RENEGOTIATING HEALTH CARE

Resolving Conflict to Build Collaboration

SECOND EDITION

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CONTENTS

Part Four Evolving Health Care Practice

Part Five Shaping Purpose

PREFACE

In the fifteen years since the first edition of this book appeared, its basic premises have not changed. First, conflicts and differences are an inevitable part of your work and relationships in health care. Second, how you handle those differences affects what you can and cannot accomplish as a person and as a professional. Third, to benefit from those differences, you must not only be prepared to change what you do, you must also be ready to examine and perhaps shift the very assumptions that impel you to do it.

Much, however, has changed. New treatments, technologies, business models, and regulations have tangibly transformed the substance of health care negotiation. The United States is coming to grips with the massive health care overhaul legislation that became law in 2010. The human elements of health care—the training and work of nurses, doctors, administrators, researchers, technicians, and others as well as the expectations of patients—have also evolved as new discoveries have become available and as demographics shift. And even though the substantive questions about which people negotiate and find themselves in conflict have fluctuated, the presence and importance of these very human sides of the enterprise have not.

Health care work is a constant negotiation. You are continuously engaged in making decisions, taking actions, and selecting options—sometimes on your own and many times under the direction of others. You exchange intangibles such as information, expertise, opinion, knowledge, and skill as well as tangibles such as money, equipment, space, supplies, and personnel. Because your responsibilities are so closely intertwined with those of others, orchestrating mutual involvement is largely a matter of negotiation. That differences and sometimes conflict emerge along the way is to be expected. The effectiveness of your work is dependent on the proficiency of those exchanges and interactions.

In your hands is a set of tools in the shape of a book. Its purpose is to provide you, as a health professional, with a range of choices for what you negotiate

and how you go about negotiating it. These tools are designed to fit the specific circumstances of your work: what it is you strive to accomplish set in parallel with that of others. As health and health care are increasingly team endeavors, the necessary balance of expectations among people working together is achieved using models and methods intended to construct pragmatic collaboration. And for those circumstances when differences ignite into disruptive conflict, there are strategies presented that will guide you toward resolution or, when necessary, toward a dignified exit affording you minimum pain.

This book is entitled *Renegotiating Health Care*. Why *re*negotiating? Because the changes emerging in health care today require us to do much more than improve our day-to-day negotiations. These changes are affecting the very premises, expectations, relationships, and motivations that have influenced the way health care has been conducted for many years. The ground rules that guided associations between clinicians and managers, managers and insurers, and also patients and clinicians, to name but a few, are all changing. Demands for higher quality and lower costs are bringing a closer examination of every element in the system. Orthodoxies are being challenged and assumptions being questioned at every turn. New behaviors and incentives are being negotiated to satisfy the mutual expectations of all those who have a stake in the process. These new ground rules then become the basis for continued negotiation. The intention here is to speak to the change, the *renegotiation*, mindful of the ways in which this transformation affects ongoing *negotiation*.

The subtitle, *Resolving Conflict to Build Collaboration*, points to our fundamental purpose as health professionals. That is, *conflict resolution*, as a process, is considered here not only as a method for cooling a boiling dispute but also as a regular function of your work. You negotiate your differences every day. Some of these differences are resolved routinely, without much notice. In other cases these very same issues can explode into major confrontations. Such confrontations usually have their beginnings in simple negotiations that might have been better handled. Conflict resolution therefore is viewed as an integrated aspect of what you are continually doing to balance the array of expertise, values, and aspirations attending even the simplest of decisions.

The word *collaboration* in our subtitle refers to the combined activity of the host of individuals and organizations necessary for the work of health care. In the emerging health care reality, those groups and enterprises most likely to succeed are those best able to achieve efficient and effective collaboration. Whether it be two organizations forming a partnership, three physicians devising a primary specialty care alliance or a floor of nurses creating a better-coordinated work environment, those people who do collaborate—and do it well—are those who are most likely to survive and thrive. These successful collaborations foster

quality, enhance productivity, improve patient safety, reduce health disparities, and cultivate satisfaction both for those who provide health care services and for those who receive them. Technology is already beginning to enable collaboration between professionals in different cities, states, and even regions of the world. Outcome data are being aggregated to help better inform decisions. The capacity to work together will distinguish those able to leverage wider advantages and benefits from those who will not.

You need to *build* collaboration because negotiation is an ongoing process that you formulate and reformulate every day. The set of negotiation tools this book offers will serve your building process.

Who Should Read This Book

Because the purpose here is to highlight aspects of negotiation and conflict resolution particularly germane to health care and to present a model that fits its unique demands and dimensions, this book is written primarily for those who work in the field. Nonetheless, those who are consumers of health services will likely also find the insights useful, just as those who are interested in general aspects of negotiation and conflict resolution may find the dynamics of health care to inform general theoretical and methodological understanding.

How This Book Is Organized

This work is really three books in one. First, it is a guide to the concepts, methods, and techniques of negotiation and conflict resolution. This discussion ranges from the theoretical to the practical, with an emphasis on how you can build interest-based negotiation into your everyday professional repertoire.

Second, the text examines major, long-term trends that will shape the context in which you practice, from advances in technology to changes in the workforce, in patients, and in the system. This material is found mainly in Part Four, which is completely new to the second edition, and it incorporates the perspectives of a range of health care stakeholders, from frontline nurses and doctors to hospital CEOs and policymakers. The four chapters in this part are not designed to inform you about the scope and advances for each topic that they cover: changes are continual and occurring too rapidly for a comprehensive cataloguing of them here. Rather, these chapters are designed to expand your understanding of particular tectonic shifts and their potential to reframe negotiation, generate conflict, and offer fresh opportunities for collaboration and growth.

Third, this book contains a "novel"—a set of parables that play out in the context of the typical dilemmas, conflicts, and negotiations that face people working in health care settings. These stories are interwoven throughout the text and are the greatest departure from the standard format of a textbook.

People often seem compelled to create neat lists, categories, cases, and concepts to describe and understand matters of negotiation, mediation, and organization. In this organizing process it is easy to forget that each of these activities is essentially about people—what they say and do, how they feel and react, and what complex and sometimes fluky interactions they have with each other in the course of elaborate and highly consequential decision making. An approach that turns people into precisely defined objects risks creating further confusion and misunderstanding. Our novel is here to remind you of the inherently human aspects of negotiation, to illustrate those human aspects, and to inspire you by example.

A word of caution about reading the novel—it is not intended to illustrate or represent the *typical* nurse, doctor, manager, patient, or policymaker. It is also not intended to idolize, impugn, or trivialize any particular profession or type of person. Rather, it is intended to place into a plausible human dimension the considerations, problems, and consequences that arise as people work together in health care environments. Earlier, we called these sections *parables*, that is, brief and fictitious stories meant to illustrate ideas and principles. Read them as such. Do not take them too literally. Instead, ponder, contemplate, and perhaps discuss with others the insights you find in these stories and how you can generalize from them to your own situations. Because you will be reading the novel serially rather than straight through, to help you recall who's who in the various episodes, each character's first and last names alliterate (for example, *Artie Ashwood*). Remember, look for the meaning and allow yourself to engage with these characters both for who they are and for what they represent. The Appendix is a list of characters in the novel.

There is much more that is new in this second edition. For example, we have added a chapter on meta-leadership, as we find that people at all levels of organizations are increasingly being called upon to demonstrate leadership. Leadership certainly is a critical component of both negotiation and conflict resolution, and the meta-leadership framework can assist you in building the collaboration and the leverage necessary to accomplish a wider connectivity of effort. At the same time, we have, of course, kept the first-edition material that is still relevant and useful.

Why We Wrote This Book

We view the human condition as a continuous process of evolution, shaped by individuals' many intersecting journeys. We each can contribute or detract from that evolution in the paths we pursue and in the manner we conduct ourselves in our travel. This passage through life is one of exploration, discovery, learning, convergences, and departures. We make our contributions; we impose our costs. We cast our goals, set our destinations, and fulfill our aspirations. The trip sees its accomplishments and its disappointments.

Our life's journey will be marked by its many meetings: intersections with others defined by our negotiations. All our origins are varied, just as our destinations are different. The question is whether we can constructively conduct those meetings so they enhance and do not detract from the virtues we each hope to attain.

As a health care professional, you have chosen a special path for your work. You will deal with life and the quality of life. The society and the people who come for service will depend upon you to do well, to extend and enhance the value of their own journeys.

Our own work has brought us into contact with everyone from world-renowned specialists pushing the frontiers of medicine to paramedics who hit the lonely streets each night ready to serve whenever and wherever called. This has given us an appreciation for the immense breadth and depth of this endeavor called health care as well as for the character, dedication, intelligence, and caring ability of those who embrace it as their life's calling.

We hope this book nourishes you for your journey and helps you to progress through intersecting pathways in ways that enhance the ongoing process of health care change and evolution.

Happy travels.

October 2010
Cambridge, Massachusetts

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Barry C. Dorn
Eric J. McNulty

ACKNOWLEDGMENTS

WRITING A BOOK is always an intricate task. The writing itself is a solitary endeavor—each of us in turn focusing on crafting the narrative through numerous iterations to arrive at a text we hope you will find compelling, illuminating, and engaging. The preparation for writing and rewriting can also be an intensely social process. We three authors spent countless hours discussing ideas, refining concepts, and debating word choices. Doing all of this in the midst of the broadest and most contentious discussion of national health care that the United States has seen in decades made it all the more complex—and more interesting.

We also benefited from the insight, counsel, and education provided by many generous people. Among them are Margaret Anderson, of Faster Cures; Donald Berwick, MD, of the Institute for Healthcare Improvement; David Blumenthal, MD, of the U.S. Department of Health and Human Services; Mary Bylone, RN, of the William W. Backus Hospital; James Conway of the Institute for Healthcare Improvement; Kimberly Costa, RN; Christopher Crow, MD, of Village Health Partners; Martha Crowninshield O'Brien, RN; Richard Donahue, MD; Cindy Ehnes of the California Department of Managed Health Care; Eddie Erlandson, MD, of Work Ethic; John Halamka, MD, of the Harvard Medical School; George Halvorson of Kaiser Permanente; Richard Iseke, MD, of Winchester Hospital; Phillip Johnston of Johnston Associates; Patrick Jordan of Newton-Wellesley Hospital; Derik King, MD, of Emergency Consultants, Inc.; Gary Kushner, SPHR, of Kushner & Company; Lucian Leape, MD, of the Harvard School of Public Health; Paul Levy then of Beth Israel Deaconess Medical Center; L. Gordon Moore, MD, of Hello Health; Len Nichols, PhD, of the New America Foundation; Mitchell Rabkin, MD, of Beth Israel Deaconess Medical Center; Scott Ransom, DO, of the University of North Texas Health Science Center in Fort Worth; Glen Tullman, of All Scripts; Pamela Wible, MD; and Andy M. Wiesenthal, MD, of the Permanente Federation. You will meet many of these people in the text. They have introduced us to new ideas, practices, and people. They have enlarged our vistas and we are indebted and grateful.

This second edition carries with it in spirit the contributions to the first edition of this book by Phyllis B. Kritek, Velvet G. Miller, and Janice B. Wyatt. Although we have updated the text significantly to reflect the changing world of health care, much of the foundational wisdom from the original work still holds true.

We have also added to this second edition valuable insights from our colleagues Isaac Ashkenazi, MD, MSc, MPA, MNS, former surgeon general of the Home Front Command of the Israel Defense Forces, and Joseph M. Henderson, MPA, of the U.S. Centers for Disease Control and Prevention. They have been integral to the development of concept of the "basement" in Chapter Two and the meta-leadership framework and practice method in Chapter Ten. Our ongoing collaboration with them is one of the great pleasures in our work.

We are also thankful to the editorial team at Jossey-Bass for their inspiration, patience, encouragement, guidance, and editorial exactitude. Andy Pasternack, Seth Schwartz, and their colleagues have been integral to this revised second edition.

We must express our sincere appreciation to our friends and colleagues at the Harvard School of Public Health. They have supported our work and, most important, shared with us their personal experiences with the health care system as patients and caregivers. The experiences remind us that it is people the system is designed to serve, and it is people we all endeavor to keep healthy, to heal, and to comfort.

Our work would not be possible without the support of Regina Jungbluth, who manages our programs at the Harvard School of Public Health. Her diligent attention and masterful management of all of the facets of our professional endeavors affords us the freedom to research and write.

On our home fronts, the second edition of *Renegotiating Health Care* would not have been possible without the enduring support and patience of our dear families. They witnessed our late night and early morning writing forays and shared with us their life wisdom, experiences with the health system, and bountiful encouragement and confidence.

We dedicate this book to our teachers and students. Some we have met in the classroom and others in the field. This book reflects their collective wisdom, experience, and dedication to more humane health care and a healthier world.

And we offer our thanks to you, our readers, who allow us to do what we most value: to share these ideas so that they might find new homes, new uses, and new journeys. Our completion of this book is not the last step. It is the first.

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RENEGOTIATING HEALTH CARE

PART

ONE

CONFLICT

CHAPTER 1

WHY CONFLICT?

When your work is health care, your daily routine requires constant negotiation and involves some measure of conflict. Decisions affecting a number of people have to be made. Competing priorities have to be balanced. There is the pressure of time and the need for constant vigilance that the job is done correctly.

Health care work is accomplished via an intricately structured and constantly evolving set of relationships. Formal and informal rules determine who speaks to whom, who makes what decisions, who has and who does not have what information. People are organized and decisions are aligned in a cautiously defined order. The most important or momentous information, person, or decision gets the uppermost attention, and the rest trails behind. This sequence is intended to yield systematic and value-based decision making.

Most important, the work is done by people and for people. There is perhaps no endeavor more intimately tied to who you are, your identity, than the duties you perform or the care you receive through the health system. Health care is on the cusp of life and death and the quality of life. Whether you are in the role of patient, provider, or manager, your values, beliefs, and personality are exposed and interlocked with the values, beliefs, and personalities of others amid the interpersonal proximity of health care decision making, negotiation, and conflict. And if your role is in the realm of health policy, service regulation, or finance—far removed from the immediate point of care or population served—values, beliefs, and personality remain just as important even though the impact may appear far more abstract. What you do affects how—and sometimes even whether—others live.

What if this complex puzzle does not smoothly fit together? What if there are differences about what or who is more important? What if a mistake occurs? What if there is a clash of personalities among people who must closely interrelate? What if there is dissonance between the policies and procedures and the people

who inhabit these relationships? What if various professionals are working under different incentives? How will this affect what you do and how you do it?

Consider the following scenario.

It is another hectic night in the emergency department of Oppidania Medical Center. A frenzy of activity centers at the desk, where nurses, residents, attending physicians, and emergency medical technicians gather to exchange information, tell stories, and take a rare break.

Nearby, Artie Ashwood, a twenty-four-year-old graduate student, moans in one of the beds. The monitors and machines surrounding him are beeping, flashing, and filling him with life-saving fluids. He has an enlarged heart, arrhythmia, and shortness of breath. It has been three hours since he came in, and it is time to decide where he should go next. In the visitor's room, his mother, Anna Ashwood, and girlfriend, Cindy Carrington, nervously await news of his condition.

The attending physician, Dr. Beatrice Benson, oversees the work of the medical residents. On crazy busy nights, she sometimes has to remind herself, ''The emergency department is for triage—not treatment.'' She has to remember that their job is to assess the patient and decide the next step. If the problem is life threatening, they admit to intensive care. If the patient doesn't need to be in the hospital, they discharge with a treatment plan and instructions. If the problem is someplace in between, then they admit for observation and treatment. So, if it's an admission, the question is to which service?

A small cluster of staff have gathered to discuss Ashwood's condition. It defies a conclusive diagnosis: his young age is a concern. His symptoms could signal a dangerous situation. Hoping for more information, they hold him in the emergency department, waiting for stabilization. Nurses and residents are constantly monitoring his condition, but nothing changes.

Suddenly, Charlotte Chung, the triage nurse at the desk, announces the impending arrival of a patient with multiple gunshot wounds. The door to the specially equipped trauma room opens, and the staff move to their places around the gurney that will hold the seriously injured man.

Benson talks by telephone with the paramedics in the ambulance to assess the incoming patient's condition and prepare for briefing the staff. As she turns toward the trauma room, Chung suggests that the young man with the enlarged heart be admitted to one of the floors in the hospital, because it is looking like a busy night.

Preoccupied, Benson says, ''Good idea,'' and walks off with no further instruction. Chung snaps a pencil in two as she watches Benson head toward the incoming patient.

There are, so far, three people in our story. Artie Ashwood's fate is in the hands of the people who surround him. He is in great pain. He is frightened. He does not know what is happening to him and what it might mean for the rest of his life. People are asking him questions, many of them repetitive. Some of those who speak to him seem genuinely concerned about how he is doing. Others seem to be asking rote questions from a prescribed list. He is afraid of being lost in this loud mass of people. He overhears that a gunshot victim is on the way. Might the hospital explode in shots if the attackers come here to finish the job? Even more frightening, might the nurses and doctors who have been at his side forget him once someone sicker arrives? He has been waiting for a long time. Can't they just fix him up and move him along already? He is intimately dependent on people who now seem otherwise occupied.

As the attending physician in the emergency department (ED), Dr. Benson oversees and has responsibility for the work of the ED medical residents and physicians. She simultaneously tends to many constituencies and concerns and is interdependent with many parts of the system. She is vigilant on behalf of the patients, watchful over the residents, and in touch with others in distant departments. When she asks, "Is intensive care backed up?" she hears a variety of answers: "Yes, we can accept a patient severely cut in an accident at work." "No, we are not taking a nine-months-pregnant, cocaine-addicted woman being dumped by a suburban hospital." By its very nature, her work is in the short term: her responsibility is to keep the flow of patients moving. She sees patients for a matter of hours before they disappear into the labyrinth of the hospital or out to discharge. She rarely sees them again. The long term is an abstraction. She has some power and influence, though others in the hospital understate the authority she believes is hers. There is, however, no underestimating when it comes to responsibility. For a miscalculation, the attorneys will chase Dr. Benson with their lawsuits, the administrators will challenge her wastefulness, and the patients will complain about their delayed or inadequate care. She is constantly negotiating and continually trying to keep the many parts of the system in balance.

Ostensibly, as the triage nurse in the ED, Charlotte Chung has the role of screening patients and determining the severity and urgency of their conditions. In fact her function is to create order among the unpredictable and sometimes chaotic flow of patients arriving at the ED. That order must align with the contingent of nurses, physicians, and other personnel staffing the shift. It is a matter of creating a fluid balance. Patients arrive at the hospital in pain or discomfort and are all anxious to be seen at once. Family or friends who accompany them advocate, question, and worry. It is up to her to decide who will be seen when, by whom, and where: she holds the criteria and judges each case

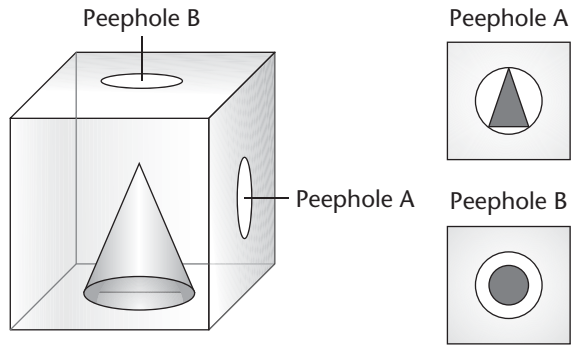
accordingly. Physicians, nurses, technicians, and housekeeping personnel scurry to keep up the pace, caring for one patient and preparing for the next. They depend on Chung to make the right calls, to hold off patients who cannot yet be seen, and when the staff are overloaded, to focus on only the most severely ill. Her desk is like a lightning rod for conflict. She mediates among the needs of patients, the capacity of the staff, and the personalities who may explode under the pressure and stress of the decisions she is required to make. Her greatest sources of irritation are the obstacles erected by those, especially physicians, who hold greater authority but who carry far less perspective and understanding than she does.

Each of these people is part of the same reality, yet their perspectives are very different. The question is whether their distinct responsibilities, concerns, and decisions can combine in a congruent manner, allowing each to satisfactorily achieve his or her reason for being in the ED this night. If they can, the interaction will be productive and mutually beneficial. If they cannot, friction is inevitable. Conflict often has its roots in common experiences seen from different perspectives and with expectations that are seemingly at odds.

Different Purposes

The complexity of health care interaction and decision making can be illustrated by the simple analogy of the cone in the cube (Figure 1.1). Two people peer into different holes in an otherwise opaque cube. Their task is to determine what is inside. The person peering into peephole A, on the side of the cube, sees a circle. The person peering into peephole B, on the top of the cube, sees a triangle. They are both viewing the same shape but from very different perspectives.

FIGURE 1.1 Look in the Cube



The person peering into peephole A points to his extensive education and expertise, declaring, "Do you realize how smart I am? If I say it's a triangle, then it's a triangle!" The person peering into peephole B counters, "I don't care how smart you think you are. I control the budget in this institution. If I say it's a circle, it's a circle!" Although this analogy is simple, it is emblematic of the failure to account for the multiple dimensions of a problem. Whether those involved are physician and nurse, patient and clinician, or administrator and payer, there are myriad ways for people to get mired in different perspectives and positions on the same problem. Achieving an integrated perspective is at the heart of the health care negotiation and conflict resolution process.

We often begin our health care negotiation and conflict resolution course with a classic game theory simulation exercise called *Prisoners' Dilemma*. (For a discussion of Prisoner's Dilemma and game theory, see Luce & Raiffa, 1957; Goldberg, Green, & Sander, 1987; Rahim, 1992.) This exercise demonstrates the difficulty of negotiating when people have little opportunity for direct or prolonged interaction, like prisoners in different cells trying to communicate. Each participant in the exercise is part of a foursome divided into two pairs. The two pairs sit with their backs to each other—which intentionally limits any direct interaction between the pairs—and an instructor moves messages on paper between them. In a series of transactions, they exchange *X*'s and *Y*'s, which when combined could translate into either gains or losses for each of the two sides.

To simulate conditions in real organizations, the directions for the exercise are purposefully ambiguous. One line in the directions encourages the participants to "do the best you can to achieve a high level of benefit from the transactions." The unspoken quandary is that the *high level of benefit* is intentionally left open to interpretation. Because they must begin negotiating immediately, the players often do not have a common definition for what they are trying to achieve. As a result, one of the four players may assume that *winning* means his pair receives more points than the other pair. Another player may conclude that winning requires collecting more points while also reducing the other side's points. A third may assume that winning means each team receives an equal score. And finally, the fourth may surmise that winning means both teams get a score close to zero.

The problem is readily apparent. If each player assumes a different interpretation of high level of benefit, there is certain to be conflict. In essence, one person is playing one game, *defeat the opponent*, while his or her partner is playing another game, *let's all win together*.

Even among the most subdued of players, the interchange becomes eagerly animated. At face value they are only exchanging *X*'s and *Y*'s—symbols with no inherent value. The heated exchanges emerge from the underlying belief systems, perspectives, and objectives that influence the players' actions during the game.

Each person is playing, in part, to advance and validate his or her own belief system. It is common for someone to say during the after-exercise debriefing, "It wasn't that I was going for points. I was trying to show that we can play to win together." It is also common to hear, "I love to win, no matter what I am doing." Each party strives to justify the principles that frame his or her behavior.

The cone in the cube problem and Prisoner's Dilemma parallel the situation in the ED: different perspectives on the same problem combined with differing objectives, a recipe for a high level of consequences and emotional conflict.

Artie Ashwood stares up at the tiles of the hospital ceiling. He is in a great deal of pain. He is frightened. He wants his computer. Then he could go online and get answers for himself about what is happening to his body. They won't even let him use his smart phone, which would let him turn to his online social networks for help. He hopes that the people around him will care for him well. His confidence in the system is flagging.

Ashwood's condition continues to defy a conclusive diagnosis. Hoping for more information, Dr. Dave Donley, the resident who has been following Ashwood, holds him in the emergency department, waiting for the stabilization. Nothing changes.

Her earlier suggestion to move Ashwood still unheeded, Charlotte Chung signals Dr. Benson over to the triage desk and asks if anyone might be ready to move along. The waiting room is full, and the gunshot wound is stretching everyone thin. Perhaps if Benson decides on her own, things will start happening. This is a nursing maneuver Chung learned a long time ago. Turn your problem into someone else's and then hand her your solution. When she chooses it, congratulate her wise decision. She dislikes having to play this game but smiles to herself every time it works.

Benson nods and shifts into command mode. She calls over to Dr. Donley, "We're too busy to hold this fellow any longer. Call cardiac intensive care and tell them we've got an admission. Tell them he needs to go up there right away."

It has been a busy shift on the cardiac intensive care unit (CICU) as well. Seven of the CICU's eight beds are filled. Six of these patients require heavy-duty care. The seventh patient had been sent up by the ED three hours ago, and once the CICU nurses and physicians completed the workup and admission, it was clear that the ED had misjudged that patient: it was not a case requiring intensive care. The CICU had had enough of the ED for one night. With three hours left in the shift, the CICU staff were hoping the night would calm down.

The chief resident of the CICU, Dr. Eli Ewing, knows that he is running an expensive unit. That misjudged patient not only consumed a great deal of unnecessary time and work, it also cost the hospital and some insurer a lot of money. Ewing believes he has a responsibility to screen out patients who do not

require this most technical level of care. Ewing also has a responsibility to the staff. In the parlance of the teaching hospital, a *wall* is a resident who succeeds in keeping out admissions to the unit. A *sieve* is someone who doesn't know how to say no. Walls are heroic, sieves are not—and Ewing is clear about which he prefers to be.

Ewing takes the call from Donley. Still smarting from the last case, Ewing listens sardonically to the report on Ashwood's enlarged heart. Donley admits he is not certain that the patient is in a medical crisis. Ewing's reaction is terse: the patient doesn't need to be admitted to the CICU and the unit is not going to take him. He suggests calling one of the general medical floors, which can do a far better and far less expensive job of babysitting. Ending the call abruptly, Ewing turns to the CICU staff and smiles, ''Another victory!''

Donley is perplexed. Is there something he is missing? He walks into the bustling trauma room, where Benson is now intently overseeing work on the patient with the gunshot wound. He explains the situation. Benson barks back, ''Tell Ewing he is taking the patient. End of story.''

The ensuing back-and-forth goes nowhere. Forty-five minutes later, Benson emerges from the trauma room to find Ashwood still in the bed. ''They just won't take him,'' the frustrated resident explains in defeat.

Enraged, Benson grabs the phone and demands that the CICU chief resident get on the line. ''I want you down here right now.'' It is now a battle of rank versus wall.

''Look,'' Ewing replies sharply, ''this guy doesn't need to be admitted to the CICU. If you want him in for observation, send him to one of the medical floors. We've already had to sweat out one misread from you guys tonight.''

''Fine, then let's see what Fisher thinks about this case.'' Dr. Fred Fisher is medical director for the medical center. This is now a power contest. Benson has no doubt that she will win.

The CICU resident pauses. ''Fisher? You're going to run to Fisher over this?'' Ewing decides that Benson wouldn't risk escalation unless she were sure of how Fisher will react. ''All right, don't get too worked up. I'll be down.''

The parties in this emergency department admission scenario are in a situation similar to Prisoner's Dilemma. They have little opportunity to meet. Yet they must engage in a series of transactions and reach a set of common decisions that are utterly interdependent. As with the cone in the cube, they are looking at the same patient but seeing very different images.

Although the parties share many common objectives, their definition of *high level of benefit* is heavily influenced by their immediate context, be it a crowded emergency department or an overworked CICU staff. The ED weighs the care required by each patient against that needed by other patients flowing into the

hospital. Therefore, decisions are relative to ED conditions at the moment, as well as the patient's immediate medical needs. The CICU's decisions are based on far more standard criteria. An insurer will not reimburse the hospital for this expensive level of care if a patient's condition does not warrant it. Thus the emergency room staff have one set of criteria for admitting a patient to the CICU, and the CICU staff have a very different set.

When the ED attending physician ordered the CICU admission, the problem with the patient still wasn't clear. The possibilities ranged from minor to life threatening. So the admission decision was made with limited information and a great deal of ambiguity. However, once parties adopt a line of thinking, they can become allegiant to it. Each believes there is much at stake, be it the patient's life, the work of the staff, money, time, or professional prestige. The interchange then becomes passionate as the parties defend principles. "The emergency department decides who is admitted and to which department they are going," maintains Benson. "Without that authority, I can't make this place work."

Ewing counters, "Only the CICU can determine who needs its care. Without that authority, this hospital would turn into expensive chaos. With the threat of lawsuits hanging over us, no physician wants to take the risk of undertreating a patient. Before you know it, every patient will be sent through the CICU as a precaution."

Each of the parties, from his or her own perspective, was trying to wield the control necessary to satisfy his or her considerations. Nonetheless, given the different criteria that the parties brought to the task, it was likely that they would experience a great deal of conflict in the process. The CICU resident was trying to insulate the system as well as his staff from the issues he foresaw. The attending physician was trying to maintain a reasonable balance in the ED while doing what she felt was best for the patient. The ED resident was mediating between the two. And the patient was hoping that the people who would determine his fate could assure him the best possible level of care.

Bottom line, what binds the people, institutions, and activities that we call *health care* is the patient. Although the patient focus is a constant, there are so many different meanings and interpretations of what good patient care is that, ironically, it often becomes a fulcrum for passionate conflict.

The Complexity of Conflict

The first step in negotiating and resolving conflict is beginning to understand it. Even the effort to begin reflecting can mark a turning point, because polarized disputants are often more interested in winning than they are in understanding.