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Overcoming Barriers to Change

***249** GUESS WHO IS NOT COMING TO DINNER: WHERE ARE THE PHYSICIANS AT THE HEALTH-CARE MEDIATION TABLE?

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The symposium of healthcare mediation professionals held at Hamline University School of Law was conducted as a “dinner party” of invited guests to establish guiding principles for the healthcare industry as it relates to alternative dispute resolution. [\[FN2\]](#) The goal of mediation is to resolve conflict by negotiating a solution that is amicable, efficient, sustainable, and acknowledges the identity, individuality and integrity of all parties. [\[FN3\]](#) Those at this “table” were a cross section of educators and service providers in the healthcare profession, and of mediators and conflict resolution providers to the healthcare network in the United States today. Notably only ten of eighty attendees at the Hamline symposium were physicians.

Healthcare professionals were under-represented at this discussion table, with the exception of those involved in the management, regulation, and business organization aspects of healthcare. Other healthcare professionals who belong at a discussion of the guiding principles of conflict resolution are those actually providing the healthcare services to patients. Such professionals would include physicians, nurses, social workers, psychologists, physician assistants, nurse practitioners, and ***250** paramedical support providers. [\[FN4\]](#)

This essay examines three questions regarding the observation of who is “at the table” in designing a system of standards and principles to guide us all in our work as we strive to resolve healthcare conflicts. Particularly, the focus of this essay is on the physician providers themselves: specifically, the questions which relate to whether physicians need to be present; why physicians are under-represented in these pertinent discussions; and what can be done to bring them to the table.

Conflict is an inevitable part the human condition because individuals have such a variety of beliefs, interests, needs, and values. [\[FN5\]](#) The purpose of this symposium was not to end conflict; but to create durable principles of resolving conflict which then as a welcomed by-product may decrease the incidence or intensity of conflict. Conflict itself is neither good nor bad, but how we handle conflict is either healthy or unhealthy.

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. The unique perspective of physicians cannot be assumed or imagined by others. Other professionals conducting healthcare dispute resolution may, to some degree, represent absent parties but cannot *251 think, collaborate, invent, and soul search for missing physicians. Our assumptions regarding others are often incomplete, inaccurate, unfair, or under-representative of what the potential contributors' opinions or experience might realistically be.

II. Why are Physicians Absent or Under-Represented?

Historically, the answer to this inconvenient question lies in the culture, the demands and to some extent, in the mindset of physicians. Medical education teaches physicians to think inductively. [FN6]

Physicians start with a broad technical base of laboratory and other diagnostic information. Then through a process of elimination, medical practitioners begin to slowly narrow the pyramid of information until physicians reach - if not the only - at least the best answer to the question: “What is wrong with this patient?” A similar process is then used to construct treatment and educational plans for the patient. This mindset or thinking modus operandi is, by comparison, the opposite of the legal mind, from whom the vast majority of healthcare conflict managers or mediators hale. [FN7] Such minds use deductive reasoning to arrive at a desired goal: a settlement, a resolution, or a position. The traditional legal mindset starts with the desired end product and gradually builds a case by collecting more and more evidence on a broadening base to support the desired goal. Communication or even the desire to communicate is not easy when the mindsets of the participating parties differ drastically.

In examining the second question of why physicians are absent or under-represented, one must explore the cultural aspect of medicine. Hospital barriers to change include bureaucratic, complex, highly departmentalized structures that serve to preserve the traditional culture of medicine, which employs silence *252 regarding conflict. [FN8] Conflict historically has been perceived as avoidable and the reason, to some degree, that patients go untreated. This culture of silence in medicine is a paradox. All other aspects of medicine such as peer review, evidence-based practice, designing of diagnostic and therapeutic protocols, conferencing regarding challenging cases for the purpose of education, as well as better service, are accomplished only through communication. Indeed, in these ways, medicine is a model of how to communicate. However, in dealing with conflict, errors and dissatisfied patients, medicine denies, delays, and defends itself to its own detriment, not to mention the patient's harm and/or frustration. [FN9] This paradox is rooted in the psyche of the traditional physician whose self-worth and identity are of, by, and for the successful practice of medicine. Anything short of an error-free evaluation and treatment of the patient's problem strikes a blow not only to the practice's record books, but also to the self-worth of the physician. Prior to determining whether to proceed, the classic physician mentality asks himself or herself, “Who am I if not correct and respected for my competence in my work?” To risk an unwanted answer to that internal question, it has historically been practical to deny conflict, delay its discovery and, when forced to deal with it, respond defensively. Part of this reaction stems from the fear of lawsuits. The cause of this generalized fear lies in the traditional advice physicians have received from risk managers.

Further inhibiting a physician's participation in conflict resolution is the complexity of the work and its tools. Medicine is the employment of technical knowledge, growing at exponential rates, together with the wisdom of experience and the art of judgment in a social context where most matters are gray. So complex is the practice of medicine that, while there are spheres of organization and tradition, there is no whole over-arching system *253 tying together the provision of care, access to care, and payment of care. The United States health-care system cannot be said to be broken, because it is not a unified system and has never been whole.

Finally, in analyzing the second question of why physicians are under-represented in this important conversation, one must look at the rigorous demands currently thrust upon the physician as a provider of care. Historically, the answer to the proverbial question "Why not?" is "I don't have time." This is an excuse - not an explanation. However, this excuse greatly inhibits the conversation. Indeed, we all have exactly the same amount of time everyday of our lives. It is how we choose or how someone else chooses for us to use our time that necessitates some things coming first, and some left undone. It is important to note that regulations had to be imposed on medicine to restrict residents in training from working beyond an eighty-hour workweek, and longer than thirty-six hours straight. No doctor would advise a patient to live in this capacity. Depending on the specialty, once a physician completes training, he or she may take a position that offers little improvement in work hours, especially in surgical specialties.

As the population in the United States grows, science advances, and healthcare becomes more expensive. In this backdrop, physicians are expected to increase production by shortening clinic visits, provide more clinic visits, and shorten the length of hospital stays. As a direct result of all these demands, there is increased documentation, increased regulation, and increased non-patient-care, time-consuming duties attached to physician's work. Workplace time dilemmas are compounded with private time obligations and choices. Indeed boundaries between workplace and home times are often blurred and inconsistent.

The majority of physicians are married, and most of those have children. Medical marriages and families are challenged, but so are those of other professionals whom choose to have both a career and family. Who comes first, demands of work or demands of home? If something or someone must wait, who or what will *254 that be? What do such "Sophie's choices" do to the emotional health of the average physician? [FN10] How does that emotional health affect patient safety and communication?

Time with patients is combined with preparation and educational duties that tends to vary with the practice venue but which are present, to some degree, for all physicians. If one wants to advance in the hierarchy of the profession, one must add professional organization participation, research, publishing, and administrative offices and duties. Where in this schedule does one put coming to the "table" to design and participate in the healthcare resolution arena? What will it replace? Who will compensate the physician in time or money for that participation?

Time is the ultimate luxury. If more time is unavailable to accomplish the work but would make the physician's life more enjoyable and would improve the quality of the work, then time becomes a luxury, indeed the ultimate luxury. While physicians are familiar with material luxuries, they experience little of time's ultimate luxury.

III. 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 an-

swer 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.

Physicians are comfortable with data. Evidence-based medical practice demands data. The data must be collected by commonly accepted methods and standards and must be subject to peer review. State-of-the-art medicine is really state-of-the-data medicine. This is the new norm in medicine and nothing dictates *255 changes in medical practice more data collection and review. Likewise, data regarding the results of ADR of medical conflicts will be an essential element to attract practitioners and other leaders in medicine to participate in the process of mediation of healthcare conflicts. Data regarding the use of ADR methods are necessary to answer and educate the medical community's questions concerning ADR. For example, what percent of healthcare conflicts are amenable to ADR such as mediation? To what sorts of disputes does it apply? Has it been shown to be quicker, less expensive, as durable, and as acceptable to complainants as litigation? Have statutes allowing non-punitive apology to patients actually worked? What is the law in my state? To what extent has the legal profession accepted and used alternative methods? How have the incomes, and thus the motivation, of lawyers changed by using alternative methods of conflict resolution? Have practices retained continuity of care with conflicted patients after ADR, as advertised?

Aside from the collection of data, the same time-honored scientific method used in data collection should be utilized when preparing and presenting the results. Such methods are instrumental in engaging the scientific community with their own reasoning. In short, data will be needed and until such data is received, physicians' attitudes will likely be: no data, no deal.

Physicians have hoped for an alternative to litigation for resolving disputes. [FN11] However, change is difficult to effectuate. Physicians will be interested in changing conflict management if it is tied to improved patient safety. For example, the leadership of Cedars-Sinai Medical Center in Los Angeles met physician resistance in introducing a computerized order entry system until it was presented as a patient safety measure. [FN12] Despite concerns for *256 patient safety, the reality of income preservation will need to be addressed. The age of the entrepreneurial, self-employed physician is passing, and in many locales (urban more than rural), it has already passed. For physicians to participate, their employers will have to agree.

The reality is that employers of physicians will need to accept ADR before Physicians do. Thus, the questions become, who are the employers; how can they be educated (with data); and what will the incentive be for their participation? Physicians will still want to analyze the merits of ADR for themselves, but their motivation, short of their employer's involvement, will by necessity be dampened, if not precluded, by their employer's decisions. Employers will need to see dispute resolution as part of quality improvement and error reduction as well as a cost savings.

It should be noted that there are medical employers who are themselves physicians or controlled by physicians. In those cases, the physician-employers will be concerned with traditional business decisions, as well as healthcare issues such as reduction of losses and preservation of income. Physicians will need their employers to be accepting of ADR to the extent that salaried time will be allowed physicians for their participation as a short-term cost for a long-term gain. If the employers do not see the physicians' time spent in this endeavor as important as the time spent for continued medical education and participation in state and national medical societies, then the employers will have a conflict with their physicians over ADR development and use. A change in medicine's approach to conflict resolution needs to preserve the status and psychological safety provided physicians

by their position in the profession. Psychological safety is enhanced when leadership makes an effort to include all stakeholders in change. [FN13] Another incentive for physician and employer participation is that mediation is a more efficient way to resolve claims and reduce errors than traditional methods that *257 involve reporting disputes to the National Practitioner Data Bank. [FN14] A healthcare dispute resolved in ADR obviates the need to report the incident to the NPDB.

Lastly, physicians make better owners than renters, as do we all. If physicians see ADR as a function of the legal system only, that enthusiasm for quality that comes from ownership or shared ownership of the process will be lost. What can be done to foster ownership by physicians? Several possibilities exist. Through education, physicians will, understanding the merits of ADR, and even more so from experience, physicians' interest in ownership would be born. If the actual work (meetings) involved in the process were on either neutral turf or on medical turf (clinic, office, hospital), the venue itself would drive ownership. The most endearing aspect fostering ownership is a concept of mediation in general that decision-making in the resolution of conflict belongs equally to both parties: the patient as well as the healthcare provider (doctor or institution).

The practice of medicine is a practical science applied through relationships. If the traditional destruction of the doctor-patient relationship by litigation could be avoided with mediation, physicians not wanting to abandon their patients would be interested. Continued access to the provider during conflict is the most striking difference between mediation versus litigation. [FN15]

Another convincing concept of healthcare mediation assuring an ownership attitude by physicians is what we might call "Don't L.E.A.P. to compensate." By this mnemonic I mean that it is just as and often more important to the patient for the doctor to provide four key resolution features before compensation *258 (financial or otherwise) becomes of interest. These four components of the process include:

Listen: The doctor actively, carefully, and patiently listens to the patient. [FN16]

Explain: The doctor acknowledges immediately post-adverse event that something happened, and then begins a thorough process of investigating the circumstances. A systematic approach to disclosure improves quality, reduces errors, and increases patient safety. [FN17]

Apologize: The doctor addresses the patient's disappointment, pain, and suffering in an empathetic and sincere manner. [FN18] The concept here being that because you express sympathy toward the victim whose house burned does not mean you set the fire. Physicians have historically feared the consequences of apology rather than see how it can improve their image to self and others. [FN19] Apology helps heal both patients and providers. [FN20]

Plan: The patient needs and receives from the doctor details of a plan to prevent the untoward event from ever happening again to them or anyone else.

When these four items are provided, the compensation becomes more reasonable if even necessary. The physician is the best, if not the only participant, who can provide these four essentials, giving undeniably the attitude and reality of ownership *259 to the physician.

Hamline University School of Law and the Healthcare Law Institute have provided a valuable "dinner discussion" of the issues and challenges of alternative dispute resolution in healthcare conflict in an effort to construct guiding principles for use in defining and improving the process. One of those consensus principles states

that all stakeholders to the extent possible need to be “at the table.” [FN21] In this essay, I have addressed the fact that physicians are currently under-represented in this discussion. The questions of why physicians should be there and what is keeping them away, as well as how to get them involved were presented. It is in all of our self-interests that physicians “come to dinner” and be engaged at the “table.”

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[FN2]. Alternative Dispute Resolution [hereinafter ADR] encompasses a panoply of out-of-court alternatives to traditional litigation. This essay focuses on one of those alternatives, mediation, and the role it currently plays and ought to play within the healthcare profession.

[FN3]. Charles B. Rodning, *Coping with Ambiguity and Uncertainty in Patient-Physician Relationships: III. Negotiation*, 13 *J. Med. Human.* 212, 215 (1992).

[FN4]. Examples of these providers include physical, occupational, and respiratory therapists.

[FN5]. Rodning, *supra* note 3.

[FN6]. Coby J. Anderson & Linda L. D'Antonio, *A Participatory Approach to Understanding Conflict in Healthcare*, 21 *Ga. St. U. L. Rev.* 817, 819 (2005).

[FN7]. *Id.*

[FN8]. P.J. Short & M.A. Rahim, *Total Quality Management in Hospitals*, 6 *Total Quality Mgmt.* 255 (1995).

[FN9]. See generally David Maxfield et al., *Silence Kills: The Seven Crucial Conversations for Healthcare* (Vital Smarts 2005), [http://www.aacn.org/aacn/pubpolcy.nsf/Files/SilenceKills/\\$file/SilenceKills.pdf](http://www.aacn.org/aacn/pubpolcy.nsf/Files/SilenceKills/$file/SilenceKills.pdf).

[FN10]. ‘Sophie's Choice’ encompasses the position of having to make a tragic choice between two options, both unbearable. William Styron, *Sophie's Choice* (Random House 1979).

[FN11]. See generally T.B. Metzloff, R.A. Peeples & C.T.Harris, *Empirical Perspectives on Mediation and Malpractice*, 60 *Law & Contemp. Probs.* 107 (1997).

[FN12]. See P.G. Rossos, H. Abrams, R. Wu & P. Bray, *Active Physician Participation Key to Smooth MOE/MAR Rollout*, *Healthcare Q.*, Special ed. 2006, at 56.

[FN13]. R. Ramanujam & D. M. Rousseau, *Making it Safe: The Effects of Leadership Inclusiveness and Professional Status on Psychological Safety and Improvement Efforts in Healthcare Teams*, 27 *J. Organizational Behav.* 941 (2006).

[FN14]. E.A. Dauer & L.J. Marcus, *Adapting Mediation to Link Resolution of Medicine Malpractice Disputes with Healthcare Quality Improvement*, 60 *Law & Contemp. Probs.* 185 (1997). The National Practitioner Data Bank (NPDB) was established through Title IV of *Public Law 99-660*, the Healthcare Quality Improvement Act

of 1986 with the intent to keep unprofessional or incompetent practitioners from moving from State to State without disclosure or discovery of their previous damaging or incompetent performance.

[FN15]. L.J. Marcus & B.C. Dorn, *Renegotiating Health Care: Resolving Conflict to Build Collaboration* (Jossey-Bass 1995).

[FN16]. M. Saulo & R.J. Wagener, *Mediation Training Enhances Conflict Management by Healthcare Personnel*, 6 *Am. J. Managed Care* 476 (2000).

[FN17]. See B.A. Liang, *A System of Medical Error Disclosure*, 11 *Quality & Safety in Health Care* 64 (2002).

[FN18]. D. Kaufman, *Healing Words: The Power of 'I'm Sorry' in Medical Practice*, *MD Consult* (Jan. 27, 2007), available at <http://www.mdconsult.com/das/news/body/892550322/wpar/0/182888/1.html?nid=182888&date=week&general=true&mine=true>.

[FN19]. A. Lazare, *Apology in Medical Practice: An Emerging Clinical Skill*, 296 *JAMA* 1401 (2006).

[FN20]. See generally Lucian L. Leape, *Understanding the Power of Apology: How Saying "I'm Sorry" Helps Heal Patients and Caregivers*, 8 *Focus on Patient Safety* 1 (Winter 2005).

[FN21]. M. Woods, *Healing Words: The Power of Apology in Medicine* (2d ed. 2004).