



Hamline Journal of Public Law and Policy  
Spring 2008

Special Feature:

Fall 2007 Symposium on Advanced Issues in Dispute Resolution

Doctors and Lawyers: Pathways to Collaboration

**\*287 PHYSICIANS: LISTEN UP AND TAKE YOUR COMMUNICATION SKILLS TRAINING SERIOUSLY**

Bobbi McAdoo [\[FN1\]](#)

Copyright (c) 2008 Hamline Journal of Public Law and Policy; Bobbi McAdoo

## I. Introduction

[E]ffective communication has been linked with increases in patient and physician satisfaction, better adherence to treatment plans, more appropriate medical decisions, better health outcomes, and fewer mal-practice claims. [\[FN2\]](#)

These are exciting times for medical professional education. The need for physicians to receive training in communication skills may have reached a “tipping” point. [\[FN3\]](#) The diffusion of innovation theory suggests that, if this is so, general acceptance will follow exponentially. [\[FN4\]](#) Since we know that effective listening is one key to client satisfaction, this is good news.

**\*288** Systems change is difficult, and changes in professional education are no exception. Therefore, the Guiding Principles resulting from the Hamline Symposium must explicitly support the institutional requirements for communication skills training now in place for medical professionals. Moreover, the reach of this training should encompass the understanding of communication skills as one tool in conflict resolution generally to support the overall improvement of our health care delivery systems.

This short essay will look at the broad institutional support now in place for communications skills training in the medical field. Then, the effect of mediation skills training will be examined for its role in changing the approach some lawyers take to conflict resolution and the practice of law. Physicians, as well as nurses, medical technicians, insurers and regulators can all learn from this example; its potential should inform the Guiding Principles.

## II. The Health Law Symposium

As I listened to Symposium speakers educate participants about the incredible complexity of disputes in the health care field, I was struck by the inevitable conflicts caused by different visions of optimal outcomes for patients, whether these conflicts are between differently trained physicians and nurses, between physicians and patients who feel bewildered by a host of unexplained treatment options, or between insurance providers and phys-

icians and patients, each with slightly different objectives for patient care decisions. The need to understand the interests [FN5] of these different actors and, more importantly, to enhance the opportunities for meaningful communication between and among them seemed obvious and missing.

If asked about the predominant work of physicians, it is doubtful many would answer that it is the resolution of conflict between people. Therefore, the need for training in the theory and \*289 practice skills associated with conflict resolution (e.g., conflict theory, negotiation skills, and communication skills) may not be intuitive. [FN6] But the existence of research-based support for this training undoubtedly contributed to the present inclusion of communications skills training, including “active listening” for others' interests and perspectives, as necessary in medical education.

### III. Communication Skills in Health Care Training and Education

Research in the 1960's established a foundation for the importance of communication in physician-patient relationships. [FN7] It has only been in the last decade, however, that key organizations of the medical profession have acknowledged its importance. Consider the following efforts in medical training and education by a plethora of medical organizations concerned with quality and performance improvement for physicians:

In the face of growing awareness of the magnitude of deaths from medical errors, the Institute of Medicine (IOM) initiated a major project to examine all aspects of the health care industry. In a widely cited and influential publication, \*290 *To Err is Human*, recommendations were made by the IOM to improve patient safety in the areas of leadership, improved data collection and analysis, and development of effective systems at the level of direct patient care. Under the principle “Create a Learning Environment,” a key objective was: “Develop a working culture in which communication flows freely regardless of authority gradient.” [FN8]

Since 1999, the American Board of Medical Specialties (ABMS) and the Accreditation Council for Graduate Medical Education (ACGME) require demonstrated competency in six core areas through a Maintenance of Certification (MOC) process. One core competency reads:

Interpersonal and Communication Skills - Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically sound, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader). [FN9]

The Medical Schools Objectives Project (MSOP) of the Association of American Medical Colleges (AAMC) has \*291 developed learning objectives and assessment tools for medical school programs. One example encompasses a specific communication standard requiring students to demonstrate “the ability to communicate effectively, both orally and in writing, with patients, patients' families, colleagues, and others with whom physicians must exchange information in carrying out their responsibilities.” [FN10]

As part of the MSOP, the AAMC issued a white paper, *Contemporary Issues in Medicine: Communication in Medicine*, in October 1999, to identify the core behaviors and interpersonal skills that should be taught and assessed to fulfill the AAMC communication standard. [FN11]

The American Medical Association (AMA) launched an Initiative to Transform Medical Education (ITME) in 2005. The ITME report (2007) calls for the re-conceptualization of many aspects of medical education including the need to ensure that the core content of medical education includes: “information acquisition and applica-

tion, self-assessment, professionalism, and specialized communication skills.” [FN12]

**\*292** Comparison of the Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree published by the Liaison Committee on Medical Education (LCME) shows increasing attention to the requirement of communications skills instruction as part of an M.D. program of study. [FN13]

The Federation of State Medical Boards Special Committee on Maintenance of Licensure has proposed that physicians seeking re-licensure should demonstrate continued competence in, among other areas, “interpersonal and communication skills.” [FN14]

The United States Medical Licensing Examination (USMLE) has implemented a clinical skills assessment to ensure that students can demonstrate ability to interact/communicate with standardized patients. [FN15]

**\*293** Most of these requirements are relatively new. Their consistency in calling for communication skills training is breathtaking. The question, of course, is whether this will make a difference to the practice of medicine. On the basis of experience with mediation skills training for lawyers, it could make a lot of difference. A handful of very simple concepts from this training, when tailored to the needs of the medical field, have the potential to help medical professionals address a broad range of conflicts in hospitals, in clinics, with insurers, or with patients. To the degree that the demand for communication skills training in medical education can be put into the context of its relevance to conflict resolution generally, this will broaden its usefulness to the health care field.

#### IV. “The Lawyer's Philosophical Map”

As I listened at the Symposium, much of what I heard resonated for me with challenges faced by lawyers in the early development of the Alternative Dispute Resolution (ADR) [FN16] field: would ADR change the lawyer/client relationship; how could a lawyer practice in this “new” way if not all lawyers were doing it; did the suggestion of ADR make the lawyer look weak; how did ADR relate to the “usual” way of lawyering, i.e., applying the law to the facts of the case. In an important 1982 article, Professor Leonard Riskin articulated the framework (or “map”) under which lawyers work and recognized the limitations caused by the usual assumption in litigation that every problem faced by a lawyer can be solved by a judge or jury applying the correct legal rule. [FN17] In **\*294** promoting the possible use of mediation, [FN18] Riskin liberated thinking away from sole reliance on the traditional “lawyer's philosophical map,” which he believed constrained lawyers from the kind of creative problem solving that is often needed in the best interests of clients. Professor Riskin wrote:

Mediation training and practice can help lawyers question the many (often unconscious) value pre-suppositions that underlie normal lawyer behavior--for example, assumptions about adversariness and rules, how lawyers behave, and what clients want--from which we tend to operate automatically. Mediation training, in other words, may help lawyers break out of the ‘mental grooves and compartments’ characteristic of the lawyer's conventional world view. This can lead not just to mediation but to legal services that are more responsive to the needs of clients and of society. [FN19]

During the last twenty-plus years, I have trained hundreds of people, primarily lawyers, in mediation skills. The purpose of the training was most often to prepare neutrals to deliver mediation services in court connected cases; occasionally, training prepared **\*295** stakeholders to participate in mediation sessions. [FN20] At the end of typical 30-hour training sessions, it was not uncommon for several lawyer trainees to speak with me privately

and say something like, “I can't perform this neutral role. I am too much of an advocate. But I will never practice law the same way after this training.”

What did those lawyers mean?

At the risk of gross simplification, I point to two specific components of mediation skills training that help lawyers to forsake the traditional “philosophical map” in their practice of law: 1) the distinction between “positions” and “interests”; and 2) the emphasis on communication skills, specifically “active listening.” [FN21]

The classic book, *Getting to Yes*, popularized the importance of looking behind the positions of parties in conflict to understand their interests, i.e., that which is motivating them, their \*296 “needs, desires, concerns, and fears.” [FN22] Professors Fisher, Ury, and Patton articulated the notion that the human interest in taking care of basic needs--“security, economic well-being, a sense of belonging, recognition and control over one's life” [FN23]--when addressed, can “increase the chance of both reaching agreement and, if an agreement is reached, of the other side's keeping to it.” [FN24] Mediation skills training programs for lawyers use this concept as a tool to help parties “mutualize” their differences: to help parties “recognize areas of shared concerns, interests, or benefits.” [FN25] Alternatively, differing interests, if identified, also can assist parties to resolution because of trade-offs made in the give-and-take of the negotiation process. [FN26]

Another key mediator tool taught in mediation training programs is the ability to “actively listen” to parties' stories: focus on verbal and non verbal messages; understand the expression of psychological and substantive needs and interests; express appropriate empathy; reframe; “loop back” and summarize as necessary; ensure that each party understands the perspective of \*297 the other and hopefully, through this, refocus parties towards a future that includes resolution. [FN27]

Those lawyers who felt they would change the way they practiced law after mediation skills training found their standard “philosophical map” first challenged, and then changed, during the training. They acquired new skills to enable them to communicate more deliberately and accurately with their clients and to involve them meaningfully in the decision-making process. Importantly, they also realized that negotiating with opposing counsel on the basis of both clients' interests, instead of just legal positions, expanded the range of good options for resolution. [FN28]

It seems obvious (now!) that lawyers should intuitively welcome the chance to enhance their understanding of how to do their job, i.e., resolve conflict. It also seems obvious (now!) that lawyers, in order to adequately represent their clients, should resonate with the need to listen carefully to what their clients and opposing counsel's clients articulate as their priority needs. But this requires that lawyers re-conceptualize their professional roles and expand their repertoire of skills beyond what was demanded on their traditional “philosophical map.”

What I heard at the Symposium suggested that now physicians 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. [FN29] 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 \*298 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 pro-

fession as a whole.

## V. Conclusion

Training in communication skills is being recognized as critically important by the key institutional players in the medical field. Using mediation skills training as an example, we can expect that this training will have a far-reaching effect on the resolution of a broad array of conflicts in the medical profession. Therefore, the Guiding Principles need to strongly support the communications skills mandate and call for its delivery in an expansive framework of conflict resolution.

[FN1]. Professor and Senior Fellow, Dispute Resolution Institute, Hamline University School of Law. Many thanks to Jim Coben and Cindy Jesson and their staffs for a stimulating “conversation.” My heartfelt thanks also to my colleague Peter Thompson and my husband Jim Gahlon for their suggestions and encouragement and to Ross Oden for his excellent research assistance.

[FN2]. Gregory Makoul & Raymond H. Curry, *The Value of Assessing and Addressing Communication Skills*, 298 JAMA 1057, 1057 (2007). Makoul and Curry cite a Canadian study in which “low scores on the communication component of a standardized clinical skills examination indicated higher risk for patient complaints about physicians to medical regulatory authorities.” *Id.* at 1058.

[FN3]. See generally Malcolm Gladwell, *The Tipping Point: How Little Things Can Make a Big Difference* 3-14, 253-59 (2002) (discussing the theory of tipping points as agents of social change through the creation of “social epidemics,” which result in the potential for widespread acceptance of ideas).

[FN4]. See, e.g., Greg Orr, Book Review, *Diffusion of Innovations*, by Everett Rogers (Mar. 18, 2003), available at <http://www.stanford.edu/class/symbys205/Diffusion%20of%20Innovations.htm>.

[FN5]. See *infra* notes 22-27 and accompanying text.

[FN6]. At the Symposium, however, there were many references to the need for this training. In fact, at the final session, it was suggested that a basic Conflict Resolution 101 course would have been helpful for the health care participants at the Symposium.

[FN7]. See Barbara M. Korsch, Ethel K. Gozzi & Vida Francis, *Gaps in Doctor-Patient Communication: Doctor-Patient Interaction and Patient Satisfaction*, 42 *Pediatrics* 855 (1968). Korsch and her colleagues found correlations between patient satisfaction and physician reassurance: patients wanted attention to their ideas and expectations and a clear statement of causation. *Id.* at 866-867. They further found that physician-patient “communication could be satisfactory and effective ‘in as little as 5 minutes.’” *Id.* at 868-69; see also Vida Francis, Barbara M. Korsch & Marie J. Morris, *Gaps in Doctor-Patient Communication: Patients' Response to Medical Advice*, 280 *New Eng. J. Med.* 535, 538 (1969) (patient satisfaction level correlated to patient compliance).

[FN8]. Institute of Medicine, *To Err is Human: Building a Safer Health System* 178 (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson eds., 2000). The IOM report stated that “[t]echniques for such communication can be taught,” and that “such a change in communication patterns” needs to begin “at least with medical residency training and nursing training.” *Id.* at 180; see also Institute of Medicine, *To Err is Human: Building a Safer*

Health System (Nov. 1999), available at <http://www.iom.edu/Object.File/Master/4/117/0.pdf> (summarizing the principle publication).

[FN9]. American Board of Medical Specialties, MOC Competencies and Criteria, [http://www.abms.org/Maintenance\\_of\\_Certification/MOC\\_competencies.aspx](http://www.abms.org/Maintenance_of_Certification/MOC_competencies.aspx) (last visited Apr. 6, 2008).

[FN10]. American Association of Medical Colleges, Report I: Learning Objectives for Medical Education: Guidelines for Medical Schools 7 (Jan. 1998), <http://www.aamc.org/meded/msop/msop1.pdf>.

[FN11]. American Association of Medical Colleges, Report III: Contemporary Issues in Medicine: Communication in Medicine 3 (Oct. 1999), <http://www.aamc.org/meded/msop/msop3.pdf>. Professor Gregory Makoul, a well-known scholar in the medical communications field, authored the White Paper. *Id.* at 2. Makoul has developed a communication skills behavioral assessment instrument as one framework for medical education. See generally Gregory Makoul, *The SEGUE Framework for Teaching and Assessing Communication Skills*, 45 *Patient Teaching & Counseling* 23 (Oct. 2001). The SEGUE framework groups 32 skills into the following components of a medical encounter: “Set the stage; Elicit information; Give information; Understand the patient's perspective; [and] End the encounter.” *Id.* at 23, 32-33 (emphasis omitted).

[FN12]. American Medical Association, Initiative to Transform Medical Education: Recommendations for Change in the System of Medical Education 2-3 (June 2007) (emphasis added), <http://www.ama-assn.org/ama1/pub/upload/mm/377/finalitme.pdf>.

[FN13]. The 1985 version does not make explicit any requirement for communication skills content; the 1997 version makes communication skills instruction and evaluation explicit, but the prescription is not nearly as developed as the content requirement specified in the 2007 version. Compare Liaison Committee on Medical Education [LCME], *Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree [Standards]* 2-3, 15 (2007), available at <http://www.lcme.org/functions2007jun.pdf>, with LCME, *Standards* 13-15 (1997) (on file with author) and also with LCME, *Standards* 13-14 (1985) (on file with author). The previous Standards, on file with the author, are only available upon request from the LCME.

[FN14]. Special Committee on Maintenance of Licensure of the Federation of State Medical Boards, Draft Report 12 (2007) (final report expected May 2008), [http://www.fsmb.org/grpol\\_SpecialCommittee.html](http://www.fsmb.org/grpol_SpecialCommittee.html).

[FN15]. Makoul & Curry, *supra* note 2, at 1058. “The idea of communication as bedside manner or history taking has given way to a reconceptualization of communication as a measurable clinical skill.” Gregory Makoul, *Communication Skills in Medical Education and Beyond*, 289 *JAMA* 93, 93 (2003) (emphasis added).

[FN16]. Alternative Dispute Resolution (ADR) refers to a range of processes “alternative” to resolving disputes in a trial setting, including arbitration, mediation and neutral evaluation. Many have taken to using the term “Appropriate” in place of “Alternative” to better convey the positive reason(s) to use these processes and to acknowledge that litigation is not really the norm for resolving disputes. See generally Stephen J. Ware, *Principles of Alternative Dispute Resolution* (2d ed. 2007).

[FN17]. Leonard L. Riskin, *Mediation and Lawyers*, 43 *Ohio St. L.J.* 29, 45 (1982).

[FN18]. Mediation is a facilitated negotiation process: a neutral third party facilitates communication between

parties to help them reach their own agreement. The parties control the issues to be discussed, the decision-making norms to be applied and whether to accept a settlement. Empirical data suggests mediation can be appropriate for all types of civil cases, although it is “often cited as being a good process for communication and relationship issues, for overcoming emotional barriers to settlement, and for cases needing creative non-monetary solutions.” Bobbi McAdoo & Nancy A. Welsh, *Court-Connected General Civil ADR Programs: Aiming for Institutionalization, Efficient Resolution and the Experience of Justice in ADR Handbook for Judges 5* (Donna Stienstra & Susan M. Yates eds., 2004).

[FN19]. Riskin, *supra* note 17, at 59.

[FN20]. My predominant work in training stakeholders was as a trainer for the United States Postal Service (USPS) mediation program. Although beyond the scope of this essay, the experience of the USPS in changing system culture through its mediation initiative could be instructive for legal and medical environments (e.g., law firms, hospitals, etc.). See, e.g., Lisa B. Bingham, *Mediating Employment Disputes: Perceptions of REDRESS at the United States Postal Service*, 17 *Rev. of Pub. Personnel Admin.* 20 (1997); see also Barbara McAdoo, *Transformative Mediation and Its Role in Changing Corporate Culture*, 1 *J. of Alt. Disp. Resol. in Emp.* 12 (June 1999).

[FN21]. This statement is not meant to minimize the important scholarly work of the last thirty years that adds considerable sophistication and nuance to the understanding of mediation and conflict resolution. See generally, e.g., Bernard Mayer, *The Dynamics of Conflict Resolution: A Practitioner's Guide* (2000); Robert H. Mnookin, Scott R. Peppet & Andrew S. Tulumello, *Beyond Winning: Negotiating to Create Value in Deals and Disputes* (2000); *The Handbook of Conflict Resolution: Theory and Practice* (Morton Deutsch & Peter T. Coleman eds., 2000); American Bar Association Section of Dispute Resolution, *The Negotiator's Fieldbook: The Desk Reference for the Experienced Negotiator* (Andrea Kupfer Schneider & Christopher Honeyman eds., 2006); the prolific writings of Carrie Menkel Meadow; and many, many others. Rather, my limited purpose is to illustrate that key concepts that have changed some lawyers' approach to lawyering are actually quite simple. This does not mean that they are always easy to implement.

[FN22]. Roger Fisher, William Ury, & Bruce Patton, *Getting to Yes: Negotiating Agreement without Giving In* 40 (2d ed. 1991). The classic example is that of two sisters, each with the position that she wants the whole orange over which they are arguing. A wise mother discovers that one sister needs all of the peel for a frosting recipe; the other sister wants all of the juice. With these interests in mind the mother can fully meet the desires of each sister. See *id.* at 57.

[FN23]. *Id.* at 48. In the context of physician/patient disputes, several speakers at the Symposium talked about the fact that instead of a position of desiring huge dollar amounts for some medical error (the ultimate fear for physicians), patients express their need for apology and an assurance that new procedures are in place to prevent future occurrence of the error.

[FN24]. *Id.*

[FN25]. Mark D. Bennett & Scott H. Hughes, National Institute for Trial Advocacy, *The Art of Mediation* 21 (2d ed. 2005). At the Symposium, the prevalence of workplace disputes was widely discussed; mediation has been particularly successful in employer-employee, supervisor-supervisee and co-worker disputes where there is a shared interest in good results for the workplace as a whole.

[FN26]. Fisher et al., supra note 22, at 40-43; Russell Korobkin, *Negotiation Theory and Strategy* 141 (2002).

[FN27]. See generally Bennett & Hughes, supra note 25, at 86-107. Professor Lela Love has articulated the “building blocks” of resolution that can be heard by a good listener: “interests, issues, proposals, feelings, principles, values, rules, visions, stories,” and the alternatives available to parties who do not settle. Lela P. Love, [Deconstructing Dialogue and Constructing Understanding, Agendas, and Agreements](#), 38 *Fam. & Conciliation Cts. Rev.* 27, 30 (2000).

[FN28]. Fisher et al., supra note 22, at 56-80 (discussing the expansion of the “fixed pie” and creating options for mutual gain).

[FN29]. See supra notes 9-16 and accompanying text.

29 Hamline J. Pub. L. & Pol'y 287

END OF DOCUMENT