

A Practical Innovation Whose Time Has Come

by Carole Schneider Houk
and Barbara I. Moidel

A few years ago, the Track One Committee of the Society of Professionals in Dispute Resolution (SPIDR) produced a seminal work entitled *Designing Integrated Conflict Management Systems: Guidelines for Practitioners and Decision Makers in Organizations*. This document was well received by SPIDR and ACR members for its lucid discussion of how to move beyond individual dispute resolution processes such as mediation and arbitration to more systemic conflict management systems that prevent, manage and resolve conflict.

The Committee's thinking at the time was focused on *internal* integrated conflict management systems (ICMS)—that is, how an organization prevents, manages, and resolves internal conflicts among employees, peers, staff, and direct affiliates (such as students in a university setting). However, the report barely touched upon *external* ICMS, which applies to managing conflicts involving outsiders to the organization—vendors, customers, business partners, subcontractors, and others, particularly as they relate to the mission or purpose of the organization.

In the health care field, most conflict resolution efforts to date have involved individual disputes among doctors, nurses and staff. Conflict resolution efforts have also occurred between patients and providers. Thousands of mediations have been conducted in medical malpractice actions, some court-ordered and some voluntarily sought by the parties; but these usually have been limited to instances where the parties are represented by counsel, the litigation is fairly advanced, and settlement is focused around payment of monetary damages. Designing an ICMS to manage health care disputes involving quality of care is a new innovation, and one that promises to both promote patient safety and reduce medical malpractice costs. As the ongoing medical malpractice liability crisis causes physicians to abandon their practices, move to different states, retire early, or stop high-risk specialty practices such as obstetrics, a conflict management approach that offers alternatives to jury verdicts needs to be examined.



The Status Quo

Experience has demonstrated that patients and families with health care concerns consistently seek a straightforward explanation of unexpected occurrences, an acknowledgement of their suffering, an apology if warranted, and an assurance that processes and policies are being implemented to ensure that the adverse event does not recur with another patient. But physicians have been hesitant to fully disclose medical errors, or to even offer an apology for an unexpected outcome, for fear of being sued.

That fear is not unfounded. Physicians and hospitals have seen a 175 percent increase in malpractice jury awards since 1994, reaching a median of \$1 million in 2000 (G. Vandecruze, quoting Jury Verdict Research Co. statistics in “Has the Tide Begun to Turn for Medical Malpractice?”, *The Health Lawyer*, December 2002). The reality also is, however, that few patients who suffer from medical errors actually sue as a result. A 1990 Harvard University study suggested that fewer than one in eight victims of medical negligence actually files a claim. Of those who do pursue litigation, two-thirds of these plaintiffs walk away

empty-handed, with 61 percent of the cases dismissed or dropped, and 32 percent settled with an average payout of \$300,000. Of the 7 percent that actually go to trial, plaintiffs prevail in only one in five of those instances—a total of 1.3 percent of all claims filed (Physician Insurers Association of America statistics, reported in “Hype Outpaces Facts in Malpractice Debate,” *USA Today*, March 5, 2003).

One explanation for the low recovery rate may be the inequality of information that each party has at the initiation of a medical negligence lawsuit. Patients who suffer from medical errors often lack information regarding the quality of care they received, and that information is usually not forthcoming except under the pressures of discovery in litigation. Faced with a “corporate loss of memory,” patients are often forced to sue to find out what really happened. This systems failure is part of what is being addressed by the Organizational Ombuds model at the National Naval Medical Center (NNMC) in Bethesda, Maryland.

Innovation at National Naval Medical Center

The National Naval Medical Center is the first acute health care institution in the United States to establish an integrated system to resolve health care disputes involving unexpected outcomes, medical errors, and possible malpractice significantly earlier in the process and outside of traditional legal venues. The Hospital’s administration supports the identification and resolution of these disputes at an early stage while the patient-provider relationship is still viable, communication is possible, and costs can be controlled. The role of the Organizational Ombudsman and Mediator is to intervene early at the lowest possible level and resolve disputes that could potentially result in malpractice claims, with the overarching purpose of improving patient and family satisfaction, quality of care, patient safety, and systemic performance. Additionally, it helps eliminate miscommunication that compromises the ability of the hospital to render excellent patient care.

The Organizational Ombudsman and Mediator program at NNMC was established as a full-time funded position in July 2001 after a successful four-month pilot run. The Ombuds serves in a traditional organizational ombudsman role as an impartial third party who facilitates discussions between disputing individuals; focuses upon underlying issues, needs and interests; clarifies perceptions; frames issues; helps to create options; and assists in reaching sustainable and mutually satisfactory solutions. Techniques include listening, coaching, shuttling between patients and providers, and conducting face-to-face mediations. As a trained and certified mediator and ombuds, the NNMC Organizational Ombudsman and Mediator offers information to the patient and family, assists the provider in making decisions about the disclosure of information, and provides coaching to help physicians and other providers prepare for difficult conversations with patients.


In the past 20 months, the results of this program have been

stunning: of the 170 health care cases handled by the Organizational Ombudsman and Mediator, 169 have been resolved to the satisfaction of both patients and providers; none have resulted in legal claims or monetary payments; and the resolutions have focused on making sure that the unexpected outcome or medical error does not recur. Lessons learned from cases are analyzed and translated into immediate recommendations to facilitate improvements in patient care delivery and reduce medical errors.

Why Things Are Changing

According to a 1999 Institute of Medicine report entitled *To Err Is Human: Building a Safer Health System*, medical errors cause between 44,000 and 98,000 patient deaths in U.S. hospitals each year. This makes medical errors in hospitals the eighth leading cause of death in the U.S. As a result, a patient safety movement has been promoted by the National Patient Safety Foundation, hospitals themselves, and by their accreditation sponsor, the Joint Commission on Accreditation of Health Care Organizations, which now requires disclosures to patients of “unanticipated outcomes” of care. This movement examines health care as an industry where systemic improvements, sometimes borrowed from aviation and the military, could significantly reduce the incidence of such mistakes.

Additionally, health care institutions are starting to recognize the need to develop a culture that will enable professionals to disclose error in a blame-free environment, thus encouraging institutional learning and improvement from error. In addition to the NNMC, several programs across the country are promoting openness in their risk management policies and programs, most notably the Veterans Affairs Medical Center in Lexington, Kentucky, which has had an “honesty policy” for the past 15 years.

In recognizing the need for cultural change, NNMC has emerged as a pioneer in the field of conflict resolution. The results of its innovative integrated conflict management approach to health care concerns—a near 100 percent resolution rate, no litigation to date, and no monetary payouts—have exceeded all expectations of performance. With luck, this integrated conflict management system can serve as a standard in the health care industry. 



Carole Schneider Houk, Esq., is the Principal of Resolve Advisors LLC. She is a conflict management systems designer and trainer and is working with several health care systems to introduce the health care ombuds throughout the U.S. She is an active member of ACR’s Health Care and Organizational Conflict Management Sections.

Barbara I. Moidel championed and designed the Organizational Ombudsman and Mediator Program at the National Naval Medical Center. She serves as the Navy’s first Organizational Ombudsman and Mediator in a health care setting.