EFFECTIVE DISPUTE RESOLUTION IN THE HEALTH CARE INDUSTRY: PROGRESS AND OPPORTUNITIES

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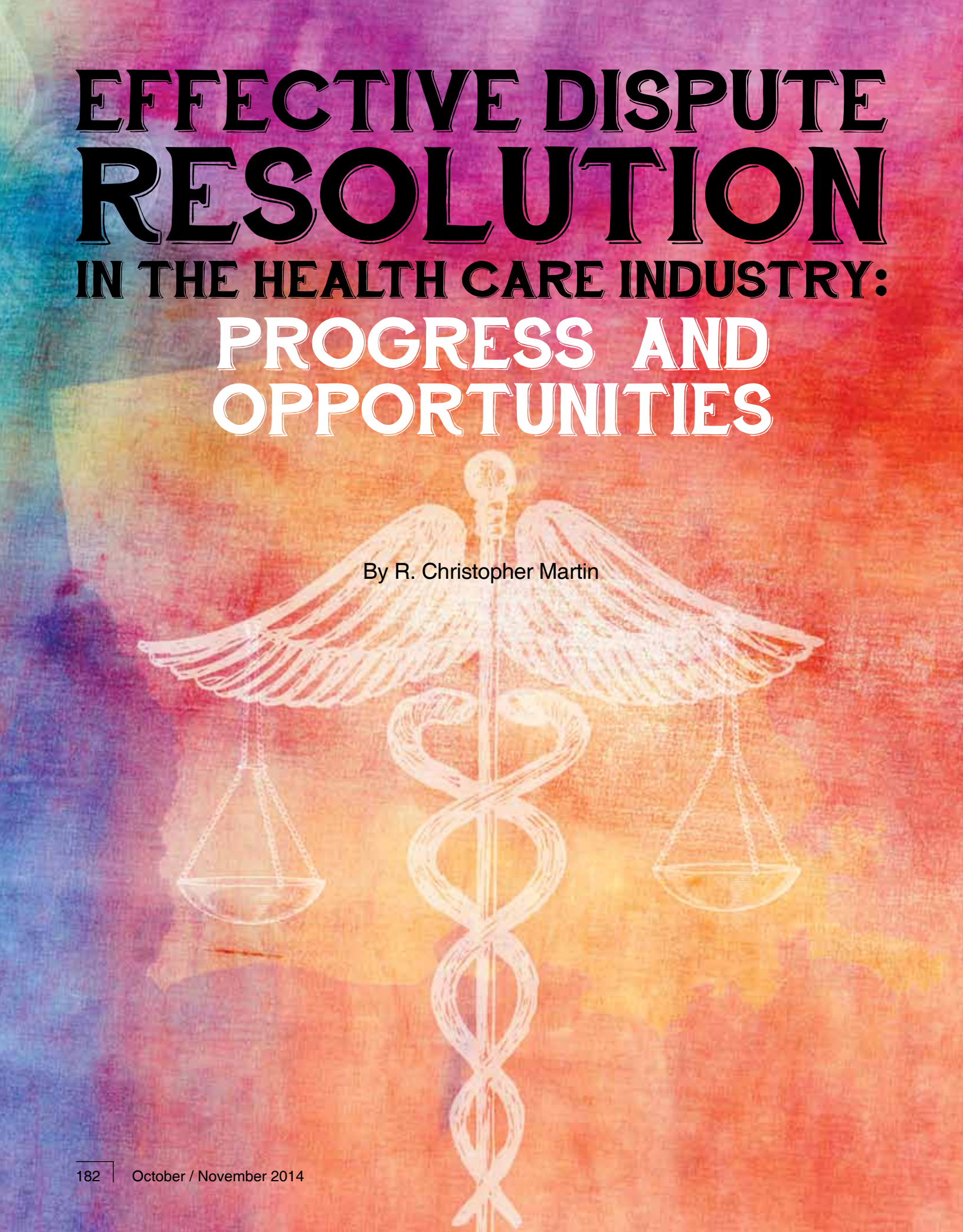

All great changes are preceded by chaos.
—Deepak Chopra

Hardly a week passes without a news story about changes in our health care system. Nationally, the Patient Protection and Affordable Care Act, also known as PPACA, the "Affordable Care Act" or "Obamacare," is being implemented, yet still faces legal challenges.[1] Changes in payment systems that reward quality rather than the volume of services delivered are spurring new business models that are blurring the lines between providers and insurers. To illustrate, consider the clear trend toward more direct hospital employment of physicians and other forms of hospital-physician integration such as clinical integration, bundled payments and accountable care organizations. Similarly, Louisiana has just completed a massive transition of its charity care system to various public-private partnerships. Couple these tectonic changes in the landscape with increased funding for fraud enforcement activity at the federal level and you have a perfect storm of change that will produce new and different types of disputes.[2] This article will briefly explore the current state of dispute resolution nationally, discuss a few programs that are working in hospitals elsewhere, and describe some effective dispute resolution approaches currently used in the health care arena.

In 2011, researchers returned to the Fortune 1000 (including several large for-profit health systems and insurers) to conduct a follow-up survey (from 1997) to gain more recent information regarding the use of alternative dispute resolution (ADR) and explore how ADR practices had changed over the last 15 years.[3] The research revealed a dramatic decline in arbitration usage, except in the consumer area. Mediation and other interest-based options have replaced arbitration, with mediation usage rising in almost every type of dispute covered. Concerns about arbitration include the difficulty of appealing rulings; concern that arbitrators may not follow the law; the perception that arbitrators tend to compromise; the lack of confidence in neutrals; and the high costs. Arbitration has "become too much like litigation," whereas mediation has the advantages of privacy, informality, flexibility and, above all, control. Other dispute resolution options increased such as fact finding, early neutral evaluation, early case assessment and in-house grievance programs for non-union employees. One clear trend was away from hardball litigation towards more creative alternatives.

Health care is a diverse and complex industry with an imbalance of power, knowledge and interests among the various stakeholders, including hospitals (and other in-patient facilities such as skilled nursing facilities and long-term acute care facilities), physicians, nurses (and other mid-level providers), insurers and patients. Those working in hospitals, for example, participate in the ultimate team sport and encounter a number of interprofessional relationships and dynamics and complex communication skills and challenges. Health care providers (and leaders) are concerned about patient safety and privacy; preservation of ongoing relationships and reputations; the adverse impact of personal distractions; an aversion to public controversy; and the overall stress of daily life and death consequences. Such concerns can, and will, lead to more systematic, strategic approaches to conflict resolution and more creative, collaborative dispute resolution processes.[4]

Institutions and individuals have five different styles for managing/responding to conflict. They are avoidance, accommodating, competing, compromising and collaborating.[5] The Fortune 1000 study suggests a gradual movement away from conflict avoidance to a culture of more compromising and, hopefully, ultimately to collaboration. Collaborating with and among health care providers takes open, honest and respectful communication. It takes more time and energy and enhanced listening skills. However, for caregivers, fear of retaliation and lack of support by organizational leaders create mistrust and can actually create more conflict.

Recognizing the need for stronger leadership that stresses a collaborative approach and more effective communication and conflict management, the Joint Commission, which accredits and certifies more than 20,500 U.S. health care organizations and programs, took action. In 2009, it required that health care organizations establish policies and procedures for regular communication among leaders on issues of quality and safety (Standard L.D.02.03.01); conflict management among leadership groups (Standard LD.02.04.01); a system for resolving conflicts among individuals working in the hospital (Standard LD.01.03.01, EP7); and in regard to disruptive behavior, "a process for managing disruptive and inappropriate behavior" (Standard LD.03.01.01.).[6]

Despite these requirements, it seems that hospitals still generally rely on *ad hoc* approaches to resolving conflict and their use of ADR is still tactical and reactive rather than proactive, systematic and strategic. However, this creates opportunity for lawyers who represent health care clients to learn more about conflict resolution processes such as coaching, collaborative law, third-party facilitation and even formal mediation training.[7] With such enhanced skills, lawyers can help this industry make the full transition to a culture of collaboration.

There are some effective dispute resolution programs used in other parts of the country that could be adopted for use in Louisiana. In the medical malpractice and medical error arena, one success story is the University of Michigan Health System (UMHS) which implemented an early disclosure and offer of compensation program more than 10 years ago. It represents a radical departure from the traditional "deny and defend" paradigm.[8] UMHS promotes patient safety through honesty, transparency and accountability with a stated goal of becoming the safest hospital system in the nation. At UMHS, if a patient is injured due to inappropriate care, its policy is to offer patients a prompt apology and fair compensation. However, if the adverse outcome is not the result of inadequate care, the hospital generally refuses to settle regardless of the cost or expediency. New claims have decreased from 2.1 claims per 100,000 patients per month to roughly .75 claims. The average time from claim to resolution has dropped from 1.3 years to nine months. Costs and legal fees have decreased as well.

Similarly, the "Seven Pillars" process adopted by the University of Illinois Medical Center in Chicago in 2006 spread to 10 Chicago area hospitals as a demonstration project in 2010.[9] The seven elements are reporting; investigation; communication; apology with resolution; process and performance improvement; data tracking and analysis; and education. Settlement time for malpractice cases has reduced from five years to one year. Litigation costs have decreased by at least 70 percent. Interestingly, the hospitals have waived almost $6 million in hospital and professional fees where care was found to be substandard or unreasonable.

Another area gaining traction is the growing trend of apologizing for medical errors. The data suggests that, as apologies increase, civil actions and financial recoveries by patients decrease.[10] At least seven states (Nevada, Florida, New Jersey, Pennsylvania, Oregon, Vermont and California) mandate written disclosure of unanticipated outcomes to patients. In order to encourage these disclosures, these states prohibit communications about the errors from being admitted as evidence of liability for the disclosed event. Some states, such as Pennsylvania, require written disclosure of serious events to patients within seven days of occurrence or discovery and such notification made pursuant to the statute does not constitute "acknowledgement or admission of liability."[11]

Louisiana does not go that far. La R.S. 13:3715.5 makes a distinction between a statement of sympathy and an admission of fault. Apologies are protected, but not the accompanying acknowledgments of fault. So "I am sorry that *you are hurt*" is protected, but not "I am sorry *that I hurt you*." One commentator has argued that if these apology statutes are truly designed to foster more open communication between patients and providers and encourage providers to apologize to patients for medical errors, then legislation should provide broader protection of physician's statements. "Legislating a physician's syntax seems counterintuitive to the overall goal of open communications."[12]

In Louisiana, traditional litigation focused-evaluative mediation is being used to mediate medical malpractice claims, business disputes and personal injury claims, but mediation is not available statutorily in medical peer review. In health care, peer review is a self-policing system where physicians monitor the appropriateness of patient care delivered by their fellow physicians. Reported disruptive conduct, impaired conduct or quality of care concerns are some instances that can trigger peer review. These disputes are very personal, stressful and can carry dire consequences for the physician such as practice restrictions, summary suspension and/or termination of hospital privileges. The physician is entitled to a peer-review hearing, but such hearings can be very expensive, disruptive and stressful. In contrast, Texas, for example, allows a physician to request mediation, a less expensive venue to explore resolution.[13] If Louisiana had such a detour, it could save time, money and a lot of workplace stress and trauma.

In health care, hybrids of mediation, especially more facilitative, interest-based approaches, are being used, especially in clinical settings where conflict is more about values, relationships, patient safety and staff workloads than about money. These approaches offer a collaborative, interest-based, rather than a rights-based, approach, where the mediator keeps the parties together, is comfortable with emotional conversations, and encourages active participation of all parties.

Elder mediation focuses on conflicts that arise in the context of issues related to the aging process such as housing and living arrangements, finances and insurance, guardianship, health care and end-of-life planning and decision making. In elder mediation, the mediator meets with the family members and advocates for mutual respect and understanding to promote problem solving. Elder mediators are specially trained to understand the effects of aging on individuals and families.[14]

Bioethics mediation is used to ameliorate conflict with difficult end-of-life choices, such as continuing care versus withholding life-sustaining treatment. The mediator, a hospital employee or an outside neutral, consults with the medical team to better understand the medical situation. The mediator then meets with the patient's family and the medical team and coaches each how to talk and listen to one another in more productive ways; clarifies misconceptions; provides

medical data; defuses deeply held values and emotions; and identifies common interests towards finding a common solution.[15]

Another hybrid is physician co-mediation. When a dispute involves exclusion of a physician from a network or involves a quality of care issue, it might be advantageous to use an experienced health care attorney/mediator and a physician with a particular background and experience in the specific issues. Such co-mediation may add credibility to the process especially if the disputants are physicians. Sometimes physicians prefer to listen and/or talk to physicians rather than attorneys. Obviously the co-mediators must work well together with the appropriate skill set to be effective co-mediators.[16]

Finally, other traditional techniques such as early neutral evaluation and early case management can be used in the initial stages of litigation before parties have incurred the cost of extensive discovery. In early neutral evaluation, a neutral evaluator conducts a confidential session to hear both sides of the case and offers a non-binding assessment of the case. The neutral evaluator also may help with case planning by clarifying arguments and issues. Early case assessment uses different approaches aimed at effectively managing the conflict by actively and systematically analyzing various aspects of a case and developing appropriate strategies consistent with business goals.[17]

Conclusion

In conclusion, as the quote from Deepak Chopra suggests, health care is in a chaotic time. However, out of such chaos comes opportunity, as lawyers, to do our part to contribute to a culture of collaboration. There are some innovative programs around the country that Louisiana could adapt to the local needs of our communities. As health care disputes increase, hybrids of mediation and other processes will evolve to address them with the overall goal of ensuring that we all receive the right care, at the right time, in the right setting.[18]

FOOTNOTES

1. Halbig v. Burwell, No. 14-5018, Slip Opinion (D.C. Cir. July 22, 2014); King v. Burwell, No. 14-1158, Slip Opinion (4 Cir. July 22, 2014).

2. Press release by Dept. of Health & Human Services, Feb. 26, 2014; for every $1 spent on health care fraud and abuse investigations in last three years, the recovery/return on investment is $8.10.

3. *See* Thomas J. Stipanowich and J. Ryan Lamare, "Living with ADR: Evolving Perceptions and Use of Mediation, Arbitration and Conflict Management in Fortune 1,000 Corporations," 19 Harv. Negot. L. Rev. 1 (2014) and Pepperdine University and Legal Studies Research Paper No. 2013-16; J. Ryan Lamare, "The Evolution of ADR Systems at Large U.S. Corporations," Dispute Resolution Magazine, ABA Section on Dispute Resolution, Vol. 20, No. 1.

4. Marti G. O'Hare, "A Case-Study for Effective Conflict Management in the Healthcare Workplace: Lessons from *Babb v. Centre Community Hospital,*" AHLA Labor and Employment Practice Group Publication, Vol.12, issue 3, Dec. 2013; Haavi Morreim, "Malpractice, Mediation and Moral Hazard: The Virtue of Dodging the Data Bank," 27 Ohio St. J. on Disp. Res. 109 (2012); Pam Marshall, RN, LLB, LLM (ADR) and Rob Robson, MDCM, FRCP(C), "Conflict Resolution in Healthcare: An Overview," Interaction, Vol. 16, No. 1/2 (2003); Gary A. Balcerzak, MS, and Kathryn K. Leonardt, MD, MPH, "Alternative Dispute Resolution and Healthcare: A Prescription for Increasing Disclosure and Improving the Patient Safety," Patient Safety and Quality Healthcare, July/August 2008; Dale C. Hetzler, Deanne R. Messina and Kimberly J. Smith, "Conflict Management in Hospital Systems: Not Just for Leadership," 5 Am. J. Mediation 65 (2011).

5. Antoine Hymer, MS, RN, "Conflict Resolution," Journal of Nursing online at *http://rnjournal.com/journal-of-nursing/conflict-resolution*, last accessed on Aug. 10, 2014.

6. The Joint Commission: 2011 Comprehensive Accreditation Manual for Hospitals: The Official Handbook.

7. Charity Scott and Debra Gerardi, "A Strategic Approach to Managing Conflicts in Hospitals: Responding to the Joint Commission Leadership Standards, Parts 1 and 2," 37 Joint Commission J. Qual and Patient Safety, 59-79 (2011); Jean Reister Conrad and Jeanne F. Franklin, "Addressing the Art of Conflict Management in Healthcare Systems," 16(3) Dispute Resolution Magazine 15 (2010); Haavi Morreim, "Conflict Resolution in Healthcare," AHLA Connections Magazine, January 2014, pages 28-32. E.H. Morreim, "In-House Conflict Resolution Process: Health Lawyers As Problem Solvers," (Feb. 1, 2014), The Health Lawyer 2014: 25(3):10-14.

8. Richard Boothman, JD, and Margo M. Hoyler, "The University of Michigan's Early Disclosure and Offer Program," Bulletin of American College of Surgery, AM. Coll. Surg. 2013 March, 98(3):21-25.

9. T.B. McDonald, L.A. Helmchen, K.M. Smith, et al., "Responding to patient safety incidents: The "seven pillars," Qual. Saf. Health Care, published online March 2010; Andis Robeznieks, "Full disclosure first, Alternative med-mal approaches show promise," Modern Healthcare Magazine, posted Feb. 2, 2013.

10. Chris Stern Hyman, "Mediation and Medical Malpractice: Why Plaintiffs, Hospitals and Physicians Should Be at The Table," Dispute Resolution Journal, August/October 2011.

11. Nicole Saitta, MA, and Samuel D. Hodge, Jr., JD, "Efficacy of a Physician's Words of Empathy: An Overview of State Apology Laws," Journal Am. Osteopath Association 2012, 112(5)302-306; D. Wojcieszak, J. Banja, C. Houck, "The Sorry Works! Coalition: Making the Case for Full Disclosure," JC Journal on Quality and Pt. Safety 2006:(32)(6):344-350.

12. Robert B. Gibson and Laura A. Del Vecchio, "Effects of 'Full Disclosure' on Litigation," For the Defense Magazine, November 2006 (41-47, 64).

13. Texas Health and Safety Code Section 241.101(d).

14. Sally Abrahms, "Oh, Brother! With Parent Aging, Squabbling Siblings Turn to Elder Mediation," AARP Bulletin, Sept. 20, 2010, online at: *www.aarp.org/relationships/family/info-09-2010/elder_mediation.print.html*; "What is Elder Mediation?," online at *www.acrelder.org/what-is-elder-mediation/*.

15. Autumn Fiester, PhD, "Bioethics Mediation & The End of Clinical Ethics As We Know It," Cardozo J. of Conflict Resolution, Vol. 15:501-513(2014); Ellen L. Waldman, "Bioethics Mediation at the End of Life: Opportunities and Limitations," Cardozo J. of Conflict Resolution, Vol. 15:449-471 (2014).

16. Michael D. Roth and Dr. Leonard M. Fromer, "Identifying and Resolving Disputes in New Accountable Care Settings," AHLA Connections Magazine, Dec. 2013, Vol. 17, Issue 12.

17. CPR Early Case Assessment "ECA" Toolkit (2010), accessed at *www.cpradr.org*.

18. For services, there are at least three organizations (JAMS, American Arbitration Association and the American Health Lawyers Association) that offer health care specialized panels of mediators, arbitrators and peer review hearing officers.

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