Conflict Management Toolkit

AMERICAN HEALTH LAWYERS ASSOCIATION

ALTERNATIVE DISPUTE RESOLUTION

CONFLICT MANAGEMENT TOOLKIT

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Healthcare Conflict Management Toolkit

Overview of Healthcare Conflict Management

I. Introduction

The healthcare industry is subject to increasing strains due to demands for broader access to care, greater accountability to consumers, and improved quality of care, while facing more work for less pay, staffing shortages, stiffer regulatory enforcement, and decreased reimbursement. Little wonder that strains lead to stress that often leads to conflict.

For decades hospitals and other healthcare providers and organizations have recognized the need for managing conflict within the healthcare workplace in order to assure that conflict does not impede quality care and patient safety. The old paradigm of the physician as "captain of the ship" and the kind of order that may have flowed from it has yielded to social, regulatory, and legal changes, including gender equality, patient autonomy, and legal accountability/tort liability. As early as 1988 the American Hospital Association published its first study recognizing the value of alternative dispute resolution (ADR) as an effective tool for dealing with conflicts that arise between and among hospital administration, the governing body, and the medical staff. [1]

Effective January 1, 2009, The Joint Commission is requiring that healthcare organizations establish policies and procedures for conflict management among leadership groups (Standard LD.02.04.01). The Joint Commission references conflict management in its leadership standards, placing responsibility for implementation and application of conflict management variously on the organization, its governing body, and its leaders. The standards and their elements of performance refer to: (1) "a system for resolving conflicts among individuals working in the hospital" (Standard LD.01.03.01), (2) "an ongoing process for managing conflict among leadership groups" (Standard LD.02.04.01), and (3) in regard to disruptive behavior "a process for managing disruptive and inappropriate behavior" (Standard LD.03.01.01, Element of Performance 5). (See the full text of cited standards and elements of performance in Exhibit A.)

(N.B. It should be noted that The Joint Commission will defer to an organization's good faith judgments and reasonable efforts to meet the conflict management standards. Although the AHLA ADR Toolkit is an effective approach in dealing with conflict management, it is not required

[1] American Hospital Association, Office of Legal and Regulatory Affairs, Legal Memorandum: Number Thirteen, The Report of the Task Force on Dispute Resolution in Hospital-Medical Staff Relationships, August 1988.

that hospitals employ the toolkit in order to comply with Joint Commission standards. The toolkit is merely a resource available to assist hospitals in managing conflicts.)

The Joint Commission has also expressed increased concern that disruptive or intimidating behavior can threaten patient safety and quality of care. Indeed, The Joint Commission issued a Sentinel Event Alert on July 9, 2008, "Behaviors That Undermine a Culture of Safety," describing such behaviors and urging organizations to address unprofessional behaviors through formal systems. Notably, the Alert identified the lack of conflict management skills as a root cause of disruptive behavior. To remedy this The Joint Commission recommended interventions such as educating team members, encouraging inter-professional dialogue, and developing an organizational process for addressing intimidating and disruptive behavior. (See the full text of the Alert in Exhibit B.) For purposes of this toolkit, we would add that unprofessional, disruptive behavior is certainly not to be laid solely at the feet of medical practitioners; rather, it can be found in any individual lacking in communication skills and sound professional judgment. The unmistakable message is that any type of conflict management an organization implemented would be beneficial in creating and maintaining a culture of safety that in turn would promote and protect quality of patient care.

The challenge for healthcare organizations is to assess their current problem solving techniques and responses to conflict. How a particular healthcare organization implements policies and procedures to meet The Joint Commission standards will be unique to that organization.

The American Health Lawyers Association (AHLA) Alternative Dispute Resolution (ADR) Service is providing this toolkit to help healthcare organizations focus on early management of disputes. The AHLA ADR Service is contemplating how to meet new needs in the conflict management area. The AHLA ADR Service concentrates on providing conflict resolution services to the healthcare market: mediation, arbitration, and neutral case evaluation. These conflict resolution services are available to an organization that could not manage a particular conflict internally. However, the toolkit may reduce the need for formal conflict resolution or serve as a precursor to formal dispute resolution methods.

II. Purpose

The purpose of this toolkit is three-fold:

A. To provide INFORMATION to the healthcare organization's management and staff regarding the continuum of conflict management beginning with conflict identification, information gathering, fact-finding, and delineation of issues and stakeholders;
B. To assist the organization to structure in response to conflict a PROCESS of informal conciliation/negotiation/mediation initiated by a lay person which

could lead to a formal mediation process conducted by an experienced healthcare conflict manager or intervener ("intervener" is a term devised to describe the individual who intervenes to manage a conflict); and

C. To provide SAMPLES of policies, procedures, guidelines, and forms to allow a healthcare organization to establish its own conflict management system.

III. Conflict Management: How to Get Started

Today's healthcare environment arguably provides a "perfect storm" of opportunities for conflict. As Don Buckley, an experienced healthcare executive, CEO, and a commentator on conflict management described in materials for an AHLA ADR teleconference in the spring of 2008, *"*Healthcare is in the midst of many changes which bring forth misunderstandings, hard feelings, and definitely conflict. The hospital, in particular, is an arena with many diverse players with diverse interests, goals, personalities and levels of achievement." All of this provides the atmospheric conditions for the growth of conflict.

A. Continuum of Conflict

Conflict is a dynamic process, just as conflict management is a process. Conflict does not always surface in gale proportions. An essential element of a conflict management process is recognition that there are stages of conflict, with appropriate interventions at different stages. The stages of conflict can range from robust argument within a single meeting to longstanding opposing, entrenched positions of medical staff, administration, and the governing body. Depending upon the culture or needs of the organization and the type of conflict, an administrator or leader can use various communication skills and negotiation techniques to manage a conflict. A more formal process conducted by an experienced, skilled mediator may be appropriate in managing more complex conflicts. Therefore, any conflict management policy or system must allow for a variety of interventions, from informal methods, such as persuasion, facilitation, conciliation, or negotiation, to formal methods, such as structured negotiation, mediation, or series mediations. An effective conflict management system must be staged and proportional to allow for application consistent with the nature and seriousness of the conflict. It goes without saying that early recognition of conflict and an appropriate level of intervention must be a primary objective of conflict management.

B. Conflict Anticipation and Preparation

If conflict is predicted, what kinds of preparations can be made to deflect the storms of conflict? A proactive, skillful management team can prepare stakeholders to recognize and deal with conflict in a carefully considered process with responses appropriate to the stage of conflict. First, however, there must be commitment of top management to support a conflict management process and adoption of some foundational principles. This is similar to the "buy-in" and commitment required to lead a hospital in

the implementation of quality improvement efforts or a compliance program. Top management should present (using internal staff resource) or sponsor (using external consultant experts) initial educational presentations to the governing board, the medical staff, nursing leaders, and administration to make the case for developing a conflict management program.

Once a facility commits to develop a conflict management program, certain management decisions must be made to integrate the program into day-to-day operations. These decisions would include the basic "who, what, when, where, and how" questions that need to be addressed in the establishment of any new program. In the discussion below the roles of the stakeholders, trainers, and interveners are broadly described so that each organization can be flexible in implementing its own conflict management policies and procedures that are best suited to existing management structures. The key point is that conflict management must have a "home" or a defined place within the organization from which to educate and provide conflict management resources throughout the rest of the organization.

C. Foundational Principles

Foundational principles necessary to support conflict management include: (1) a willingness to acknowledge the existence of conflict, (2) open communication, (3) dealing with conflict within an environment of mutual respect, (4) acceptance and tolerance of different perspectives through the process, (5) commitment to fundamental fairness, (6) educating all stakeholders about conflict management, (7) developing a conflict management process with policies and procedures with input from stakeholders, and (8) holding stakeholders accountable to use the conflict management process.

Top management should relate these foundational principles for conflict management to the organization's mission, as well as to the objective of The Joint Commission conflict management standard: to protect patient safety and quality of care. Obviously any conflict management process must be consistent with and in furtherance of the organization's mission and values.

D. Stakeholders

Stakeholders are broadly defined to include governing board members, executive officers, medical staff members, administrators, managers, all employees, volunteers, and patients. At appropriate stages of the implementation of the conflict management process top management should provide or sponsor education/training sessions appropriate for different groups. Training should vary in length and complexity as suitable for the group, but with emphasis on the foundational principles

(recognition of conflict, openness, mutual respect, tolerance, training, and input) for all groups.

E. Trainers/Interveners

The trainers may be either internal staff or outside consultants, as determined by the organization in consideration of the particular group of stakeholders, skill sets of internal staff, budget constraints, institutional culture, and other factors. Many hospitals have staff resources in various departments (e.g., risk management, human resources, legal, and/or employee health) and professional positions (e.g., an omsbud or chaplain) who have counseling, communication, negotiation, and facilitation skills. For those hospitals it may not be necessary to use outside consultants or to do so only for initial presentations or training to set up a "train the trainer" approach. The essential requirement, however, is for top management to make decisions on trainers and the training approach that are suitable for the organization's environment. Note that The Joint Commission standard specifically references use of either internal or external consultants.

F. Training Objectives

The objectives of training are to educate the stakeholders to allow for (1) understanding of the foundational principles (see subsection D. above), (2) early recognition and intervention in response to conflict, (3) maintaining objectivity while limiting subjectivity and emotion, (4) neutral information and fact gathering, and (5) commitment to follow the conflict management process, policies, and procedures.

IV. Conflict Management Policies and Procedures

A. Unique to Each Organization

Each organization needs to develop its own conflict management policies and procedures in order to reflect its unique culture, needs, and values with due consideration of the continuum of conflict, the foundational principles of conflict management, its stakeholders, and the educational process and types of trainers suitable for its circumstances.

B. Samples

Exhibit C contains sample policies and procedures for reference purposes that may be a starting point or suitable for modification to meet the needs of a particular organization.

V. Basic Techniques of Informal Conflict Management

A. Identification of the Intervener

The intervener generally would be internal to the organization, as identified in the organization's conflict management policy. However, the

intervener could be external, depending on the organization's culture, needs, and the nature of the conflict.

B. Intervener's Identification of and Instructions to Participants
The intervener should explain his/her role in implementing the conflict management process according to the organization's policies and procedures. The intervener should emphasize the foundational principles of the process to assure the participants of his/her commitment to follow the process. The intervener should identify the necessary participants, refer them to the policies and procedures for guidance throughout the process, and stress his/her expectation of conduct consistent with the policies and procedures. The intervener should discuss the expectations of confidentiality of the process, as defined in the organization's conflict management policy.

C. Efficient Conduct of the Information Gathering Stage
The intervener should move quickly since conflict can conflagrate. The intervener should set a time frame or schedule for interviews and other information gathering. The intervener should ask questions and listen carefully to answers. If necessary, the intervener can ask for written information, documents, or statements from the participants. Additionally the intervener may seek information independently as circumstances or subject matter may require.

D. Objective Analysis of Information
The intervener should objectively analyze the information gathered first to determine if additional information is necessary and/or more questions need to be asked and answered. Next, the intervener should attempt to state the problem in an objective way since "a problem well-stated is a problem half solved."[2]

E. First Meeting with Participants
The intervener should ask each participant to make an initial statement. The intervener may wish to revise his/her previous attempt to state the problem based on new information or positions taken in the initial statements.

F. Seeking Common Ground: Techniques and Settings
The intervener should attempt to obtain the participants' agreement on the statement of the problem. Once there is a working agreement, the intervener should try to bring the participants or positions to common ground by using techniques such as (1) using reflective statements of the positions, (2) attempting de-positioning by eliminating non-issues or less important issues, or (3) asking questions regarding key issues such as "what is the best way to….?" or "what options are there to….?" The

[2] Quotation attributed to Charles F. Kettering, a U.S. electrical engineer and inventor (1876 – 1958).

setting for use of these techniques can vary. The participants and intervener may be within the physical location of the organization, or they may be off-site in a location deemed to be more neutral or conducive to the process. The participants may be in the same room, in separate rooms for caucusing, or in separate meetings with work assignments. Depending upon the complexity of the dispute, the intervener may set up additional sessions.

VI. Formal Conflict Management

A. Reasons for Formal Conflict Management

If informal methods of conflict management following the organization's conflict management policies and procedures have failed to resolve the dispute or reduce the disruptions flowing from the conflict, then legal/compliance/risk management issues or threats to patient safety and quality of care may require more formal dispute resolution methods. As alluded to in the Introduction, the organization will need to move along the continuum of conflict management.

The organization will still want to find a way to address the issues in ways that are efficient, timely, confidential as appropriate, conducive to reestablishing or preserving relationships as much as possible, and productive consistent with the facility's mission of providing quality health services. The organization may recognize a need for greater expertise or an "outside" neutral.

B. Types of Formal Conflict Management

Along the continuum of conflict resolution, **mediation** is a more formal process than the conflict management process envisioned in Sections IV and V. But mediation does offer the aforesaid benefits. Often described as a facilitated negotiation, the process features a skilled third party neutral who acts as facilitator and not a decision-maker, leading the participants to consider their long term interests rather than positions, and consistent with those interests to explore possible solutions.

Neutral case evaluation is a tool that involves a neutral third party who with agreement of the disputing parties provides an objective evaluation of a matter in dispute such as its merits or monetary value. Neutral case evaluation can be invoked when the participants cannot agree on facts or terms of a compromise that is under discussion in mediation, negotiation, or other discussions.

Arbitration is the most formal of these three ADR options. It is often described as private litigation and is useful when the need for a binding decision by a third party is recognized but still hoped to be attainable

through a process that offers benefits of timeliness, efficiency, and lower cost, with potential for confidentiality.

The participants will need to decide which ADR method is appropriate, how to select the mediator or arbitrator, and which rules of procedure will apply. The AHLA ADR Service offers resources to assist with these decisions.

Further information is available on the AHLA ADR Service training page. (http://www.healthlawyers.org/adr) Contract provisions calling for the use of these methods or a combination thereof are appended to the AHLA ADR Service's Rules of Ethics, also available on the website. Consulting them may be helpful to how an organization chooses to provide formal options at the end of its conflict management continuum.

VII. Conclusion

The objective of conflict management is related to the goal of advancing the quality of health services. While improvement in patient care through the reduction of error rates is an outcome that can be measured, the AHLA believes that conflict management processes aim more broadly at creating culture shift, which is more difficult to measure but which is a key to achieving quality goals.

Conflict management is a means to establishing a cooperative learning and performance culture in which all players know and understand their roles, support each other in them and learn from each other. Conflict management should not be handled as a perfunctory process designed to merely shut down disputes. Rather, it should be considered a process to open difficult situations to effective discourse, resolution, and learning. Consistent with that view of the process, we recommend that an organization's conflict management program include periodic assessment and re-thinking as the organization gains experience from its initial efforts.

EXHIBIT A

I. The Joint Commission, Hospital Accreditation Program, Chapter Leadership, *Standard LD.01.03.01. Element of Performance 7 for LD.01.03.01*: "The governing body provides a system for resolving conflicts among individuals working in the hospital." Pre-publication version, 2008, The Joint Commission on Accreditation of Healthcare Organizations.

II. *Standard LD.02.04.01* The [organization] manages conflicts between leadership groups to protect the quality and safety of care.

III. *Elements of Performance for LD.02.04.01*

A. Senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups.
B. The governing body approves the process for managing conflict among leadership groups.
C. Individuals who help the hospital implement the process are skilled in conflict management. Note: These individuals may be from either inside or outside the hospital.
D. The conflict management process includes the following:

- Meeting with the involved parties as early as possible to identify the conflict
- Gathering information regarding the conflict
- Working with the parties to manage and, when possible, resolve the conflict
- Protecting the safety and quality of care

E. The hospital implements the process when a conflict arises that, if not managed, could adversely affect patient safety or quality of care.

IV. *Standard LD.03.01.01*. Leaders create and maintain a culture of safety and quality throughout the organization.

V. *Elements of Performance for LD.03.01.01*

A. The hospital has a code of conduct that defines acceptable, disruptive and inappropriate behaviors.

B. Leaders create and implement a process for managing disruptive and inappropriate behaviors.

EXHIBIT B

The Joint Commission

Sentinel Event Alert

Issue 40, July 9, 2008

Behaviors that undermine a culture of safety

Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(1,4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions. (2) Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients. (7, 8, 11) All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

Intimidating and disruptive behaviors in health care organizations are not rare.(1,2,7,8,9) A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator. (2,10) While most formal research centers on intimidating and disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators. (1,2) Several surveys have found that most care providers have experienced or witnessed intimidating or disruptive behaviors. (1,2,8,12,13) These behaviors are not limited to one gender and occur during interactions within and across disciplines.(1,2,7) Nor are such behaviors confined to the small number of individuals who habitually exhibit them.(2) It is likely that these individuals are not involved in the large majority of episodes of intimidating or disruptive behaviors. It is important that organizations recognize that it is the behaviors that threaten patient safety, irrespective of who engages in them.

The majority of health care professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The preponderance of these individuals carry out their duties in a manner consistent with this idealism and maintain high levels of professionalism. The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work environment – one that is readily recognized by patients and their families. Health care organizations that ignore these behaviors also expose themselves to litigation from both employees and patients. Studies link patient complaints about unprofessional, disruptive behaviors and malpractice risk.(13,14,15) "Any behavior which impairs the health care team's ability to function well creates risk," says Gerald Hickson, M.D., associate dean for Clinical Affairs and director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center. "If health care organizations encourage patients and families to speak up, their observations and complaints, if recorded and fed back to organizational leadership, can serve as part of a surveillance system to identify behaviors by members of the health care team that create unnecessary risk."

Root causes and contributing factors

There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care.(10) Organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it. (9,11) Intimidating and disruptive behavior stems from both individual and systemic factors.(4) The inherent stresses of dealing with high stakes, high emotion situations can contribute to occasional intimidating or disruptive behavior, particularly in the presence of factors such as fatigue. Individual care providers who exhibit characteristics such as self-centeredness, immaturity, or defensiveness can be more prone to unprofessional behavior.(8,11) They can lack interpersonal, coping or conflict management skills.

Systemic factors stem from the unique health care cultural environment, which is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and fear of or stress from litigation. These pressures can be further exacerbated by changes to or differences in the authority, autonomy, empowerment, and roles or values of professionals on the health care team, (5,7,16) as well as by the continual flux of daily changes in shifts, rotations, and interdepartmental support staff. This dynamic creates challenges for inter-professional communication and for the

development of trust among team members.

Disruptive behaviors often go unreported, and therefore unaddressed, for a number of reasons. Fear of retaliation and the stigma associated with "blowing the whistle" on a colleague, as well as a general reluctance to confront an intimidator all contribute to underreporting of intimidating and/or disruptive behavior.(2,9,12,16) Additionally, staff within institutions often perceive that powerful, revenue-generating physicians are "let off the hook" for inappropriate behavior due to the perceived consequences of confronting them.(8,10,12,17) The American College of Physician Executives (ACPE) conducted a physician behavior survey and found that 38.9 percent of the respondents agreed that "physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue."(17)

Existing Joint Commission requirements

Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01)* that addresses disruptive and inappropriate behaviors in two of its elements of performance:

> EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.
>
> EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

In addition, standards in the Medical Staff chapter have been organized to follow six core competencies (see the introduction to MS.4) to be addressed in the credentialing process, including interpersonal skills and professionalism.

Other Joint Commission suggested actions

1. Educate all team members – both physicians and non-physician staff – on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.(10, 18,19)
2. Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.(2,4,9,10,11)
3. Develop and implement policies and procedures/processes appropriate for the organization that address:
   - "Zero tolerance" for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.
   - Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff.
   - Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior.(10,18) Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.
   - Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.(11)
   - How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).
4. Develop an organizational process for addressing intimidating and disruptive behaviors (LD.3.10 EP 5) that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.(4,10,18)
5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution.(4,7,10,11,17,20) Cultural assessment tools can also be used to measure whether or not attitudes change over time.
6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of

instances of unprofessional behaviors and the risk of harm to patients.(10,17,18)

7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services(20) and patient advocates,(2,11) both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods.(10) Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.
8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal "cup of coffee" conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. (4,5,10,11) These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety.(4,5) Make use of mediators and conflict coaches when professional dispute resolution skills are needed.(4,7,14)
9. Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, (11) with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.
10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.(1,2,4,10)
11. Document all attempts to address intimidating and disruptive behaviors.(18)

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* The 2009 standards have been renumbered as part of the Standards Improvement Initiative. During development, this standard was number LD.3.10.

EXHIBIT C

A. Opportunities for Conflict Management

Standard wisdom holds that the savvy business person views a challenge as an opportunity. So too can the healthcare provider, manager, or lawyer view the challenge of conflict as an opportunity for organization improvement through use of a conflict management system.

The opportunities inherent in a conflict management system include: (1) recognition of conflict as an indicator to allow early identification of problems, (2) promotion of a proactive response to problems and conflict, (3) encouragement of a culture of mutual respect, open communication, and problem solving during inquiry or intervention relating to conflict, and (4) a means of working towards potential resolution.

To be more concrete, the opportunities for conflict management in healthcare can be categorized according to various functions and relationships, as indicated below. While the Joint Commission leadership standard 2.40, effective January 1, 2009, focuses on governance and organization relationships among and between three hospital entities: (1) the medical staff, (2) the governing body, and (3) administration, the opportunities for conflict management extend far beyond the those relationships into areas of patient care, employment, and business operations as demonstrated by the list below.

Medical staff/governing body/administration potential conflict issues

- Conflicts between physicians
- Conflicts between physicians and non-physicians (e.g., nursing staff, allied health professionals)
- Impaired and disruptive practitioners
- Election and selection of medical staff officers
- Contractual arrangements with physicians (independent contracts; exclusive contracts)
- On-call issues (selection of personnel and payment issues)
- EMTALA issues
- Charity care, uninsured, or underinsured patient issues
- Requirements of professional malpractice insurance coverage to obtain and maintain medical staff privileges
- Ethical issues/challenges related to the mission and goals of the organization
- Requirements for medical staff membership
- Unilateral adoption and amendment of medical staff bylaws
- Licensing and accreditations requirements, which may impact medical staff bylaws
- Mergers and acquisitions of hospitals and combining medical staff members requiring revision of medical staff bylaws
- Impact on patient safety of decreased number of primary care providers and nursing staff
- Use of hospitalists
- Allied health practitioners privileging and supervision

- Budget constraints adversely affecting existing and future medical programs
- New technology, resulting in need for expenditure on sophisticated equipment
- Electronic medical records in the hospital and in private practices, interoperability issues, and requests for hospital financial assistance
- Outsourcing of medical care (e.g., telemedicine, teleradiology)
- Employee/employer conflicts (N.B. This must be done in consideration with other human resources policies.)
- Labor union issues
- Hospital/physician arrangements and Stark and fraud and abuse implications
- Conflicts of interest within the governing body and medical staff
- Vendor relationships with medical staff
- Role of research and hospital/medical staff financial support
- Department/department conflicts relating to resource allocation

Patient Care Issues

- Treatment issues, including timing and location
- Adverse outcomes and sentinel events: discussing the issues with patients and resolving questions patients may have, including monetary issues
- End-of-life decisions, including dealing with intra-familial differences
- Health insurance coverage issues
- Coverage of "experimental" procedures and treatments
- Drug treatment coverage disputes
- Billing disputes
- Transfer of patients from a higher level of care to a lower level of care
- Patient competency issues
- Conflicts between the organization's mission and values and the patient's values and religious beliefs
- Cultural issues and their impact on patient safety and care
- Need for interpreters or other accommodations for special needs patients
- Emancipated or "mature" minors issues related to consent, confidentiality and payment
- Experimental trials and institutional review board issues
- Ethics committee issues
- Consent issues related to religious reservations (e.g., Jehovah's Witnesses)
- Ethical issues related to institutional policies or mandates related to care, e.g., related to religious directives or practitioner "conscience provisions"
- Human rights complaints

All of the issues listed above (and many more that will arise as new developments occur in healthcare) can give rise to conflict in the healthcare environment. A conflict management system, established by hospital policy and supported by institutional commitment, will allow for early identification, intervention, and a greater likelihood of resolution.

EXHIBIT C

B. Conflict Management Policy Drafter's Checklist

I. Introduction

Once an organization has decided to develop a conflict management policy it will need to take preliminary steps to allow for reasoned policy development process. The organization leader who is accountable for developing the policy might consider the following checklist.

II. Checklist

A. Assess the organization's readiness for a conflict management system in relation to the organization's mission and its willingness to embrace foundational principles to support conflict management. Provide a statement of purpose to be endorsed by leadership.

B. Obtain designation of an organizational "home" for conflict management implementation, oversight, and accountability within the organization's structure and submit a plan for appropriate staffing assignments.

C. Survey existing problem solving and conflict management resources within the organization, e.g., current practices, policies, or procedures, as well as current staff resources in various departments and offices such as risk management, legal, employment assistance, chaplain, ombudsman, human resources, etc. Specifically assess availability of in-house resources for conflict management program training, management, and interveners. Plan availability of external resources to use when needed for training and for formal conflict management processes.

D. Devise ways to integrate existing resources, functions, and practices, as appropriate, into the design of a new comprehensive, organization-wide system of conflict management.

E. Organize training on conflict management for the governing board, leadership, and key stakeholders within the organization to gain support for conflict management.

F. Draft a conflict management policy and procedures with input from the board, leadership, and key stakeholders.

G. Hold training sessions to educate all staff on the conflict management policy and procedures, including on-going training sessions to account for turnover as well as for educational updates as the conflict management system matures.

EXHIBIT C

SAMPLE

C. _____ HOSPITAL
HOSPITAL POLICY

POLICY NO. _____

TITLE: Conflict Management

EFFECTIVE DATE: January 1, 2009

PURPOSE

To establish a process for conflict management among all stakeholders in the hospital to protect patient safety or improve the quality of care provided by the hospital.

POLICY

All hospital facilities, operating on campus or off-campus, considered being a department of the hospital and operating under the hospital's Medicare provider number will follow the established process for conflict management.

The Joint Commission Leadership Standard 02.04.01 provides as follows:

A. Senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among the leadership groups;

B. The governing body approves the process.

C. The organization implements the process when a conflict arises that, if not managed, could adversely affect patient safety or quality of care.

D. Individuals who help the organization implement the process, whether from inside or outside the organization, are skilled in conflict management.

The goal is to develop and implement a conflict management process so that conflict does not adversely affect patient safety or quality of care.
Foundational principles necessary to support conflict management include:

A. A willingness to acknowledge existence of conflict;
B. Open communication;
C. Dealing with conflict within an environment of mutual respect;
D. Acceptance and tolerance of different perspectives through the process;
E. Commitment to fundamental fairness;
F. Educating all stakeholders about conflict management;
G. Developing a conflict management process with policies and procedures with input from the stakeholders; and
H. Holding stakeholders accountable to use the conflict management process.

PROCEDURE

Every stakeholder in the hospital is encouraged to utilize opportunities for conflict management in the hospital. Stakeholders are broadly defined to include governing board members, executive officers, medical staff members, administrators, managers, all employees, volunteers and patients.

Conflict management training is available for all stakeholders in the hospital. All attempts at informal conflict management shall be attempted prior to formal conflict management. Situations that cannot be resolved with informal conflict management may need formal conflict management. Formal conflict management may involve the utilization of experts to assist from outside the organization.

Informal conflict management is a process. The process for conflict management is as follows:

A. Each stakeholder involved in the conflict shall acknowledge the conflict between the stakeholders in the hospital. The different perspectives or positions of the stakeholder shall be shared in an environment of respect.

B. Each stakeholder shall have the opportunity to ask questions of the other stakeholders and to gather information to better understand the basics of the conflict facts from the stakeholder as well as the perspective of the other stakeholders.

C. Each stakeholder shall engage active listening skills when discussing the conflict.

D. Each stakeholder shall state the position of the other stakeholders. The stakeholders shall have the opportunity to discuss the positions without judgment with the intent of protecting the safety of patients and improving the quality of care and consistent with Foundational principles.

E. The process of conflict management is achieved by utilizing the following techniques and settings:

    1. Using reflective statements of the positions;
    2. Attempting de-positioning by eliminating non-issues or less important issues;
    3. Asking questions in a forum of respect; and
    4. Engage different methods for conflict management:
        a. Caucus,
        b. Work assignments,
        c. Multiple meetings with adequate time.

NOTE: This is only a sample policy. Each hospital will need to modify or create a policy, which accurately reflects the conflict management process unique to the culture of the hospital.

EXHIBIT C

D. Conflict Management Intervener's Checklist

I. Introduction

The first steps in managing a particular conflict will be based on the organization's conflict management policy. The policy should specify that conflict management should be implemented, according to the policy provisions, whenever there is a situation giving rise to conflict that could affect patient safety and quality of care. The policy should further indicate how the conflict management process is initiated and who chooses the conflict management intervener. Once the intervener has been designated, the checklist below can give the intervener guidance as to next steps.

II. Intervener's Checklist

A. Identify who the participants will be in the conflict management process. Participants necessary to the management of the conflict may include not only the individuals engaged in the conflict, but also their supervisors or others who may be affected by the conflict or its consequences. (For example, a dispute between administration and physicians may affect the finances and mission of the organization to the extent that the governing body should be represented in the conflict management.)

B. Review and distribute to all participants the applicable organization policies, documents, bylaws, or other materials, including the organization's conflict management policy.

C. Gather facts relating to the conflict. Consider whether to request written materials from the participants, in the form of either a statement of facts or a position statement.

D. Advise participants to be prepared to discuss the conflict and to obtain the appropriate organizational authority to move the process forward, if not to fully settle all relevant issues related to the conflict.

E. Schedule the place, date, time, and duration of the conflict management session(s).

F. Explain to the participants the "ground rules" of the session:

1. The intervener:
   a) Is neutral as to the process,
   b) Will guide the discussion, balance the participation of all the participants, model mutual respect and integrity for the participants, and help the participants work towards resolution of the conflict,

   c) Will emphasize the importance of confidentiality within the process to promote candor and the effectiveness of the process, but will not guarantee

d) confidentiality due to the need to be ultimately accountable to the organization.
e) May use various techniques such as caucusing (dividing like-minded participants into separate groups to clarify or modify their position in response to an offer from the other side), "homework assignments" (i.e., re-writing a policy, rule, or bylaw to address the situation giving rise to conflict so that it can be considered at a subsequent session), and other methods the intervener deems appropriate.

2. The participants:
   a) Will demonstrate mutual respect during the process,
   b) Will cooperate in good faith with the intervener,
   c) Will focus on facts and advocate in a reasoned and civil manner,
   d) Will attempt to define and narrow issues, and
   e) Will try to view issues with an open mind or from a different perspective.

G. Provide to the participants either an oral or written summary of what was accomplished ("the outcome") during the conflict management session. The summary could include additional facts, definition or clarification of issues, agreement on options for resolution, agreement to meet again, or the barriers to reaching resolution.

H. Obtain responses (oral or written) to the summary from the participants.

I. Assist with implementation of the outcome as appropriate. If the outcome does not indicate next steps or lead to resolution, the intervener should assist the participants in choosing a more formal method of conflict management according to the organization's policy.

J. File a report of the outcome within the organization according to organization policy. The report will document the use of the conflict management process and provide evidence, as necessary, of how the conflict was managed. (Note: Creating and maintaining a report raises confidentiality and privilege issues related to peer review, incident reports, employee records, ADR materials etc. The organization will need to look to state laws, regulations, case law, and adaptation of its own policies to assure confidentiality and privilege as appropriate.)

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