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• USING DISPUTE RESOLUTION TO RESOLVE HEALTH CARE CONFLICTS: AN ESSENTIAL TOOL IN HOSPITAL RISK MANAGEMENT •

Dr. Robert Robson & Pam Marshall
mediate.*calm*

INTRODUCTION

Dispute resolution (DR) practice and theory have developed significantly over the past several decades. The practice is commonly referred to by many names, including:

- Mediation
- Conciliation
- Arbitration
- Alternative dispute resolution (ADR)
- Facilitation
- Negotiation

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USING DISPUTE RESOLUTION TO RESOLVE HEALTH CARE CONFLICTS: AN ESSENTIAL TOOL IN HOSPITAL RISK MANAGEMENT
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The techniques are being used to resolve conflict in a wide range of formal and informal manners. DR has demonstrated its applicability in many domains, including business, legal affairs, neighbourhood disputes, international conflict, national policy discussions, and aboriginal claims, to name just a few.

While DR and conflict management (CM) techniques are being used in many areas, their use in the health care field is relatively new. Health care is not listed as an area of practice in the largest Canadian DR/CM organization (Conflict Resolution Network[1]) and while the larger U.S.-based Association for Conflict Resolution (ACR[2]) has had a Healthcare Section for more than a decade, the activities of that section have been relatively limited.

It is not surprising that the potential use of DR/CM techniques as a tool for hospital and health care facility risk managers has remained relatively unexplored. Lack of awareness may be one of the reasons why DR techniques are not being widely used in the health care field. It may also be that traditional legalistic and adversarial approaches are seen as more appropriate in this area due to a widespread fear of, and desire to avoid, litigation. However, the experience of the authors indicates that the health care field is ripe and ready for alternatives.

The episode[3] described below illustrates how DR/CM techniques were used successfully to re-

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solve a longstanding conflict in a large urban community hospital in Canada. It will help identify how these techniques can be used by risk managers to augment their role and responsibilities to resolve conflicts within institutions.

RISK MANAGEMENT: SELF-PROTECTIVE VS. HUMANISTIC MODELS[4]

There exists a large body of knowledge about the general concept of risk management as well as its specific application in health care facilities. A number of definitions exist and the component steps or tasks of a risk manager have been analyzed extensively.[5] More recently attention has focused on "clinical risk management" as a distinct field[6] and the role of risk managers in the entire patient safety movement[7] has come under discussion.

From a broad philosophic perspective most definitions of risk management fall within the "self-protective" vision or perspective. This is understandable and reflects the origin of the risk management field within the insurance industry. Recently, within the health care field, a broader "humanistic" perspective[8] has developed, encouraged in part by a number of articles[9] analyzing the ethical aspects of patient care (notably the concept of "truth-telling").

A quick review of some respected texts on health care risk management reveals little or no interest or knowledge of DR/CM activities and techniques. The limited coverage of the subject ranges from one page of discussion in a 938-page text[10] to two short paragraphs in 370 pages[11] to a high of an entire chapter, albeit somewhat outdated, in a third text of 570 pages.[12]

Finally, it was only in the latter part of 2002 that the large U.S.-based organization (American Society for Healthcare Risk Management — ASHRM[13]) organized a teleconference on the use of ADR in resolving health care disputes and promoting patient safety. The general lack of information about DR/CM activities and how they might complement the role of risk managers may explain the relatively limited use of these techniques.

WHAT IS DISPUTE RESOLUTION?[14]

There has been significant growth in the field of dispute resolution over the past 50 years.[15] This has been marked by the development of varying theo-

ries, the elaboration of major training initiatives,[16] and the expansion of the skills and techniques of DR/CM into a large number of social, political and economic domains. Particularly in the last two decades, the emphasis on the prevention of conflict has gained significant ground as the economic advantages of "organizational conflict management (OCM) systems design"[17] have become clear to large corporations, primarily in the U.S.

The reality of conflict as an inevitable part of human interaction has been identified and recognized. Disputes are a natural part of life and their positive and effective resolution requires that we learn certain skills and gather an understanding of how better to deal with them at various levels of interactions.

The range of possible responses to conflict is summarized in Table 1[18] and responses fall into one of four broad categories. Examples of interventions are listed within the various categories and sub-groups.

As the field has developed, significant differences in style and approach of DR practitioners have been analyzed and categorized. The various approaches range from the more hands-off ("transformative") to the more directive or "evaluative". Different styles or methods may be appropriate to certain types of problems and not others. The "facilitative" style is situated between the above two extremes and results in a distinctive blended approach.[19]

In the past, the common term ADR has been understood to mean "alternative dispute resolution". However, as the DR/CM movement has gained an element of maturity and self-confidence "ADR" has gradually been transformed to mean "appropriate" dispute resolution. This reflects the reality that litigation is simply one alternative method of solving problems, albeit one that is usually less satisfactory, more costly and involves much less control for the parties than the possible resolutions using DR techniques.[20]

Major challenges remain on the agendas of the various DR/CM professional organizations. These include issues such as credentialing and certification of practitioners, the validity of various training programmes, and the potential need for and value of a transparent "informed consent" discussion with the parties concerning the approach most commonly adopted by a given DR practitioner called in to help resolve a conflict.

DR/CM TECHNIQUES IN ACTION

THE PRESENTING PROBLEM

A young surgeon moved from one part of Canada to a relatively large urban community hospital in the early 1990s. Prior to that, he had practised in a jurisdiction outside Canada. He seemed to fit in quickly and was considered a good clinician, a good communicator, and was easily accessible to nursing staff in the event of complications or problems. Indeed, in the first several years of his practice, he was the primary choice of nursing staff for their own required surgical procedures or investigations because of his knowledge, skills, and bedside manner.

The positive relationship began to deteriorate about five years prior to the intervention described below. A number of questionable clinical decisions (including a post-operative death from hypovolemic shock) and a more abrupt personal manner raised warning flags. Attempts to discuss these matters led to rebuffs by the surgeon. The Chief of Surgery was asked to intervene. Unfortunately, this led to more problems, as the Chief did not consistently document the actions suggested or the advice given. In addition, the Chief was depicted as being arbitrary and unfair in some interactions with the surgeon.

Inevitably, this problematic approach led to the development of "camps" within the hospital, some supporting and some criticizing the surgeon's actions and comportment. After some further clinical problems[21] the hospital imposed a period of supervision on the surgeon. The surgeon agreed to this option as an alternative to a referral to the provincial licensing body which the hospital considered. The period of supervision (eight months) evolved without major incident. The two staff surgeons who agreed to "supervise"[22] the surgeon-in-question's practice were unable to find evidence of incompetence or unprofessional behaviour. Despite no findings of clinical problems, the perception of the nursing staff was that the surgeon remained quite cool and distant.

Following completion of the period of supervision, the surgeon returned to full privileges in the hospital and sadly, problems recurred. Nursing staff felt that on many occasions the surgeon had been less than truthful, altering the treatment of patients in the recovery room without notifying the nurses, then subsequently denying having done this. Another severe patient complication occurred post-op and the

surgeon's response included a clearly false alteration of the clinical record. When confronted, the surgeon could not provide an explanation, yet he quickly acknowledged that his action had been wrong. As a result, the hospital suspended the surgeon's privileges which led to the required referral to the licensing body.

The review that followed took longer than desired but eventually led to a suspension of the surgeon's licence to practice for 18 months. It was agreed that 12 months of that suspension would be suspended if certain conditions were met by the surgeon. A date for a return to practice in the hospital was set by the licensing body and initially postponed by the hospital because of concerns voiced by nurses, administration and some medical staff about the surgeon's return. In response to these concerns, the hospital decided to retain the services of a group of health care mediators to facilitate the reintegration of the surgeon to the hospital.

THE DIAGNOSIS

Initially, the situation presented as a straightforward problem involving the reintegration of a general surgeon into the clinical fabric of a community hospital, following a suspension of his licence to practice. The unique notion of using third-party neutrals as facilitators in this process was seen as a positive approach to give nursing staff and administration an opportunity to express their concerns in discussion with the surgeon. The need to involve the nurses was particularly acute as a number of the highly experienced staff nurses had threatened to resign if the surgeon returned.

Mediators know that adequate preparation is one of the keys to the successful resolution of a particular conflict. In this particular case, preliminary discussions with the administrative team held as part of the preparatory work revealed significant distrust on the part of many nurses towards the hospital, based on a previous case unrelated to the practice of the general surgeon.[23]

A second step in preparation involved a review of documentation of previous meetings and activities related to the surgeon's past problems. In reading this information, it became clear that the management of the general surgeon's initial "problematic behaviour" had been largely undocumented and had proceeded in a manner inconsistent with usually accepted due process.

While this was acknowledged by some members of the administrative team as being less than optimal, it was not perceived as being a major problem compared to what they perceived as being serious transgressions by the surgeon. However, the surgeon continued to receive support from many colleagues at the hospital, an indication suggesting that others believed that the surgeon had been treated somewhat unfairly in this matter. It also served to confirm mediators' standard operating credo that "there are at least three sides to every story".

Clearly, the situation involved more than simple reintegration of the surgeon. There was significant distrust on various levels between and amongst all of the parties — the management team, the nursing staff, some of the medical staff, and, of course, the surgeon. In fact, this is a common finding in conflict situations that arise in health care facilities.

Complex adaptive systems such as health care generally involve multiple players with multiple inter-dependent relationships and potentially conflicting objectives in the delivery of any particular service or product. The varying cultures (of the organization, of various professional groups, of support workers, and of the patients and their families) make for a delightful if challenging icing on this many-layered "cake".

THE TREATMENT

In this case, the authors were the primary DR team. We outlined a work plan for the parties that involved a four-stage process. The suggested goal was to assist the parties to develop a consensus-based facilitation agreement that would respond to the various needs and interests of all affected parties. Early on in the process it was recognized that a basic primer about conflict management and dispute resolution was required.

Many people have limited understanding and experience of the role of mediators or facilitators. This lack of awareness was evidenced in this case by the fact that some members of the administration believed that "mediation" was not what was necessary. This stance clearly reflected their misunderstanding that a mediator is someone to be called in at the eleventh hour of a nasty labour dispute — obviously not the case here.

The proposed four-stage process, as outlined in Table 2, was explained to all parties early on, during the initial information-gathering stage. The need for adequate and ongoing explanation and reassurance about the role of the facilitator/mediator and for the openness of the process was understandable given the history of incomplete communication and resultant mistrust between many of the parties.[24]

Stage 1

The information-gathering stage involved individual or group interviews with more than 25 of the nurses, all of the immediate supervisors and programme directors, all members of the management group, members of the medical staff as well as the Medical Staff Association, and the general surgeon.[25]

A key element of this preparatory phase was the insistence by the DR team that all staff at the hospital have the opportunity of a private confidential meeting to discuss any concerns they may have about the situation. Both telephone numbers and e-mail addresses were provided so that staff could contact the DR team directly. This led to three additional meetings.

The information gathering was helped significantly by the hospital's timely provision of clear and comprehensive documentation concerning the situation of the surgeon as well as other background information.[26] Reaching this level of co-operation is essential to a positive outcome.

Prior to instituting the four-stage process, the DR team was faced with the challenge of defining the interested parties who should be present at the table. Initially, there was significant hesitation on the part of the management team to be present as anything more than observers. After spirited discussion, the group named three representatives who were given authority to sign an agreement if they felt it reflected the essential interests of the hospital. This was a key step forward, as there is frequently significant reluctance on the part of administrators to see themselves as involved parties (in essence to be seen as "part of the problem") preferring instead to be identified as "conveners" of the process.[27]

The four-stage process reflected a reasonably classic interest-based negotiation approach to problem-solving. The facilitative style of both members of the DR team also reflected a traditional "mediation" approach to conflict resolution. The ten individuals representing the three distinct parties sitting around the table were reminded on a regular basis of the four-stage process, exactly where they were situated at a given time and what the relative responsibilities of the parties and the mediators were at that time.[28]

Stage 2

The facilitation process itself took place over two days. The most difficult piece involved the progression from Stage 1 to Stage 2 at the end of the first morning. Several of the nurses had openly challenged the honesty of the surgeon and expressed their acute discomfort at working in a situation where they were essentially treated with disrespect that undermined their professionalism. The surgeon was clearly uncomfortable in the face of this "assault". While he acknowledged that he felt bad about the series of events that led to his suspension, he was clearly not comfortable taking such public responsibility for his actions.[29]

During the lunch-break on the first day, the DR team decided a private caucus with the surgeon was necessary to discuss the strong feelings of the nurses as well as his reaction. The DR team identified that culture and gender could be influencing the surgeon's approach and manner of participating. He clearly was not comfortable exhibiting spontaneous public expressions of sadness, weakness or regret. Nevertheless, it was important for the progress of the process to provide the surgeon with a private opportunity to express some of these feelings.[30]

Following the lunch-break, the surgeon read a brief statement he had written. In it he acknowledged previous errors and accepted responsibility for the consequences of his actions. He also apologized to the nurses and expressed regret for having created a situation that made them acutely uncomfortable. This declaration was the equivalent of a charge of dynamite releasing a log jam.

The nurses were struck by the apparent sincerity of the surgeon. When he said he had hesitated to express his feelings in the past because he felt "everybody was against him" the nurses admitted that they had been "recruited" by the administration to provide information about possible wrongdoings on his part, over a period of several months, without his knowledge. While this was upsetting news for the

surgeon to hear and difficult for the nurses to reveal, it had the effect of allowing the nurses and the surgeon to focus more on their common interest of creating a positive working environment through an effective re-integration of the surgeon to the unit.

Stage 3

Stage 3 extended from the first afternoon into the second morning. The option-generating stage was helped enormously by the requirement for all parties to do some homework over night. This assignment consisted of each person describing what the future relationship (post re-integration of the surgeon) should ideally look like from their point of view, and what specific actions they could take to help consolidate such a relationship. Everyone committed to the homework and returned the next morning with written comments.[31]

Stage 4

Stage 4 took place on the final afternoon. A five-page facilitation agreement was drafted and ultimately signed by all parties.[32] This stage consisted of a review of the circumstances that led to the present conflict, an appropriate expression of regret by the surgeon for previous actions, and a clear outline of the responsibilities of the various parties in the event of any future problems. Importantly, a separate section dealing with communication expectations and responsibilities was produced and all parties agreed that it would be posted in the appropriate clinical units.

OUTCOMES

As part of the service provided by this particular DR team, a meeting between the working group that signed the facilitation agreement and the DR team was held at six weeks and three months post-agreement. A further visit is planned for the near future.

Because of the specificity of the five-page facilitation agreement, there were several objective verifiable measures that could be reviewed to determine whether the agreement was being respected and was "holding". All parties expressed satisfaction at the first two meetings that these various details were being respected.[33] On a very simple human resources level, the nurses who had threatened to leave if the surgeon were reintegrated were still actively working in the units. The surgeon, of course, was delighted once again to be practising his profession and contributing to his community.

On a more general level there were expressions of satisfaction with respect to improved communication at several levels. Nursing staff in particular felt more involved in the day to day activities of their units because of their direct input in the details of both the reintegration and communication plans.

Experience in the U.S. has shown that the involvement of parties in both the investigation of medical errors or adverse clinical outcomes as well as the crafting of systems changes has resulted in significant lessons learned in terms of patient safety.[34] The DR team is convinced that this was achieved in this instance though specific outcomes that might reflect such change were not sufficiently defined to substantiate this impression.

Administration of the hospital was satisfied that one definitely measurable outcome was the dramatic savings of legal fees following the successful resolution of this problem. In addition to the beneficial outcomes listed above such as improved relationships and empowering individuals to resolve their problems, substantial cost savings is a significant and consistently recognized result[35] of using DR techniques and professionals.

CONCLUSION

This article has described one recent example of the application of interest-based dispute resolution techniques to help resolve a serious multi-party conflict of long duration in a large urban community hospital. In the realm of dispute resolution, there is no one-size fits all answer. Conflicts have no singular point of creation and no uniform method of resolution. Dispute resolution in each case must be tailored to meet the needs of the specific situation. The role of DR professionals is one of assistance, not control.[36] The use of third-party neutrals in all manner of health care disputes can become a useful tool in the options available to hospital quality assurance and risk management personnel.

[*Editor's note*: Rob Robson, MDCM, FRCP(C), is an emergency physician, health care mediator, and founding Director of **mediate**.*calm*, a dispute resolu-

tion services company that specializes in collaborative resolutions of health care disputes. Pam Marshall, RN, LLB, LLM is a registered nurse, mediator and a Senior Associate with **mediate**.*calm*.

For more information visit the website at: <www.mediatecalm.ca>. An interactive discussion forum relating to dispute resolution issues in health care is an integral part of the website: <www.mediatecalm.ca/mediatecalm/index.asp>. Please direct inquiries to: <info@mediatecalm.ca>.]

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[1] More information can be obtained through the organizational website, <www.crnetwork.ca> or from the quarterly magazine *Interaction*.

[2] Again, more information is available through <www.acresolution.org>. The Spring 2003 issue of the organization's quarterly magazine *ACResolution* will focus on the theme of ADR in health care. A more academic *Conflict Resolution Quarterly* is published by John Wiley and Sons.

[3] The example that is described is an "anonymized" version of a real situation. The underlying fact situation has been described accurately with some elements modified in order to respect the confidentiality of the various parties involved.

[4] We do not wish to suggest that this "dichotomy" describes all of the currents or viewpoints within the risk management field, nor do we wish to suggest that these are mutually exclusive. Most facilities are probably best served with a balanced application of both perspectives.

[5] See the authoritative *Risk Management Handbook for Health Care Organizations* (3d ed.), R. Carroll, ed. (San Francisco: Jossey-Bass, 2001); or F. Kavaler and A.D. Spiegel, *Risk Management in Health Care Institutions: A Strategic Approach* (Sudbury, Mass.: Jones and Bartlett Publishers, 1997). Both of these texts provide a primarily U.S. focus on the topic.

[6] See *Clinical Risk Management*, C. Vincent (ed.) (London: BMJ Publishing Group, 1995). This text reflects more information from the U.K. context.

[7] The U.S.-based National Patient Safety Foundation has done excellent work in this field and is promoting active discussion and research on several fronts. See <www.npsf.org>.

[8] S.S. Kraman and G. Hamm, "Risk Management: Extreme Honesty May be the Best Policy", *Annals of Internal Medicine*, 1999, 131:12, 963-67. This article describes the experience of a large VA hospital in Kentucky. Of interest is the overlap of the skill sets of the DR practitioner and those who developed the programme in Kentucky.

[9] Several excellent articles include the following: L.M. Peterson and T. Brennan, "Medical Ethics and Medical Injuries: Taking our Duties seriously", *Journal of Clinical Ethics*, 1990, 1:3, 207-11; A. Wu, et al., "Do House Officers Learn From Their Mistakes?", *JAMA*, 1991, 265:16, 2089-94; F. Baylis, "Errors in Medicine: Nurturing Truthfulness", *J. of Clinical Ethics*, 1997, 8:4, 336-40; D. Finkelstein, A. Wu, N.A. Holtzman, M.K. Smith, "When a Physician Harms a Patient by a Medical Error: Ethical, Legal, and Risk-Management Considerations", *J. of Clinical Ethics*, 1997, 8:4, 330-35.

[10] *Risk Management Handbook for Health Care Organizations* (3d ed.), *supra*, note 5.

[11] *Risk Management in Health Care Institutions: A Strategic Approach*, *supra*, note 5.

[12] *Clinical Risk Management*, *supra*, note 6.

[13] For more information visit the website <www.ashrm.org> ASHRM provides its members with a wide array of learning opportunities as well as specific training and accreditation programmes.

[14] It is clearly not possible to provide a comprehensive overview of the field in this short article. There are many excellent texts which summarize different aspects of the DR/CM field. These include: *Dispute Resolution: Negotiation, Mediation and Other Processes* (3d ed.), S.B. Goldberg, F.E.A. Sander and N.H. Rogers (eds.) (Gaithersburg, NY: Aspen Publishers, Inc., 1999); *The Handbook of Conflict Resolution — Theory and Practice*, M. Deutsch and P.T. Coleman (eds.) (San Francisco: Jossey-Bass Publishers, 2000); *The Mediation Process — Practical Strategies for Resolving Conflict* (2d ed.), C.W. Moore (ed.) (San Francisco: Jossey-Bass Publishers, 1996); B. Mayer, *The Dynamics of Conflict Resolution — A Practitioner's Guide* (San Francisco: Jossey-Bass Publishers, 2000). A number of good references from Canadian DR practitioners provide excellent background as well, including: J. Macfarlane (ed.), *Rethinking Disputes: The Mediation Alternative* (Toronto: Emond Montgomery Publications, 1997); J. Macfarlane (ed.), *Rethinking Disputes: Readings and Case Studies* (Toronto: Emond Montgomery Publications, 1999); D.P. Emond, *Commercial Dispute Resolution* (Aurora: Canada Law Book, 1989); C.A. Picard, *Mediating Interpersonal and Small Group Conflict* (Ottawa: The Golden Dog Press, 1998).

[15] An easily readable summary is found in: L.R. Singer, *Settling Disputes* (2d ed.) (Boulder, CO: Westview Press, 1994).

[16] One of the earliest training programmes was established at Harvard Law School as part of the Program on Negotiation. The underlying texts for these sessions have gained widespread popularity, selling in

the several millions of copies. This is a reflection of clear accessible writing as well as the elaboration of a system that can be seen to be useful and applicable to both the commonplace and the complex. See R. Fisher, W. Ury and B. Patton, *Getting to Yes* (2d ed.) (New York: Penguin Books, 1991); and W. Ury, *Getting Past No* (New York: Bantam Books, 1993).

17 See C.A. Constantino and C. Sickles Merchant, *Designing Conflict Management Systems* (San Francisco: Jossey-Bass Publishers, 1996); and K.A. Slaikeu and R.H. Hasson, *Controlling the Costs of Conflict* (San Francisco: Jossey-Bass Publishers, 1998).

18 This table is a hybrid of the efforts of several writers, including L. Singer in *Settling Disputes* (2d ed.), *supra*, note 15 and K. Slaikeu in *When Push Comes to Shove: A Practical Guide to Mediating Disputes* (San Francisco: Jossey-Bass Publishers, 1996).

19 An excellent summary of these differences is provided in an article by L.L. Riskin, "Understanding Mediators' Orientations, Strategies and Techniques: A Grid for the Perplexed", *Harvard Negotiation Law Review*, 1996, 1:7, 7-49.

20 A fascinating overview of the relative advantages of ADR versus litigation can be found in a recent article by R.C. Adams, and S.L. Cook, "The Case for Early ADR Intervention", *The Colorado Lawyer*, 2002, 31:12, 11-20.

21 This included the use of a procedure that was clearly not approved within the hospital and another post-operative death that was unexpected.

22 The supervision consisted of random review of office charts on a weekly basis and mandatory consultations with one of the supervisor prior to certain specified procedures.

23 A charge of criminal negligence causing death that was brought against a nurse working in another part of the facility following a patient death was eventually dismissed, but only after many nurses felt their colleague had been "abandoned" by the hospital.

24 An interesting systems analysis of health care by P. Plsek can be found in Appendix B of the Institute of Medicine Report, *Crossing the Quality Chasm: A New Health System for the 21st Century, Committee on Quality of Health Care in America, Institute of Medicine*, National Academy Press (Washington, D.C.: National Academy Press, 2001) at 322-30.

25 As a courtesy, a meeting was held with the representatives of the unionized workers at the facility to explain the process.

26 This included the By-laws and Regulations of the hospital as well as the decision of the licensing body. Initial hesitations about questions of confidentiality were dispelled when the ethical duties and standards to which mediators must adhere were explained.

27 It was of interest that legal counsel were not parties to the process, even though both the surgeon and the hospital had retained counsel and kept their respective lawyers aware of all developments.

28 At every step the DR team explained that no solution could be crafted that would be in violation of the hospital by-laws and regulations concerning medical staff matters.

29 This is consistent with the interesting work of Wu who has identified the health care practitioner as the "second victim" in many cases of serious medical error and poor patient outcome. See A.W. Wu, **"**Medical Error: the second victim", *British Medical Journal*, 2000, 320, 726-27.

30 One of the important skills of DR professionals is to be aware of how the culture, gender, education and life experiences of individual parties will impact a mediation or facilitation.

31 The purpose of the homework is more about encouraging the parties to keep the process in mind over the break of the evening than to get the right answers — many kinds of questions could be used as long as it relates to the goal of the process and solidifies the importance of each person's contribution to the ultimate success of the project.

32 Having access to a computer and printer in order to create, revise and review the document as it is being developed by the parties is essential. As the document is being written and rewritten, the parties can have copies in front of them and make their own changes and additions. This solidifies the parties' commitment to and creates excitement about the progress they are making towards agreement. Success breeds success.

33 These included specified meetings to review communications issues as well as other standards with respect to numbers and types of cases, the mechanism in which the cases were booked, as well as periodic review of the surgeon's office practice.

34 Direct personal communication with a hospital ombud practising in a large U.S. naval hospital, based on the analysis of 89 cases resolved in the first 11 months of the introduction of an integrated hospital neutral programme (an article based on this has been accepted for publication in *JAMA* in Spring 2003). For more information on the issue of patient safety and medical errors, the authoritative Institute of Medicine report is an excellent source: L.T. Kohn, J.M. Corrigan and M.S. Donaldson (eds.), *To Err is Human: Building a Safer Health System*, edited by Committee on Quality of Health Care in America, Institute of Medicine (Washington, D.C.: National Academy Press, 1999). For a Canadian perspective see also the recent report by the Royal

College of Physicians and Surgeons: *Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care* (Ottawa: National Steering Committee on Patient Safety, 2002).

[35] See R.C. Adams, and S.L. Cook, *supra*, note 20.

[36] These broad themes are explored in greater detail in an article by one of the authors: P. Marshall, **"**Would ADR Have Saved Romeo and Juliet?", *Osgoode Hall Law Journal*, 1998, 36:4, 776-802.

TABLE 1: RESPONSES TO CONFLICT

Avoidance	**Collaboration**			**Higher Authority**	**Unilateral Power Play**
	(Unassisted Negotiation)	*Assisted Negotiation*			
		Mediation	*Hybrids*		
	• Local Initiatives	• Facilitation • Conciliation • Regulatory Negotiation	• Ombuds Function • Fact-Finding • Mini-trial • Neutral Evaluation • Summary Jury Trial • Non-binding Arbitration • Med-Arb	• Binding Arbitration • Boards or Agencies • Litigation (Courts)	• Physical Violence • Strikes, lockouts • War • Etc.

Note: Movement from the left to the right on this grid represents a progressive loss of control of the outcome by the parties and also inevitably represents an increase in costs to the parties.

TABLE 2: MEDIATION AND FACILITATION PROCESS

	What the Facilitator does	***What the parties do***

Opening: Welcome & Introduction	• Explains the process
	• Explains the facilitator/mediator role
		• Discuss and decide on ground rules
		  • Confidentiality
		  • Respect
		  • Timelines

Stage One: Telling the story	• Asks questions in order to clarify the issues	• Each person in turn speaks about the situation
Stage Two: Identifying Issues	• Helps create issue list • Reinforces ground rules as required	• Agree on what are the issue(s) in dispute • Seek to find common ground
Stage Three: Generating options for resolution	• Helps parties generate options • Helps parties stick to the issues as identified	• Suggest as many alternatives as possible • All ideas have potential merit at this stage • No criticism of ideas
Stage Four: Reaching Agreement	• Assists in development of agreement • Writes down agreement as developed by parties	• Decide on points of agreement • Sign agreement if ready • Agree on next steps if more time required
Closing	• Ensure parties understand agreement as reached and next steps • Acknowledge everyone's hard work	• Ensure agreement is acceptable to all • Acknowledge everyone's contribution • Determine next steps as required
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