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Innovative Approaches to Managing Health Care Conflict

***401 HEALTHCARE CONFLICT MANAGEMENT: AN OBLIGATION OF THE BOARD**

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I. Summary

When an issue with the magnitude of the conflict within healthcare confronts an industry, its resolution should not be left to the administrative and operational staff of the many entities involved. The very top level of authority within each organization should be held responsible for ensuring that sufficient conflict management resources and processes are identified and implemented. Because of the relationship between conflict within an organization and patient harm, this obligation rests with the organization's board.

II. Introduction

We watched as the snow quickly diminished the panoramic view from the top floor of the Klas Center at Hamline University. It was, after all, mid-November, and the floor-to-ceiling windows of this large gathering space let in the beauty of the moment while protecting us from the cold. On the morning of the first day of the Symposium, the group consisted of well-respected, experienced and qualified men and women involved in healthcare who were, or represented: physicians, nurses, educators, attorneys, conflict managers, researchers, safety experts, quality experts, pediatric and adult patients, hospitals, other providers, ethicists, educators, policy makers, state and federal regulators, state and federal government payors, and private payors. The virtual whiteout *402 lasted only a few beautiful minutes as we began the struggle to put our arms around the range of healthcare conflict we were addressing at the symposium. It was thrilling to be part of this group, and to have the luxury of spending two full days absorbed in this topic. And it was difficult, nearly impossible, to capture all of the implications of healthcare conflict that arose in so many ways and to attempt to make sense of it all.

III. Conflict in Healthcare

While the many implications of conflict in healthcare are important, the one that seemed to be a constant theme was that conflict within and among stakeholders in healthcare directly and indirectly harms patients in so

many ways. Physical harm flows from inadequate communication ending in adverse outcomes or errors. [FN3] Emotional harm and heightened stress are caused by the confounding conflict that attends the complex interaction among payors, beneficiaries, providers and the many related evaluators and intermediaries. [FN4]

The sources of conflict and resulting harm in the healthcare environment are documented well. Ranging from articles published in law review journals to articles published by professional organizations, much attention has been given in recent years to both the sources of conflict in the healthcare environment, and to the effect of such conflict on issues including, but not limited to, patient safety, financial concerns and litigation. For example, internal disputes are documented as sources of conflict in *403 the hospital setting. [FN5] Internal disputes include those conflicts that exist “among hospital employees or between the hospital and its employees.” [FN6] The Veterans Health Administration in 2005 found that more than three-quarters of nurses surveyed, and nearly half of physicians surveyed said they had witnessed disruptive behavior among nurses and physicians. [FN7]

It comes as no surprise to those involved in healthcare that this kind of disruptive behavior oftentimes threatens patient safety. [FN8] With medical errors affecting approximately one in ten patients around the world, [FN9] one wonders how many of these errors are a result of conflict among provider personnel. The World Health Organization released a list of nine solutions “aimed at improving patient safety.” [FN10] Third on this list was improving communication during patient hand-over. [FN11] The Joint Commission considers miscommunication to be the leading cause of sentinel events reported in the United States. [FN12] Another study found that nurses were increasingly frustrated with the inability to deliver correct medications to patients due to a strained relationship between the hospital and pharmacies. [FN13] (The difference between *404 communication gaps and strained relationships may be significant. When relationships are strained, is there real hope that communication will improve?)

The study went on to state that conflict was not isolated to nurses or even between nurses and physicians, but actually existed throughout the hospital hierarchy. [FN14] Surgeons experienced conflict with other surgeons regarding the basic scope of physician credentialing, specifically, who was entitled to perform what type of surgery. [FN15] These issues can cause longstanding conflict among caregivers, which not only threatens effective communication among caregivers, but also threatens patient safety. [FN16]

Unfortunately, conflict exists not only among the professional staff, employees and employers of a hospital, but also between caregivers and patients. Conflicts between patients and hospitals stem from a variety of issues, including the lack of good communication, multicultural differences, and the complex clinical environment. [FN17]

IV. Application of Conflict Systems

One primary area of conflict is in the way unintended outcomes of treatment are communicated and resolved. Various studies have found that when a medical error occurs, either serious or minor, most patients want acknowledgement that a mistake has been made, an apology, information as to why the mistake occurs so that it does not occur again, and sometimes an assurance that some form of compensation will be made. [FN18] While these appear to be easy solutions, laws regarding full disclosure and the legal *405 effect of apology by physicians vary from state to state. [FN19] Traditionally, lawyers advised physicians not to offer apologies or information regarding responsibility for unintended outcomes because the admissibility of such statements in court could lead to further liability for the hospital. [FN20] Unfortunately, without full disclosure the likelihood that

mistakes will be repeated is high because physicians and hospitals are unable to learn from their mistakes. [FN21] Recently, in response to research showing that disclosure and apology lessen the likelihood of litigation, the laws have begun to evolve. [FN22] Apology and/or disclosure laws have been enacted in several states, either protecting apology from being used as evidence of an admission of liability in court or requiring disclosure in the event of a serious error, increasing the pressure upon providers to adopt adequate communication and resolution systems. [FN23] Thus, hospitals experience conflict not only among employees, but also among professional staff, as well as between employees and patients. These sources of conflict lead to a decline in patient safety and an increase in medical errors, costing hospitals an enormous amount of money and perhaps their reputation as well.

V. Patient Safety and the Board

The board of directors (or board of trustees) of an organization is responsible for the decisions and systems that *406 control operations within a company. [FN24] The board owes a duty to the organization to assure that the employees and leadership of the company have adequate systems and policies to address the operational demands of their business. [FN25] In any business there are some fundamental concerns that are to be addressed by the board in order to facilitate operations. [FN26]

Within each industry there are additional specific obligations imposed on the company by regulatory and legal requirements. In some industries statutes, regulations and legal doctrines have been developed to place responsibility, even criminal responsibility, on the leaders within an organization. [FN27] It is the duty of the board to assure that the administration of the organization addresses these additional requirements. [FN28] Within a healthcare provider, among other duties, the board is responsible for the oversight of quality/patient safety, physician peer review, and professional credentialing. [FN29] The Joint Commission, the *407 primary accrediting body for hospitals, [FN30] establishes many requirements for the organization and operation of the board of a hospital. [FN31]

VI. Conflict and Patient Safety

Patient safety is a broad area that includes any aspect of delivering clinical services to patients. [FN32] The goal of patient safety efforts is to prevent the unintended harm caused by error and to create systems to protect against preventable unintended outcomes. [FN33] Significant resources have been invested in quantifying the harm caused by error in healthcare, and in identifying those systems and processes that should be targeted as first lines of attack on unintended harm. [FN34]

*408 At the same time, conflict managers and some healthcare risk managers have embraced full disclosure and apology as the appropriate thing to do when preventable harm occurs. [FN35] This approach helps create a culture of resolution instead of litigation, and has shown financial benefits when properly implemented. [FN36] It brings the resolution of these events into line with the patient safety processes that are so dependant on an open exchange of information about system failures in order to make improvements.

VII. The Challenge

However, it has been the frustration of conflict management professionals involved in healthcare that there seems to be no general industry adoption of conflict management principles by healthcare organizations. [FN37]

This lack of general *409 adoption is despite research showing the prevalence of conflict in many aspects of healthcare operations. [FN38]

Healthcare, as an industry, represents sixteen percent of our economy. [FN39] 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.

The board must insist that systems to prevent and manage conflict, attendant to the obligations carried out to assure the proper treatment of patients, be funded and implemented. Patient safety programs track occurrences and near misses, chart the frequency of deviations from protocol, and perform root cause analysis on events that cause or threaten harm to patients. They should also be expected to address the existence of unresolved conflict and have the same attention paid to training in conflict management as they do training in other behavioral systems that directly impact the delivery of care.

VIII. Conclusion

Culture and leadership are the most powerful indicators of an organization's ability to model behavior. We know that communication issues are the leading cause of preventable adverse *410 events. [FN40] We also know that communication difficulties are often part and parcel to conflict. [FN41] It is time to look at healthcare conflict management as an issue that cannot be dealt with from the bottom up. Yes, conflicts arise at the very personal and interpersonal level. But these conflicts must be seen as symptoms of an underlying systemic need—the need for those accountable for the very existence of the enterprise to champion prevention and management of conflict. It is an obligation of the board that has been overlooked for far too long, and to the great detriment of patients.

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[FN3]. William Ide, WHO Lists 9 Ways to Prevent Health Care Errors, Voice of Am., May 2, 2007, available at <http://www.voanews.com/english/archive/2007-05/2007-05-02-voa63.cfm>; see also The Joint Commission, Sentinel Event Statistics, <http://www.jointcommission.org/SentinelEvents/Statistics/> (last visited Apr. 2, 2008).

[FN4]. Managing Conflict, 27 Am. J. Critical Care Nurse 46, 46-47 (Supp. Feb. 2007); The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada, Jt. Comm'n J. on Quality and Patient Safety, Vol. 33 No. 8, pp.467-76 (Aug. 2007).

[FN5]. Orna Rabinovich-Einy, [Beyond IDR: Resolving Hospital Disputes and Healing Ailing Organizations Through ITR](#), 81 St. John's L. Rev. 173, 182 (2007).

[FN6]. *Id.* at 182.

[FN7]. Study: Infighting Among Doctors and Nurses is Frequent and Harms Patients, *Healthcare Risk Management*, Vol. 27, No. 3, at 25 (Mar. 2005), available at http://www.ahcpub.com/hot_topics/?htid=1&htid=1480.

[FN8]. *Id.*

[FN9]. *Id.*; supra note 3.

[FN10]. Press Release, Pan American Health Organization, WHO Launches “Nine Patient Safety Solutions” to Save Lives and Avoid Harm, (May 2, 2007), available at <http://www.paho.org/English/DD/PIN/pr070502.htm>.

[FN11]. *Id.*

[FN12]. Amy D. Waterman et al., *Communication During Patient Hand-Overs*, Patient Safety Solutions (World Health Organization, Geneva, Switzerland), Vol.1, Solution 3, May 2007, at 1, available at <http://www.jcpatientsafety.org/fpdf/Presskit/PS-Solution3.pdf>.

[FN13]. Janice L. Dreachslin & Diane Kiddy, *From Conflict to Consensus: Managing Competing Interests in Your Organization*, *The Healthcare Executive*, Nov./Dec. 2006, at 9.

[FN14]. *Id.*

[FN15]. *Id.*

[FN16]. *Id.* at 11.

[FN17]. *Managing Conflict*, supra note 4, at 46.

[FN18]. Paul B. Hoffman, *Responding to Clinical Mistakes*, *The Healthcare Executive*, Sept./Oct. 2006, at 33; see also Norman G. Tabler, Esq., *Should Physicians Apologize for Medical Errors*, *Health Law.*, Jan. 2007, at 25; see also Anita Slomski, *The Hardest Word*, *Protomag.com*, Fall 2007, at 24.

[FN19]. Tabler, supra note 18, at 23; see also Rachel Zimmerman, *Doctors' New Tool to Fight Lawsuits: Saying I'm Sorry*, *Wall St. J.*, May 18, 2004, at A2.

[FN20]. Hoffman, supra note 18, at 33; see also Zimmerman, supra note 19, at A2.

[FN21]. William A. Nelson & Justin Campfield, *Ethical Implications of Transparency*, *The Healthcare Executive*, Nov./Dec. 2007, at 33.

[FN22]. See, e.g., Lucian L. Leape, MD, *Full Disclosure and Apology: An Idea Whose Time Has Come*, *Physician Executive* (Mar./Apr. 2006); Nelson & Campfield, supra note 21, at 33; see also Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 *Mich. L. Rev.* 460 (2003) (analyzing the legal debate over apologies).

[FN23]. See, e.g., States With Apology Laws, <http://www.jcpatientsafety.org/fpdf/Presskit/PS-Solution3.pdf>. www.sorryworks.net/lawdoc.phtml (last visited Apr. 1, 2008).

[FN24]. [Ga. Code Ann. § 14-3-830](#) (2007) (describing the standard of conduct required for directors of nonprofit organizations); see also [Ga. Code Ann. § 14-2-830](#) (2007) (describing the standard of conduct required for directors of business corporations).

[FN25]. Peter R. Gleason & Alexandra R. Lajoux, *The Governance Hierarchy: Arbiter of Progress for Boards*, Ethisphere, 2007, at 18, Q3.

[FN26]. *Id.*

[FN27]. *United States v. Park*, 421 U.S. 658, 668 (1975) (stating “individuals other than proprietors are subject to the criminal provisions of the [FDCA] [because] ‘the only way in which a corporation can act is through the individuals who act on its behalf’”); [Ga. Code Ann. § 16-2-22](#) (2007) (describing when an agent of a corporation may be held criminally liable for an act or the omission of an act).

[FN28]. [Ga. Code Ann. § 14-2-801](#) (2007) (providing for the business and affairs of the corporation to be managed under the direction of the board); see also [Ga. Code Ann. § 14-3-801](#) (2007) (providing for the business and affairs of a non-profit corporation to be managed under the direction of the board).

[FN29]. [O.C.G.A. § 31-7-15](#) (2007) (providing for peer review); see also Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors, (DHHS OIG, AHLA 2007); The Office of Inspector General of the US Dept. of Health & Human Services & The American Health Lawyer's Association, *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors*, (DHHS OIG, AHLA 2007), <http://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRsceGuide.pdf>.

[FN30]. The Joint Commission, *Facts About -the Joint Commission* (Mar. 2007), http://www.jointcommission.org/AboutUs/joint_commission_facts.htm.

[FN31]. The Joint Commission, *2008 National Patient Safety Goals*, (2008), http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/08_hap_npsgs.htm (last visited Apr. 1, 2008) (outlining new requirements to improve patient safety including provisions regarding the administration of medication, improving communication, and infection control).

[FN32]. *Id.*; *supra* note 3, at 3; see also Jim Conway, *Patients and Families - Powerful New Partners for Healthcare and for Caregivers*, *The Healthcare Executive*, Jan./Feb. 2008, at 60.

[FN33]. See generally Paul Davies, *First State Hospital Report Card Is Issued*, *Wall St. J.*, Jan. 20, 2005, at D5; see also Karen S. Fasler, *Combining Collaborative Law and Patient Safety Programs- A Proposal for the Use of Parallel Processes to Facilitate Early Detection of Safety Issues and Early Preparation for Injury-Causing and Near-Miss Episodes*, *16 Alternative Resolutions* 13 (2007).

[FN34]. See e.g. Curtis Brown & Keith Maurer, *Arbitrating Healthcare Billing Disputes: Best Practices for Patient-Provider and Provider-Payer Dispute Resolution*, *The Metropolitan Corporate Counsel*, Mar. 2007, at 14 (estimating administrative costs account for forty percent of all healthcare dollars spent); see also Joyce Gannon, *Mediation Helps Hospitals Steer Clear of Courtrooms*, *Pittsburgh Post-Gazette*, Mar. 7, 2007, available at <http://www.post-gazette.com/pg/07066/767315-28.stm> (describing average jury awards and mediation costs in medical malpractice suits); see also June M. Sullivan, *Recent Developments and Future Trends in Electronic Medical*

and Personal Health Records, *The Health Law.*, Jan. 2007, at 16 (stating that healthcare costs are expected to exceed 2.2 trillion dollars); see also Rachel Zimmerman, *Doctors' New Tool to Fight Lawsuits: Saying I'm Sorry*, *Wall St. J.*, May 18, 2004, at A2 (finding that big jury awards are driving healthcare costs even higher).

[FN35]. See e.g. Lucian L. Leape, MD, *Full Disclosure and Apology: An Idea Whose Time Has Come*, *Physician Executive* (Mar./Apr. 2006); Nelson & Campfield, *supra* note 21, at 33; Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 *Mich. L. Rev.* 460 (2003) (analyzing the legal debate over apologies).

[FN36]. See e.g. Lindsey Tanner, *Doctors Advised: An Apology a Day Keeps the Lawyer Away*, *Associated Press* (Nov. 2004), <http://www.law.com/jsp/article.jsp?id=1100137001367>.

[FN37]. Lola Butcher, *Lawyers Say "Sorry" May Sink You in Court*, *The Physician Executive*, March/April 2006, at 20 (finding that different states have different laws regarding the admissibility of apologies in malpractice cases); see also Norman G. Tabler, Esq., *Should Physicians Apologize for Medical Errors*, *The Health Law.*, Vol. 19, No. 3 (Jan. 2007); see also Anita Slomski, *The Hardest Word*, *protomag.com*, Fall 2007, at 21 (analyzing different approaches to conflict management in healthcare).

[FN38]. *Managing Conflict*, *supra* note 4; see also Orna Rabinovich-Einy, *Beyond IDR*, *supra* note 5; see also *Study: Infighting Among Doctors and Nurses is Frequent and Harms Patients*, *Healthcare Risk Mgmt.*, Mar. 2005, at 25.

[FN39]. Marc Kaufman & Rob Stein, *Record Share of Economy Spent on Health Care*, *Wash. Post*, Jan. 10, 2006, at A01, available at <http://www.bls.gov/oco/cg/cgs035.htm>.

[FN40]. See e.g. Janice L. Dreachslin & Diane Kiddy, *From Conflict to Consensus: Managing Competing Interests in Your Organization*, *The Healthcare Executive*, Nov./Dec. 2006, at 9; William A. Nelson & Justin Campfield, *Ethical Implications of Transparency*, *The Healthcare Executive*, Nov./Dec. 2007, at 33.

[FN41]. *Id.*