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A PARTICIPATORY APPROACH TO UNDERSTANDING CONFLICT IN HEALTH CARE

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INTRODUCTION

Alternative dispute resolution (ADR) professionals recognize the importance of culture in people's behavior when conflict arises. One definition of culture is "a learned set of rules, written and unwritten, that instruct individuals on how to operate effectively with one another and their environment. It defines not only ways to act, but also ways to react"¹ Given this definition, health care is as unique a culture as any in society today. Even within the health care community, the different professions such as doctors, nurses, and administrators operate under unique rules that affect their behaviors when presented with potential conflict.

The interaction of these various subcultures, including the clash of the health care culture with the customers it serves, presents an abundant breeding ground for conflict. There is a growing body of literature suggesting that health care professionals face more conflict and greater complexity than other professionals.² William Ury, the author of *Getting to Yes*, remarked during the Cold War that, "[a] hospital makes U.S.-Soviet relations look like a piece of cake."³ Physicians, as central players in the health care industry, are not immune to this rising tide of conflict.

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1. SELMA MEYERS & BARBARA FILNER, *CONFLICT RESOLUTION ACROSS CULTURES: FROM TALKING IT OUT TO THIRD PARTY MEDIATION* 8 (Amherst Educ. Publ'g 1997).

2. Rob Robson & Ginny Morrison, *ADR in Healthcare: The Last Big ADR Frontier?*, *ACRESOLUTION*, Spring 2003, at 20, 20.

3. Leonard J. Markus & Joan E. Roover, *Healing the Conflicts that Divide Us*, *ACRESOLUTION*, Spring 2003, at 16, 17.

Our discussions with ADR providers reveal frustration at the lack of acceptance of conflict resolution principles in the health care community. The one question ADR professionals attempting to enter the health care field ask those of us with both ADR and health care experience is: "How do I get access?" Unfortunately, it seems that many of those attempting to bring ADR to health care are unfamiliar with some of the unique cultural aspects of medicine. We compared the perceptions of conflict in medicine between health care professionals and ADR professionals and found significant misunderstandings among ADR professionals about the amount and sources of conflict in health care.⁴ This Article attempts to explain the basis of these misconceptions, by providing insight into the health care culture. We believe that by using the tools of the health care provider, research, and the scientific method, ADR professionals can gain greater access to the health care industry and build relationships with health care providers to craft participatory solutions for effective conflict resolution.

I. INDUCTION OR DEDUCTION

One possible reason for these misunderstandings between health care providers and ADR professionals, most of whom are attorneys, is the difference in the way these groups process the world around them. Consider the situation of an attorney conducting his initial interview with a client. The client will usually announce a desired result upon beginning the interview, such as "I want to divorce my husband," or "I want to sue my business partner because he stole from me." Thus, the client establishes the preferred outcome at the outset like the point of a pyramid. The lawyer's job is then to gather facts and legal precedent to accomplish this desired result, establishing the ever-growing foundation of the pyramid.

This process, defined as deductive reasoning, entails drawing inferences in which the conclusion about particulars follows

4. Coby J. Anderson & Linda L. D'Antonio, *Empirical Insights: Understanding the Unique Culture of Healthcare Conflict*, *Disp. Resol. Mag.*, Fall 2004, at 15, 15.

necessarily from general or universal premises.⁵ Not surprisingly, legal education focused on deductive reasoning for the majority of its history in this country.⁶ The Socratic Method, for which law schools are famous, is a tool for developing deductive reasoning skills.⁷ Though some legal educators are attempting to develop a broader educational toolbox for teaching attorneys, the vast majority still teach for the purpose of sharpening deductive reasoning skills.⁸

Medical education, on the other hand, focuses on the development of a logical-reasoning approach that stresses induction—the inference of a generalized conclusion from particular instances.⁹ When a patient enters a physician's office, the initial announcement usually consists of a series of symptoms. For example, "I have a sore throat, I am running a fever, and I have trouble swallowing." The doctor then proceeds to ask questions aimed at discovering if other symptoms exist, the severity and duration of symptoms, and whether the symptoms have occurred before. The doctor may order tests to gather more information on the patient. Only after gathering information in a scientific manner does the doctor begin to whittle down the possible list of conditions to the small number from which this particular patient might suffer.

In fact, the doctor may attempt several courses of treatment before reaching the final diagnosis. Thus, the doctor reaches the final result of the medical process—diagnosis and treatment of the particular condition—only after gathering and analyzing many pieces of information. A classic example of inductive reasoning, this process resembles an inverted triangle with the symptoms at the top and the point of cure at the bottom. Data gathering and analysis are the basis of the scientific nature of medical education.¹⁰

Given the divergent education attorneys and physicians receive and how they practice their chosen professions, it is not surprising

5. See generally David D. Garner, *The Continuing Vitality of the Case Method in the Twenty-First Century*, 2000 BYU EDUC. & L.J. 307, 307 (2000) (explaining deductive reasoning).

6. See *id.*

7. See *id.* at 324-26.

8. *Id.* at 307.

9. See Shea Lippell, *Creativity and Medical Education*, 36 MED. EDUC. 51, 52 (2002).

10. See *id.*

then that some discomfort might attend the entry of one profession into the world of the other. Where attorneys use emotion, argument, and rhetoric with the factual situation best suited to persuade a fact finder to choose their side, medical professionals base their decisions on actual observation and test results gathered in a scientific manner. If ADR professionals are to serve a culture as conflict-saturated and unique as health care, we must recognize these cultural differences and tailor our solutions accordingly.

Despite the abundance of conflict in health care, a thorough review of the mediation literature showed, while there have been some attempts at studying conflict or conflict resolution in health care, there is little empirical data.¹¹ In the article *ADR in Healthcare: The Last Big ADR Frontier?*, the authors suggested that there are widespread misconceptions in healthcare about ADR.¹² They encourage developing the field through the following: building alliances, developing persuasive economic arguments for using ADR in health care, and publishing written case studies and “methods to overcome resistance.”¹³

In order to better relate to health care professionals, we undertook a series of studies using the scientific principles most common in medicine to ask health care providers about their experiences with conflict in their institutions. While there is some research discussing how nurses and administrators deal with conflict in the health care industry, there is little data on physician-related conflict.¹⁴ This led us to choose physicians as the subject of our studies. We went to two large hospitals in the southern California area and studied the sources and amount of conflict physicians experience in their practice. We then asked ADR professionals some of the same questions and compared the responses. The results, which surprised researchers, providers, and ADR professionals, provide a glimpse into the depth

11. See, e.g., Robson & Morrison, *supra* note 2, at 20 (suggesting that applying ADR to the health care setting occurs infrequently and unsuccessfully because the process is not understood).

12. See *id.*

13. *Id.* at 21.

14. E.g., Genevieve Bartol et al., *Effective Conflict Management Begins with Knowing Your Style*, 17 J. FOR NURSES STAFF DEV. 1, 34-40 (2001).

and breadth of conflict in health care as well as frank suggestions for bringing conflict resolution training to the health care industry.¹⁵

II. THE IMPORTANCE OF ASKING

Mediators in general are to be lauded for their sensitivity to cultural issues in conflict resolution. For example, few of us would travel to Nepal and attempt to mediate a conflict between neighboring villages without some understanding of language and customs in the area. In studying the literature regarding conflict in health care, we found that many articles were espousing exactly that concept.¹⁶ It seemed to us that persons with little or no experience in the field were attempting to bring conflict resolution models from other cultures and paste them into the health care culture. Not unsurprisingly, these attempts were met with resistance from those in medicine who looked at professionals offering ADR services, especially those with little or no experience in health care, as outsiders who did not understand the uniqueness of the health care industry.

Realizing this perception, we analyzed how we might gain access to health care providers to determine how best to offer conflict resolution strategies to this community. First, it would be necessary to establish relationships with people inside health care at all levels. Including health care providers at the outset of our research allowed us to contact two tertiary care teaching hospitals in southern California, one civilian and one military, and established relationships with staffs at those hospitals.

Next, we designed our study using scientific methods familiar to the medical community. This ensured those in health care would accept the study's results. We interviewed thirty professionals at each institution who dealt with physician-related conflict on a daily basis. In addition to physicians, we included nurses, administrators, in-house counsel, ethicists, and patient advocates as interviewees, thus

15. See, e.g., Anderson & D'Antonio, *supra* note 4, at 15, 17.

16. See, e.g., *id.* at 15; Robson & Morrison, *supra* note 2.

ensuring a broad spectrum of opinion regarding physician-related conflict. Because the interviewers were members of the particular institution where the interviews took place, they were familiar with the institution's specific culture.

Finally, the subject of the study needed to be useful to both ADR and health care professionals. We formulated a series of research questions to gauge the expert insights into the level of conflict a physician experiences in daily practice, the sources of this conflict, the skills and styles physicians use to deal with conflict when it occurs, and the possible training methods that might be useful to assist doctors in dealing with conflict more effectively.

The results of using these steps were immediate. The first finding was the amazing response the interviewers received when they contacted potential interviewees. As stated before, we surveyed professionals from the entire range of hospital culture. Because we were looking for people who dealt with physician-related conflict on a daily basis, we targeted the highest level of the hospital administration. We were somewhat worried that we would have trouble convincing these people to agree to take up an hour out of their busy day to answer questions regarding conflict in health care. To our surprise, interviewees immediately scheduled the interviews. It was not uncommon for the person to say, "I have some time right now, can you come over?" The interviews lasted from one to four hours, averaging well over one hour per interview.

Clearly, these professionals had a story to tell regarding the effect of conflict on physicians' lives and health care in general. One story is particularly poignant and indicative of the need these experts see for better conflict resolution in health care. At the end of one particularly intense interview, the interviewee asked the interviewer to pray with him. The interviewee asked that God bless this work, that the information gathered reach the highest levels of the institution, and that those at that level come to understand the pain associated with conflict and respond by implementing solutions that take such a toll on the professionals throughout health care. This concept of health care providers as "wounded healers" was prevalent

throughout the interviews and reinforces the perception that the health care culture is ripe for effective conflict resolution strategies.

We contacted sixty-one health care professionals at the two institutions, and sixty agreed to interviews. We completed the interviews over a three month period. The interviewees were incredibly thoughtful and insightful during the interview process, often pausing to ponder the effects of conflict upon their lives and the lives of their colleagues. Many commented that no one had ever asked them these questions before, and more than one admitted the experience was cathartic, allowing them to put voice to the frustrations of dealing with conflict in the health care setting. Almost unanimously, the interviewees were supportive of, and often grateful for, the opportunity to address these concerns, and they felt optimistic that training health care providers in conflict resolution skills could improve the daily lives of both providers and patients alike.

III. THE IMPORTANCE OF NEEDS ASSESSMENT

Another major finding of the research is that even two tertiary care academic hospitals in the same geographic area have divergent needs when it comes to the conflict management skills of their doctors. For example, one question asked was, "What style of conflict resolution is most common among doctors at your institution?" These styles, as defined according to the ADR literature, are as follows:

- **Competing**—The individual's goals take precedence over relationships. A show of confidence and firmness is important in managing conflict.
- **Avoiding**—The individual has minimal concerns for the relationship and goals. Efforts to resolve conflict are useless as impersonal tolerance is seen as the best way to handle conflict.
- **Compromising**—The individual believes everyone should have the opportunity to express views and feelings as long as doing so does not interfere with progress.

- Collaborating—The individual gives equal value to the well-being of the relationship and the goals to be accomplished.
- Accommodating—The individual believes it is necessary to relinquish one's own goals to maintain a relationship, as differences serve only to drive people apart.¹⁷

At one institution, the competing style was the most common, followed by the collaborating style (see table below). The second institution showed a significant difference, with almost half of the interviewees saying that the avoiding style was the primary style of conflict resolution.

What style of conflict resolution is most common among doctors at your institution?		
	Military	Civilian
Competing	60%	37%
Avoiding	10%	47%
Compromising	3%	10%
Collaborating	24%	3%
Accommodating	3%	3%

There was also a significant difference in the perceived benefits of training physicians in conflict resolution skills. While interviewees at the military institution saw a better working environment and more satisfied patients as the primary benefits to this training, those at the civilian institution foresaw increased physician satisfaction and institutional efficiency as the most likely outcomes of this training.

Based on these questions alone, it is evident that these two institutions would require significantly different approaches if one were to attempt to provide ADR services or training to the physicians in these institutions. Thus, any "one size fits all" approach of bringing ADR skills to health care may fail simply because the needs

17. Bartol et al., *supra* note 14, at 36.

of each particular institution are unique in addition to needs of the health care culture itself being unique.

IV. PERCEPTIONS DIFFER ON SOURCES AND AMOUNT OF CONFLICT

After interviewing the health care professionals, we surveyed ADR professionals from the same geographic area using a subset of the same questions to see if the perceptions of conflict in health care were different between ADR providers and health care professionals. This comparison revealed an eye opening difference between the opinions of health care professionals and ADR providers regarding conflict in the health care environment. This comparison provides insight into how ADR providers can shift their focus to provide the services and skills the industry needs.

One major difference between those in health care and the ADR community was the perceived amount of conflict physicians experience. ADR professionals suggested that approximately one quarter of a physician's day dealt with conflict or eminent potential conflict. While this amount would certainly place a considerable burden on the system, those who work in health care perceive an even greater danger. The interviewees from the hospitals suggested that 50% of a physician's day is spent in conflict. This is a staggering number considering the toll that conflict takes on any system. Some have suggested that unresolved conflict in health care leads to medical malpractice crisis, litigation, indication of interference with health professionals' ability to practice, staff stress, increased sickness and sick leave, high staff turnover, loss of confidence, and the undermining of morale.

Another difference discovered between those in ADR and health care is the perceived source of conflict most physicians experience. We presented six relationships that physicians deal with on a daily basis and asked which relationship was the greatest source of conflict. The relationships presented include:

- Doctor-Patient
- Doctor-Family
- Doctor-Staff

- Doctor-Doctor
- Doctor-Administration
- Doctor-Insurance

As seen in the table below, there was an important difference between the two groups. The ADR group was split almost evenly between Doctor-Patient and Doctor-Insurance. Given that the general public's contact with health care is as a patient, these responses are not surprising.

Of the areas of conflict, which do you believe is the greatest source of conflict for doctors?		
	ADR	HEALTH CARE
Doctor-Patient	31%	10%
Doctor-Family	6%	10%
Doctor-Staff	13%	15%
Doctor-Doctor	6%	25%
Doctor-Admin	3%	22%
Doctor-Insure	38%	18%

Those in health care saw a very different picture. They concluded that 80% of conflict was internal to the health care system and did not directly involve patients or their families.

The response to this question illustrates the earlier discussion regarding a misperception about the culture of health care.¹⁸ While ADR professionals concentrate on medical malpractice and the Doctor-Patient relationship as a target of our conflict resolution efforts, we may be missing the vast majority of conflict that health care providers experience. As put by one health care provider, "More doctors complain about personality conflicts than patient problems." Even a pure business analysis would show that failure to serve eighty percent of your clients' needs is going to go a long way toward alienating those clients. Perhaps more than any other action, targeting these internal conflicts will increase our effectiveness with the

18. See *supra* Introduction, Part I.

medical community, thus making our services more indispensable to the health care industry.

Overall, the differences between the groups were alarming. The perceptions of ADR and health care professionals differed on eight of twelve substantive questions. These differences illustrate the lack of understanding those of us in the ADR community have of the health care culture. Without further study of our clients, closing this gap will be increasingly difficult as health care becomes more complex and the issues of those in medicine become less familiar to the general public.

V. CAUSE FOR OPTIMISM

One particularly favorable aspect of the study for ADR professionals hoping to enter the health care arena was the support voiced for training. As mentioned earlier, questions in the interview process showed a significant amount of conflict in a physician's daily practice. This conflict came from multiple sources, and the greatest amount of conflict came from sources for which the physician possesses the least skill. This line of questioning caused some interviewees to become somewhat saddened at the difficulty physicians face.

At about this point in the interview process, we asked what we considered a very important question: "Can physicians be trained to deal effectively with conflict?" Quite frankly, we expected a mixed response to this question, especially given physicians' reputation for being somewhat aloof and resistant to input and change. Much to our surprise, each person interviewed answered that doctors could develop skills necessary for effective conflict resolution.

The interviewees generally became much more optimistic when asked this question and began speaking of the benefits of training physicians in conflict management. Two quotes from nurses stand out regarding the effect training might have. One interviewee stated that "Physicians have spent most of their time with academics and clinical knowledge without being taught any conflict resolution techniques. Education on conflict resolution would be the single most important

thing we can do to improve the health care environment.” Echoing that statement, another stated that “Doctors need to know how to deal with conflict because they are the primary decision makers. So training physicians will have the greatest benefit for the health care environment.”

There was some qualification for this response. One physician-administrator, who summed up the opinion of some, said, “You can train everyone, but you can’t train everyone to competence.” This acknowledges that there are some who, despite training, will simply not master these skills. However, interviewees unanimously concluded that everyone could move on the continuum toward effectiveness.

VI. INVOLVING PARTICIPANTS LEADS TO PARTICIPATORY SOLUTIONS

In addition to the importance that culture plays in conflict resolution, another basic tenant of the mediative method is that involvement of stakeholders in the process will lead to participatory solutions. Our experience with the military hospital after the study is certainly an example of this premise.

During our interviews at these institutions, we learned much about the culture of each institution as they relate to conflict and conflict resolution. After completing the interviews, we analyzed the data, both statistically and qualitatively, and presented the results to the leadership of each institution. The leadership commented that the findings were somewhat surprising and that the data offered an instructive view of conflict at the provider level. The military command took some immediate steps to address some of the problems that identified the study. Many of those who participated as interviewees became involved in implementating these corrective measures.

In addition, two of the interviewees became champions for training in conflict resolution techniques. Soon after presenting the results of the data to the leadership, the command scheduled a two-day training in dispute resolution skills. Unfortunately, the military deployed several of the personnel scheduled for the training to Iraq. We

considered postponing the training, but our contact person at the institution, one of the study interviewees, decided to send a general e-mail to see if people were interested in the class. We were not hopeful because the training date was less than three weeks away at that point. Within two hours of this e-mail to the institution, the class reached its 20-participant limit. We offered to expand the class to 30 and within 48 hours, the class was full and had a significant waiting list. The trainees included physicians, nurses, administrators, and patient advocates. That training was so successful that we are now negotiating for a quarterly training schedule with emphasis on both intradisciplinary and interdisciplinary training. The participants in the training also advised that having trained mediators available for conflict resolution at all levels of the institution should be a hospital priority.

Although anecdotal, this experience points to the health care professional's desire for not only conflict resolution skill building but also for mediation services throughout the health care system. By building alliances within health care and asking those on the frontlines of medicine about their needs, we can gain greater access to better serve the needs of our health care customers, build relationships to foster better communication, and empower stakeholders to participate in proactive solutions as we meet our own goals as conflict resolvers.