reduce these costs. She went on to note that frequently patients spend large sums of the company's money for ineffective treatments.
- A general counsel for a health plan noted that health plans are under intense pressure to do two things: provide the broadest coverage for the broadest number of people and keep costs low. He went on to stress that managed care plans, whether regulated by the State or administered through self-insured employers, simply cannot pay for everything.
- The same panelist explained that the resolution of health coverage disputes is guided by the "coverage document." He stressed that while cost is not a deciding factor in determining coverage for individual cases, it clearly is an issue at a macro level.
- Coverage decisions for individuals are guided by coverage documents and determination of whether a procedure is medically necessary. Medical necessity is determined by careful review of opinions and recommendations by local and national providers, and medical specialists. Decision makers also take into consideration regulator perspectives, publicity issues, and whether the coverage documents may have led to a misunderstanding on the part of the consumer.

- Union representation can also play a significant role in the decision-making process, according to a large employer benefits manager.
- Coverage decision makers strive to be caring, compassionate and kind in overseeing determinations, while following a myriad of published guidelines.
- Coverage disputes arise for a variety of reasons, some of the most common being:
 - In-network vs. out-of-network care and treatment decisions.
 - The use of investigational/experimental/innovative procedures.
 - Member liability (co-pays and deductibles).
 - The use of experimental drugs and treatments after a more typical regime has proven ineffective.
 - Treatment for unexpected side effects from medically necessary care (such as tooth loss from chemotherapy or facial hair growth from the use of certain medications).
 - Whether a treatment or procedure is considered cosmetic or medically necessary.
 - Determinations of medical necessity in general.
- A policy analyst pointed out that currently payors, insurers, plans and employers are not effectively collecting data to better understand coverage disputes. Data that is collected is not being shared with policy makers or consumers in a meaningful way. Data collection, analysis and dissemination are critically important steps in legitimizing our system of resolving coverage disputes.
- External ADR organizations are handling less than four percent of all health care disputes. This statistic raises the question as to how many coverage disputes are truly resolved versus simply denied.
- A physician pointed out that it is difficult to bring outside ADR professionals into the health care system for the purpose of resolving coverage disputes because of trust and competency concerns.
- External ADR professionals may not be readily equipped with medical expertise, and internal coverage dispute personnel often do not have the mediation and communication skills necessary to truly resolve the dispute.
- Patients are angry and resentful when they feel that someone other than their physician is making decisions about their health care. Patient satisfaction relative to coverage issues is as much about decision processes as the decision itself.
- Media exposure and adverse press coverage, or the threat thereof, may influence coverage decisions.
- A physician observed that in listening to his patient talk about health care coverage, he repeatedly heard two things: First, patients felt that they were not given enough information as to why the procedure or treatment was denied; second, patients felt that decisions seemed arbitrary, and would have been interested in seeing data to support the coverage denial.
- Individuals delivering messages to patients about coverage decisions often find difficulty explaining decisions to clients, who often have limited understanding of health care and limited knowledge of their own coverage documents.
- Participants also discussed the complexity of “medical necessity,” noting that while certain procedures and treatments (like fertility treatments and breast reduction surgery) may not be “necessary” to essential bodily integrity, they are, for some, essential to quality of life.

Need for Greater Accountability

- Patients with health insurance typically do not link their premiums and the actual cost of health care. They often want the best, the newest and the latest in medical advancements, yet have no interest in understanding cost ramifications.
- We live in an entitlement culture and health care is a part of this culture. Consumers often believe that they have the right to any and all health care that they deem necessary and their health insurance will

pay for this care. Consumers are typically bewildered when presented with a statement identifying costs.

- Most consumers only become interested in costs when they are personally responsible for paying for the care.
- Participants generally agreed on lack of accountability throughout the health care system, including accountability of the medical profession, the employer, the plan, and most of all, the consumer.
- Consumers might show a greater level of accountability if health plans were owned by members. However, it may be unrealistic to ask patients to consider the “collective good” while considering a medical decision that could impact their life.
- An attorney acknowledged that the legal community needs a broader understanding of the issues involved in health coverage disputes, plus additional training in resolving those disputes.
- Americans spend more on health care than any other country, yet our health status indicators are anything but superior.

Negative Perceptions and a Lack of Trust

- A panelist serving as general counsel for a health plan acknowledged that health plans suffer from a bad reputation and are often viewed as “evil.” This general perception will be difficult to change given the continual reinforcement of it through the media, health care providers, and some politicians.

- Health plans will remain the target of criticism until they are perceived by consumers as genuinely caring about their health.
- Participants stressed the need for transparency in the decision making process. Such transparency can help to establish trust and help build confidence that the plan/employer has the patient’s best interests in mind when making coverage decisions.
- A health law attorney pointed out that all plans have grievance processes in place and that these processes rely on numerous departments (including customer service, senior management, sales, and risk management). He queried whether this multi-departmental approach, which can be viewed as cold and impersonal, has contributed to the payors’ negative reputation.
- A physician commented that decision makers in coverage determinations need additional training in communication. He suggested that blanket denials without recognition of specific and unique circumstances have only served to perpetuate a negative reputation.
- Insurance companies are not set up to make decisions on a case-by-case basis, and relatively strict guidelines are needed for fairness and consistency.
- While our system of health care is often criticized, coverage questions will arise in any system, including those based on universal health care and a single payor model.

James Jacobson
Medica Health Plans

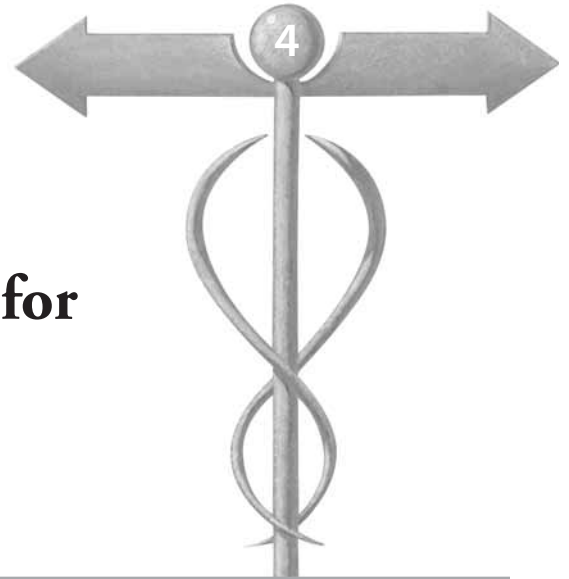
Contrary to the public perception, we don’t have a bunch of bean counters sitting around a table deciding whether someone should or shouldn’t get particular care. We have a chief medical officer and physicians who are really looking at things on a case-by-case basis and trying to make the best decisions we can make. But we have to be guided by the coverage documents that our members have and then make the best decisions we can using those frameworks.

Suggestions for Change

- Consumers need to be educated about the cost of health care and how coverage decisions are made. This education and training could be provided during open-enrollment periods for employers and plans.
- Consumers should see and understand their health care bills irrespective of whether they are responsible for any out of pocket co-pays.
- There needs to be more research about coverage disputes, how those disputes are resolved, and patient satisfaction levels.
- A physician noted that those involved in health coverage decisions, including benefits managers, human resource personnel, risk management employees, providers and attorneys, need to participate in conflict management training.
- We need to move away from a culture that views insurance and risk managers with suspicion. Early dialogue between consumers and the industry will be critical to this shift in thinking.
- Transparency throughout the entire system, including payment, coverage, cost, process, and medical necessity, is mandatory to build understanding, confidence and trust in the consumer.
- One participant speculated that cameras and/or transcripts would be a good first step in making the process more transparent.
- Multiple participants advocated for the use of an ombudsperson or point person to manage health coverage disputes. They felt that this was in keeping with a general health care model that values continuity of care.
- A physician cautioned that it is much more difficult to evaluate health outcomes than evaluate process. He explained that because outcomes are highly influenced by member health status, those outcomes can translate into misleading conclusions. Process indicators, he felt, were extremely important in evaluating patient satisfaction in health coverage dispute.

Dr. Marty Stillman
 Department of General
 Medicine, Hennepin
 County Medical Center;
 University of Minnesota

I heard an interesting idea from the service perspective: when somebody has a problem with a coverage dispute, have one liaison or one person to manage that complaint for them.



Session Four:

Developing Guiding Principles for Addressing Disputes in the Area of Provider Competency

Building on discussions from sessions one, two, and three, the facilitator led the final panel in exploring provider competency disputes. He began the conversation by asking the panel to consider the most effective ways of dealing with unsafe providers. He pointed out that since the early 1900s our society has largely relied on the medical profession to regulate itself through state licensure and provider credentialing processes. He then challenged the panel to consider whether this type of regulation remains effective in today's health care environment characterized by rising costs, rapid technology advances, and ever expanding public expectations.

The facilitator also asked the panel to consider that in 1980, fewer than 10% of Americans were enrolled in managed care organizations. Today, 90% of the insured workforce is enrolled in some type of managed care plan and those plans, together with increased government regulation, have changed the landscape of medical practice.

The following summarizes the panel's exploration of these issues along with Symposium participant comments and suggestions.

Current Environment

A physician panelist began the discussion by identifying six competencies for physicians:

- Patient care
- Medical knowledge
- Lifelong learning and assessment
- Systems-based practice
- Professionalism
- Interpersonal communications

Dr. William Winslade
University of Houston Law Center

Instead of treating disruptive behavior or impaired physicians and nurses, or even competency problems as disciplinary matters, we need to try to find ways to fix the problems that cause the behavior and put people at risk. There are some people whose licenses should be taken away, people who intentionally do unnecessary surgery or things of that sort—in egregious cases. But many of the cases of competency are really things that could be repaired.

- He went on to point out that there are specific processes in place for monitoring the above competencies. These processes, however, are not consistently applied. This lack of consistent application has led to a regulatory environment that is highly suspect, and one that leaves both providers and patients feeling vulnerable. He speculated that state medical boards will soon require a specific showing of competencies in these areas before re-licensure.
- Another panelist identified some of the most common disputes in the area of provider competency. They include:
 - Credentialing issues and processes.
 - Managed care decisions relative to health care professionals.
 - Disputes that go before the state licensing board, including over-prescribing narcotics, sexual interactions with patients, and drug and alcohol problems.
- The facilitator challenged the panel to consider how much of the provider competency record should be public. In response, a physician acknowledged that the system must balance the interests of both the provider and the patient. He went on to point out that it may not always be in the best interest of the patient to have access to the full record, nor is it always appropriate. He explained that because the state boards of medical practice evaluate issues of competency and not issues of malpractice, patients should not be privy to this information.
- This physician further noted that while state boards of medical practice are essential in investigating and regulating physicians, there are occasions where regulation is not the preferred intervention. He went on to explain that a physicians' health plan exists for the purpose of addressing physician abuse problems as well as depression concerns. This approach, he stressed, is an excellent alternative for addressing certain issues outside of a disciplinary framework.
- Currently, competency actions require a certain level of due process. A panelist stressed the importance of maintaining a system that affords a specified level of due process prior to remedial action. Such a process, according to the panelist, not only protects the provider's rights, but it also adds an element of consistency in application. However, a policy analyst challenged this assumption arguing that the "process" should never come at the expense of patient care.
- A physician stressed that disciplinary actions can be devastating for the physician. Reputations suffer tremendously, and self-esteem as well as subsequent decision making can be compromised. Moreover, disciplinary actions can adversely impact future employment opportunities and hospital privileges. Another participant wanted to stress, however, that the term "privilege" is important and that it truly is a privilege to affiliate with a health care organization, and that privileges are rightfully denied following certain incompetency determinations.
- One participant noted that all provider competency complaints seem to be handled in the same manner, when in reality some complaints address clinical issues while others address behavioral issues.
- Several participants suggested that clinical/technical competency issues are easier to deal with than more invisible conflicts, such as negative attitudes and communication with nurses and other staff.
- Several nurses pointed out that bad or inappropriate behavior is a competency issue with significant repercussions both in terms of retaining staff and patient outcomes.
- Another participant agreed with this observation, and stressed that there is not currently accepted methodology for measuring professionalism and "behavioral competency."
- According to a physician, there are predictive factors in medical school that indicate the likelihood of disciplinary action in later practice. The primary predictive factor relates to unprofessional behavior in medical school. He went on to point out that medical schools are evaluating tools to assess professional behavior (even before entrance to medical school).
- One of the panelists stressed that physicians are not the only professionals to show disruptive or unprofessional behavior.

- A physician observed that competency issues are further exacerbated by a lack of continuity of care. Patient confidence is negatively affected by a health care culture that is increasingly compartmentalized and comprised of specialists who are not in a position to examine the patient holistically.
- Several participants voiced concerns that the system of addressing competency issues is not administered fairly. They noted that nurses are terminated for specific types of conduct while the hospital administration looks the other way when a physician engages in the same conduct.
- In response, another participant noted that physicians are revenue generating and hospitals do indeed “put up with” a lot of unprofessional behavior by physicians because to do otherwise would affect the hospitals’ bottom-line. Nonetheless, she challenged the assumption that disruptive behavior is necessarily a competency issue.
- A health plan lawyer noted that the current regulatory regime is punitive in nature. A decision is made to punish the physician and that decision is often-times made public. There is little to no incentive for the physician to become involved proactively.

Competing Interests

- A health plan administrator explained that she is under significant pressure to investigate any and all complaints of clinical incompetency or concerns of unprofessional behavior. She went on to point out that the morale of the entire staff depends in part on administrative follow through.
- She also explained that different stakeholders have different interests when it comes to provider competency issues. For instance, the state is mandated to follow strict compliance guidelines. Facilities and hospitals must also focus on issues of negligence, competence, fragmentation (specialty hospitals v. general hospitals), antitrust, accreditation issues, and turf battles.

Culture of Secrecy and Fear

The facilitator asked the panel to comment on the existing credentialing process and the current framework for addressing competency issues.

- A health plan lawyer noted that our current credentialing model is fair at best, and suggested that we look to other fields for more effective models. She suggested aviation as a model that has been quite successful. Airline pilots, she pointed out, are encouraged to talk about “near misses” without repercussions. The system is not punitive or punishing in nature. This is perhaps why pilots are far more likely to report errors or issues of competency.

The expectation of the patient and I think the obligation of the practitioner is that they act as an agent for that patient inside the health care system, recommending services, guiding them to services, guiding them through the system. In other words, it’s an individual transactional conversation. But at the same time the expectation in a broader sense is that the practitioner will act as a steward of the public good of resources. There is an inherent tension between those two—you need to balance your obligation as an agent of the patient and also as a steward of public resources.

Brian Anderson, MD, MSc, FACC

- In addressing the aviation model in greater detail, one panelist observed one significant difference between the two professions. In aviation, if you are not competent, you go down with the plane. In health care only the patient suffers directly from provider incompetence.
- A physician queried whether there is a similar movement in the legal profession to implement broader, more specific competency requirements.
- According to a conflict management professional, the power imbalance in competency disputes is so significant that successful mediation is unlikely.
- Multiple participants felt that a strong patient voice was missing from the current system of evaluating competency. They went on to point out that interjecting transparency into the process would improve legitimacy. Others noted, however, that matters of specific clinical competency are outside the expertise of the patient.
- Nurses, in particular, reported a fear of reporting physician incompetence. Instead of confronting a physician regarding issues of competency, nurses may simply resign and go work elsewhere.
- Another participant observed that patients are also hesitant to report matters of possible incompetence. She noted that patients find it very intimidating to publicly discuss these issues.
- A physician commented that our current system turns a blind eye until the situation is truly out of control. He believes that this is based on a long-standing and unspoken premise in medicine that “you don’t rat on your friends.” He went on to point out that this mind-set is beginning to change as new physicians graduate from medical school. He stressed that part of professional responsibility is the ability to confront colleagues.
- One participant noted that politics and bias permeate provider competency reporting. He noted that those charged with the duty to report are oftentimes personal friends of the provider whose competency is in question.
- One panelist observed that physicians, in general, have historically seen themselves as autonomous professionals, not part of the health care team and not accountable to that team. This lack of accountability to professional colleagues has led to a culture of fear and resentment.
- One participant speculated that peer review might be an effective dispute resolution process. Several other participants strongly disagreed. They suggested that the physician community in particular has never done a good job in policing itself, and has been intensely criticized for adherence to this model.

The ethic that has existed for so many years is that as physicians we never “rat on our buddies” because we recognize that we all live in glass houses. That ethic needs to change. We’re seeing some movement in that direction with focus on competencies both in training and in licensure and board certification. We will change the culture so that physicians will readily identify their colleagues that are practicing marginal medicine or practicing medicine in which they may be violating the medical practice acts within that state, so that those physicians can get into earlier remediation and training programs and get into systems that will allow them to get back into effective medical practice. Overcoming this wall of silence within the medical profession will be a major cultural change over the next decades.

Dr. James Thompson
Federation of State Medical Boards

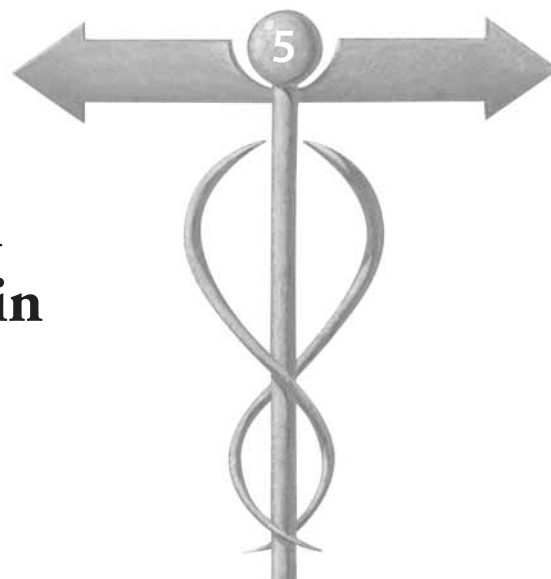
Possible Solutions

- A participant advocated for the use of an anonymous patient evaluation of the physician's care. Anonymity would encourage an honest evaluation that is currently lacking in today's system.
 - A two-prong system was suggested by a physician. One prong would focus on behavioral/unprofessional issues and the other prong would address clinical issues. Additionally, the teams addressing these issues would be distinctly different in composition.
 - There was general consensus among many participants that mediation training for all individuals addressing provider competency is critically important to improving the current system.
 - Several participants suggested transitioning from a system of high autonomy to one that values accountability. Toward that goal the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) will require hospitals to address disruptive behavior with greater accountability starting 2009.
 - A policy analyst noted that we must be committed to a culture that not only encourages reporting of competency issues but also expects such reporting. Furthermore, she urged the medical community to finally move away from a culture that is complicit in matters of incompetency to one that demands accountability.
 - Several participants recommended that competency evaluations be ongoing, with multiple sources of feedback and early intervention when warranted.
 - A physician stressed that medical school curriculum must include training on competency issues, including how and when to report suspected incompetence and how to communicate with colleagues regarding competency issues.
 - As a part of new staff orientation, human resources should stress that all staff are obligated to report matters of possible incompetency and that they will be protected from retribution. Those who make such reports should not have to risk their careers in doing so.
- A panelist pointed out that while we must expect individual accountability, our accountability system in general needs to move towards a team approach. According to the panelist, this approach will encourage a culture of respect and trust.
 - A physician advocated for a nonpunitive system based on the premise that physicians overwhelmingly want to be good physicians and do the right thing. Systems should be designed that are incremental in nature and preventive in focus, with progressive and staged discipline.
 - In response to the question, "How do we alter behavior in a system that is extremely resistant to change?" one panelist suggested the use of mentoring relationships.
 - In order to successfully address competency issues, the balance of power must be equalized. Health care providers and patients must feel safe and empowered to openly raise concerns.
 - A profiling system that allows consumers to obtain information about a physician may be useful.
 - An attorney urged that any system addressing provider competency issues should build on the Institute of Medicine's recommendation that there be far more transparency in our system.

It would be much more productive if some peer review happened before a crisis. I should be reviewed by nurses and patients on a regular basis. I should have the opportunity to do the same, with the goal again of improving patient care and improving relations—not waiting for a problem to occur.

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Guiding Principles for Creation of Dispute Resolution Systems in Health Care



Initially, symposium participants set out to define guiding principles for resolving health care disputes—principles a mediator, an ombuds, nurse, patient, physician, or lawyer could utilize as a starting place to resolve individual disputes. We came together and we learned. We learned that when these “invisible” disputes do surface, resolution is not always attempted. We learned that the idea of issuing principles assumes that there is a resolution system in place, and that is often not the case. We learned that the principles would necessarily vary depending upon the type of dispute. We agreed that health care is no place for a cookie cutter approach.

As the conversation evolved we recognized that while individual disputes varied tremendously, the attributes of a successful resolution system did not. On the first day of the symposium a commonly heard theme was that of

a “patient centered” system. But as we considered the dynamics of the health care teams treating patients the discussion shifted—much as the health care system shifted across the last 30 years from a hierarchical “captain of the ship” model of care to a “systems-based practice.” In today’s world, teamwork is necessary to reduce error and improve outcomes. Those teams include not only physicians, but other health professionals and sometimes even include payors. We came to understand that while the health professional/patient relationship was critical, so too are the relationships between the various members of the health care team. And when those relationships are in conflict, patient outcomes suffer.

With this in mind, we offer guiding principles for creating and implementing the use of relationship centered dispute resolution systems in health care.

Dr. Maureen Reed
University of Minnesota

Instead of thinking about the complexity, and the difficulties in conflict resolution in health care, I prefer to think instead in a very optimistic way: that we can in fact address these issues and that we don’t have to use the differences and difficulties in health care as a place to hide. We can boldly confront the issues and just move on.

A Dispute Resolution System in Health Care Must Be One That:

- **Centers on the Patient**

Patients can fully participate in resolving disputes only where they can overcome the information imbalance and vulnerabilities that illness thrusts upon them. Enhanced communication and streamlined processes are central to achieving this goal. Patient advocates may be useful in many settings.

- **Recognizes and Addresses Disputes Within the Health Care Team**

Patients are safer when teamwork is effectively practiced. Yet teamwork is not standard in health care. One tool of dispute resolution—mediation—has been particularly effective in addressing workplace disputes where there is a shared interest in good outcomes. Even where formal mediation is not undertaken (and given the high stakes/tight time constraints of health care delivery that may be often), mediation skills such as active listening, expression of empathy, identification of mutual interests and concerns, reframing and a focus on verbal and non verbal messages will promote quicker informal resolution among team members. These skills will help team members more quickly recognize the existence of conflict and the opportunities to put in place effective mechanisms of dispute resolution.

- **Places Individual Conflicts in the Broader Health Care Picture**

Moral hazard, in its many manifestations, should be eliminated. Patients who spend more on health care because they are not directly paying the bills and physicians who order marginal tests or prescriptions need to look beyond their individual circumstances to consider the collective burden their decisions place upon the health care system. Both patients and physicians need a dispute resolution system that compels them to do so. Payors facing coverage disputes may need to look beyond the contractual language governing an individual procedure (the immediate bottom line) to determine whether the procedure serves health and efficiency in the long term. In short, parties to a dispute need to recognize the cumulative impact of their behavior as part of the resolution process.

- **Promotes Communication Skills and Professionalism**

Most regulatory systems focus on measuring technical competence rather than the ability to work within a complex system. Creation of a relationship-centered dispute resolution system depends upon improved listening and communication skills. This requires individual providers to acquire a set of interpersonal competencies that extend well beyond medical expertise. While this training begins in the education setting, it must continue within the workplace (i.e. hospital health plans) and be assessed in both the employment and licensure settings.

Prof. Ellen Waldman
Thomas Jefferson School of Law

The first thing is we need to give patients an opportunity to talk about how they're feeling. It comes down to really basic dispute resolution concepts of going to where the patient is emotionally and acknowledging those emotions. So that's a first step.

- **Exudes Transparency**

A culture where communication flows freely needs to be created. Even where privacy concerns limit transparency as to facts (i.e. sharing the personnel record of an employee), transparency as to the conflict resolution process is possible.

Transparency will not occur unless providers and plans succeed in their attempt to communicate in the clearest possible manner. Documents and discussion should be as free of acronyms, industry-speak and bureaucratic language as possible so that the information is truly available to all.

- **Encourages Timely Truth Telling and Acceptance of Responsibility**

Patients have a right to understand as quickly as possible what happened when an unanticipated outcome occurs. Often, in the immediate aftermath, health care providers may not understand the answer themselves. But rather than accede to a “culture of silence,” immediate steps should be taken to share what is known, to describe what will be done to investigate what occurred (including the role the patient may play in the review), and to provide a timeline so that the patient will know when to expect a more complete report. Factual information should be shared when the review is complete. If mistakes were made, apologies and explanations for what steps will be taken to prevent the mistake from happening again should be forthcoming.

- **Focuses on “How Did This Happen” Rather Than “Who Did It”**

Only with a restorative, rather than punitive, approach can real change happen. A conflict should be reviewed from the assumption that mistakes at the heart of the dispute most likely are system mistakes, rarely placed at the foot of any one individual. Where an individual is at fault, remediation rather than a disciplinary approach should be the focus whenever possible. A “root cause” analysis including cultural, communication, and broader competency problems should be applied to conflicts, and not just the investigation of medical errors.

- **Recognizes the Centrality of Emotion**

Empathize with the patient and, where appropriate, the provider. Apologize if mistakes were made. Sympathize in difficult situations regardless of cause. Create a process that provides for this interaction and which applies in patient care, payor, and provider competency disputes. To honor this principle, more than a “paper review” may be required in grievance and appeal settings, as well as in other health care disputes.

Dr. Marty Stillman
Department of General Medicine,
Hennepin County Medical Center;
University of Minnesota

Data shows that when physicians and nurses and other providers feel like they are working on a productive team patient outcomes improve. It has been shown to have an effect. We can make some difference in this area by educating physicians and other providers on how we can communicate in a better fashion.

Dr. William Winslade
University of Houston
Law Center

One of the things that I take away from this conference that I didn't really appreciate coming in is the need for training of people working in the institutions in the techniques of conflict resolution. The people who are so inclined can be utilized in the institutions to help deal with those situations; especially where informal conflict resolution techniques are going to be necessary and more effective than formal dispute resolution.

Within the ADR field we've moved from a legal approach to interest-based resolution. But interest-based doesn't really work for health care organizations. We really have to move toward a relationship-based intervention. Then we deal with trust, we deal with respect, we deal with very strong emotions and fears. And to the extent we can restore people's relationships, it helps both with the complexity and to enable people to continue to work together.

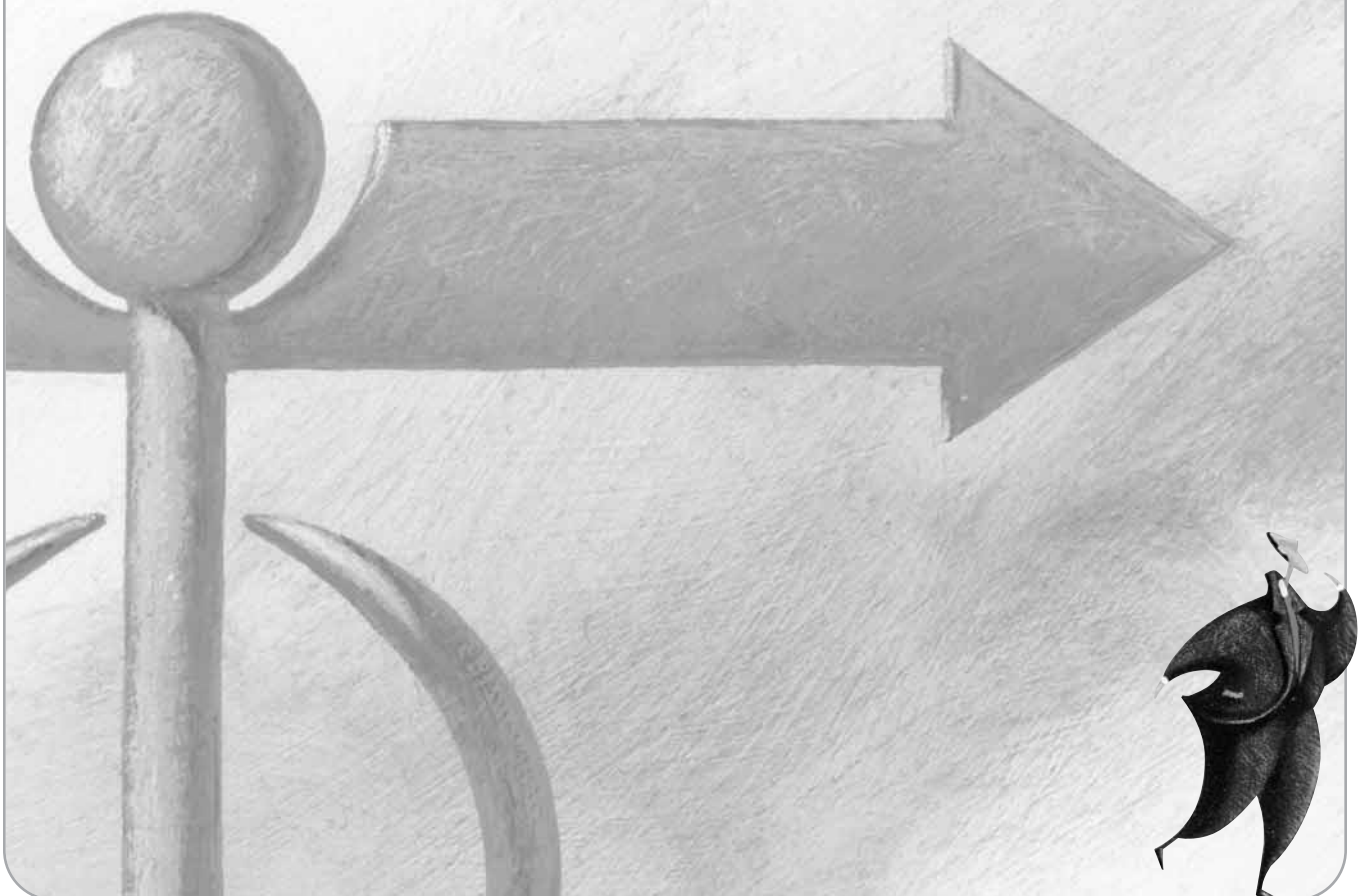
And I really think the answer is more conversation, more communication and more dialogue.

Mary Foarde
Allina Health System

Prof. Debra Gerardi
Program on Health Care Collaboration and Conflict Resolution,
Werner Institute for Negotiation and Dispute Resolution,
Creighton University School of Law

APPENDIX A PRE-READINGS

This Appendix contains introductory essays of common technical terms that participants and Theme Leaders received prior to the Hamline symposium. The symposium brought together two distinct groups: academics and professionals from both the health care and dispute resolution fields. As a result, there was a very rich and diverse mix of people who brought diverse backgrounds and expertise. These materials provided a common point of departure for the conversation.





Heading into Session One:

Reflections on What Makes Health Care Conflicts Different

By Lucinda Jesson

At some point during every health care mediation, whether I was sitting in the chair of mediator, lawyer or regulator, I put my hand to my forehead and asked: why are health care disputes so much harder? So different? So time consuming? I did not say the words out loud to my client or the parties (I hope); but compared to employment and business disputes, these were tough cases to resolve.

Why?

Below is my list of reasons. Perhaps they are simply rationalizations. Consider them the musings of someone who sat too long in a windowless room while the other party was “caucusing” with the mediator. Or, better yet, reject some and add to others. It is a starting place.

1. The information gap between providers, payors and patients

In the second half of the 20th century, our society finally moved away from the Hippocratic view that physicians should “reveal nothing of the patients’ future or present condition” while attending them. We have largely departed from Plato’s advice reminding the physician of the duty to “persuade the patient to accept treatment and to employ lies for good and noble purposes” if necessary.¹ Rather, we now accept a patient’s right of self-determination and the corresponding obligation of the physician to make “reasonable disclosures” to enable patients to make informed decisions.

But let’s be realistic: the playing field is uneven. Understanding the risks and benefits of alternative treatments is difficult enough when one is well read, versed in probability analysis and healthy. Few patients have these qualities when facing treatment decisions. And when one also has to understand the overlay of cost and insurance coverage of the various options, it is little wonder that many turn to their provider and ask “what do you think is best?” The interplay of new technologies, varied treatments, experimental research and the applicable deductibles and copays for treatment options is overwhelming.

1. Sheldon F. Kurtz, *The Law of Informed Consent: From “Doctor is Right” to “Patient has Rights,”* 50 SYRACUSE L. REV. 1243 (2000).

In the era of consumer driven health care and increased transparency, some inroads are being made. Patients come to appointments with print-outs from the Mayo Clinic website. They ask about experimental treatments trumpeted on the Internet and homeopathic remedies lining the aisles of Whole Foods. They check the quality ratings available online. They diagnose themselves and demand certain premium prescriptions.

But as a society, we still do not provide the medical and financial information necessary for most patients to make most medical decisions. Knowing how many stars your nursing home is awarded on a survey does not answer the question of whether a proposed medical procedure is necessary or not. Even if a patient could comfortably make a decision on medical necessity, we must move to the cost issues. Call your clinic and ask for the cost of a procedure (not just a range) and see if you are given a dollar amount rather than an admonition to come in and be examined. Outside of Minute Clinics, true cost transparency is difficult to find. Accurate quality comparisons are rarer.

2. The disconnect between payor and patient purchaser

Every time an American spends a dollar on physician services, ten cents is paid for by the patient. Ninety cents is paid by an insurer, whether that is an employer, an insurance company or the government.² The result is known in insurance terms as “moral hazard,” where patients spend more than optimal on medical care because they are not directly responsible for the full cost of care.

Cost sharing arrangements, such as high deductible plans and health savings accounts, are designed to entice patients to exercise more care and restraint in selecting treatments and providers and to confront the “moral hazard.” These arrangements meet with limited success. Part of this failure is due to lack of price transparency. More of the problem lies with the fact that high deductible designs do not deter spending by those with the highest needs—and highest bills. Eighty percent of health care dollars are attributable to treating chronic conditions such as hypertension, arthritis, heart disease, asthma, mental conditions and diabetes.³ In short, persons with chronic disabilities account for most health care spending. And these individuals often incur costs far beyond the high deductibles after just one hospital stay. The economic incentives to combat the moral hazard dissipate quickly after that visit.

3. “This decision should be made by physician and patient.”

How often do we hear that refrain? How often is that the case?

In the traditional, idealized physician-patient relationship, the patient enters the physician’s office and spells out her problems. With a few diagnostic aids (which fit neatly into a black bag, if need be) the physician listens, performs tests and then

2. C. Smith et al., *Health Spending Growth Slows in 2003*, 24 HEALTH AFFAIRS 1 (2005).

3. Archives of Internal Medicine, 163 (4): 437–442 (February 2003). A 2002 study found that patients with chronic conditions accounted for 76% of hospital admissions; 88% of all prescriptions filled and 72% of all physician visits.

recommends a course of action. The recommendation is based in part on science, some on history, and much on instinct. The patient listens, asks questions about options, then makes a decision.

Fast forward to today. Medical science provides many more answers than it did 50 years ago. Yet, as technology advances, physician decision-making erodes. It is no longer just the physician and patient in the room. Others are hovering: the specialist with the second opinion, the utilization review committee members, the medical director with the latest print out of “evidence based medicine” practices, the payor who sorts through variable coverage scenarios based upon the physician’s recommendation, and the husband who comes in with a print-out from the web citing an experimental treatment available in Mexico. Did I mention the regulator who questions (under the fraud and abuse laws) whether the physician has an economic interest in the referral, the prescription or the recommended treatment? And instead of the black bag we see electrocardiograms of waves on a graph and dialysis machines with chemical balances.

Technology, payment intricacies and our attempts to curb costs and monitor quality collectively result in complex decision-making. When resolving conflicts, the number of interests to consider and address proliferates.

4. Mandatory reporting and the overlay of regulation: obstacles to resolution in the name of public protection

Confidentiality. Closure. Certainty.

These are hallmarks of many legal settlements. “Put this behind you and move on with your life,” is time honored advice, but may not be realistic in many health care disputes. Take the case of the physician who is under investigation for her surgery practices at a large hospital. The immediate question for the Hospital, following investigation, is whether the surgeon’s “privileges” to practice at the Hospital should be limited or revoked. But confidential resolution may not be possible. If, for example, the Hospital finds poor patient care practices which support limiting surgical privileges, a report to the National Practitioner Data Bank may be necessary. Even if the surgeon resigns shortly after the investigation commences, a report is required. And when the surgeon seeks hospital privileges elsewhere, that adverse report follows her since hospitals are required to check the data bank when considering an application for privileges. Moreover, individual physicians who are aware of patient safety concerns and adverse actions against physicians may have a duty to report them to the state Board of Medical Practice. The Board, in turn, may institute its own investigation.

All of this is just a backdrop to the bigger question of what, if anything, patients are told of the concern over the doctor’s medical practices.

It is easy to understand the need for mandatory reports. The desire for confidentiality and closure gives way to the greater need to protect the public health. But achieving closure becomes elusive in many health care conflicts.

5. The inequities of the overall health care system cast a pall over resolution of individual disputes.

The United States has the finest health care system in the world. In some places. For some individuals. The disparities between the best and the worst of health care haunt our ability to look only at the individuals before us. Consider the following:

- Sixteen percent of Americans lack health insurance. If one views uninsurance over time, an even more disturbing picture emerges: A recent study tells us that during 2002 and 2003 about one-third of non-elderly Americans were uninsured at some point during those two years.⁴ And over 80% of the uninsured either work or reside in households with a working adult.⁵
- The uninsured are more likely to be people of color.⁶ One third of Hispanics are uninsured, as are 21% of African Americans.⁷
- An estimated 18,000 adults die prematurely each year from lack of insurance.⁸
- Between 44,000 and 98,000 Americans die each year in hospitals as a result of medical errors.⁹
- The United States spends 16% of its gross domestic product on health care, a percentage that has grown from 13.8% in 2000 and which far exceeds that of other industrialized countries. What contributes to these costs? New technologies, prescription drugs and an aging population are certainly factors. But without dramatic changes, by 2016 one out of every five American dollars will be spent on health care.

Now consider the individual with health insurance on Minnesota's Iron Range who seeks a second opinion from the Mayo Clinic about proposed surgery. Mayo is "out of network" but the patient wants the best opinion about what may be life threatening surgery. In considering this dilemma it is a challenge to only look at the patient, physician and health plan before us and not think of the broader ramifications: the 16% of Americans with no health insurance; the escalating costs of health care driven by unnecessary tests and referrals (but is this one?); the quality gaps between providers; and the disparities in treatment and outcomes for patients of color.

4. Families USA, *One in Three: Non-Elderly Americans Without Health Insurance, 2002–2003* (2004).

5. *Id.*

6. See Dianne Miller, Wolman & Wilhelmine Miller, *The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J.L. MED. & ETHICS 397, 399 (2004).

7. *Id.*

8. *Id.*

9. INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al. eds., Nat'l Acad. Press 1999).

6. It's not a matter of life and death. Except maybe it is.

In other parts of our lives we bring perspective to decision-making by using phrases like “it's only money” and “it's not a matter of life and death.” In health care disputes, the fear (sometimes unspoken) is that it could be just that: a matter of life and death. It is a fear that permeates with reason.

Uncertainty pervades diagnosis and treatment. Mistakes happen. Hospitals are dangerous places. Part of this is due to the uncertainty inherent in diagnosis and treatment. As David Eddy wrote in 1984:

Uncertainty creeps into medical practice through every pore. Whether a physician is defining a disease, making a diagnosis, selecting a procedure, observing outcomes, assessing probabilities, assigning preference, or putting it all together, he is walking on very slippery terrain. It is difficult for non physicians, and for many physicians, to appreciate how complex these tasks are, how poorly we understand them, and how easy it is for honest people to come to different conclusions.¹⁰

Advances in science have not changed this reality but reporting has better quantified the results of medical error, whether due to uncertainty or fundamental errors. Yet while we learn of the prevalence of medical errors, one of the legacies of scientific advances is that as patients we do not view death simply as a matter of fate. We expect more.

When lives are at stake (or at least people believe that to be the case) conflict resolution is harder. Harder for the family member arguing with the health plan about whether an experimental treatment should be paid for. Harder for the doctor who is under investigation for substandard surgery techniques. Harder for the regulator who must decide on the appropriate sanction for a nursing facility found to be out of compliance. Harder for all concerned when trying to resolve a dispute against a life and death backdrop.

10. David M. Eddy, *Variations in Physician Practice: The Role of Uncertainty*, 3 HEALTH AFFAIRS 74, No. 2 (Summer 1984).

Session Two:

Developing Guiding Principles for Addressing Patient Care Disputes

By Rob Routhieaux



In Session One we will have set an overall context for the Symposium. In Session Two we will begin to address specific types of health care disputes—disputes over patient care. In addition, we also begin to explore what, if any, guiding principles emerge that can help us address conflicts in health care.

If we are to succeed in developing “Guiding Principles” for addressing patient care disputes, we will need to clearly identify:

1. **Who is our intended audience for these Guiding Principles?** Are we aiming these guidelines towards attorneys who will/are representing the parties involved? Are we aiming these guidelines to mediators and other dispute resolution professionals (including judges)? What about patients and other possible parties involved, including physicians and other providers?
2. **Once we have identified our intended audiences, what exactly do we hope they will get out of these Guiding Principles?** Are we providing them a template for the process and procedures of dispute resolution? Are we giving them directions for resolving conflicts as quickly and amicably as possible? Do we want to provide them with context and details that will help them identify their own needs and expectations? Are there other goals we should be aiming for?
3. **How should we disseminate the Guiding Principles so that they reach our intended audiences in useful and timely fashion?** Should we provide them online for all interested parties? Will they be used if we send them directly to law offices and law schools? How well will they be utilized if we distribute them to health care providers and other potential parties to disputes? Should we even try to get them directly to patients or injured parties?

We will consider these and other similar questions throughout the symposium as we examine each category of disputes. But for now, let us return to patient care disputes.

What gives rise to patient care disputes?

Patient care disputes typically fall into one of the following categories:

1. *Adverse/unexpected outcomes after receiving care*—including loss of life, reduced quality of life, or extended recovery time.
2. *Adverse/unexpected outcomes after not receiving care*—including misdiagnosis, resource constraints, or delays in receiving treatment.
3. *Cost of services or adverse economic impact*—including care costs that were unanticipated, not communicated, or higher than expected, or treatment that prevented the patient from earning income.
4. *Lack of information or understanding*—patients do not fully understand diagnosis or provision of care and thus expect different outcomes/treatments.

From a patient perspective, disputes over patient care stem from “provider error” and “faulty communication” by providers (hospitals, clinics, doctors, etc.). Patient disputes focus on the following: Providers should have provided different care than they did; providers should have provided care that was not offered or suggested; providers should have found cheaper ways to provide the care; providers should have given me more information and involved me more in decision making and care choices.

From a provider perspective, disputes arise from a number of factors. These factors include patient complexity, resource limitations, unreasonable patient expectations, individual error, breakdowns in delivery systems, and litigious patients and attorneys. Providers might suggest the following: Patients do not understand the complexity of medical decision making and care; patients do not understand that we only have limited resources; patients expect miracles and positive outcomes no matter the circumstances; patients do not understand or accept that errors are bound to occur; patients (and their attorneys) are just trying to get rich at our expense.

The complexities in resolving patient care disputes

The complexities in resolving patient care disputes stem from the perceptions and motivations parties bring to those disputes. Patients and providers typically have distinctly different perspectives on the “causes” of the disputes, and very different “goals” in mind for resolution of the disputes.¹¹ As noted by a number of scholars, the American negligence-based tort system of litigation only serves to exacerbate these inherent tensions and differences in perspectives.¹²

A number of authors have discussed the importance of non-financial concerns in resolving patient care disputes. As noted by Dauer, “the tort system does little to respond to patients’ other, more frequent, non-financial needs: accountability, emotional

11. 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).

12. Edward A. Dauer, *A Therapeutic Jurisprudence Perspective on Legal Responses to Medical Error*, 24 J. LEG. MED. 40–41 (2003).

resolution, information about “what really happened,” and the assurance that such an event will never happen to anyone else again.”¹³ As a result, in developing Guiding Principles for Resolving Patient Care Disputes, we need to address the extent to which social, cognitive, and emotional components of patients can be addressed before disputes occur (perhaps preventing them), and the extent to which they can and should be addressed once a dispute has arisen.

Patient care disputes also entail social, cognitive, and emotional components for providers. Research indicates that doctors who are subject to malpractice cases experience more stress and may provide lower quality of care, and that these impacts can last well beyond resolution of legal processes. Additionally, providers, whose patients suffer unexpected complications or adverse outcomes, experience their own cognitive and emotional effects. These effects can be worsened by social factors and health provider norms that encourage “secrecy” and “looking the other way” when colleagues make mistakes.¹⁴ Thus, we also need to address the extent to which the social, cognitive, and emotional components of providers can be addressed both pre- and post-dispute.

The true complexity in addressing patient care disputes surfaces when the sets of social, cognitive, and emotional components of patients and providers become enmeshed in the legal and regulatory systems related to health care. Patients want full disclosure about “what happened and why” and may often be in search of “who is to blame for this?” Providers want to protect themselves and their colleagues from legal actions, reputation damage, and large financial losses.

Increasingly, the law of apology has tried to balance these often competing needs by allowing health care providers to apologize to patients and family members for adverse outcomes, while not allowing these apologies to be used as admission of guilt for any wrongdoing or malpractice.¹⁵ Clearly, this is a positive step—but perhaps only the first step in balancing the different needs and rights of patients and providers.

What are the most important steps in balancing the differential needs of patients and providers in addressing patient care disputes?

Internally, health providers and health systems want to understand errors and adverse outcomes to help prevent similar occurrences in the future. To do so, perspectives and data from both providers and patients need to be gathered, assessed and integrated. However, doing so once a dispute has arisen becomes increasingly difficult if providers become increasingly protective, and patients (or family members) become increasingly aggressive in placing blame or seeking compensation for damages. Health systems have some measure of protection in gathering information for quality improvement purposes.

13. *Id.*

14. See Virginia A. Sharpe, *Promoting Patient Safety: An Ethical Basis for Policy Deliberation* for an extensive review of literature and summary of these issues. Article is a special supplement to the *Hastings Center Report*, July–Aug. 2003.

15. *Id.*

However, as with the law of apology, this may serve as only a first step in ensuring that accurate and timely data is gathered after errors or adverse outcomes. Mandatory error and outcome reporting, as increasingly mandated in different jurisdictions, may be another step—though the real value of these approaches has yet to be validated.

What processes should be in place to gather and share information on errors and adverse outcomes that can help resolve disputes or prevent them from occurring in the future?

Readily available information (via the Internet and other sources) regarding medical care and often sensationalized news stories about patient care and health industry profits only complicate matters. The good news is that as we increase our knowledge sharing capabilities, health provider educational programs and health care providers can work more directly at improving diagnostic skills and provision of care. We should consider the extent to which this continually evolving state of knowledge can be shared with patients who may have limited understanding, and the best means for doing so.

Finally, we need to keep in mind that people, and patient care in general, are fraught with complexities. Disputes are inevitable. What we can do is to work proactively and diligently to keep from making preventable mistakes, and to minimize the severity and frequency of unexpected and adverse outcomes.

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Session Three:

Navigating Health Coverage Disputes

By Lucinda Jesson



It is sobering when our society celebrates the fact that health care costs rose by 7.2 and 6.9 percent in 2004 and 2005 respectively. True, this growth is slower than the annual average increases between 2000 and 2005 but it is significantly faster growth than the economy as a whole.¹⁶ The increases certainly outstrip most pay raises.

What drives these relentless costs? Three commonly tagged culprits are administrative overhead costs, higher pharmaceutical prices and escalating use of new medical technologies. Their auras haunt the discussion of coverage disputes. Here is why.

Most Americans receive their health care through some form of managed care—whether it is a health maintenance organization (HMO), preferred provider organization (PPO), or point-of-service plan (POS). These health plans “manage” by monitoring the care we receive to make sure it is medically necessary and cost-efficient. Sometimes plans deny coverage. When a health plan determines that a drug is not medically necessary, denies payment for a procedure or otherwise limits care, a dispute will ensue. As patients we want the best, the newest and the latest. But much of recent health care costs are attributable to these new drugs and procedures—which adds another layer of administrative costs inside health plans to decide which medical procedures and drugs we receive and which fall outside the coverage of our policies. Thus, administrative layers, new medical technologies, and pricy drugs—because they drive costs, they reside at the heart of coverage disputes.

Examining the coverage denial

Health care coverage encompasses the amount, duration and scope of services provided under a health plan. Denial of coverage is the decision of the insurer or managed care organization that a particular item (such as an implantable defibrillator) or service (such as chiropractic care) does not fit within the contractual definitions of coverage under the contract. With traditional indemnity insurance, a coverage denial is explicit, as with your home insurance. You make a claim to your home insurer for water damage.

16. Karen Davis, Cathy Schoen, Stuart Guterman, et al, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?* THE COMMONWEALTH FUND (January 2007).

You do not have flood insurance. The recent water damage is caused by a flood. Your claim is denied.

With managed care organizations, however, the distinction between a payor's coverage decision and a provider's denial of care is often blurred.¹⁷ The prescription is written for the drug approved by the health plan. A physician orders an X-Ray rather than an MRI, where she knows that MRIs must be pre-authorized, a procedure she finds tedious. Is there even a denial of coverage? If either the physician recommends or a patient does quick Internet research and requests a procedure denied by the health plan, the denial is clear. Then we have a dispute. But where treatment decisions are influenced by coverage dictates, outright denials evade us.

Coverage denials that best crystallize the tension between a patient's desire for the latest and the best and a health plan's desire to only pay for medically necessary treatment involve high technology procedures. Patients want access to the latest innovation, but the new treatment may not yet be shown to be standard, proper care for a specific diagnosis. And it is often costly.

Health plans deal with these issues by defining and excluding "experimental" and "investigational" treatments in their contracts. Some do so explicitly. Other health plans broadly remove from coverage therapies deemed experimental based upon "professional consensus" or the positions of other entities.¹⁸

Of course, there are payor/consumer disputes beyond coverage denials. Billing disputes over non-covered bills often find their way to small claims courts. Poor care and unmet requests for referrals may lead to complaints. But the most heated disputes involve claim denials and of these denials the most contentious involve new and experimental treatments.

Avenues for resolving consumer complaints

State and federal laws provide avenues (outside of court) for patients who disagree with health care coverage decisions. Generally, there are two types of complaint processes: internal grievances and external review. The right to access these avenues, however, depends upon both the type of health plan and the state where the dispute arose.

Internal review generally refers to a *grievance and appeal procedure maintained by the health plan*, often as a result of state or federal mandate. For example, employer health plans (both insured and self-funded) must establish procedures and timelines for disputes involving benefit claims. Moreover, state regulated health plans have separate rules about how plans must conduct their internal appeals. Different appeals processes may apply for different disputes, including expedited processes to deal with medically urgent requests.

17. Eleanor D. Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 AM. J.L. & MED. 335 (2000).

18. Joseph Clamon, *Does My Health Insurance Cover It? Using Evidence-based Medicine and Binding Arbitration Techniques to Determine What Therapies Fall Under Experimental Exclusion Clauses in Health Insurance Contracts*, 54 DRAKE L. REV. 473, 484 (2006).

In a typical internal grievance and appeal process, the patient (or his/her provider) can appeal denials of coverage or payment for services the health plan determines are not medically necessary or are experimental. Often, the first level of review (typically not even part of the formal appeal process) involves a simple file review by a member of the plan's customer relations department. If this does not resolve the complaint, most health plans provide for a formal internal review process with two levels of review. The first level generally requires a written complaint and documentation of the requested services. This complaint is internally investigated and a response provided. Some internal appeals plans allow for informal discussions during the investigation process while others do not. Response times for the health plan vary but the maximum response times according to federal ERISA regulations are 30 days if the service has not yet been provided and 60 days if it has been provided. State law often establishes shorter time frames.

If the patient is dissatisfied with the determination at the first level of appeal, most health plans permit an appeal to a panel of individuals who were not involved in the initial decision. While each plan has different rules about who is on the panel, many require that if the appeal involves medical judgment, the reviewers must consult with a health care professional. Whether this second level of appeal involves a quasi-hearing varies by health plan and state.

Some health plans offer arbitration if either party is dissatisfied with the second level appeal decision. In some health plans, these arbitrations are mandatory, while others offer non-binding arbitration (i.e., the decision is not binding and can be challenged in court).

The second non-judicial avenue for resolving patient/health plan disputes is through *external review by a government agency*. Most states have a complaint procedure for "medical necessity" denials by a state regulated health plan. These "external review" procedures only address coverage disputes, including differences over whether a treatment is experimental, but typically exclude billing and quality of care claims. When a patient files an appeal after denial of coverage, many states refer the appeal to an independent review organization, particularly if medical issues are involved. However, the review process (including the cost to the consumer, the timing of the response and whether there is an opportunity for a hearing) varies among the states. Finally, some external review processes require a consumer to first "exhaust" the health plan's internal process while others do not.

But the variation among state external review procedures often is not the largest challenge for consumers. Rather, the most difficult part of the external review process may lie in determining whether a health plan is state regulated—and subject to the external review in the first place. Here are just a few of the caveats associated with this puzzle:

In some states, external review applies to all health plans, in others, external review only applies to managed care plans.

Medicare and Medicaid enrollees often do not have access to state external review processes even if they are in a managed care public plan; however, Medicare does have a separate appeal process.

State external review programs only apply to insured products. Patients may have health care through their employers which is administered by a health plan, uses a health plan's care network, and looks to all the world like health insurance but is—in fact—a self-funded health plan. These self-insured products are not subject to state regulation. If a patient has a coverage dispute with a self-insured employer's health plan, that patient may have a legal claim. That patient may be able to complain to the Department of Labor. But that patient generally does not have access to state external review programs.

Challenges along the way

As the description of external review processes reveals, one of the most fundamental challenges is determining what avenues of appeal are available. The myriad array of internal and external options can only be determined with through knowledge of the individual's coverage. Is it employer-sponsored or individually purchased? Insured or self-funded? Subject to the Medicare appeals process or not? Moreover, once a patient identifies the avenues for appeals and the applicable time frames, additional challenges for all concerned (the patient, the provider and the payer) must be addressed. Below are three common dilemmas.

1. The Threat of “Deselection”: Physicians and other providers face the tension between an ill defined ethical duty to advocate for medically necessary patient care and an economic need to avoid “deselection” by health plans and other payers. Is it protected patient advocacy, for example, for a pediatrician to decline to send a two year old with a high fever to an off-premises clinical lab under contract with the payer, which would delay diagnosis and treatment, when the pediatrician could perform the test in her office and get the results back within a few hours? Or is this the act of a provider who is acting out of her own financial self-interest, a pattern of which is an appropriate basis for deselection by a health plan?¹⁹

2. The Need to Control Cost: The health plan administrator and self insured employer often face a different dilemma, one inherent in the fiduciary duty of the administrator. There is a limited pot of money and the administrator must not only consider the interests of the patient who seeks the experimental (and expensive) treatment, for example, but the interests of the other plan beneficiaries as well. There is not an endless supply of money set aside in reserves. In the bigger picture, this is what our society expects payers to do across the board: to keep the lid on ever increasing health care costs. This is not a popular task; moreover such care disputes increase the administrative costs politicians vilify.

19. This is a variation of one of several interesting examples Linda Fentiman discusses in *Patient Advocacy and Termination From Managed Care Organizations. Do State Laws Protecting Health Care Professional Advocacy Make Any Difference?* 82 NEB. L. REV. 508 (2003).

3. Power Differentials: Patients often face the highest hurdle because of the power differential between patients and payors. The payor has medical expertise at hand. The payor has control of the underlying facts of the dispute, only limited parts of which may be in the patient medical record. Finally, many patients lack the monetary resources to press their claims. Some organizations have started using ombuds to assist patients in navigating the appeals system, which at least begins to level the playing field. But it is just the beginning.

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Eleanor Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 Am J.L. & Med. 335 (2000).



Session Four:

Assessing Provider Competency— How Best to Resolve Differences When Patient Safety Lies in the Balance?

By Lucinda Jesson

While large malpractice cases capture the headlines, litigation is but one, highly imperfect mechanism to protect the public from unsafe providers. Since the early 1900s our society largely relied upon the medical profession to regulate itself through state licensure and private credentialing processes. But as the commercialization of health care in the late 20th century reshaped the practice of medicine, new challenges in provider competency disputes arose. To understand the current issues in provider competency disputes, this essay first addresses the changes in medical practice and then discusses how these changes impact licensure and credentialing processes. Finally, some of the specific current impediments to conflict resolution are highlighted.

What a difference thirty years can make

The two scenarios below reflect the different approaches toward protecting the public from unsafe providers. Much of the difference is a result of the commercialization of medicine. Thirty years ago, health care was primarily provided by solo and small-group practitioners. Ninety percent of Americans were insured under “fee-for-service” arrangements that had prevailed for decades. Under this system, physicians treated patients on demand while insurers paid the physicians their fee for the services provided.

Since that time, in response to rising health care costs, corporate managed care rapidly came to replace fee-for-service medicine. The term “managed care” can describe any number of groupings that attempt to reduce costs and promote better outcomes.²⁰ In short, they both arrange and pay for health care. The prevalence of managed care in the present marketplace is remarkable. In 1980, less than 10% of Americans were enrolled in managed care organizations. Today, 90% of the insured workforce is enrolled in some type of managed care plan and those plans, together with increased government regulation, have changed the landscape of medical practice.

20. Typically, managed care organizations (MCOs) have three features: 1) they select a restricted group of health care providers to serve the enrollees; 2) they accept a fixed payment per subscriber in exchange for the promise to provide necessary medical care; and 3) they attempt to control costs through techniques such as bonuses, incentives, “gatekeepers,” preauthorization requirements, incentive systems and utilization review. BARRY R. FURROW ET AL., *LIABILITY AND QUALITY ISSUES IN HEALTH CARE* 482–87 (Thomson West 5th ed. 2004).

Who is policing the providers for Sally and Amanda Patient?

Journey back to the “fee for service” world of the early 1970s. Sally Patient, who is insured through her employer by Blue Cross/Blue Shield, becomes ill. She seeks medical advice from her general practitioner, Dr. Stone. Dr. Stone has an independent practice on Main Street and medical “privileges” at Mercy Hospital, but has no other contract or employment relationship with the hospital.²¹ Dr. Stone determines that Sally Patient should have her gall bladder removed and refers her to a surgeon, Dr. Fall. Dr. Fall also has privileges at Mercy Hospital. Sally is admitted to Mercy Hospital and Dr. Fall completes the surgery. Dr. Stone, Dr. Fall and Mercy Hospital each bill Blue Cross/Blue Shield separately for their services. Sally is responsible for minor co-pays.

What assurances does Sally have that her providers practice safely? To practice medicine, each physician must be licensed (but not necessarily certified) by the state board of medical practice, a board composed primarily of physicians. If there are subsequent complaints about a physician, those complaints are investigated by the board and may result in censure and disciplinary actions including licensing restrictions, requirements for additional training, practice restrictions and license revocation. In addition, the medical staff at Mercy Hospital grant (and can rescind) medical privileges based upon their collective experience with the physician.

Now speed ahead thirty years to the present. In 2007, Sally’s daughter, Amanda Patient suffers from depression. Amanda’s managed care plan, TruCare, generally provides coverage only if Amanda receives treatment by physicians and hospitals in the TruCare network and is prescribed drugs on the TruCare drug formulary. Amanda’s treating physician at TruCare works at a clinic that is in the TruCare network. The physicians at the clinic believe that without TruCare patients, their practices would wither. They view “deselection” as equivalent to being fired. They understand that each year TruCare makes contractual offers to clinics based on the clinic’s patient outcomes, patient satisfaction, hospitalization rates, and prescription drug prescribing patterns.

Unfortunately, despite being prescribed an antidepressant, Amanda attempts suicide. Her mother finds her still alive and rushes her to the emergency room at Mercy Hospital where she is treated by an Emergency Room doctor, Dr. Faith.

What measures are taken to assure the competence of Amanda’s physicians? While health professionals are still largely “self regulated,” since 1970 the landscape dramatically shifted. There is increased regulation by the government, in part because of the government’s role as payor for 45% of health care. Part of this increased regulation is demonstrated by mandatory reporting of quality of care issues to state and federal agencies. There is increased vigilance and provider oversight by hospitals which are being held more responsible for the negligent acts of their providers, even when those providers are not employees.²² Finally, there is credentialing by managed care organizations to ensure that network physicians are competent—as well as cost effective.

21. Medical privileges generally include the authority to use the hospital to admit and treat patients.

22. See e.g., Ruth A. Anderson & Reuben R. McDaniel, Jr., *Managing Healthcare Organizations: Where Professionalism Meets Complexity Science*, HEALTH CARE MGMT. REV., 83–86 (2000).

As a result, in 2007 Amanda's physicians are licensed and sanctioned, if need be, by state Medical Practice Boards which are slowly becoming less confidential in their processes. In addition, there is more oversight and training of physicians by hospitals. An Emergency Room doctor like Dr. Faith may even be an employee. Significantly, TruCare physicians must be credentialed by TruCare. Whether TruCare considers quality outcomes or financial analyses of physician practices (known as "economic credentialing") or both when selecting providers is a matter of debate. But what is beyond debate is that managed care providers like TruCare are a relatively new addition, but a major player, in assessing provider competency.

Selected challenges to resolving provider competency disputes

Today, health care institutions (hospitals, clinics and managed care organizations) seek to assert more control over physician decision making in order to maintain quality and control costs. Regulators grow more vigilant as concerns over patient safety (like those raised in the Institute of Medicine (IOM) *To Err is Human* report) escalate.²³ One result of this increased scrutiny: more frequent legal disputes. Some of these disputes arise in the traditional context of whether a practitioner has "privileges" at a hospital. More frequently, these disputes arise in the context of termination of hospital contracts, employment terminations, and "deselection" from managed care provider lists. Finally, many of these contract and employment disputes morph into investigations by state Medical Practice Boards into a licensee's competency to practice. While the rules governing these different avenues for provider competency disputes vary, challenges to resolution (outside of litigation) are fairly constant.

- **Mandatory Reporting Obligations.**

Confidential resolution of many provider competency disputes may not be possible. If the hospital finds poor patient care practices which support limiting privileges or terminating an employment contract, for example, a report to the National Practitioner Data Bank may be necessary. The National Practitioner Data Bank is a central repository of information on doctors and other health care providers which contains reports on malpractice payments and other adverse actions.²⁴ Even if the provider resigns shortly after the investigation commences, a report is required. And when a physician seeks hospital privileges elsewhere, that adverse report follows her since hospitals are required to check the data bank when considering an application for privileges. The Data Bank is not, however, open to the general public.

23. The highly publicized IOM report concluded that medical error in hospitals accounted for up to 98,000 inpatient deaths annually. It also focused attention on successful efforts to address medical error, including the need for more open communication and discussions about error and safety and a systems approach to health care delivery. *To Err Is Human: Building a Safer Health System* (Institute of Health, Nov. 1999), available at www.iom.edu/Object.File/Master/4/117/0.pdf (summarizing the report).
24. The National Practitioner Data Bank was created, in part, to prevent doctors with disciplinary history from moving from one state to another, from one hospital to another, without detection. Its website is available at www.npdb-hipdb.com/npdb.html.

Malpractice settlements over a certain amount must be reported.²⁵ Moreover, individual physicians who are aware of patient safety concerns and adverse actions against physicians may have a duty to report them to the state Board of Medical Practice. The Board may then begin its own investigation.

In short, despite the IOM report, which urges open discussion of medical error and safety practices, the reality of the mandatory reporting obligations in the National Practitioner Data Bank and related state program inhibit open discussion—and resolution.

- **The Specter of Litigation.**

Because of the mandatory reporting obligations, fear of litigation from other patients and investigation by licensing boards make it difficult for providers to honestly address what happened—and certainly to apologize for something that went wrong. Some states have enacted statutes which prevent apologies from being admissible at trial to address this concern and encourage open dialogue, but the effectiveness of these laws is an open question.

- **Treatment or Discipline? How to help impaired health professionals while protecting patient safety.**

It is difficult to address provider competency without acknowledging that many safety risks are due to health care workers with past and present substance abuse problems and, to a smaller degree, mental disorders and physical limitations. These situations raise issues of both patient safety and the need to accommodate physicians and other providers with disabilities. Many states take a rehabilitative approach through programs which encourage self reporting and non-punitive measures—with monitoring—to address the tension between patient safety and the need for treatment. But the tension remains.

- **Secrecy vs. Openness: which serves the individual and the greater good?**

Mistakes are inevitable. Discussion of mistakes would create the opportunity to learn from them. But in a system where a mistake places a provider's license and livelihood in jeopardy, true openness is hard to come by. And, of course, many complaints of provider misconduct are without merit.

These are some of the reasons for protecting internal reviews through a “peer review” privilege and shrouding Medical Practice Board investigations in secrecy unless and until a decision to discipline a licensee is made. But there is less accountability to the public—including patients—in this closed society. And reports of up to 98,000 inpatient deaths a year raise concerns about the effectiveness of self regulation largely cloaked in secrecy.

25. See Ansley Boyd Barton, *Recent Remedies for Health Care Ills*, 21 GA. ST. U. L. REV. 831 (Summer 2005).

- **The Need for—and Extent of—Due Process**

Traditionally, statutory and/or common law required that some minimum due process (a notice of the charges and an opportunity to be heard in response to them) be provided a physician before her or his privileges were denied or withdrawn by a hospital. While due process requirements vary among states, the concepts are institutionalized as part of the hospital accreditation process administered by the Joint Commission on Healthcare Organizations.²⁶ Whether similar minimum due process protections should apply to hospital contracts, employment decisions, and managed care contracting claims is more debated—and less settled as a matter of law. But ensuring timely notice to providers of competency concerns and a fair process to resolve them is at the heart of resolving competency disputes.

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Jennifer K. Robbennolt, *What We Know and Don't Know About the Role of Apologies in Resolving Health Care Disputes*, 21 Ga. St. U. L. Rev. 1009 (2005).

Susan Zuckerman, *Mediating Regulatory Disputes Involving Licensed Professionals: The Connecticut Department of Public Health's Experiment*, 62 APR Disp. Resol. J. 14 (2007).

26. Hospitals that seek immunity from actions for damages (except for civil rights claims) under the Health Care Quality Improvement Act (HCQIA), 42 U.S.C. 11101, also must establish minimum procedures for revocation or reduction of privileges. Health plans may also have immunity under HCQIA for adverse decisions if they have a review process that meets these minimum due process standards.

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APPENDIX C

ESSAY TOPICS

Post-Symposium Reflective Essays Published in
Volume 29 of the *Hamline Journal of Public Law & Policy*
(Spring 2008)

Dr. Armand H. Matheny Antommaria
**How Can I Give Her IV Antibiotics at Home
When I Have Three Other Children to Care
For?: Using Dispute System Design to Address
Patient Provider Conflicts in Health Care**

James Coben
**An Intentional Conversation About Conflict
Resolution in Health Care**

John Conbere and Alla Heorhiadi
**Preparing Physicians to Manage Conflict,
or, How the Physician Leadership
College Teaches Physicians to Use Interest-
based Processes**

Dale Hetzler and Carly Record
**Healthcare Conflict Management:
An Obligation of the Board**

Jay Hoecker
**Guess Who's Not Coming to Dinner:
Where are the Physicians at the Healthcare
Mediation Table?**

Diane Hoffmann
**Are Health Care Conflicts Really All That
Different? A Contrarian View**

Carole Houk
**Beyond Apology to Early Non-Judicial
Resolution: The MedicOm Program
as a Patient Safety-Focused Alternative to
Malpractice Litigation**

James P. Jacobson
**To Pay or Not to Pay, That is the Question:
Coverage Disputes Between Health Plans
and Members**

David Matz
**The Inevitability and Perils of "Invisible"
Health Care Conflict**

Bobbi McAdoo
**Physicians: Listen Up and Take Your
Communication Skills Training Seriously**

Linda Morton
**Encouraging Physician-Attorney
Collaboration Through More Explicit
Professional Standards**

David Riemer
**Follow the Money: The Impact of Consumer
Choice and Economic Incentives on Conflict
Resolution in Healthcare**

Charity Scott
Doctors as Advocates, Lawyers as Healers

Charles Wiggins
**"He's Such a Jerk!": Education as a Response
to Professionally Inappropriate Behavior**

APPENDIX D ESSAY EXCERPTS

A Preview of the Published Symposium Proceedings
(Volume 29, *Hamline Journal of Public Law & Policy*,
Spring 2008)

Dr. Armand H. Matheny Antommaria

How Can I Give Her IV Antibiotics at Home When I Have Three Other Children to Care For?: Using Dispute System Design to Address Patient Provider Conflicts in Health Care

While the explicit language of principle-based negotiation may not be familiar to health care providers, this approach is congruent with the American Council of Graduate Medical Education's (ACGME's) Outcomes Project. The Outcomes Project emphasizes evaluating residency programs in terms of the program's outcomes rather than its structure or processes. As part of the Project, the ACGME identified six general competencies. These general competencies focus not only on knowledge, but also on skills and attitudes. While medical knowledge is one competency, they also include patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice. While instruction in interpersonal and communication skills often focuses on topics such as breaking bad news or discussing advanced directives, it could also include negotiation. Alternative dispute resolution providers could partner with residency training programs to provide skill training to residents.

John Conbere and Alla Heorhiadi

Preparing Physicians to Manage Conflict, or, How the Physician Leadership College Teaches Physicians to Use Interest-based Processes

Physicians are obviously key stakeholders in health care. One of the factors in managing conflict in health care is the ability of physicians to participate in interest-based processes. We define interest-based processes as those which aim to satisfy the interests of all involved parties, to the extent this is possible. We do not claim that all conflict has to be resolved in an interest-based manner. However, inability to use interest-based approaches in resolving conflict makes one unable to participate effectively in modern conflict management processes, such as principled negotiation and mediation. Research suggests that physicians might have tendencies that actually make it harder for them to use interest-based conflict resolution processes such as principled negotiation, mediation and collaborative decision-making...[W]hy is it likely that physicians do not live up

to the espoused values of constructive conflict resolution? There is an individual and an organizational reason. The individual reason is that under pressure people are much more likely to resort to core beliefs rather than to espoused values. Many physicians are under stress, work long hours and deal with the continuing failure to adequately fund health care. The physicians often have an inadequate understanding of the business and administrative processes in their organizations, and therefore feel left out of decision-making process. This feeling coupled with stress makes it hard for physicians to embrace, promote, and model a new way of thinking. The organizational reason is that often, when employees are trained in interest-based processes and are eager to use them, the existing culture of the workplace does not allow them to apply new skills.

Dale Hetzler and Carly Record

Healthcare Conflict Management: An Obligation of the Board

Healthcare, as an industry, represents sixteen percent of our economy. It is no small task to change the culture of such a vast industry to adopt conflict management as an integral part of its operation. By recognizing that conflict management is a fundamental part of achieving the goals of patient safety, the duty to create and maintain broad conflict management systems within an organization becomes part of a fundamental call for patient safety improvement. Just as the board requires organizational leaders to provide processes and policies to address clinical failures, the board should require leaders to address communication failures represented in organizational conflict.

Jay Hoecker

Guess Who's Not Coming to Dinner:

Where are the Physicians at the Healthcare Mediation Table?

I. Do Physicians Need to be Present?

My premise is that physicians need to be at the “discussion/decision table” as much as pilots need to be at the airline industry’s table, teachers at the education table, or miners at the mine safety table. Physicians and their employers are often at the center of malpractice claims. Physicians’ services based on training and experience is the fuel that runs the furnace of healthcare. Services provided and conflicts resulting from those services have their birth in the education, research, and practice of physicians; therefore physicians must take active part of the ownership of the healthcare conflict resolution process if that process is to be a durable and workable one. What Can Be Done to Bring Physicians to the “Table?” This is the hardest and most important question, and has no certain or easy answer. Key elements to the answer involve several realities. To come to the “table” physicians will need three basic things: (a) data; (b) the dictates, mandates, or incentives of their employer; and (c) a willingness and desire to share ownership of the process.

Diane Hoffmann

Are Health Care Conflicts Really All That Different? A Contrarian View

[C]onflicts between lawyers and clients and between physicians and patients involve a harm inflicted on a vulnerable patient or client caused by a trusted professional. The conflicts may include communication issues; data or expert judgment disputes over whether a standard of care was violated; differences over the process used to deal with the dispute (apology, transparency, opportunity to be heard); differences over the procedure used to arrive at appropriate compensation as well as what constitutes appropriate compensation; structural barriers such as legal rules governing discovery and the introduction of evidence, and value judgments over whether the professional deserves to be punished for his or her wrongdoing.... The relationships are also similar in that there is a power imbalance between the professional and the client in large part resulting from a difference between the professional's and the client's expertise and knowledge about the substantive issues at stake. Patients and clients come to these professionals because they do not know how to diagnose or treat medical problems or because they do not know the relevant law or how to bring a lawsuit.

Carole Houk

Beyond Apology to Early Non-Judicial Resolution: The MedicOm Program as a Patient Safety-Focused Alternative to Malpractice Litigation

If patients and families desire open, honest communication, why have physicians been shying away from it? On one hand, there are fears of legal repercussions. In federal courts and in all but a handful of states, apologies are admissible against the declarant; physicians are therefore instructed by their lawyers not to apologize. While these concerns can be alleviated by changes in laws, such as state laws barring admission of apologies, some fears do not have their genesis within the legal system.... By removing the secrecy and fear that surround a potential malpractice case, healthcare providers, families, and patients alike may be able to re-instill trust in the medical system and stave off costly litigation expenses. Instead of allowing patients' and families' anger, dissatisfaction, feelings of disappointment, and frustration to ignite and lead to malpractice lawsuits, this difficult experience can be channeled into an integrated conflict management system where patient and family needs can be addressed and fulfilled, open communication and transparency can be promoted, and a culture of identifying system vulnerabilities and collaborating in improving the healthcare system can be supported—truly, a better way.

James P. Jacobson

To Pay or Not to Pay, That is the Question: Coverage Disputes Between Health Plans and Members

It's not easy being a health plan these days. Health plans are commonly blamed for virtually all of the ills in the health care system, including increasing costs, rising premiums, the growing uninsured population, and restrictions on access to life-saving drugs and procedures. During the political season, candidates portray health plans as greedy, unethical, self-serving entities that collect large premiums and then deny coverage

for those in need...Contrary to popular myth, it is not health plan “bean-counters” who are making coverage decisions. Rather, when the coverage concern involves an issue such as in-network care or an “experimental” procedure, medical professionals employed by the health plan, such as physicians and specially-trained nurses, typically review the medical records and, if necessary, consult with outside experts. The health plan also consults, as appropriate, with the member’s physician. The health plan then makes its determination based on the member’s medical condition and treatment needs. If the member is dissatisfied with the plan’s coverage decision, the member has the right to appeal, which usually include both internal and external appeals.

David Matz

The Inevitability and Perils of “Invisible” Health Care Conflict

[T]here is a lot of invisible conflict. This occurs because there are many interactions among highly trained, highly-strung, ambitious professionals, among whom status and experience levels are not always well correlated, working in tight time constraints on problems with high stakes both personally and professionally...[B]ecause the conflict is visible to no one aside from the parties, the number of people who can take responsibility to contain or resolve it is sharply limited...there are many pressures in the organization that work to keep the conflict invisible: these may tend both to contain and resolve it, or to keep parties from focusing attention on it, allowing it to fester. Some pressures that will do this include: a) The culture disfavors “whining”; b) The level of authority that influences advancement and preferment disfavors “whining”; c) The time pressure on professional work does not allow leeway for confronting the conflict; d) The requirements of teamwork (civility, sharing, and trust) override the impulse to confront the conflict; e) Allowing a conflict to become public suggests that one can’t “handle it” alone, a significant weakness in a culture of competence; f) There is a widely shared clarity about decision-making authority even when the decision made and the person making it is resented.

Bobbi McAdoo

Physicians: Listen Up and Take Your Communication Skills Training Seriously

[P]hysicians and other medical professionals must think beyond their traditional philosophical maps. Teaching more effective communication skills in medical training, acknowledged as necessary to the improvement of health care, is a welcome step. The value of using these skills in the broader role of conflict resolution is also a necessity. Given the existence of conflict at every level of the medical profession, affecting the adequacy of medical practice at the individual patient level, conflict resolution could be far-reaching. Some lawyers changed the way they practiced law given their experience in mediation skills training and a new expertise around the concepts of “interests” and “active listening skills.” This small example constitutes support for the hope that physicians and others, with training in communication skills broadly contextualized to the need for conflict resolution, can affect healing in the medical profession as a whole.

Linda Morton

Encouraging Physician-Attorney Collaboration Through More Explicit Professional Standards

[T]hough we lament any rifts between our professions, our greater need, in this society, is to problem solve complex issues effectively. To do so, it is imperative for our professions not just to cooperate, but also to collaborate. Our collaborations will not only help solve complex societal issues, but may also help heal our professional misunderstandings, and even allow for greater professional satisfaction. Training and experience in interprofessional collaboration is certainly important to effective interdisciplinary problem solving. We argue here that, as an initial step in support of this training, the professions of law and medicine must articulate stronger support for interprofessional collaboration in their own professional standards... Though each profession has created standards that may hint at the further collaboration of the professions, we believe the standards do not go far enough. For example, both medical and legal standards stress the teaching of communication skills. However, these communication skills are emphasized only with members of the doctor's or lawyer's own profession, or the doctor's patient and the attorney's client. If we are to close the professional gap between doctors and lawyers, and thus give teeth to the idea of interdisciplinary problem solving, it is incumbent upon the leaders of each profession to create standards specifically encouraging, if not mandating, interprofessional communication and collaboration in their professional training.

David Riemer

Follow the Money: The Impact of Consumer Choice and Economic Incentives on Conflict Resolution in Healthcare

How exactly could ADR professionals help to reform the American health care system? In the short term, perhaps, they might play a useful role in encouraging companies to join together—or, in the case of very large firms, to act on their own—to adopt the cost-conscious “multiple choice” purchasing method. By thus expanding workers' choices while creating strong incentives for health care providers to lower costs and improve quality, they would also promote more efficient and less error-prone delivery of health care, which in turn would marginally diminish the number of health care conflicts... ADR professionals could seek out an important role to play in this reform process. A score of political, ideological, fiscal, legislative and administrative conflicts must be addressed and mediated in order to enact sound laws and programs that provide everyone with health insurance, control cost, improve quality, drive out error, and lower the number of health care conflicts. Who better to help than the trained professionals who make a living solving conflicts? The rough-and-tumble of forging legislative compromise may be territory that ADR professionals have seldom ventured to enter. But the rubicon that divides individual disputes from societal disputes is one that needs to be crossed. The elected leaders and other actors engaged in the legislative process have shown us for decades that they have great difficulty in producing a fair, affordable, high-quality, low-error, low-conflict health care system for this nation. Perhaps they would now be open to professional help as they struggle to overcome their own conflicts about the shape of a new American health care system that produces good results and that the body politic can accept.

Charity Scott

Doctors as Advocates, Lawyers as Healers

If the doctor as a fiduciary is putting the patient's interests above his own or others' interests, then when the needs of the patient require it, the doctor advocates for the patient's interests. Advocating for the patient's welfare reflects the long-standing beneficence principle of medical ethics. To carry out their ethical duty of beneficence (acting in the patient's best interests) and duty of loyalty (respecting and promoting the patient's autonomy to define her best interests), physicians should be able to adopt the advocacy role for their patients as easily and naturally as lawyers have traditionally adopted it for their clients. While it may seem counterintuitive, this view of the physician's advocacy role is not new. Indeed, the AMA has called on physicians to advocate for their patients' welfare in order to promote the physician-patient relationship, and other professional societies have endorsed the view of doctors as their patient's advocate....[A]lternative role models for lawyers, reflecting a sense of the potential healing nature of legal counsel, are increasingly prevalent in legal writings and professional statements. A rich literature has developed which describes the lawyer as the client's "friend," a "wise counselor," and a "problem-solver." Some of greatest lawyers in history have promoted a kinder, gentler, and more constructive role for attorneys, envisioning them as peacemakers and consensus-builders. Recently emerging developments have also envisioned numerous alternative ways of practicing law and pursuing life in the legal profession, including "religious lawyering," "preventive law," "collaborative law," and "therapeutic jurisprudence"...What would conflicts look like if patients were cared for by doctors who viewed themselves as healing advocates? How would conflicts be handled if patients and their providers were represented by lawyers who viewed themselves as zealous healers? The purpose of this essay is to nudge both professions toward adopting and internalizing these alternative and perhaps counterintuitive self-images.

Charles Wiggins

"He's Such a Jerk!": Education as a Response to Professionally Inappropriate Behavior

The doctor's early professional indoctrination stresses individual decision making in a profoundly hierarchical power environment. Nonetheless, physicians usually work as members of a team, and the profession struggles to respond to the "disruptive physician," one who impedes the collaboration necessary to fulfill the healer's role...Lawyers, especially litigators, operate much more overtly in an individualistic milieu. To provide the zealous advocacy required by their professional codes, they frequently take on a disruptive role....Disruptive behavior by both doctors and lawyers is more than just unpleasant. It can be counterproductive, injurious to others, and corrosive of the aspirations at the core of both disciplines. If there is a remedy for the behavior that causes this disease, it will undoubtedly be found in the challenge of a novel approach to training professionals effectively. Clinical legal education provides one model. Its practitioners have developed a body of knowledge and a battery of techniques to address the tension between preparing for an industrialized profession and keeping alive the interpersonal dynamic so critical to the altruistic and empathic aspects of the work. Medical education now faces a similar challenge.

APPENDIX E SELECTED BIBLIOGRAPHY

The Fall 2007 Biennial Symposium on Conflict Resolution: An Intentional Conversation About Conflict Resolution in Health Care November 8–10, 2007 Saint Paul, Minnesota

This document is a work in progress. Please email your suggestions for additions to Sukhsimranjit Singh, DRI Postgraduate Fellow (ssingh01@hamline.edu). No claim is made that this is a comprehensive catalogue of resources; rather this bibliography has been intentionally tied to the anticipated themes of the Symposium. We hope the bibliography will be helpful for all those participating, as well as for those with general interest in the field.

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Symposium Theme and Session Descriptions

The American health care system affects every man, woman and child in our country. It encompasses over 16% of our Gross Domestic Product. Costs of care continue to rise and insurance premiums routinely increase at double-digit rates. Regulators and health care managers impose policies that affect medical decisions and access to treatment. Advertising and internet research drive patient medical requests while the threat of malpractice claims impacts physician judgment and decision-making. Ultimately, fewer Americans can afford the high price of health and many feel disengaged from crucial health and life decisions.

At the same time, we hold onto important myths about our system: that doctors and patients are still in charge of our medical decisions; that the American system promotes egalitarian principles of fairness and open access to the finest care in the world; that individual citizens have real choices about the management of their health. This intractable clash between myth and reality has consumed policy-makers and fueled conflict at many levels for years.

This clash between myth and reality is even more complex in light of our rapidly changing society. Health care decisions are influenced by different and competing value systems: an increasingly diverse and aging population of patients; a growing universe of traditional and non-traditional health care providers; the ever-expanding role of third-party payors; suppliers promoting rapidly changing technologies and marketing directly to patients; policy-makers who promote increasingly divided ideologies and regulators caught in the middle. The result is an overwhelmingly complex set of challenges that provoke conflict at all levels.

How do we move forward? How can professionals from the conflict resolution field be constructive partners with health care professionals in working through these many difficult and complex conflicts? The 2007 Symposium on Advanced Issues in Dispute Resolution addresses these two questions.

Recognizing that the system cannot be easily “fixed” or the problem “solved,” the 2007 Symposium will specifically focus on how health care professionals and conflict resolvers can work together to identify essential guiding principles for addressing conflicts across the health care field. The Symposium will bring nationally recognized representatives of patients, health care providers, payors and regulators together with experienced conflict resolution professionals to identify and articulate a key set of principles for responsible decision-making in health care conflicts.

Session One: Building a Context for Conversation— What Makes Health Care Conflicts Different?

Given the complexity of health care, the challenge of where to begin addressing its conflicts can be daunting. Session one builds a context for our conversation by framing key questions that will help participants discern the scope and complexity of health care conflicts.

Core questions to be addressed in Session One include:

- What role does increased patient access to information and the proliferation of direct advertising play in creating conflict?
- How do increased patient life-span and rapidly improving, yet costly, technologies increase conflict?
- How does the life-and-death nature of health decisions impact decision-making and conflict?
- What is the impact of the uninsured segment of the population on health care decision-making?
- What are the inherent tensions between patients, providers, payors and regulators?
- How do the economic peculiarities of the health care field complicate decision-making at all levels?
- How does the health care field's heavily regulated environment—including mandatory reporting—impact disputes and disputing?
- Is the care of health an entitlement that changes how we understand/address conflicts?
- How does the culture of health care contribute to adverse outcomes that result in inter and intra-organizational conflicts?
- How will a decreasing availability of experienced health care professionals impact conflict within care settings?

Session Two: Developing Guiding Principles for Addressing Patient Care Disputes

Patient-provider conflicts arise from a range of situations, including adverse outcomes, treatment timing and location, decisions over appropriate treatment plans, whether and when to discontinue treatment, and many others. These tensions are exacerbated by existing conflicts among health professionals within patient-care settings. This session focuses on representative examples of patient care challenges and provides a forum to identify principles for constructive resolution of such conflicts. Theme leaders will model a conversation about how to identify conflict resolution principles, followed by small group break-out sessions where participants will themselves develop helpful principles for addressing such conflicts.

Session Three: Developing Guiding Principles for Health Coverage Disputes

An ever-increasing number of conflicts in the health care field arise in relation to coverage. A patient's request for a specific drug or treatment often results in a conflict seen through a variety of lenses: that of the employer who seeks to contain costs; the payor who carefully designs coverage limits; the regulator who weighs in on what constitutes mandatory benefits; the patient who expects treatment to be covered, and the provider who struggles with managed care guidelines, ethical responsibilities and stringent fraud and abuse laws. Additional complications arise in cases of poor quality care, where questions surface of who, if anyone, should pay and what information should be provided to patients about these disputes. The different perspectives of patients, providers and payors create profoundly different expectations and understandings of what can and should be done regarding health coverage. Following an opening conversation about the challenges of coverage disputes, participants will again meet in small groups to identify principles for constructive conflict resolution.

Session Four: Developing Guiding Principles for Addressing Disputes in the Area of Provider Competency

A third category of conflicts in the health care field arises in relation to provider competency. This discussion will focus on provider conflicts, including those over the granting of "privileges" and credentialing of practitioners by hospitals; the complaint and discipline process by health licensing boards; and the credentialing (and de-credentialing) of providers by managed care organizations. We will examine in small groups how conflict resolution is impacted by the peer review privilege, current credentialing mechanisms, mandatory reporting obligations and physicians' ethical obligations.

Session Five: Synthesis

The previous sessions have addressed different categories of conflicts in the health care field. This final session will synthesize the insights that emerged from earlier sessions and will seek to identify an over-arching set of principles for addressing a wide variety of health-care conflicts. Moreover, we will consider whether these declared conflict resolution principles are helpful in addressing much larger policy challenges facing the American health care system.





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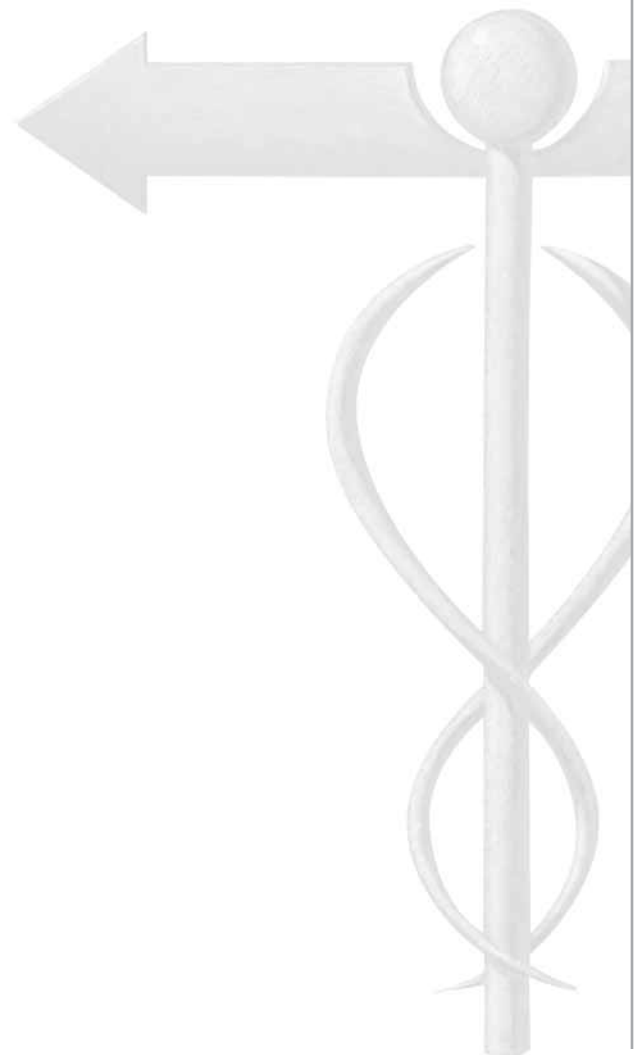
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Web Resources

HEALTH CARE CONFLICT RESOLUTION DATABASES

Alternate Dispute Resolution, South Carolina Bar

Mandatory Medical Malpractice Mediation
www.sctbar.org

AMA, Commission on Health Care Dispute Resolution Process

www.ama-assn.org
[/ama/pub/category/6074.html](http://ama/pub/category/6074.html)

Atkins Mediation Services

Health ADR Articles
www.mediate.com/Atkins

Center for Law, Health and Society, Georgia State University

<http://law.gsu.edu/clhs>

Health Care Resolutions

www.healthcareresolutions.com

National Arbitration Forum

www.adrforum.com

National Library of Medicine and National Institute of Health

www.pubmed.gov

ADR AND HEALTH CARE ORGANIZATIONS

American Health Lawyers Association

Professional association for health lawyers (maintains a panel of mediators and arbitrators with health law background).
www.AHLA.org

Health Care Mediations, Inc.

Mediation, training and system design services for health care organizations.
www.Healthcaremediations.com

Health Care Negotiation Associates

Providing negotiation and consulting services for health care organizations.
www.HCNA.net

The Mediation Group

Providing ADR services in multiple content areas including healthcare.
www.themediationgroup.org

HEALTH CARE ORGANIZATIONS

American College of Healthcare Executives

Professional association for health care executives and managers.
www.ache.org

American College of Physician Executives

Professional organization for physician executives and managers.
www.acpe.org

American Hospital Association

Professional association for hospitals and other health care facilities.
www.aha.org

American Medical Association

Professional association for physicians.
www.ama-assn.org

American Medical Group Association

Professional association for medical group practice managers and physicians.
www.amga.org

American Nurses Association

National nursing association.
www.ana.org

American Organization of Nurse Executives

National association for nurse executives and nurse managers.
www.aone.org

American Society for Healthcare Human Resources Administration

Organization for professionals in health care human resources administration and management.
www.ashhra.org

Joint Commission of Accreditation of Healthcare Organizations

National accreditation association for hospitals.
www.jcaho.org

National Information Center for Health Services Administration

Center for research and information related to health services administration.
www.nichsa.org

National Patient Safety Foundation

National association dedicated to improving patient safety within the nation's health care facilities.
www.npsf.org

Related Symposia/Themed Publications

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ABOUT THE DISPUTE RESOLUTION INSTITUTE

Established in 1991, the Dispute Resolution Institute offers rigorous academic discourse, hands-on simulation experience, and cross-disciplinary examination of alternative dispute resolution themes in domestic and summer abroad courses for law students, lawyers, and other professionals. The Dispute Resolution Institute's mission is to educate students in the full range of theory and skills needed to be successful creative agents of conflict resolution and social healing both at home and abroad.

Ranked by *U.S. News & World Report* in the top five among American law school dispute resolution programs for the last eight years, Hamline complements its diverse international and domestic ADR course offerings with impact scholarship, research, and practice.

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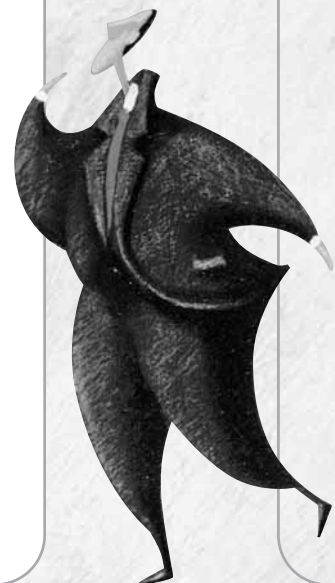
Hamline University School of Law established the Health Law Institute in 2006 to provide a broad range of learning opportunities to students, scholars and health care professionals. During its inaugural year, the Health Law Institute began to educate the leaders of today and the leaders of tomorrow. Through specialized classes and externships from professors, who know both the courtroom and the boardroom, the Health Law Institute instilled real-life health law experience in our students. Through the Institute's national speaker series and advanced expertise classes for working professionals, we partnered to learn with the Upper Midwest's health care community of lawyers, managers, compliance officers, and policy makers. We are committed to instilling practical skills, providing a forum for health law policy issues, and nurturing scholars and practitioners through our curriculum and events.

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