THE CULTURE OF HEALTH CARE: HOW PROFESSIONAL AND ORGANIZATIONAL CULTURES IMPACT CONFLICT MANAGEMENT

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INTRODUCTION

> *"Culture matters. It matters because decisions made without awareness of the operative cultural forces may have unanticipated and undesirable consequences. . . . The argument for taking culture seriously, therefore, is that one should anticipate consequences and make a choice about their desirability."*[1]

The expansion of alternative dispute resolution within the past 30 years, in both the public and private sectors, is well-documented.[2] However, despite this expansion, attempts to expand alternative dispute resolution (ADR) and conflict management services into health care organizations have had little success.[3] A 1997 survey of Fortune 1000 companies that had adopted some form of organizational conflict management strategy indicates that those organizations experiencing high levels of market pressure were most likely to adopt a preventive approach—use of ADR in all types of disputes with a comprehensive set of policies designed to manage conflict.[4] Given the intense market pressures within the health care

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1. EDGAR H. SCHEIN, THE CORPORATE CULTURE SURVIVAL GUIDE 3 (1999).

2. DAVID B. LIPSKY ET AL., EMERGING SYSTEMS FOR MANAGING WORKPLACE CONFLICT: LESSONS FROM AMERICAN CORPORATIONS FOR MANAGERS AND DISPUTE RESOLUTION PROFESSIONALS 75 (2003).

3. Harry N. Mazadoorian & Stephen R. Latham, *ADR for Health Care Organizations*, DISP. RESOL. MAG., Fall 2004, at 8, 10.

4. LIPSKY ET AL., *supra* note 2.

industry in the past 20 years, it is curious that the industry has not widely adopted effective conflict management strategies.[5]

There is empirical evidence indicating a tight connection between organizational culture and conflict in health care organizations.[6] Review of corporate adoption of ADR approaches indicates that resistance to organizational conflict management systems correlates to organizational culture and views of conflict, to the "motives and objectives of stakeholder groups," to the lack of analysis of existing systems resulting in little data for decision-making, and to the diminishing impact of a "precipitating event" or crisis over time as the perceived threat recedes from organizational memory.[7] In fact, the cultural view of conflict and its impact on organizational performance is an indicator of an organization's willingness to develop conflict management systems.[8] This Article will begin to outline how the interplay between organizational culture and the cultures of health care professions may be a source of conflict within complex health care organizations and how underlying cultural assumptions may be affecting responsiveness to the efforts of dispute resolution professionals in the industry to provide services for addressing conflict.

Understanding organizational culture, how to assess culture, and the ways cultural beliefs affect approaches to conflict management is a relatively new field of study.[9] Pettigrew first used the term "organizational culture" in 1979, and a review of the literature indicates that "organizational culture" has many definitions.[10] The functions of organizational culture are: to "convey a sense of identity" for members, to "facilitate commitment" to a larger goal, to "enhance social systems' stability," and to provide a means for making sense of the organizational environment in order to guide

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5. Mazadoorian & Latham, *supra* note 3, at 9.

6. *See* Geoffrey Bloor & Patrick Dawson, *Understanding Professional Culture in Organizational Context*, 15 ORG. STUD. 275 (1994), *available at* http://www.findarticles.com/p/articles/mi_m4339/is_n2_v15/ai_16043940/pg_1.

7. LIPSKY ET AL., *supra* note 2, at 300, 301, 307, 312.

8. LIPSKY ET AL., *supra* note 2, at 301.

9. TIM SCOTT ET AL., HEALTHCARE PERFORMANCE AND ORGANISATIONAL CULTURE 130 (2003).

10. *Id.* at 1, 3.

behavior.[11] The study of organizational culture as a means for understanding differences contributing to organizational effectiveness began in the 1980s with studies analyzing quality differences between U.S. and non-U.S. companies.[12] These efforts led to numerous models and approaches for how best to understand organizational culture with the goal of effecting changes to the culture that would move organizations toward more efficient and effective performance.[13] Areas of agreement among the various theorists seem to point to the complexity of organizational culture, the difficulty of assessing culture, and the consensus that "a basic function of organizational culture is to stabilise and establish a way of living. Resistance to change is therefore inherent to culture."[14] Given the stability of culture and the inherent resistance to change, it is clear that factors that demand change, such as market conditions or changes in public demands, can create an environment in which a great deal of conflict develops as organizations implement changes that may uncover competing values and beliefs held by members of the organization and by its professional groups.

A little-researched area is the interplay between organizational culture and the culture of professional groups working within the organization.[15] "The significance of professional identity and orientation may be one key to help unlock the culture of health care organisations."[16] Professional subcultures transcend organizations and professional associations, and continuous identification with other members of the professional group reinforce them.[17] Specialized training, practice environments that reinforce group norms, and limited inter-professional education lead to stable subcultures that both help define and simultaneously resist the goals

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11. *Id.* at 18 (adapted from Linda Smircich, *Concepts of Culture and Organizational Analysis*, 28 ADMIN. SCI. Q. 339, 345-46 (1983)).

12. *Id*. at 14.

13. *See id*. at 58.

14. *Id*.

15. *See, e.g.,* Pieter Degeling et al., *Mediating the Cultural Boundaries Between Medicine, Nursing and Management—The Central Challenge in Hospital Reform*, 14 HEALTH SERVICES MGMT. RES. 36 (2001).

16. SCOTT ET AL., *supra* note 9, at 22.

17. *Id*. at 22.

set forth by the broader organizational culture.[18] In health care, establishment of group norms within subspecialty cultures divides subcultures even further.[19] A more detailed discussion of professional subcultures within the health care system follows.

Dominant professional cultures can have a large impact on the values and assumptions of the organization, and threats to dominance can create conflicts among various professional groups that may not share the same set of values.[20] Changes to the environment external to the organization create opportunities for shifts in professional dominance as market pressures and societal expectations force changes to organizational practices—changes that may threaten deeply held beliefs among members of the dominant groups.[21] Conflicts arise when values and assumptions held by one group clash with those of another group, and professional disputes over treatment protocols, scope of practice, credentialing boundaries, and supervisory authority reveal these conflicts.[22] These disputes may impact the organization as other subgroups enter the conflict and as the organization diverts resources toward managing the conflict's impact. Disputes between professional groups and groups outside the organization, such as consumers or public agencies, may also result from differences in beliefs. In one study, researchers measured values held by patients, residents, and faculty physicians and found that there were values discrepancies between the groups, with the greatest difference related to having the same doctor for more than one year—the top priority for patients but a low priority for residents and faculty physicians.[23] These researchers also described three different conceptual metaphors for how each group saw their role during the clinic visit. Patients described a clinic visit as "a series of locks," with

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18. THERESA J. K. DRINKA & PHILLIP G. CLARK, HEALTH CARE TEAMWORK: INTERDISCIPLINARY PRACTICE AND TEACHING 65-66 (2000); SCOTT ET AL., *supra* note 9, at 26.

19. SCOTT ET AL., *supra* note 9, at 25.

20. Bloor & Dawson, *supra* note 6.

21. Joseph S. Bujak, *Culture in Chaos: The Need for Leadership and Followership in Medicine—Competing on the Edge*, PHYSICIAN EXECUTIVE, May-June 1999, *available at* http://www.findarticles.com/p/articles/mi_m0843/is_3_25/ai_102274374/pg_1.

22. DRINKA & CLARK, *supra* note 18, at 80; Degeling et al., *supra* note 15, at 46.

23. C. Scott Smith et al., *Cultural Consensus Analysis as a Tool for Clinic Improvements*, 19 J. GEN. INTERNAL MED. 514, 514-15 (2004).

various stages for receiving care.[24] The residents used a "docket" model, with the focus on efficiency and who controls the clinic agenda for the day.[25] The faculty physicians sought "balance" between ideal and realistic goals.[26]

Addressing conflicts that involve differing values and assumptions can be daunting and requires particular skills and processes that elicit cultural beliefs by uncovering those unconscious assumptions that motivate behavior among members of the professional groups, among members of the organization at large, and among those who seek their services. Current traditional and alternative dispute resolution models are not sufficient. Finding and testing new models for addressing these conflicts will require a greater understanding of the role of organizational and professional cultures in health care dispute resolution.

It is difficult for dispute resolution professionals outside of health care to appreciate the complexity of health care culture and the types of conflict that the clinical setting generates. Many ADR practitioners express frustration at the obvious disconnect between the great need for better conflict management within health care organizations and the lack of responsiveness by the industry. A recent study indicates that perceptions by ADR practitioners and physicians regarding various aspects of conflict within health care are not aligned. In one study, Coby Anderson and Linda D'Antonio demonstrated that the two groups differ in their perceptions as to "the sources and amount of conflict doctors experience, . . . [as to] what relationships doctors deal with best, and . . . [as to] the optimal time and manner for training doctors in conflict-resolution skills."[27] Improved assessment of the needs of health care professionals may enhance access to health care organizations and improve the effectiveness of services offered.

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24. *Id. at 516.*

25. *Id.*

26. *Id.*

27. Coby Anderson & Linda L. D'Antonio, *Empirical Insights—Understanding the Unique Culture of Health Care Conflict*, DISP. RESOL. MAG., Fall 2004, at 15, 15 [hereinafter *Empirical Insights*]; *see also* Coby J. Anderson, J.D. & Linda L. D'Antonio, Ph.D., *A Participatory Approach to Understanding Conflict in Healthcare*, 21 GA. ST. U. L. REV. 817 (2005).

Public calls for changes in the culture of health care to improve safety and quality, and data indicating that the work environment of health professionals is contentious and unhealthy, suggest that the need for conflict management services is increasing.[28] Given the stability exhibited by professional cultures, it is likely that initiatives that threaten established hierarchies and deeply ingrained beliefs will meet with much resistance, even in the presence of rational data supporting the changes. Appropriate conflict management services that address the sources of the disputes and create safe environments for making choices that improve care without destroying identity can lessen the frustration, sense of loss, fear, and pain encountered by health care professionals as these conflicts play out in day-to-day clinical interactions.

An exploration of the culture of health care and its various subcultures will provide insight into the sources of resistance by health care professionals to dispute resolution services and can enable development of better processes for managing and preventing health care related conflicts. It may also assist in defining strategies for inviting health care organizations to make use of conflict management techniques that facilitate culture change and improve the environments in which providers deliver health care.

I. THE CULTURE OF HEALTH CARE

Managing conflict requires an understanding of the context in which the conflict occurs. A look at the evolution of the health care system in the United States provides some context for a more detailed examination of organizational culture and its professional subcultures. Research conducted by W. Richard Scott and others takes a broad look at the vast changes in the health care industry

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28. INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (2000) [hereinafter TO ERR IS HUMAN]. *See generally Intimidation: Practitioners Speak Up About This Unresolved Problem (Part I)*, ISMP MEDICAL SAFETY ALERT (Inst. for Safe Medication Practices, Huntingdon Valley, Pa.), Mar. 11, 2004 [hereinafter *Practitioners Speak Up*], *available at* http://www.ismp.org/MSAarticles/IntimidationPrint.htm; AM. ASSOC. OF CRITICAL-CARE NURSES, AACN STANDARDS FOR ESTABLISHING AND SUSTAINING HEALTHY WORK ENVIRONMENTS (2005), *available at* http://www.aacn.org/aacn/pubpolcy.nsf/Files/HWEStandards/$file/HWEStandards.pdf.

occurring since the 1960s.[29] In analyzing these changes, the researchers focused on "institutional actors, institutional logics, and governance systems."[30] The 1960s brought about changes to a system dominated by physician "cultural authority," in which the basic assumptions within health care organizations were premised on "*quality of care*, as defined by the physician."[31] Professional autonomy over care delivery was the dominant value within the industry until about 1965.[32] During the 1960s, Medicare and Medicaid legislation improved access to care, and there was a rapid growth in the numbers of health care facilities and providers and a growing movement toward specialization in medical care.[33] In fact, by 1970, physicians practicing as general primary care practitioners comprised only forty percent of total non-federally employed physicians.[34] These changes brought about a shift toward "equity of access" as a driving value and an expanded role of the federal government in the financing of health services.[35] Increased complexity in financing and delivery of care led to fragmented governance of health care organizations and conflicts associated with competing demands from regulators, administrators, physicians, and patients.[36]

Increased access to services through public funding and insurance, increased technology, and expanding numbers of service providers led to increased costs and expenditures for health services.[37] From the early 1980s through the present, the industry focus has been on

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29. W. Richard Scott, *The Old Order Changeth: The Evolving World of Health Care Organizations*, *in* ADVANCES IN HEALTH CARE ORGANIZATION THEORY 23, 36-39 (Stephen S. Mick & Mindy E. Wyttenbach eds., 2003).

30. *Id*. at 26.

31. *Id*. at 35.

32. *Id.* at 35.

33. *Id*. at 35-36.

34. *See* American Medical Association, *Physicians in the United States and Possessions by Selected Characteristics*, *at* http://www.ama-assn.org/ama/pub/category/2688.htm (Dec. 12, 2004).

35. Scott, *supra* note 29, at 36.

36. *Id*. at 37.

37. Drew Altman & Larry Levitt, *The Sad History of Health Care Cost Containment as Told in One Chart*, HEALTH AFF. WEB EXCLUSIVES (Jan. 23, 2002), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.83v1.

efficiency and cost containment.[38] New structures for financing care, such as HMOs; new structures for professional practice, such as IPAs, PPOs, and multi-specialty groups; and new delivery structures, such as integrated delivery systems, began to form in response to market forces and increased competition within the industry.[39] With the heightened focus on efficiency and the need to comply with vast regulatory requirements, the need for professional health care administrators became increasingly important within organizations. These changes caused the professional autonomy of physicians to decrease, the political power of professional associations to diminish, and health care as big business to emerge as the dominant model.[40]

In the past few years, quality of care, patient safety, and the expanding role of the health care consumer have begun to emerge as environmental forces that will likely effect the continued evolution of the industry.[41] There is an expanding focus on consumer-based care, in which consumers are more accountable for both financing and managing their health services.[42] Increased access to health information and to quality data and increased direct marketing by pharmaceutical companies is fundamentally changing the relationship between patients and their physicians.[43] Rewards offered to consumers who choose physicians who demonstrate better outcomes, as measured by health plans and employer score cards, in exchange for greater coverage of costs further demonstrates the power shift accompanying these changes. Already, large employers offer incentives for employees who choose providers who have agreed to

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38. Scott, *supra* note 29, at 37.

39. David Mechanic, *Managed Care and the Imperative for a New Professional Ethic*, 19 HEALTH AFF. 100 (2000), *available at* http://content.healthaffairs.org/cgi/reprint/19/5/100.pdf.

40. Scott, *supra* note 29, at 38-39.

41. Kenneth W. Kizer, *Patient Safety: A Call to Action: A Consensus Statement from the National Quality Forum*, 3 MEDSCAPE GEN. MED. 1 (Mar. 21, 2001), *at* http://www.medscape.com/viewarticle/408114; *Practitioners Speak Up*, *supra* note 28; Bujak, *supra* note 21, at 2.

42. *Fact File: Consumers in the Driver's Seat?*, HEALTHLEADERS MAG., Apr. 1, 2004, *available at* http://www.healthleaders.com/magazine/factfile53881.html.

43. Kent Bottles, *The Effect on the Information Revolution on American Medical Schools*, 1 MEDSCAPE GEN. MED. 2 (July 23, 1999), *at* http://www.medscape.com/viewarticle/407991.

practice according to designated clinical practice guidelines.[44] Furthermore, as Medicare's pilot pay-for-performance model of reimbursement expands throughout the industry, even more emphasis will be on quality as determined by prescribed public standards.[45]

The tug of war between cost cutting and quality that is inherent in a market-driven system creates systemic conflicts that impact the work environment within health care organizations. Descriptions of the current work environment and levels of satisfaction of health professionals offer some insight into the extent to which conflict is a day-to-day occurrence for many practitioners. Research indicates that 50% of physicians' daily practice involves dealing with conflicts—mostly with other physicians and administrators.[46] In a study by Lynda Beaudoin and Linda Edgar, environmental and social "hassles" had an impact on the work-life of nurses because they divert time from patient care to search for equipment, to perform housekeeping functions, to call for missing medications, to coordinate scheduling, and to handle other non-direct care functions.[47] The results of cutbacks in staffing have shifted non-nursing responsibilities to bedside nurses leading to feelings of frustration, burnout, and stress and, in turn, to increased turnover. A 1996 survey of 600 hospitals indicated that 86% reported staff morale to be a serious problem.[48] For nurses, unit culture impacts quality of

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44. Arnie Milstein, M.D., Breaking News from the Pay-4-Performance Movement: Purchasers Provide a Roadmap for Market Success, Remarks at the Sixth Annual National Patient Safety Foundation Patient Safety Congress (May 5, 2004) (noting that Boeing will pay 100% for services if the employee's hospital participates in The Leapfrog Group, an organization that seeks to use the market to reduce medical errors); *WHSA Board Adopts Patient Safety Project*, WEEKLY REPORT (Wash. State Hosp. Ass'n, Seattle, Wash.), July 23, 2004, *available at* http://www.wsha.org/ArchiveWeeklyReports/07-23-04.htm; *Hospital Safety Incentive for Boeing*, Regence Blue Shield, *at* http://www.wa.regence.com/boeing/traditional/benefitIncentive (last visited July 13, 2005).

45. *See* Jeff Tieman, *Experimenting with Quality: CMS-Premier Initiative to Reward Best, Punish Worst*. MODERN HEALTHCARE, July 14, 2003, at 6; *HQI Overview*, Premier, *at* http://www.premierinc.com/all/quality/hqi/ (last visited Apr. 16, 2005).

46. *Empirical Insights*, *supra* note 27, at 16.

47. Lynda Egglefield Beaudoin & Linda Edgar, *Hassles: Their Importance to Nurses' Quality of Work Life*, 21 NURSING ECON. 106, (2003), *available at* http://www.medscape.com/viewarticle/457087.

48. Blair D. Gifford et al., *The Relationship Between Hospital Unit Culture and Nurses' Quality of Work Life*, J. HEALTHCARE MGMT., Jan-Feb 2002, at 13.

work life, which correlates to retention of staff.[49] Physician satisfaction with residency programs is linked to the clinical environment and how well the residents work together as a team.[50] Programs and policies for addressing "disruptive behavior" are common, and recent surveys indicate that approaches for dealing with outbursts are inconsistently effective.[51] Evidence of intimidation, verbal abuse, and breakdowns in teamwork and communication indicate that cracks in the organizational environment are impacting the ability of health care professionals to deliver safe and effective care.[52] In fact, breakdowns in interpersonal communication cause 60% of all sentinel events.[53] In response to the increased literature supporting the need for healthy work environments, the Association for Critical Care Nurses has recently released Standards for Healthy Work Environments to begin addressing the sources of conflict present in organizations throughout the country.[54]

In the presence of a scarcity of resources and major shifts in power, many disputes within health care organizations take on life-or-death significance as administrators fight to maintain financial viability, as clinicians fight to retain autonomy and control over quality of care, and as consumers demand high quality and access to an ever-expanding menu of treatment options. The heart of these disputes may be more than just financial concern and power-brokering; it may be that changes in the health care environment are

49. *Id.*

50. Francis S. Nuthalapaty et al., *The Influence of Quality-of-Life, Academic, and Workplace Factors on Residency Program Selection*, 79 ACAD. MED. 417, 417 (2004).

51. David O. Weber, *Poll Results: Doctor's Disruptive Behavior Disturbs Physician Leaders*, PHYSICIAN EXECUTIVE, Sept.-Oct. 2004, at 6, *available at* http://www.acpe.org/pej_article/disruptivebehavior_weber.pdf.

52. *Practitioners Speak Up*, *supra* note 28; Janice K. Cook et al., *Exploring the Impact of Physician Verbal Abuse on Preoperative Nurses*, 74 ASSOC. OPERATING ROOM NURSES J. 317 (2001); INSTITUTE OF MEDICINE, KEEPING PATIENTS SAFE: TRANSFORMING THE WORK ENVIRONMENT OF NURSES 215-16 (2004), *available at* http://www.nap.edu/openbook/0309090679/html/.

53. *Sentinel Event Statistics: Root Causes of Sentinel Events (All Categories; 1995-2004)*, Joint Commission on Accreditation of Healthcare Organizations, at http://www.jcaho.com/accredited+organizations/ambulatory+care/sentinel+events/root+causes+of+sentinel+event.htm (last visited Apr. 16, 2005) [hereinafter *Sentinel Event Statistics*].

54. AM. ASSOC. OF CRITICAL-CARE NURSES, AACN STANDARDS FOR ESTABLISHING AND SUSTAINING HEALTHY WORK ENVIRONMENTS: A JOURNEY TO EXCELLENCE 4 (2005), *available at* http://www.aacn.org/aacn/pubpolcy.nsf/Files/HWEStandards/$file/HWEStandards.pdf.

triggering threats to the core beliefs forming the foundation of the professional cultures that practice within health care organizations.

II. LEVELS OF ORGANIZATIONAL CULTURE

An organization is fundamentally an "ongoing conversation" among those who come into contact with it, and organizational culture forms much of the nonverbal component of that conversation.[55] One can describe organizational culture on three levels: "artifacts" (visible behaviors and structures), "espoused values" (mission, strategies, philosophies), and "basic underlying assumptions" ("unconscious. . . beliefs, perceptions, thoughts, and feelings").[56] When behaviors occur that seem contrary to stated values, conflicts can arise as individuals struggle to make sense of the environment and the disconnect between what is indicated to be of importance and what is actually reinforced through organizational behavior. This disconnect indicates that deeper assumptions motivate behaviors and that these assumptions may be contrary to the stated values put forward by the group or organization and may be of more significance to the individual.[57] To the extent that these assumptions are part of identity, they serve as a strong driver of behavior, may be difficult to uncover, and can serve as a major barrier to behavioral changes.[58] A look at each of these layers can help paint the picture of the culture of health care and its professional subcultures.

A. Artifacts

Artifacts are the more visible components of group culture.[59] They include such things as uniforms, work hours, staffing levels, communication patterns, jargon, making decisions, level of formality,

55. Anthony L. Suchman, *The Influence of Health Care Organizations on Well-Being*, 174 W. J. MED. 43 (2001).

56. SCHEIN, *supra* note 1, at 15-20.

57. *Id.* at 19.

58. SCOTT ET AL., *supra* note 9, at 36-37; JAY ROTHMAN, RESOLVING IDENTITY-BASED CONFLICT IN NATIONS, ORGANIZATIONS AND COMMUNITIES 6 (1997).

59. SCHEIN, *supra* note 1, at 15-16.

and running meetings.[60] Artifacts are typically observable and can frequently be the focus for disputes. For example, there has been much debate about the appropriate number of work hours for medical residents and in July 2003, the Accreditation Council of American Graduate Education issued new standards for residency programs limiting work hours for all specialties to eighty hours per week.[61] Conflicts result as hospitals reallocate work loads, as surgical training programs modify established practices, and as faculty struggle with creative solutions for meeting strict criteria in an unpredictable environment.[62] Another example is the debate over whether the law should mandate, or health care organizations determine, appropriate nurse-to-patient staffing ratios.[63] Conflicts associated with communication patterns within clinical teams provide a third example. Recent evidence links breakdowns in communication and teamwork-particularly inappropriate "hierarchy and intimidation"-to serious harm and death to newborns.[64] Disputes at the level of artifacts, despite serving as a focal point for conflicts, may not reflect the cause of the conflict; they may merely be a symptom of a deeper clash between values and assumptions as seen below.

B. *Espoused Values*

Espoused values are those philosophies or goals found in mission statements, professional oaths, or offered as principles in which an organization or group believes.[65] These may reflect deeper assumptions, or they may come to be superficial rationales for group

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60. *Id.*

61. *ACGME Duty Hours Standards Fact Sheet*, Accreditation Council for Graduate Medical Education, *at* http://www.acgme.org/acWebsite/newsRoom/newsRm_dutyHours.asp (last visited Apr. 16, 2005).

62. Michael Romano, *Lightening Their Load: As Teaching Hospitals Grapple with New Rules Limiting Residents' Hours on the Job, Cost and Management Issues Remain Among the Challenges*, MODERN HEALTHCARE, Apr. 28, 2003, *available at* http://www.modernhealthcare.com/article.cms?articleId=29242 .

63. Barbara Tone, *What Works?: Nurse-Patient Ratios, Professionalism, and Safety*, NURSEWEEK, May 3, 1999, *available at* http://www.nurseweek.com/features/99-5/ratios.html.

64. *Preventing Infant Death and Injury During Delivery*, SENTINEL EVENT ALERT (Joint Commission on Accreditation of Healthcare Orgs., Oakbrook Terrace, Ill.), , *available at* http://www.jcaho.org/about+us/news+letters/sentinel+event+alert/print/sea_30.htm.

65. SCHEIN, *supra* note 1, at 17.

behaviors.[66] When espoused values are the justification for practices and behaviors, language such as "that is the way we do things around here" or "we have always done it that way" reflect the values.[67] Espoused values in health care include patient-centeredness, teamwork, quality care, safety, and patient advocacy. Many health care organizations and health care professionals hold and put forth these values. Yet for all the similarity in espoused values across health care organizations, it is clear that culture in various organizations can be quite different and that there are different levels of consistency between stated values and observed behaviors. For example, organizational practices related to visiting hours and appointment scheduling can vary greatly, and these differences provide insight into whether the organization believes or merely promotes the value of "patient-centeredness."[68]

C. Assumptions

Assumptions held by members of an organization manifest in observable artifacts and behaviors. Assumptions are often unspoken and may "drop from consciousness" over time as they become more deeply integrated and reinforced by others who hold the same assumptions.[69] Within organizations, assumptions form when "joint learning" leads to workable solutions that are passed on to new members who enter the organization and that become the accepted way of doing things.[70] Shared assumptions lead to more consistent behaviors among members of an organization where varying assumptions lead to multiple approaches or ways of working. When there are differences, conflicts may result that potentially damage working relationships. It is necessary to have processes to deal with these differences in order to restore effective working relationships

66. SCOTT ET AL., *supra* note 9, at 17-19 (citing SCHEIN, *supra* note 1, at 64).
67. SCHEIN, *supra* note 1, at 76.
68. Don Berwick, *Don Berwick's Challenge: Eliminate Restrictions on Visiting Hours in the Intensive Care Unit*, Institute for Healthcare Improvement, *at* http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Literature/DonBerwicksChallengeEliminateRestrictionsonVisitingHoursintheIntensiveCareUnit.htm (last visited Apr. 16, 2005).
69. SCOTT ET AL., *supra* note 9, at 64.
70. SCHEIN, *supra* note 1, at 20.

that enable interdependent groups to negotiate their daily interactions.[71]

Deeply held assumptions can underlie various components of work life including the design of systems and processes, the measurement and correction of errors, "group boundaries and identity," "allocation of rewards and status," and "the nature of authority and relationships."[72] Because medical errors can lead to large and protracted disputes, it is worth looking at some assumptions underlying error reporting and correction in health care organizations. Underlying assumptions impact the way organizations measure and correct errors, as demonstrated by the current push to encourage better reporting of errors and near misses by hospital employees and physicians and by the recommended shift to a systems-based analysis of health care delivery failures.[73] Numerous documents show that there are a great deal of preventable deaths and injuries to patients due to medical treatment and that situations leading to this harm are often related to longstanding system failures that key stakeholders knew of but did not report—sometimes repeatedly.[74] This phenomenon, documented within health care organizations across several countries, indicates that financing systems, legal systems, and national culture may be less of a factor than the culture of health care itself:

> It is striking that the causes and characteristics of major failures in different countries with different ways of organizing and funding health care are remarkably similar. This may suggest that the problems—and their potential solutions—are deeply

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71. ROGER FISHER & SCOTT BROWN, GETTING TOGETHER: BUILDING RELATIONSHIPS AS WE NEGOTIATE 132-33 (1988).

72. SCHEIN, *supra* note 1, at 30.

73. INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 78-80 (2001) [hereinafter CROSSING THE QUALITY CHASM], *available at* http://www.nap.edu/books/0309072808/html/R1.html. A systems-based analysis of error involves looking at all of the contributors to an error rather than focusing on the actions of a single individual or group.

74. Kieran Walshe & Stephen M. Shortell, *When Things Go Wrong: How Health Care Organizations Deal With Major Failures*, 23 HEALTH AFF. 103, 105 (2004).

> embedded in the nature of clinical practice, the health care professions, and the culture of health care organizations.[75]

Recent work by national patient safety organizations suggests that moving from a model of individual causation to a systems-based approach for correcting unsafe practices would lead to improved safety and would remove barriers to self-reporting of events that could lead to future harm.[76] However, use of error correction systems—such as root cause analysis or systems analysis, which seek to avoid personal blame—are not successful in cultures valuing competition and where employees actively pursue active avoidance of personal blame.[77] Despite integration of root cause analysis as a response to sentinel events since 1995, physicians may still mistrust the process due to continued actions by the organization or their peers that reinforce the deeper assumption that someone is to blame.[78] Additionally, performance improvement plans resulting from root cause analysis often focus on re-education of the clinicians and reinforcement of the policies as acceptable means for preventing recurrences. This response further reinforces individual responsibility for adverse events. Building trust and reinforcing teamwork are necessary before a move toward system-based error analysis can be effective.[79] Building trust and teamwork within health care cultures where there is "endemic secrecy, deference to authority, defensiveness, and protectionism" and where excessive objectivity constrains authenticity and increases interpersonal distancing will be difficult and will require interventions that help to uncover underlying assumptions, enabling those who hold them and those who they affect to fully appreciate their impact.[80]

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75. *Id*. at 108.
76. CROSSING THE QUALITY CHASM, *supra* note 73, at 78-79.
77. SCHEIN, *supra* note 1, at 40.
78. *Sentinel Event Statistics*, *supra* note 53. In a 2002 root cause analysis facilitated by the author, a senior physician began the meeting by presenting phone records of pages received by a resident assigned to the patient involved in the sentinel event and by stating, "I have brought evidence that this doctor is not to blame for the event, and she never received any of the pages alleged to have been made."
79. SCHEIN, *supra* note 1, at 40.
80. Walshe & Shortell, *supra* note 74, at 110; Suchman, *supra* note 55, at 44.

III. A LOOK AT PROFESSIONAL SUBCULTURES

Structurally, health care organizations are complex adaptive systems that have evolved from professional organizations.[81] Professional organizations' characteristics include: a public mandate for the services, highly skilled and educated practitioners, strong values, and a desire to provide services for the well being of society as a whole.[82] Within these bureaucracies, dominant coalitions form with membership tied to professional affiliation, the level of expertise, and the acceptance of the profession's values.[83] As health care has become more technical and complex, health care organizations have taken on the characteristics of complex adaptive systems.[84] As such, the importance of hierarchies, predictability, and uniformity disappear, and success comes from strong networks and relationships across various levels, from "sense-making," and from "loose coupling."[85] To be successful, these organizations must foster effective working relationships across the professions, between departments, and throughout affiliated facilities.

Complex organizations commonly contain many subcultures, each with its own set of tacit assumptions.[86] Within professional groups, socialization into the profession passes on assumptions and values. The values represent meaning and become the basis for formation of professional identity. Artifacts representing these values include use of specialized language, adherence to professional hierarchy, appropriate dress, and adoption of accepted approaches toward problem-solving and communication. In health care, each

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81. Ruth A. Anderson & Reuben R. McDaniel, Jr., *Managing Healthcare Organizations: Where Professionalism Meets Complexity Science*, HEALTH CARE MGMT. REV., Winter 2000, at 83, 86.

82. *Id*. at 85.

83. *Id*. at 87.

84. Characteristics of complex adaptive systems as used in the scientific model include: dynamic states, complicated enmeshed relationships, feedback loops that generate change, emergent, self-organizing behavior, and a sensitivity to small changes resulting in big effects. James Begun et al., *Health Care Organizations as Complex Adaptive Systems*, *in* ADVANCES IN HEALTH CARE ORGANIZATION THEORY 253, 255-57 (Stephen S. Mick & Mindy E. Wyttenbach eds., 2003).

85. Anderson & McDaniel, *supra* note 81, at 88.

86. Tim Scott et al., *Implementing Culture Change in Healthcare: Theory and Practice*, 15 INT'L J. FOR QUALITY HEALTH CARE 111, 112-13 (2003).

professional subculture develops in relative isolation without inter-professional mingling until the indoctrination process is complete.[87] This separation creates barriers to understanding between professional groups as to role, language, approaches to patient care, and professional values.[88] Organizational culture, impacted over time by the presence of the professional subcultures, further reinforces the socialization begun during training.[89] As the professions co-mingle within the organizational culture, opportunities for conflict arise as values clash.[90] As professionals make decisions based on unshared assumptions and as communication fails in the face of differing professional language and goals, adverse patient outcomes can give rise to conflicts.[91] Additionally, conflicts occur when assumptions held by members of the various subcultures diverge from the values of the organization, leading to behaviors that are contrary to these values and becoming a source of frustration for hospital administrators.

The philosophies of practice among the various professional groups are very different and lead to ingrained values and assumptions within each professional group. Physicians typically learn a reductionist, "technical rationality" approach to diagnosis and treatment of individual illnesses, integrating physical data to rule-in or rule-out a likely cause of the illness.[92] Nurses, alternatively, learn a holistic, patient-centered approach that includes physical, emotional, and spiritual components of healing.[93] Values reinforced during the nursing education process include patient advocacy and quality of life. The nurse becomes the coordinator of care, integrating information and orchestrating treatment activities from the various members of the treatment team, while incorporating the needs of both the patient and the family in determining treatment priorities. Working from these divergent philosophies, it is easy to see the

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87. DRINKA & CLARK, *supra* note 18, at 65-66.
88. *Id*. at 69-80; SCOTT ET AL., *supra* note 9, at 25.
89. DRINKA & CLARK, *supra* note 18, at 67.
90. *Id*. at 76-78.
91. *Id*.
92. Bottles, *supra* note 43.
93. DRINKA & CLARK, *supra* note 18, at 73.

challenges associated with communication and identification of treatment priorities, which often lead to inter-professional tensions and interpersonal conflicts.

The professions differ significantly in how they view their ability to work together. Recent studies assessing levels of teamwork and collaboration reveal that physicians and nurses have quite different perceptions regarding levels of communication and cooperation. In a survey of intensive care nurses and physicians, 73% of physicians believed that collaboration with nurses was high or very high, while only 33% of nurses in the same units believed that to be true.[94] A study published in 2004 indicates that doctors were satisfied, significantly more often than nurses, with the inter-professional cooperation between the two groups.[95] The researchers posited that the operational definition of cooperation is quite different for the two groups.[96] Physician satisfaction with the level of cooperation depended mostly on their feeling that all professions were working together toward the same goals for the patients.[97] Nursing satisfaction was more dependent upon their overall job satisfaction.[98] According to the researchers, for physicians, "good co-operation means having their therapeutic decisions effectively implemented and being kept informed about their effect. . . . To [nurses], co-operation does not only mean communicating medical observations or administering medication, but also being appreciated for their independent contributions to the healing process."[99] In a 2001 study looking at factors considered core to clinicians' identity, physicians "regarded inequalities of power as natural, necessary and beneficial."[100] Nursing clinicians, not surprisingly, rejected this view.[101] In addition, doctors

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94. Eric J. Thomas et al., *Discrepant Attitudes About Teamwork Among Critical Care Nurses and Physicians*, 31 CRITICAL CARE MED. 956, 957 (2003).
95. Unni Krogstad et al., *Doctor and Nurse Perception of Inter-Professional Co-Operation in Hospitals*, 16 INT'L J. FOR QUALITY HEALTH CARE 491, 493 (2004).
96. *Id.* at 494-96.
97. *Id.* at 496.
98. *Id.*
99. *Id.*
100. Degeling, *supra* note 15, at 41.
101. *Id.* at 38.

viewed clinical work as individualistic, as compared to nurses, who considered clinical work more as a collective undertaking.[102]

The professions also differ in their perceptions and approaches to conflict. An intensive care study found that physicians were less likely than nurses to report inappropriately resolved disagreements, while nurses indicated that they believed physicians poorly received their input and that it was difficult to assert themselves.[103] A 2001 study looked at how hospital professionals handle cooperational conflicts.[104] The researchers' findings indicate that physicians tolerate more stress and disagreement than members of other professional groups before recognizing a conflict.[105] It is unclear whether this is a coping technique, an avoidance tendency, or an insensitivity to a collaborative environment.[106]

The subculture of non-clinical (i.e., lay) managers is another group with specific beliefs that impact conflict resolution.[107] A 2001 study found that lay managers oppose the "medical ascendancy model of clinical unit management" and support hierarchical models for managing clinical work processes—in direct opposition to the responses of physician and nurse clinicians.[108] This finding helps explain the difficulties associated with resolving conflicts arising from resource allocation decisions, with attempts to implement standardized clinical care guidelines, and with efforts to advance quality reforms—managerial actions that risk running counter to desires for professional autonomy. It is understandable how this mixture of different world views can contribute to ongoing, recurring clinical conflicts.

Communication styles by members of the groups also vary, particularly in conflict situations. In non-conflict situations, the

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102. *Id*. at 39, 42-43.

103. Thomas et al., *supra* note 94, at 957-58.

104. Morton Skjørshammer, *Co-Operation and Conflict in Hospitals: Interprofessional Differences in Perception and Management of Conflicts*, 15 J. INTERPROFESSIONAL CARE 9, 9-12 (2001).

105. *Id.*at 10-11.

106. *Id.* at 9-12.

107. Lay managers refer to those professionals who are trained in business or in other non-clinical disciplines and who have supervisory responsibilities for clinical operations.

108. Degeling, *supra* note 15, at 41-42.

communication style of nurses and social workers is nurturing; however, in conflict situations, the communication style of nurses is more like that of physicians—avoidant.[109] Of the five Thomas-Kilman modes of communication, nurses are predominantly avoidant, with compromising as the second most common style.[110] Given nurses' collectivist view of clinical work, this avoidance tendency may reflect an approach to conflict in which the focus on preserving relationships within the group take precedence over the needs of the individual.[111]

Understanding the differing perceptions of the existence and response to conflict may give insight into the resistance toward collaborative dispute resolution mechanisms, particularly within an environment containing differing perceptions regarding power imbalances and containing opposing approaches to professional practice (i.e., individualistic vs. collective). In light of these broad differences in interests and values, it is apparent that there is a strong need for interest-based processes that address the deeper assumptions driving behaviors. However, given the insular nature of clinical training and professionally imposed hierarchies, awareness of non-hierarchical (i.e., non-power-based) methods for addressing disputes is quite low. There is a strong tendency to cling to respect for authority and to deference to those with positional authority as the ones responsible for dealing with conflict. It is difficult to know if this is a symptom of avoidant behavior or a reflection of beliefs concerning the role of authority. In light of the deeply ingrained problem-solving drive of clinical professionals, utilization of a facilitated process may even feel like a sign of failure, especially if what appear to be simple problems keep recurring and remain "unsolvable." This concept is particularly poignant in light of the need for and valuing of "remaining in control."

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109. DRINKA & CLARK, *supra* note 18, at 80.

110. Patricia E.B. Valentine, *A Gender Perspective on Conflict Management Strategies of Nurses*, 33 J. NURSING SCHOLARSHIP 69, 69-74 (2001).

111. Degeling, *supra* note 15, at 39.

IV. UNCOVERING ASSUMPTIONS—SOME CLUES INTO THE BELIEFS OF HEALTH CARE PROFESSIONALS

A look at some of the perceptions and behaviors of these subcultures sheds light on just how different the clinical professions really are. It is not yet clear what assumptions are driving some of these behaviors. Examining the determination of status, authority, and rewards within an organization or group can provide some insight.[112] An example of each follows.

A. Rewards

In an article examining barriers to learning within health care organizations, the authors offer an anecdotal story which demonstrates how nurses reward their peers. Its authors observed that problem-solving happens locally, without regard for the impact of the solution on the system as a whole. In the story, when faced with a repeated shortage of linen, nightshift nurses arranged for a taxi cab driver to go to another hospital in town, obtain linens, and deliver the linens.[113] Clinicians highly reward problem-solving to meet the immediate needs of patients, particularly in the face of broken systems that do not ensure resources are available when they are necessary.[114] This suggests that independent problem-solving is an underlying assumption among nurses that enables nurses to complete their work effectively.

B. Status and Authority

Novice clinicians must often learn appropriate professional behavior by watching and mimicking more senior clinicians. After observing 128 hours of professional interactions in an operating room, one commentator determined that, in response to tension

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112. SCHEIN, *supra* note 1, at 44-47.

113. Anita L. Tucker & Amy C. Edmondson, *Why Hospitals Don't Learn from Failures: Organizational and Psychological Dynamics That Inhibit System Change* 8, 45 CAL. MGMT. REV. 55 (2003).

114. *See generally* Beaudoin & Edgar, *supra* note 47, at 106

within the surgical team, novices either mimic their teacher's style, or posture and exhibit withdrawal from the situation.[115] The researchers described a situation in which a new physician observes an experienced physician.[116] The experienced physician rapidly demands additional equipment despite available unused equipment close at hand and the circulating nurse responds promptly with the equipment—visibly irritated by the demands.[117] When a novice physician imitates the observed behavior and asks for additional equipment, the nurse responds: "Who's asking for another monitor?. . . Not Dr. NEW Fellow? He's not requesting anything, is he?"[118] Laughter throughout the team followed the exchange.[119] The novice clinician received a public lesson about status and appropriate behavior across the professional groups, wherein, despite her irritation, the nurse tolerated the frequent requests of the staff surgeon because of the status and authority acquired through the surgeon's experience.[120] Interestingly, in this example, a senior resident tries to divert the novice's requests to prevent the chastisement.[121] Actual practice is replete with examples of how novice practitioners learn to respect and earn clinical status. The pecking order that emerges within and across the professional groups reflects the high value afforded experience and expertise.

A disconnect between espoused values and behaviors indicates there are deeper cultural assumptions affecting decision-making and how people work together.[122] A look at how organizations approach their commitment to patient safety gives some insight into what this disconnect looks like in practical terms. Since the release of the Institute of Medicine report, *To Err is Human*, the public has increasingly focused on patient safety.[123] Many hospitals have put

115. Lorelei Lingard et al., *Team Communications in the Operating Room: Talk Patterns, Sites of Tension, and Implications for Novices*, 77 ACAD. MED. 232, 234-35 (2002).
116. *Id.* at 236.
117. *Id.*
118. *Id.*
119. *Id.*
120. *Id.*
121. Lingard et al., *supra* note 115, at 236.
122. SCHEIN, *supra* note 1, at 19.
123. *See* TO ERR IS HUMAN, *supra* note 28.

safety into their marketing materials and mission statements, and accrediting organizations have developed clear goals for improving safety.[124] There is much agreement that the health system should be safer and that safety is a top value among organizations and practitioners. However, a look at perceptions and practices within the industry indicates that the stated value does not always match the behavior. In a 2004 survey of hospital CEOs, only 16% indicated that patient safety was one of their top three concerns.[125] Additionally, a 2004 survey of 1700 intensive care unit nurses, physicians, clinical staff, and administrators revealed that:

"eighty-four percent of physicians and sixty-two percent of nurses and other clinical care providers see some number of their coworkers taking shortcuts that could be dangerous to patients;"

"eighty-one percent of physicians and fifty-three percent of nurses and other clinical care providers have concerns about the competency of some nurse or other clinical care provider they work with;" and

"77% of nurses and other clinical-care providers work with some who are condescending, insulting, or rude [and] 33% work with a few who are verbally abusive—[persons who] yell, shout, swear, or name call."[126]

Despite the obvious implications for safety, the survey indicates that direct communication with these co-workers regarding the concerns is quite limited:

Among physician respondents, "81% [were] concerned about a nurse's or other clinical-care provider's competence," and "8% [had] spoken with this person and shared their full concerns." Also, "68% [were] concerned about a physician's competence," but "less than 1% [had] spoken with this physician and shared their full concerns."[127]

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124. *See Sample Outline for a Patient Safety Plan*, Joint Commission on Accreditation of Healthcare Organizations, *at* http://www.jcaho.org/accredited+organizations/patient+safety/plan+outline/index.htm (last visited Apr. 16, 2005).

125. *Top Issues Confronting Hospitals: 2004*, American College of Healthcare Executives, *at* http://www.ache.org/PUBS/Research/ceoissues.cfm (last visited Apr. 16, 2005).

126. DAVID MAXFIELD ET AL., SILENCE KILLS: THE SEVEN CRUCIAL CONVERSATIONS FOR HEALTHCARE 4-5 (2005), *available at* http://www.aacn.org/aacn/pubpolcy.nsf/Files/SilenceKills/$file/SilenceKills.pdf.

127. *Id.* at 11.

Among nurse respondents, "75% [were] concerned about a peer's poor teamwork," and 69 % indicated "the problem with this peer had gone on for a year or more."[128] However, only "16% [had] spoken with this peer and shared their full concerns," and concerns about competence of another nurse were brought to that person's attention by staff nurses only 3% of the time and by supervisors only 16% of the time.[129]

Statements suggesting why respondents did not discuss their concerns with their colleagues reveal that they found it "difficult" or "impossible to confront," that they believed it was "not their job," and that they believed the conversation would not "do any good."[130] In fact, anecdotal reports within the survey's focus groups indicate that not only is there avoidance of direct communication but that there are elaborate "work-arounds" to avoid the confrontation as seen in the following situations described by the focus groups:

> "A group of eight anesthesiologists agree a peer is dangerously incompetent, but they don't confront him. Instead, they go to great efforts to schedule surgeries for the sickest babies at times when he is not on duty. This problem has persisted for over five years."[131]

> "A group of nurses describe a peer as careless and inattentive. Instead of confronting her, they double check her work—sometimes running in to patient rooms to retake a blood pressure or redo a safety check. They've "worked around" this nurse's weaknesses for over a year. The nurses resent her, but never talk to her about their concerns. Nor do any of the doctors who also avoid and compensate for her."[132]

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128. *Id.* at 8.
129. *Id.* at 11.
130. *Id.* at 10.
131. *Id.* at 2.
132. MAXFIELD ET AL., *supra* note 126, at 2.

What are the professional cultural assumptions that are so strong that they override obvious interventions that would improve safety and prevent harm to patients? What is the impact of mixed messages resulting from the disconnection between espoused values and professional behaviors? This ongoing dichotomy between organizational values and actual practices can contribute to general mistrust and breakdowns in working relationships as people struggle to make sense of the environment and come to believe what they see rather than what they hear. Attempts by leaders to foster safer practices by instituting changes may meet great resistance because these assumptions take silent precedence over mandates for change, even if those changes are rational. Response to this resistance by organizational leaders can involve coercive actions—like removal of block time for surgeons—or making one professional group responsible for policing another group's compliance—such as requiring nurses to monitor physician compliance, thereby functionally blocking collaborative practice.[133] In health care, resistance may contribute not just to conflicts but may lead to harm by creating a barrier to implementing recommended safety practices.[134]

The behaviors and reports by health care professionals described above begin to paint a picture of the professional subcultures as well as the culture of health care organizations generally. However, observing behaviors does not reveal underlying assumptions motivating those behaviors. Identifying these assumptions can shed light on what drives behaviors.[135] It is necessary to uncover these deeper assumptions before any individual or group can decide on different behavior choices that may open the door for resolution of recurring or intractable conflicts.

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133. Barbara LeTourneau, *Physicians and Nurses: Friends or Foes?*, 49 J. HEALTHCARE MGMT. 12, 14 (2004).

134. Degeling, *supra* note 15, at 42-43.

135. SCHEIN, *supra* note 1, at 25.

V. ASSUMPTIONS WITHIN PROFESSIONAL SUBCULTURES

"There is perhaps nothing as powerful for defining, enriching, and deepening identity as conflict over identity."[136]

Health care professionals' behavior to conceal information that could prevent future patient harm appears to contradict their professional values of patient advocacy and to "do no harm," indicating that deeper assumptions motivate these behaviors. Physicians tend to take a "pathologized view of the world" in that their training taught them to look for problems or deficiencies.[137] This viewpoint is very mechanistic and implies the existence of a causal link to every problem. The goal is to seek out and correct the cause. This forms the basis for the process of differential diagnosis, in which physicians link a set of symptoms (effects) to potential causes and rule those causes in or out to make an accurate clinical diagnosis. Unsurprisingly, a common response to the application of this linear, problem-solving approach to treatment errors or delivery of care failures is to seek fault in someone's actions as the cause of the failure.

Additionally, within the culture of health care lies the highly valued and rewarded belief in "being in control."[138] In health care's complex and unpredictable environment, control is never attainable. However, clinicians and leaders' expectation of control remains strong.[139] This expectation reinforces deeply held assumptions of individual accountability, of the physician as solely or primarily responsible for the quality of care, and of individualistic and competitive work styles as beneficial.[140] The concept of the physician as the team leader who works autonomously and who is solely responsible for the quality of care that a patient receives is well-developed during medical school and residency.[141] Acknowledging

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136. ROTHMAN, *supra* note 58, at 34.
137. Suchman, *supra* note 55, at 44.
138. *Id.*
139. *Id.*
140. *See* Degeling, *supra* note 15, at 42-43.
141. Robert Michels, *Medical Education and Managed Care*, 340 NEW ENG. J. MED. 959, 960 (1999).

that one's actions may have contributed to harm could trigger what Suchman referred to as "the imposter syndrome"—the fear that someone will find out that one lost control.[142] The need to maintain the illusion contributes to other unsafe behaviors, such as failure to ask for help, over-commitment to workload, and neglect of personal health.[143] Patients have adopted assumptions regarding physician responsibility as well. According to a 2002 survey of patients and physicians, "seventy percent or more of both groups of respondents who reported experience with an error assigned 'a lot' of responsibility to the physicians involved," and 55% of patients and physicians chose "mistakes made by health professionals. . . "[as] a more important cause" of medical error than mistakes made by health care institutions.[144] The presence of these underlying assumptions may explain why, even in the face of data supporting human factors and latent system errors as inherent contributors to errors and direct experience with colleagues who demonstrate unsafe practices, there is still underreporting of information that could be beneficial for improving outcomes. With both health care professionals and patients holding assumptions that create unrealistic demands for control and perfection, it is clear that there will need to be fundamental changes in the culture of health care before open reporting and systems-based error correction models will be effective.[145] Finding techniques to uncover assumptions and test their validity against more recent environmental changes may help remove some of the resistance to change and assist the various groups to work more productively together.

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142. Suchman, *supra* note 55, at 44 (citing K. Henning, et al., *Perfectionism, The Imposter Phenomenon and Psychological Adjustment in Medical, Dental, Nursing and Pharmacy Students*, 32 MED. EDUC. 456 (1998)).

143. Suchman, *supra* note 55, at 44.

144. Robert J. Blendon et al., *Patient Safety: Views of Practicing Physicians and the Public on Medical Errors*, 347 NEW ENG. J. MED. 1933, 1934-35 (2002).

145. Donna B. Jeffe et al., *Using Focus Groups to Understand Physicians' and Nurses' Perspectives on Error Reporting in Hospitals*, 30 JOINT COMMISSION J. ON QUALITY & SAFETY 471 (2004).

VI. USING ADR TO ADDRESS CULTURE-BASED CONFLICTS IN HEALTH CARE

There is much opportunity for integrating the principles of dispute resolution into the delivery of health services. Given the environment's complexity and the impact of professional culture, the ADR community will need to consider how to modify itself to meet this unique industry's needs. A beginning point would be to reconsider the concept of ADR as currently packaged. Non-litigation alternatives include a mix of power-based and interest-based processes. Power-based processes may settle terms of a dispute but will not address the causes leading to the conflict or lead to stable behavior changes. In addition, the professional culture of those providing arbitration or heavily evaluative processes may be in direct conflict with the professional culture of those experiencing the conflict. Legal professionals have their own cultural assumptions and values that may not mesh with those of the health care sector.

Interest-based processes are more amenable to addressing culture issues than power-based processes, but for health care conflicts, as currently designed they may be too time intensive or too far removed from where they can do the most good, such as in the clinical setting. Additionally, approaches that only address more superficial interests without taking into consideration cultural assumptions or interactions between organizational and professional cultures may be ineffective and could worsen conflicts or leave the participants even more frustrated.[146] Finding effective ways for integrating the best of interest-based conflict resolution with additional techniques for uncovering cultural and identity needs may help move health care organizations toward more collaborative cultures and may improve the work environment for thousands of health professionals. The following subsections introduce some things to consider in redesigning conflict management services for health care organizations.

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146. ROTHMAN, *supra* note 58, at 9.

A. Time Considerations

The health care environment operates around the clock, allowing very little time for meeting together. Due to the over-commitment of health care workers, scheduling challenges are tremendous and take much attention and many resources. Techniques for working within professionals' time constraints are essential. Mediators may need to schedule frequent facilitated meetings, may need to schedule them for shorter periods of time, and may need hold them very early in the morning, in the middle of the night, or on weekends. Additionally, those working in health care tend to focus on solutions immediately and frequently exhibit "process intolerance," creating a need for process structures that balance the time constraints with the assessment steps necessary before the group can consider any solutions.

B. Power Imbalances

Power imbalances intertwined within health care disputes depend on professional group membership, level of experience, gender, positional power, market power, union affiliation, and many other variables. Dispute resolution processes must recognize these imbalances and consider ways to foster open communication without jeopardizing individuals who may make themselves vulnerable to retaliation or scapegoating due to the shared information. Subtle methods of retaliation are common within health care culture and fear of this retaliation inhibits health care professionals from addressing conflicts themselves. Examples of these actions include: discontinuance of patient referrals, inappropriate assignments of patients, failure to provide backup for heavy workloads, and exclusion from committees and other political forums.

C. Language

Health care organizations, like any specialized industry, have their own language. Within the organizations, there are further language challenges in communicating with clinicians whose livelihood and professional affiliation rest on their knowledge of the special

language of medicine. With the time constraints mentioned, it is difficult for those doing dispute resolution to become proficient in medical jargon, common practices, and technical nuances within the process itself. Stopping the process frequently for clarification on common medical terms may give health care professionals the impression of a lack of competence given the strong tie between competence and clinical expertise. For clinical conflict management, process modification may entail integration of clinical expertise into the dispute resolution team in order to improve comprehension and time management and in order to overcome initial credibility barriers set by participants in the process.

D. Interdependencies

With the complexity of health care organizations, it will be a rare conflict that does not involve multiple groups, departments, or facilities. Communication structures across these entities are not well-developed, and identifying effective ways to limit the scope of the conflict management intervention without omitting key stakeholders is a challenge.

E. Money

The focus on cost containment in health care is alive and strong. Often, organizational leaders will forego dispute resolution interventions in the early stages of a dispute, leading to more expensive interventions once the parties have formed stronger positions. Additionally, the risk of having only a limited amount of time with the participants due to budget constraints limits the effectiveness of any process and may require ethical decisions by consultants as to whether it is appropriate to begin an intervention at all or to take an intervention in a direction that may open old wounds and risk discontinuing before addressing the deeper issues. Additionally, different professional groups have different levels of access to funds; nursing groups and social workers have less money available than physicians for hiring consultants but may have a greater understanding of the benefits of a collaborative process.

Adjusting reimbursement expectations to the realities of resource availability can improve access and increase the likelihood that more complete interventions may be available.

F. Autonomy

Interest-based processes such as mediation strongly promote the principle of participant autonomy. This is congruent with some health care professionals' desire for autonomy. Despite this congruence, many health care professionals look to leaders to make decisions as to who is right or wrong in conflict situations and may be uncomfortable with the personal responsibility built in to facilitative processes. Managing expectations as to mediation benefits and the decision-making process is essential when working with health care groups, and a facilitator may need to repeat these expectations throughout the process.

G. Reputation and Identity

Conflict management processes must respect the need for maintaining reputation within the organization while addressing dysfunctional behaviors that may be contributing to the conflict. Reputation correlates to status in health care and can be difficult to regain once damaged. Health care professionals have strong identity ties to their profession, and facilitators' suggestions to acknowledge the value of other professional groups' contributions may meet with strong resistance, suggesting identity conflicts wherein acceptance of the value of "other" appears to diminish the value of self. Techniques designed to address identity conflicts may be helpful in facilitating inter-professional disputes.[147]

H. Patients

Behind most clinical conflicts lies a patient who has faced or faces potential harm. This is always in the minds of those working in health

147. *Id.* at 8.

care and can be a strong basis for finding initial common ground. It can also heighten clinicians' fears that their license is at risk, that they will face lawsuits, or that they will cause harm when team functioning breaks down. The high levels of emotion that accompany these fears make health care disputes emotionally charged and make addressing these fears an inherent part of the process. Additionally, health care organizations are just beginning to incorporate patients into interest-based processes involving quality of care. Patients and families' lack of access to the process because of liability fears is a serious barrier to effective resolution of disputes involving this important group of stakeholders. National organizations are just now putting forward recommendations for liability system improvements to increase access to broader alternatives for resolving quality of care disputes.[148]

I. Data

Health care professionals, particularly physicians, are very data-driven, and finding ways to collect data on best practices, improved outcomes, and cost savings associated with conflict management interventions will enhance dispute resolution professionals' ability to market services to health care clients. This data will also provide information to the dispute resolution industry as to what works well. Making use of pilot projects, data collection within mediation programs, and participant surveys can provide some initial foundation for developing the field and improving the receptiveness of health professionals.[149]

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148. JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS, HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR IMPROVING THE MEDICAL LIABILITY SYSTEM AND PREVENTING PATIENT INJURY 14-16 (2005), *available at* http://www.jchao.org/news+room/press+kits/tort+reform/medical_liability.pdf.

149. *See* Virginia L. Morrison, *Heyoka: The Shifting Shape of Dispute Resolution in Health Care*, 21 GA. ST. U. L. REV. 931, 931-33 (2005).

J. Skills

Until very recently, communication and conflict resolution skills were not a part of clinicians and health care administrators' professional training. Organizations need to modify their training and professional curricula to address the barrier caused by the lack of ability to address conflicts directly. Recent mandates by the Accreditation Council for Graduate Medical Education, the Commission on Accreditation of Health care Management Education, and the American Nurses Association indicate that these competencies will be compulsory for future students; however, given the strong reliance on modeling and mimicry common in health care training, it will be important to expand access to training to those who are already working and training others.[150]

K. Expanding the Tool Box

Typically, ADR professionals limit the process tools they provide—arbitration, mediation, facilitation, and training. Expansion of services to include other process tools—such as appreciative inquiry, dialogue, world café (i.e., a network of small conversations in large group settings to facilitate discussion), transformational interviewing, and narrative inquiry—can enhance flexibility and provide access to methods for uncovering underlying assumptions that are motivating behaviors. Additionally, utilizing tools designed

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150. The Accreditation Council for Graduate Medical Education has recently begun to require that all U.S. residency programs provide training in "interpersonal and professional communication skills." ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., COMMON PROGRAM REQUIREMENTS 4 (2004), *available at* http://www.acgme.org/acWebsite/dutyHours/dh_dutyHoursCommonPR.pdf. In Fall 2003, the Commission on Accreditation of Healthcare Management Education (formerly the Accrediting Commission of Education for Health Services Administration), modified its criteria for accrediting postgraduate programs in health administration to include the addition of education in "conflict and change management skills, and written and oral communications skills." *Accreditation Criteria*, Commission on Accreditation of Healthcare Management Education, http://www.cahmeweb.org/criteria.htm (last modified Mar. 7, 2005). The Nursing Code of Ethics, revised and adopted by the American Nurses Association in 2001, states: "The nurse maintains compassionate and caring relationships with colleagues and others with a commitment to the fair treatment of individuals, to integrity-preserving compromise, and to resolving conflict." AMERICAN NURSES ASSOCIATION, CODE OF ETHICS FOR NURSES WITH INTERPRETIVE STATEMENTS 1.5 (2001), *available at* http://www.ana.org/ethics/code/protected_nwcoe303.htm

to assess culture—such as "cultural consensus analysis," "competing values framework," and "culture inventories" as part of conflict assessments—may provide better information for consultants and participants.[151] Redefining and modifying the offered services to meet the needs of the health care industry can expand the usefulness of ADR and improve access to a much-needed service for those struggling within health care organizations.

CONCLUSION

Not all conflicts are culture-based; however, in the face of intractable or chronic conflict situations that exhibit identifiable patterns across organizations and professional groups, it is worth considering the impact of culture and how to address the levels of culture as part of the conflict management process. The challenges of addressing organizational culture and the complex needs of professional groups should not deter those providing dispute resolution services from advancing the development of services for the health care industry, particularly given the impact of conflict and communication breakdowns on safe outcomes for patients. Current research into patient safety and quality of care indicates that finding effective methods for managing these conflicts is a necessary step toward reducing preventable death and injury to patients during the course of treatment. This alone is a reason for ADR professionals to look for ways to improve access to services that will foster collaborative cultures as a means for reducing the risk of harm to those entering the health care system. Additionally, improving the work lives of those who dedicate themselves to caring for others can improve morale, increase retention, impact the availability of future health care professionals, and return hope to an industry seeking answers to complex problems. The ADR community has much to offer and has an important role to play in the creation of safer healing environments.

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151. Smith et al., *supra* note 23, at 516; SCOTT ET AL., *supra* note 9, at 63-65.