

**2014** HOSPITAL  
AUTHORITY  
醫院管理局研討大會 CONVENTION

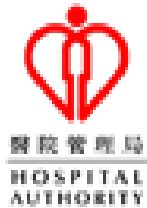


# **Conflict Resolution in the Public Sector: *Applied Mediation Skills***

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Co-chairperson, Committee on Complaints  
Management & Patient Engagement

**8<sup>th</sup> May, 2014**

# Quality



## Baseline PSS Key Findings released in June 2011

Low Score

Great Variation

Max Score Desired

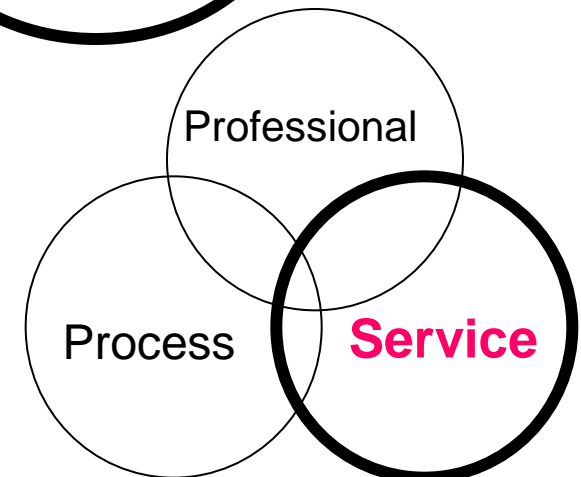
Counter-Intuitive

Opportunity to talk to doctor	Info - Infection control	Info - Medication	Info - Involvement in clinical decision making for treatment or discharge
Info - Medication Side Effect	Info - Discharge (danger sign, contact person)	Info - Treatment	

Choice of food

Quality of food

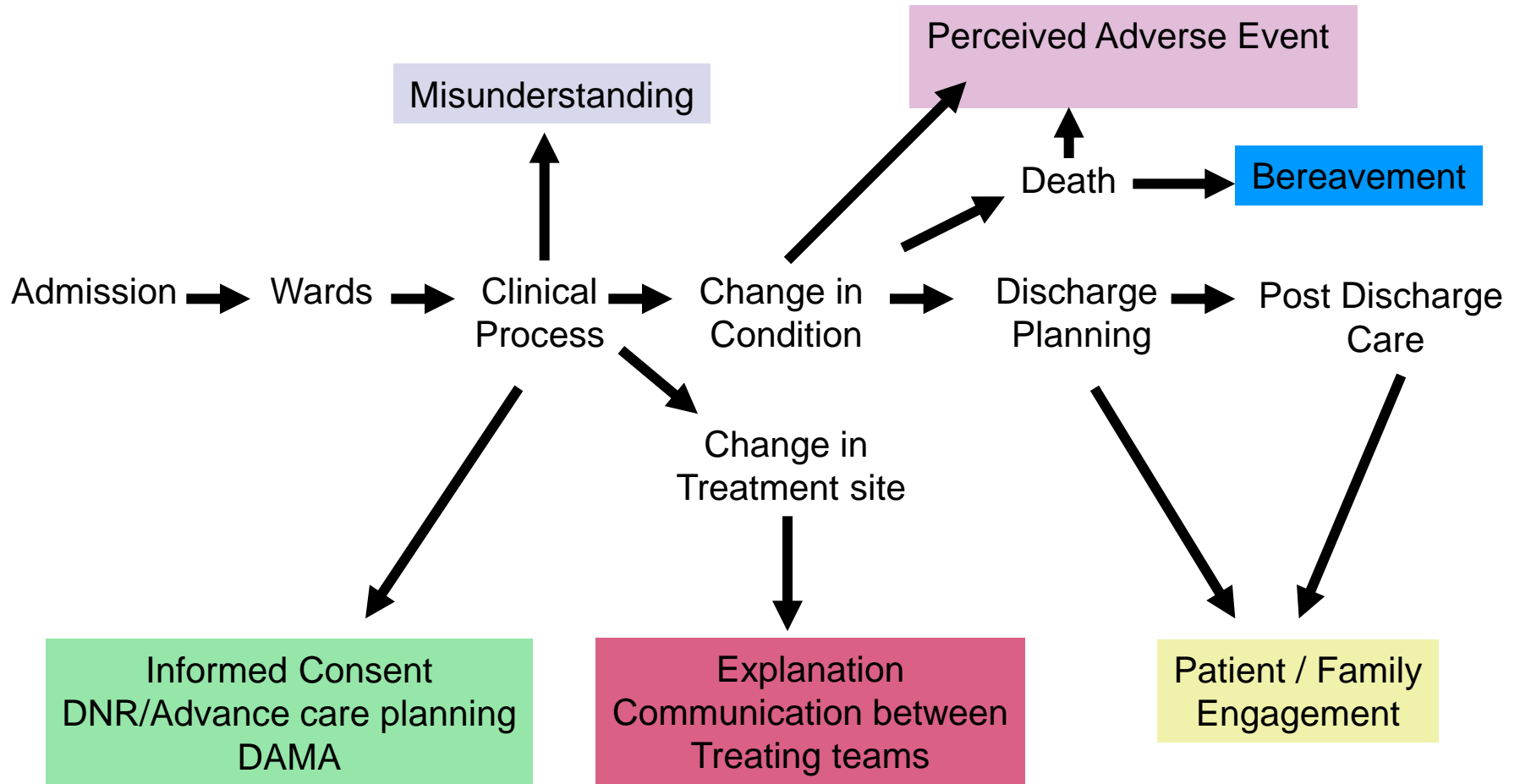
Channel to express/complain



A photograph of three hikers on a mountain trail. The hiker in the foreground is wearing a white shirt, black shorts, and a red backpack. The hiker in the middle is wearing a white shirt and black shorts. The hiker in the background is wearing a red shirt and black shorts. They are walking on a dirt path that leads up a grassy hillside. In the background, there is a large, rocky mountain peak under a blue sky with some clouds.

# Common Ground and Interest: The Patient Journey

# Conflicts and Complaints



Positive Patient Experience:  
The Team Approach

# Perceived Adverse Events

**MEDIATION**  
(Process / Skills)

Senior Clinician Intervention

Independent Expert Opinion

**KNOWN COMPLICATION**  
Perceived error / negligence

( Informed Consent / Possible Cx, DNR,  
Changed Condition, Difficult Discharge,  
Changed Treatment /Setting, Different  
Family Perceptions/Expectation,  
Different Clinical Opinions)

**PREVENTABLE ERROR**

!!!

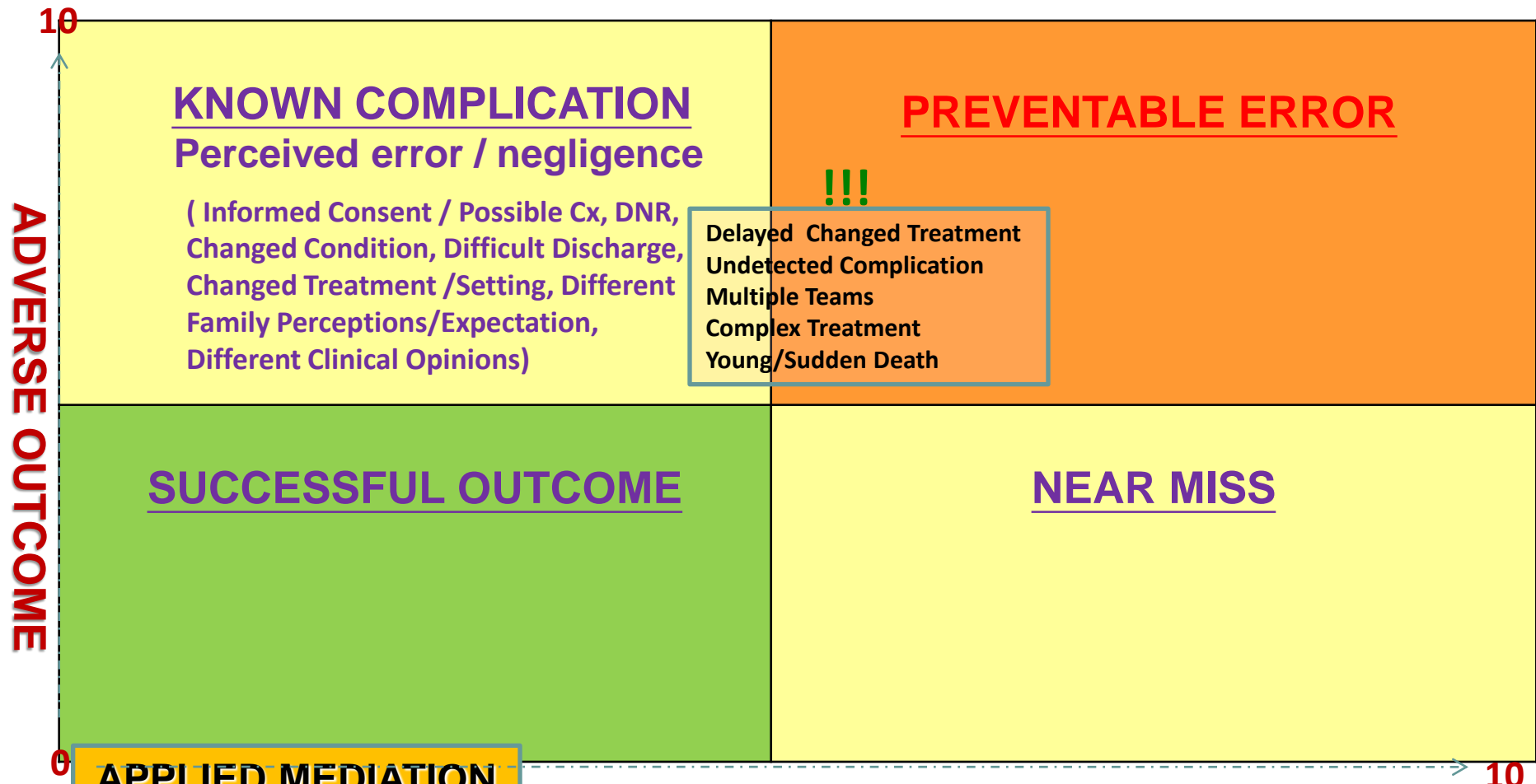
Delayed Changed Treatment  
Undetected Complication  
Multiple Teams  
Complex Treatment  
Young/Sudden Death

**SUCCESSFUL OUTCOME**

**NEAR MISS**

**APPLIED MEDIATION**  
Skills  
(Skills/ Process)

**ERROR (Human / System)**



# To Err is Human

( Family Practice Management 2007; July/Aug: 44-49)

**Error:** failure of a planned action to be completed as intended ( execution or planning)

**Adverse event:** injury caused by medical management rather than the underlying condition of the patient

- **Errors and adverse events intersect:**  
preventable adverse event, an apology might be appropriate
- **Negligent adverse events:**  
preventable adverse events  
legal criteria:
  - duty and standard of care
  - breach
  - causation

# Patient's decision to sue

(MPS Casebook 2004; 12(4): 11-12)

- 2/3 claims from patients who had not suffered an adverse outcome or due to negligence
- Predisposing factors:  
rudeness, delays, inattentiveness,  
miscommunication, apathy, no communication
- Precipitating events:  
adverse outcomes, iatrogenic injuries, failure to provide adequate care, mistakes, providing incorrect care, system errors

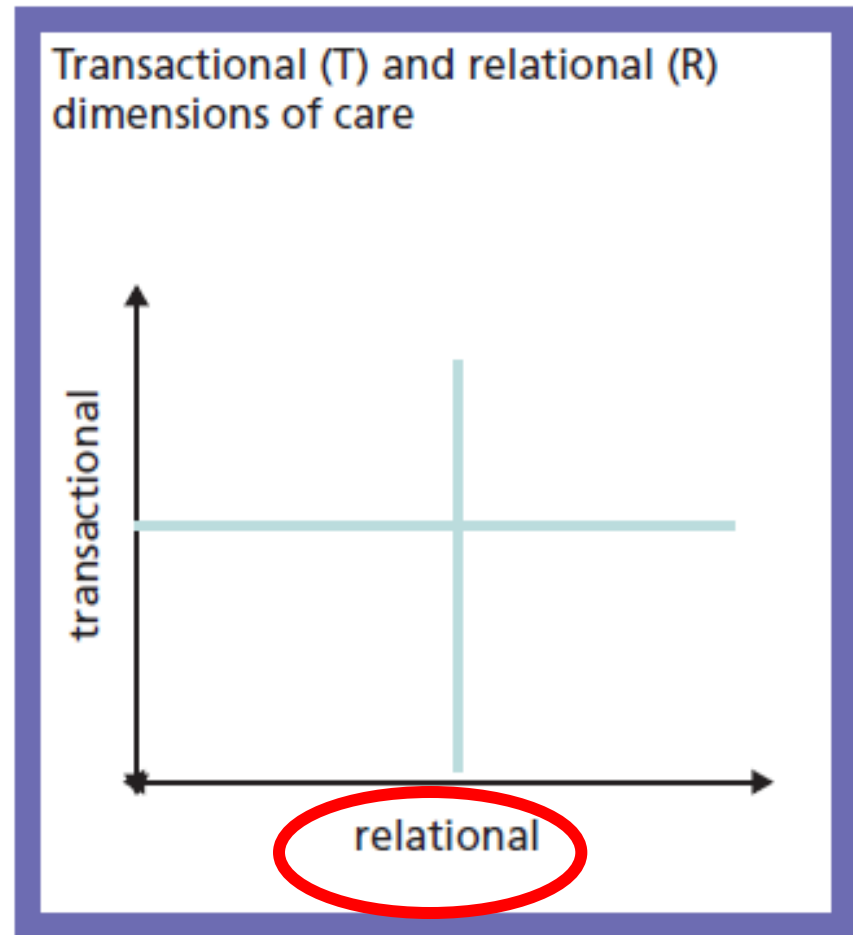


## Figure 1: Transactional and relational dimensions of care

### Patient centred care

- Compassion, empathy and responsiveness (R)
- Co-ordination and integration (T)
- Information, communication and education (T&R)
- Physical comfort (T&R)
- Emotional support, relieving fear and anxiety (R)
- Involvement of family and friends (T&R)

Source: Institute of Medicine, *Crossing the Quality Chasm*, 2001



### 'What matters to patients'?

Developing the evidence base for measuring and improving patient experience

Project Report for the Department of Health and NHS Institute for Innovation & Improvement

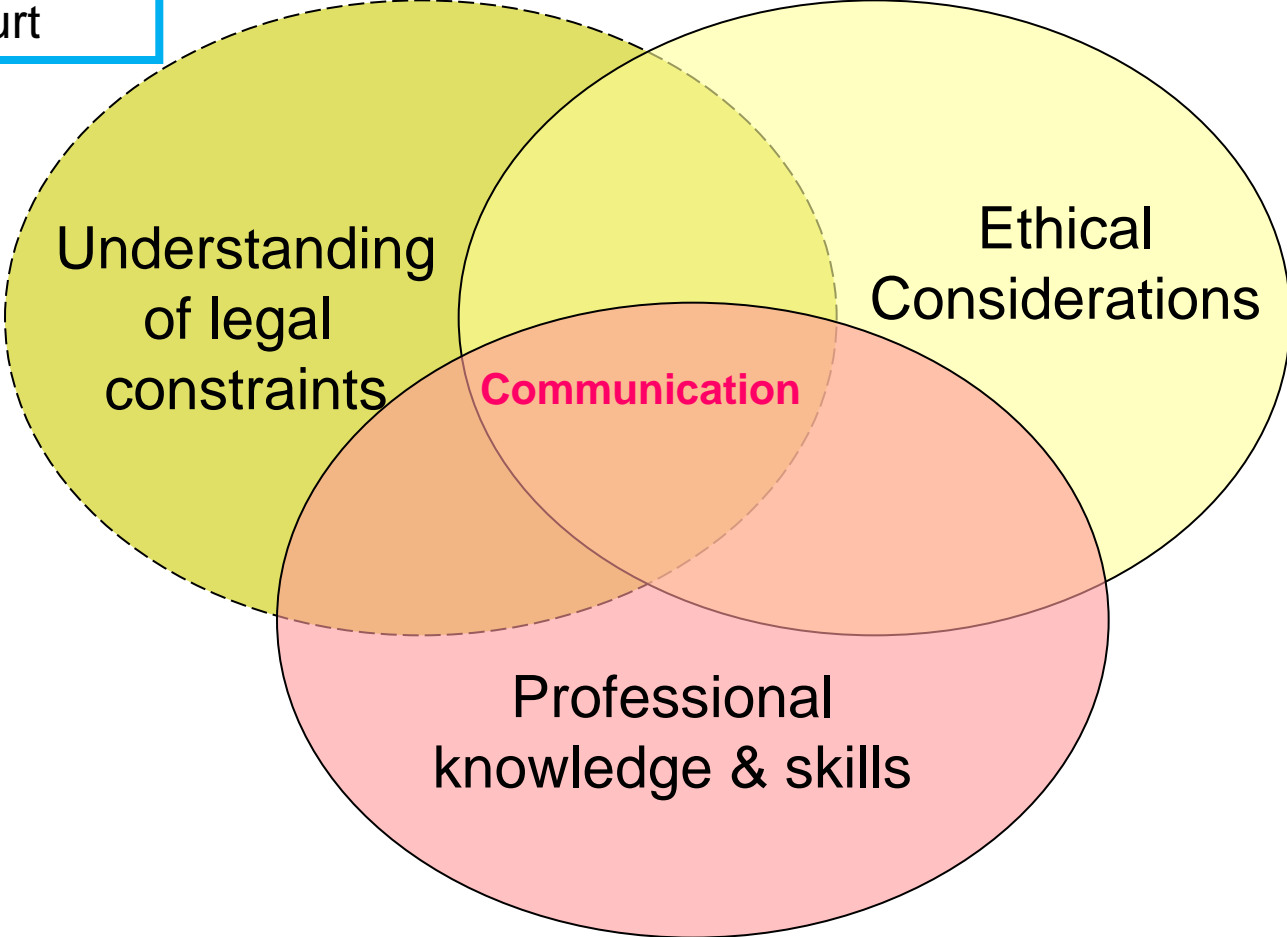


? THE MODERN  
HEALTHCARE  
PROFESSIONAL?

# The Modern Healthcare Practitioner

Patient

Legal Profession  
& Court



Public

Family  
members

Colleagues

## Is anyone listening?

A report on complaints handling in the NHS

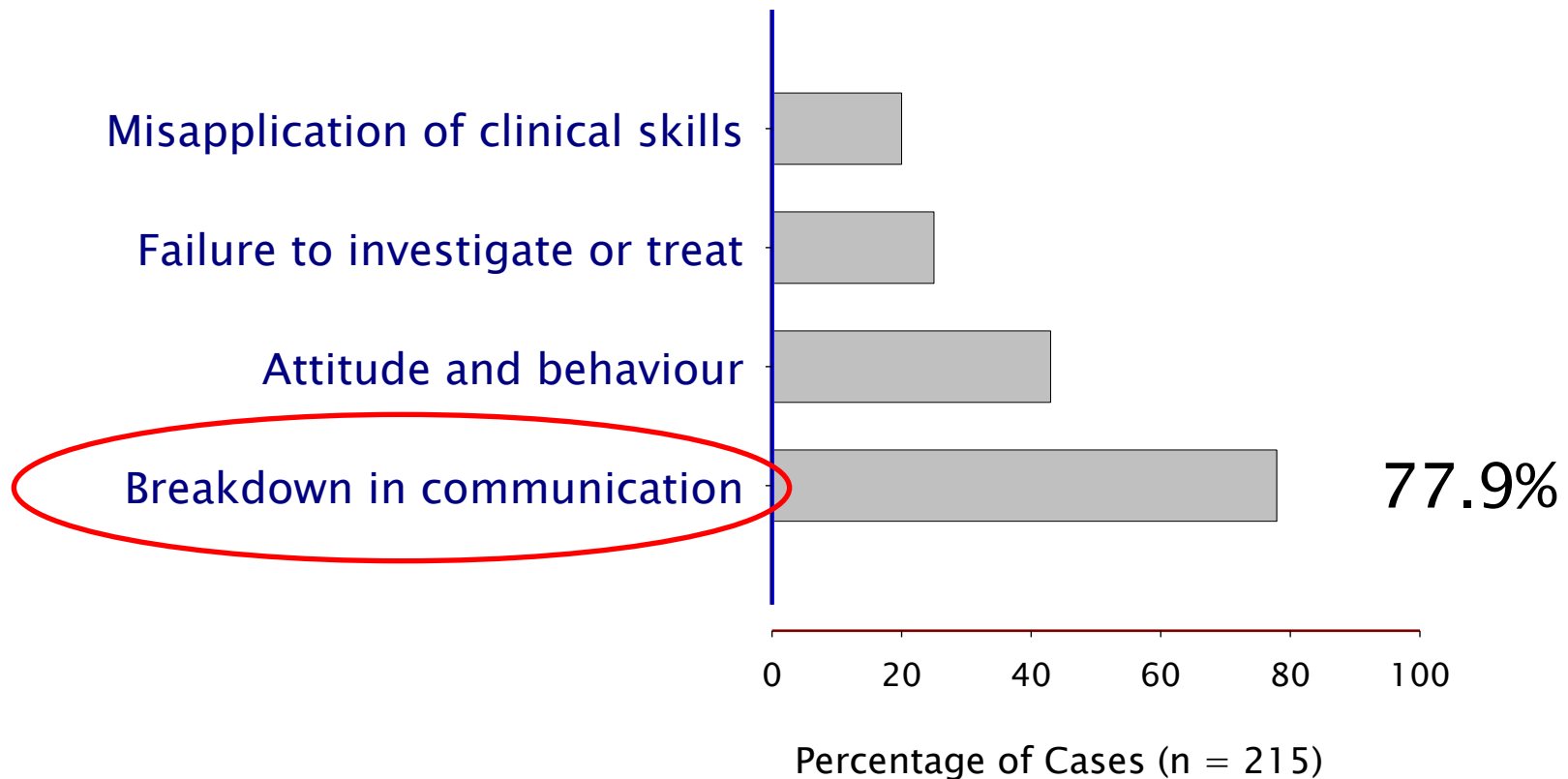


- 1) Complaint resolved as close as possible in place and time to the events complained
- 2) Receive an explanation and an apology where warranted
- 3) Any necessary action taken to prevent repetition



# What types of Complaints are they?

## Complaints substantiated after peer review



Anthony Back  
Robert Arnold  
James Tulsky



# Mastering Communication with Seriously Ill Patients

Balancing Honesty with Empathy and Hope



CAMBRIDGE

Medicine

3. Offer your clinical experience as a way of creating new possibilities.
4. Follow-up by asking the patient what he is taking away.

## CHAPTER 7: CONDUCTING A FAMILY CONFERENCE

1. Prepare the people and the messages for the conference.
2. Introduce all participants and the purpose of the conference.
3. Assess what the family knows and expects.
4. Describe the clinical situation.
5. Ask each member of the family for concerns.
6. Explore the patient's values and how they should influence decision making.
7. Propose goals for the patient's care, and be prepared to negotiate.
8. Provide a concrete follow-up plan.

## CHAPTER 8: DEALING WITH CONFLICTS

1. Notice there is a disagreement.
2. Find a nonjudgmental starting point.
3. Listen to and acknowledge the other person's story/concern/viewpoint.
4. Identify what the conflict is about, and try to articulate it as a shared interest.
5. Brainstorm options that address the shared concern.
6. Look for options that recognize the interests of everyone involved.
7. Remember that not every conflict can be resolved.

## CHAPTER 9: TRANSITIONS TO END-OF-LIFE CARE

1. Prepare yourself.
2. Ensure the patient or family understands the medical situation.

edited by Elisabeth Macdonald



# difficult conversations in medicine

to continue, while summarizing or repeating what you have heard confirms that you have been listening as well as understanding and encourages further communication.

Positive pauses can be helpful to let the other person relate what they want to say, rather than what you want to know. In active listening mode it is wise to minimize your use of questions. Every time you ask a question you dictate the agenda. This is perfectly allowable when you are checking facts but less helpful when you wish to convey real interest in the other person's viewpoint.

When patients or relatives are having difficulty expressing their feelings it can be helpful to reflect these feelings and volunteer a suggestion such as 'It sounds as though you found this very distressing?' or 'You must have found this rather worrying?' Such a suggestion may 'legitimize' the patient's emotion and encourage them to elaborate. On the other hand, an inexperienced listener who misjudges the emotion or the patient's readiness to confess to it may damage the rapport that had already been established. Most patients will appreciate your effort to be understanding even if you are a bit wide of the mark.

Active listening can prove an invaluable tool in fraught circumstances. When feelings are running high and the patient is voicing anger and distress, it can be very productive to affirm your interest with positive silence. The patient is given free reign and is able to express themselves and their agenda to their own satisfaction. Most angry people tend eventually to run out of steam. By active listening their anger is defused. Eventually, at an appropriate moment, the active listener can respond with an appropriate comment such as 'Okay what would you like to do about it?'

One technique to encourage patient communication, which is frequently employed in the psychological and psychiatric specialities, is that of silence. Positive, receptive and encouraging silence is a further non-verbal stimulus for the patient to continue. This can be a useful means of reaching out to the shy patient who finds it difficult to engage.

## Active listening

- ◆ Look
- ◆ Nod
- ◆ 'I see'
- ◆ Repeat phrase
- ◆ Summarize
- ◆ Pauses
- ◆ Minimize questions
- ◆ Reflect feelings

## Physical surroundings

Most conversations can be facilitated by congenial surroundings. In the medical context, this means that where possible conversations should take place in a quiet, private and if

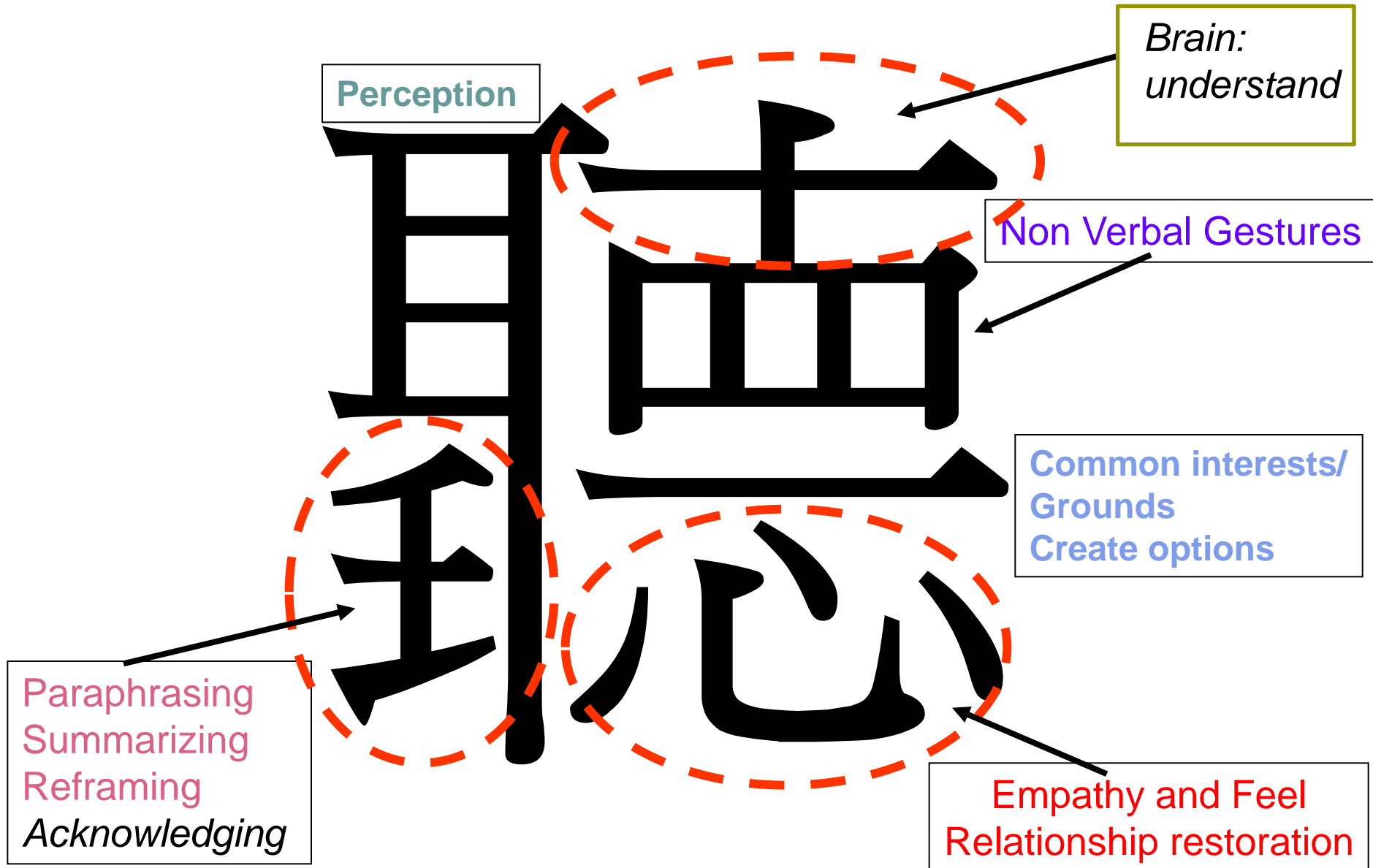
A red graphic of a person with arms raised, forming a heart shape. The person's head is a solid red circle, and their arms are raised in a 'V' shape, with the hands positioned at the top of a large heart outline. The entire graphic is rendered in a solid red color.

**The Heart of Communication**

**Active Listening**



# ACTIVE, EMPATHETIC, RESPONSIVE LISTENING



# Active Listening

- Acknowledge Feelings (*to show appreciation*)
- Perception (*to understand*)
- Paraphrase (*to show you understand*)
- Summarize (*to focus*)
- Reframing (*to change perception*)
- Common interests and grounds (*to connect*)
- Find options of care (*to seek solution*)
- Follow through (*to show responsibility*)



Demo

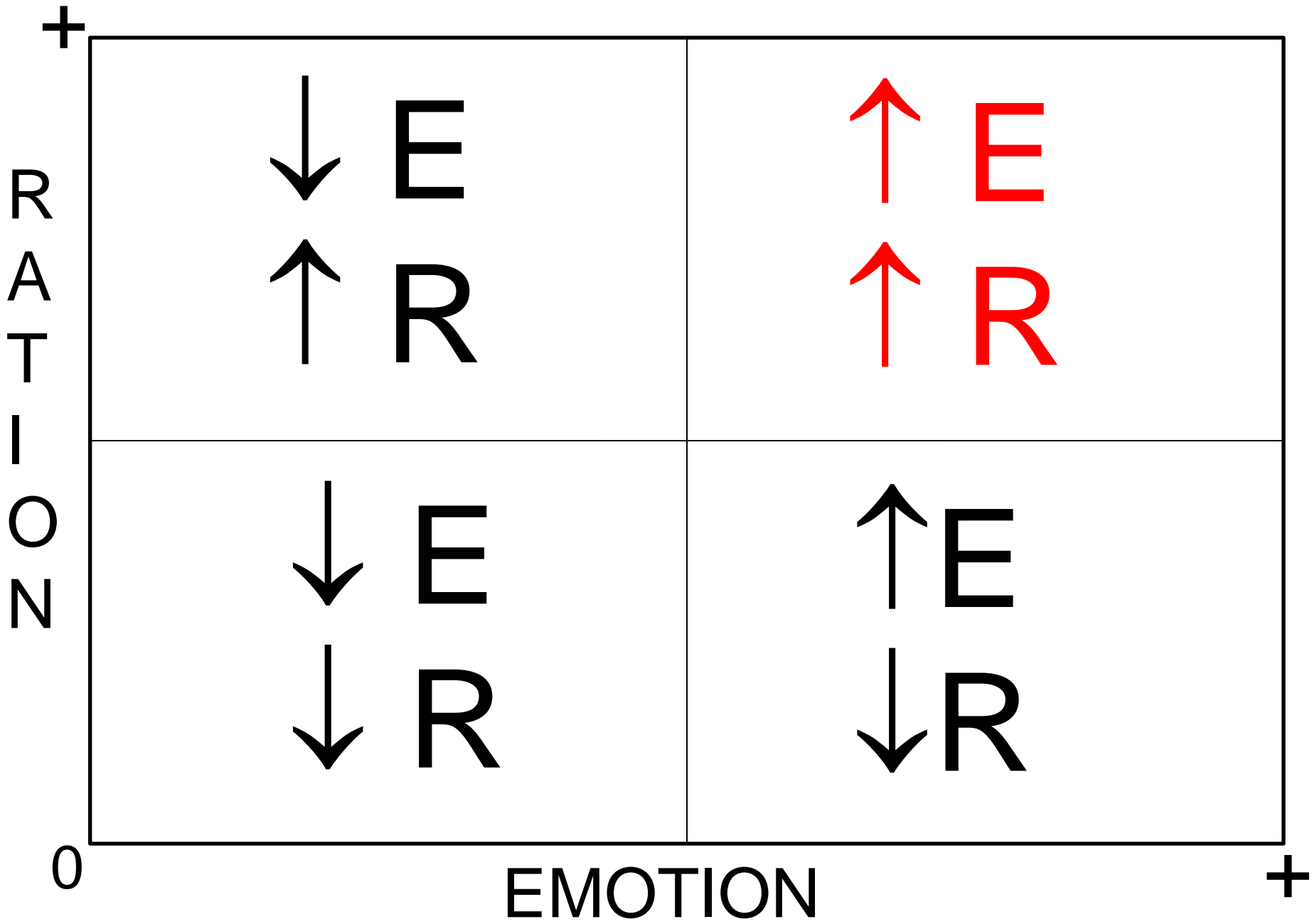


I D E A T I O N

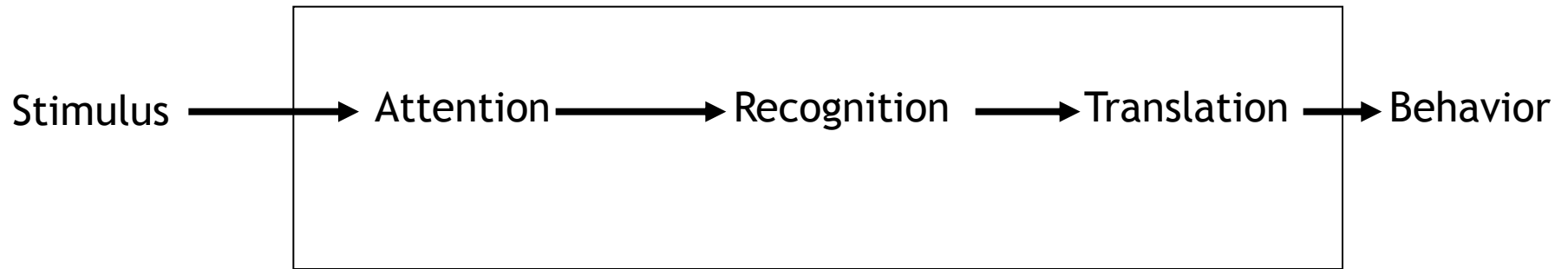


P I N K Y L A I

Exterior-Emotion  
Interior-Rational



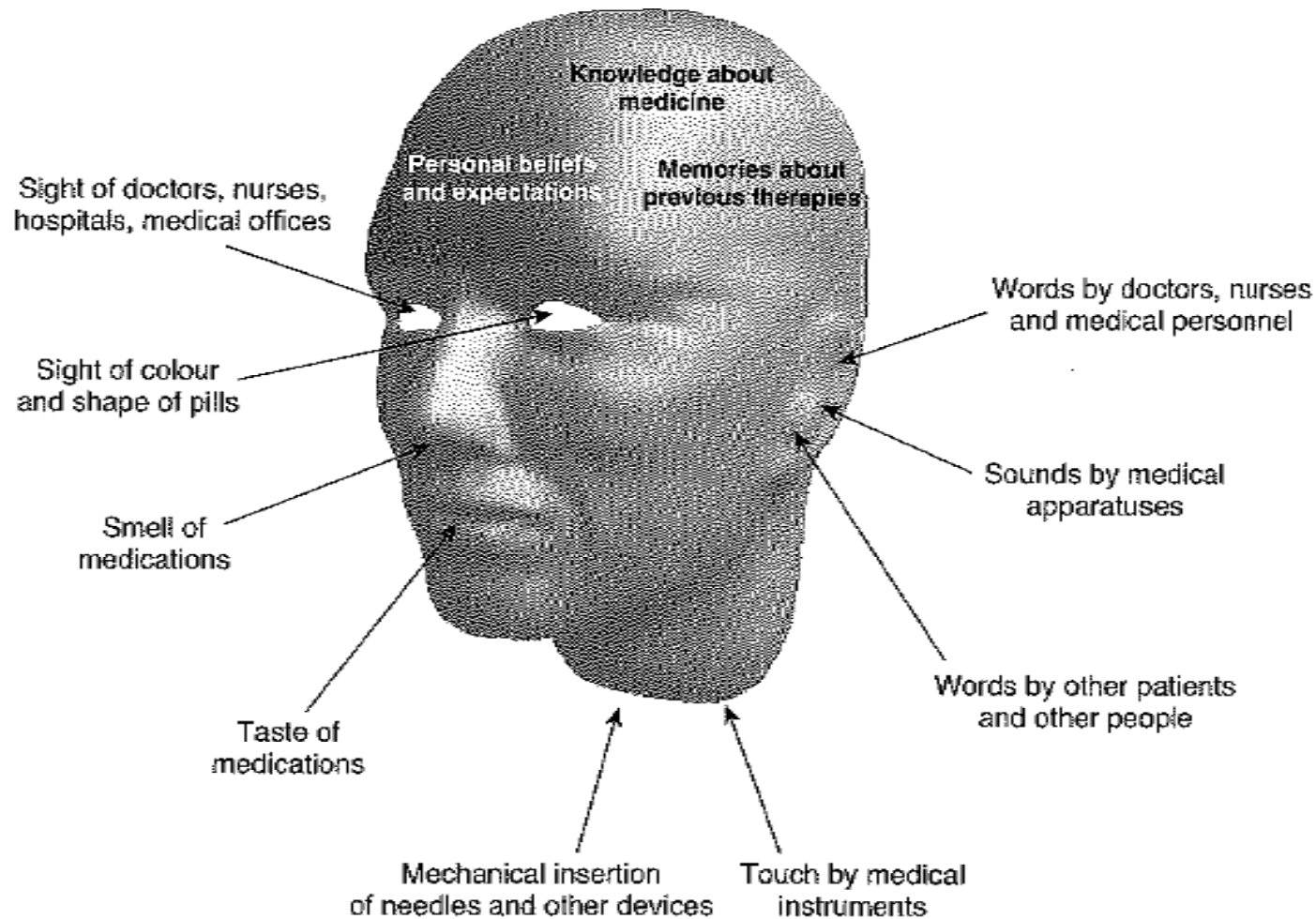
# The Perceptual Process



Perception → Thinking → Emotion → Behaviour

**Perception is Reality**

# Social / sensory stimuli around the patient



During a therapy, many social/sensory stimuli are present around the patient, and represent the psychosocial context, or the ritual of the therapeutic act. In addition, the patient's internal psychological states contribute to the psychosocial context as well. The placebo effect, or response, is the effect of this psychosocial context on the patient's brain.

# Reframing of Perception

- ❖ Remove “toxic” content to make the statement more palatable
- ❖ Soften the party’s demands to make them more acceptable to the other
- ❖ Express statements in more neutral or positive language to avoid further conflicts

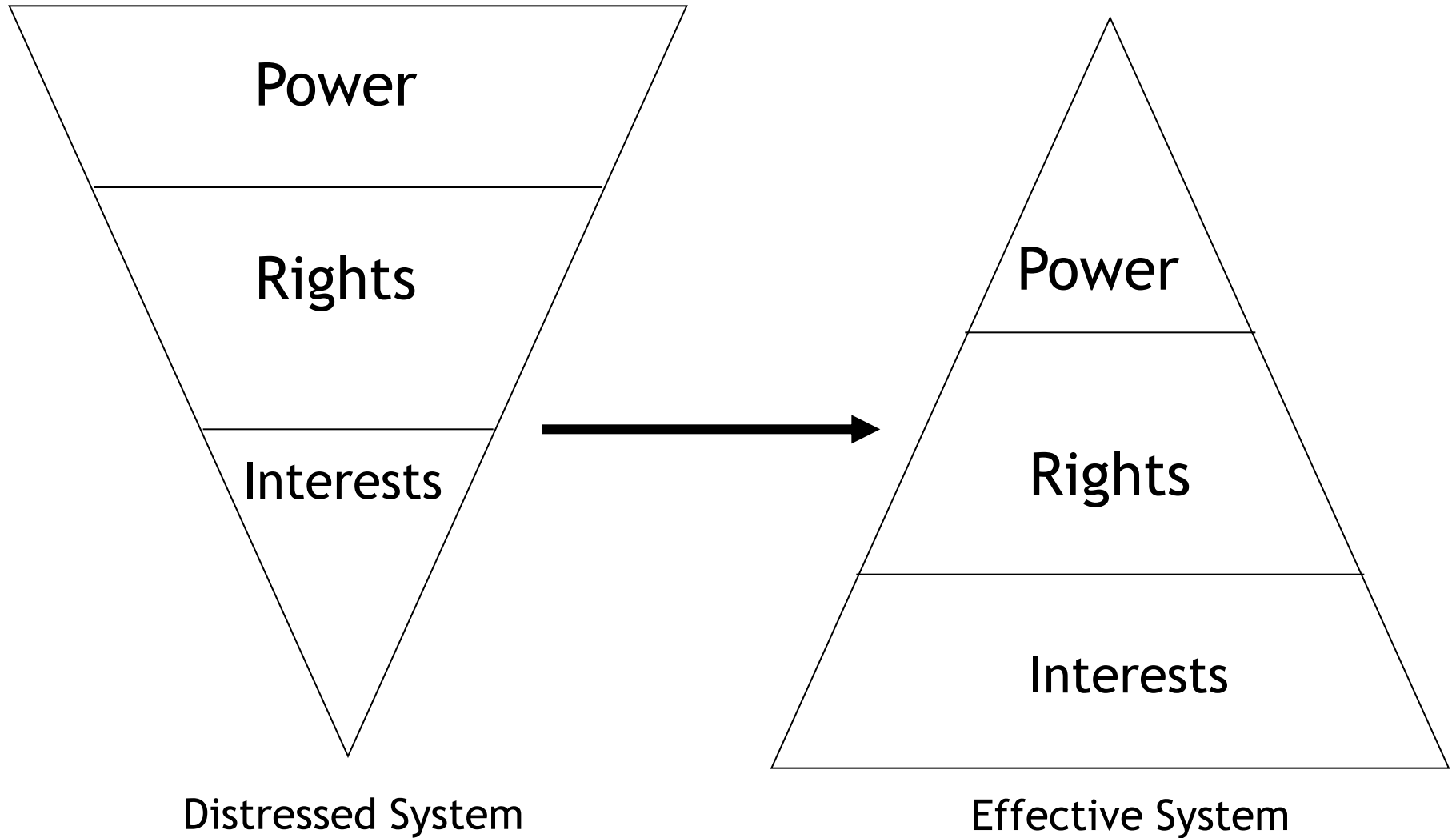


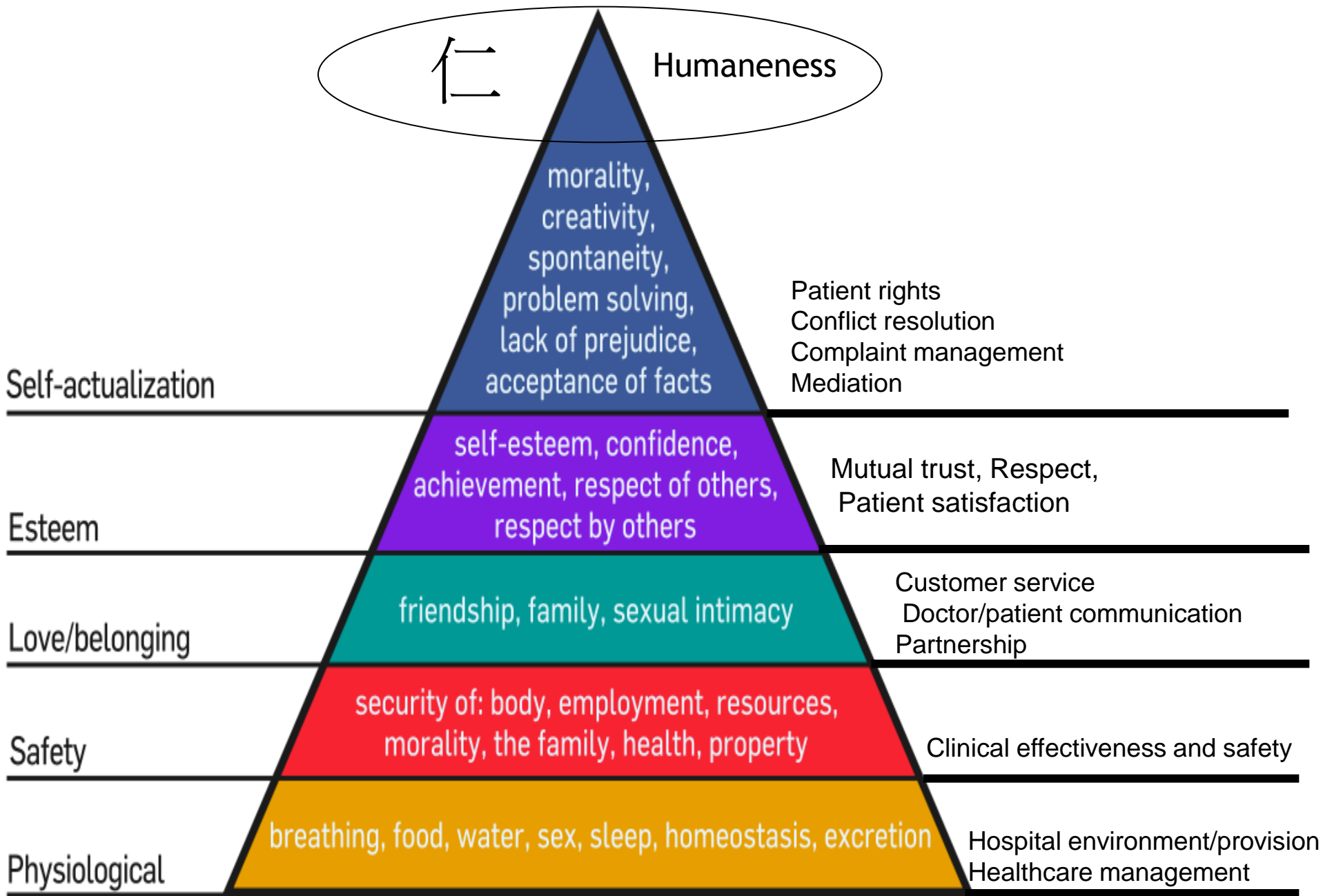
# Sharing from oncologist

- 冇得搞
- 搞唔搞都一樣
- 做咗都有命享
- 你哋呃阿伯係錯，病人係有知情權
- 你哋冇權決定病人嘅治療

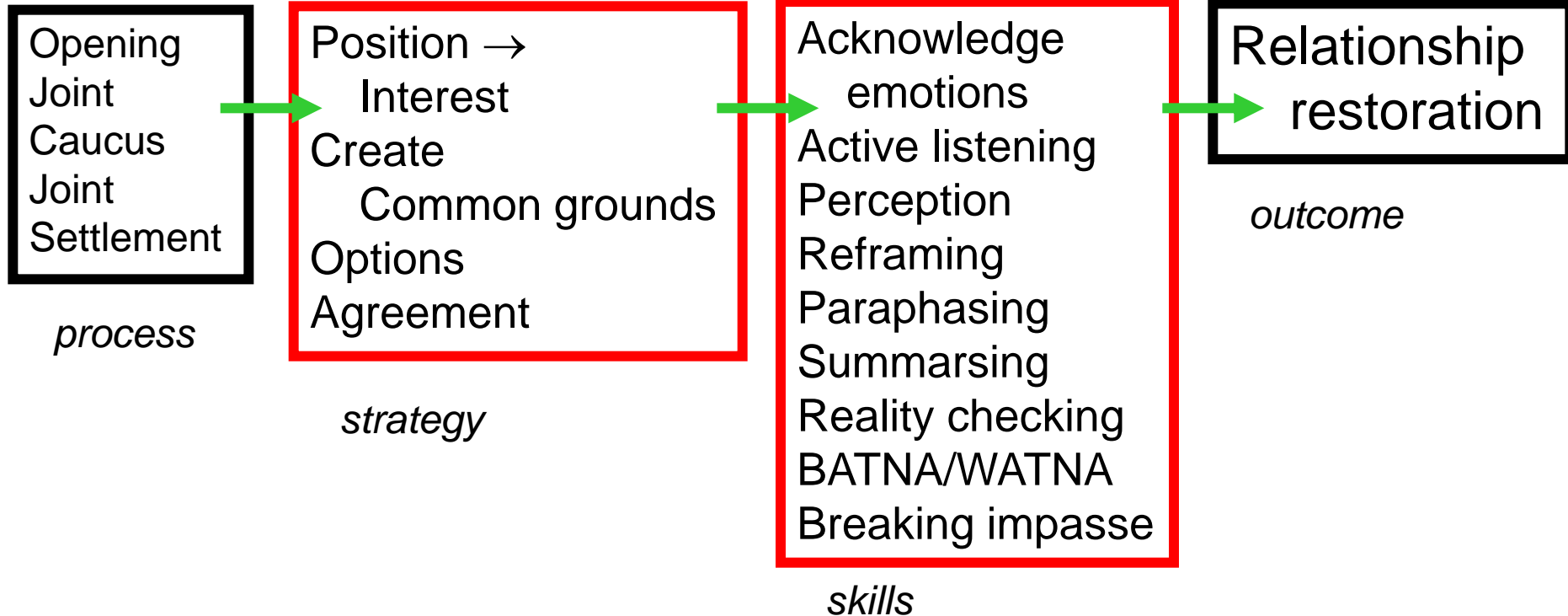
- 現有嘅治療效果唔係太好
- 我地有好多藥物方法去令你舒服D
- 做咗個手術(或電療)好大機會副作用多過好處(仲辛苦多咗)(得不償失)
- 我明白你地屋企人緊張病人嘅心情，但我地幫病人治療都要俾佢知道病情

# Reframing towards Interests

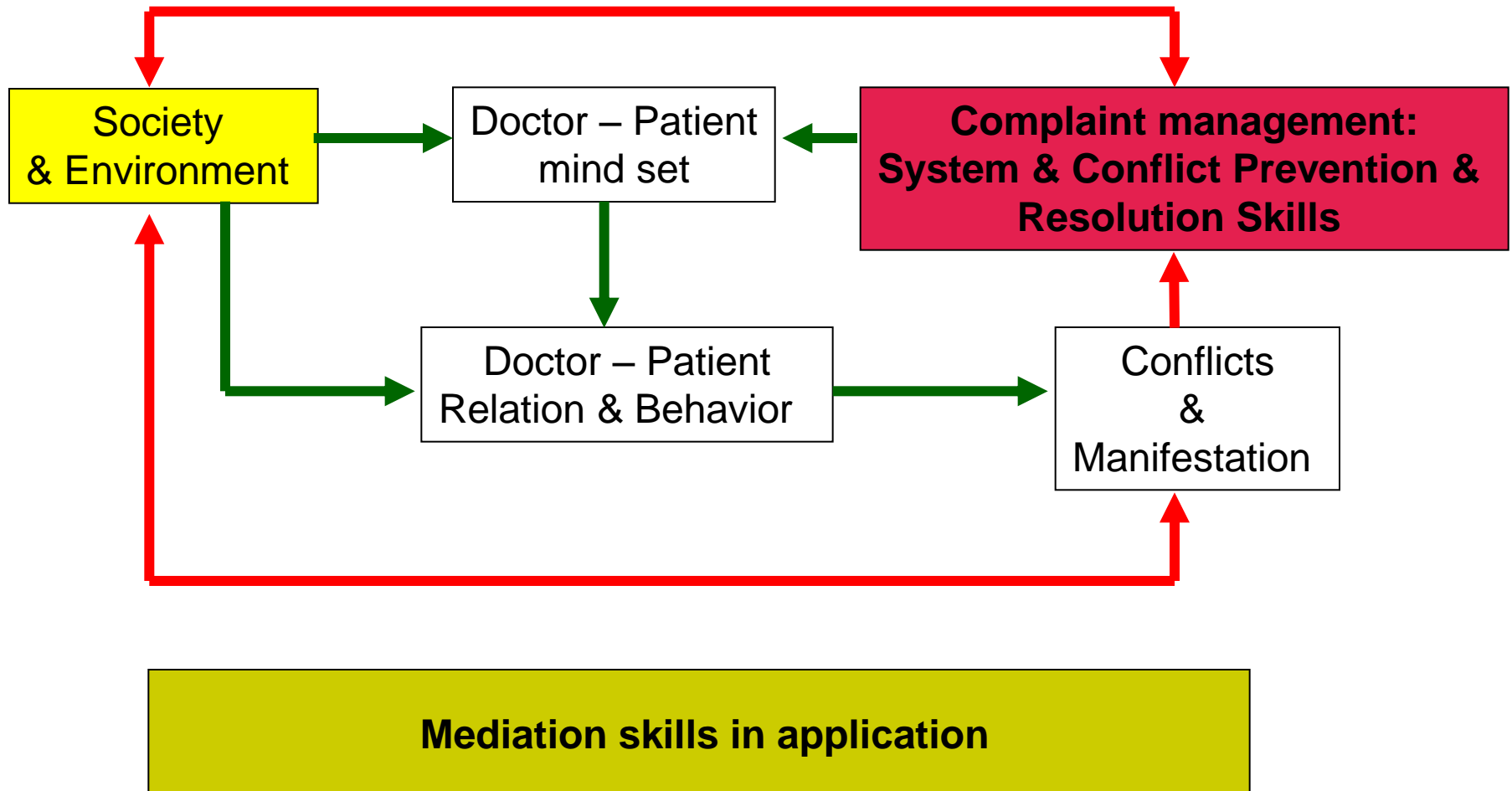




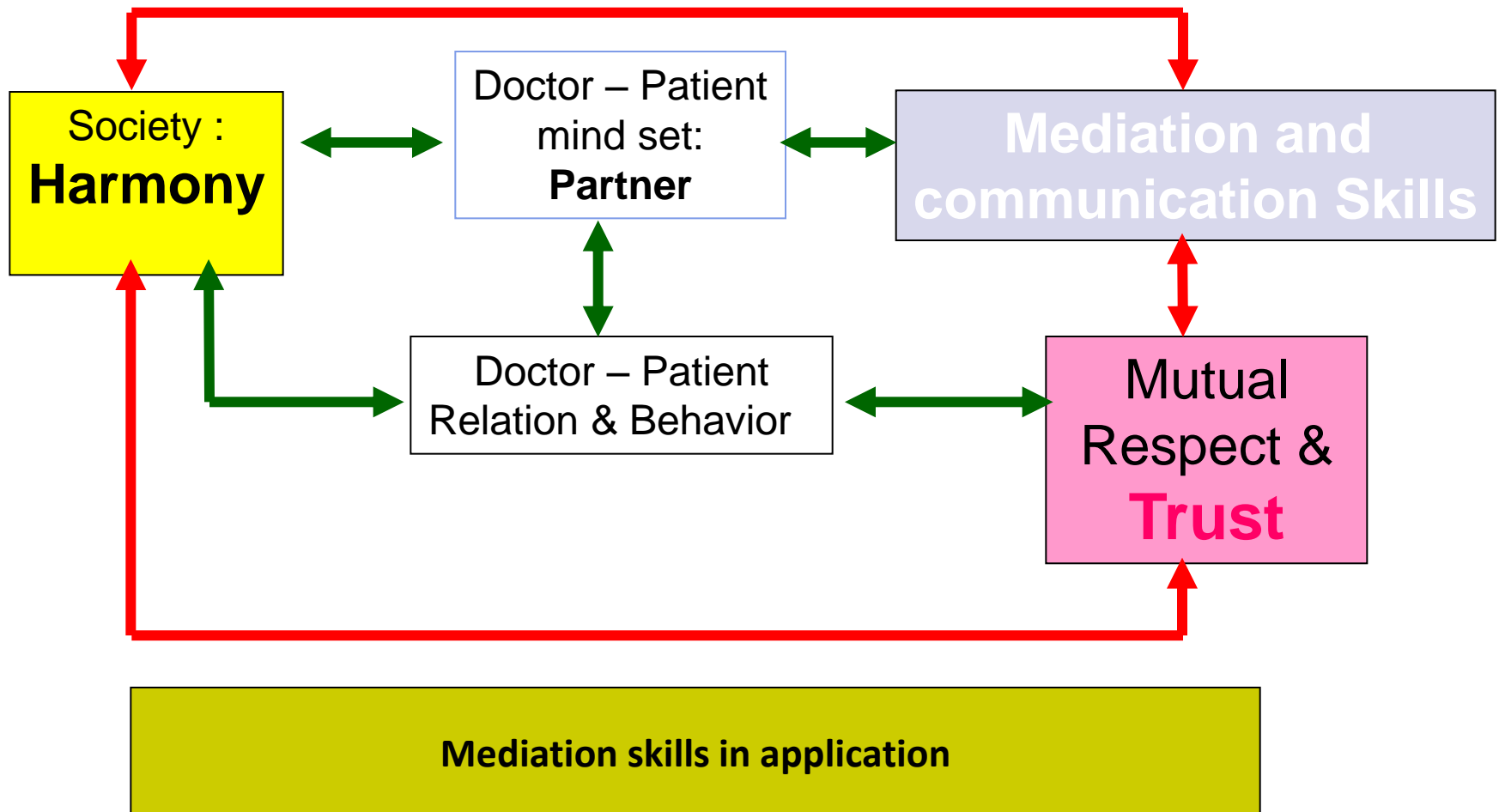
# Deconstructing Mediation



# Complaint Management Loop



# Patient Experience Loop



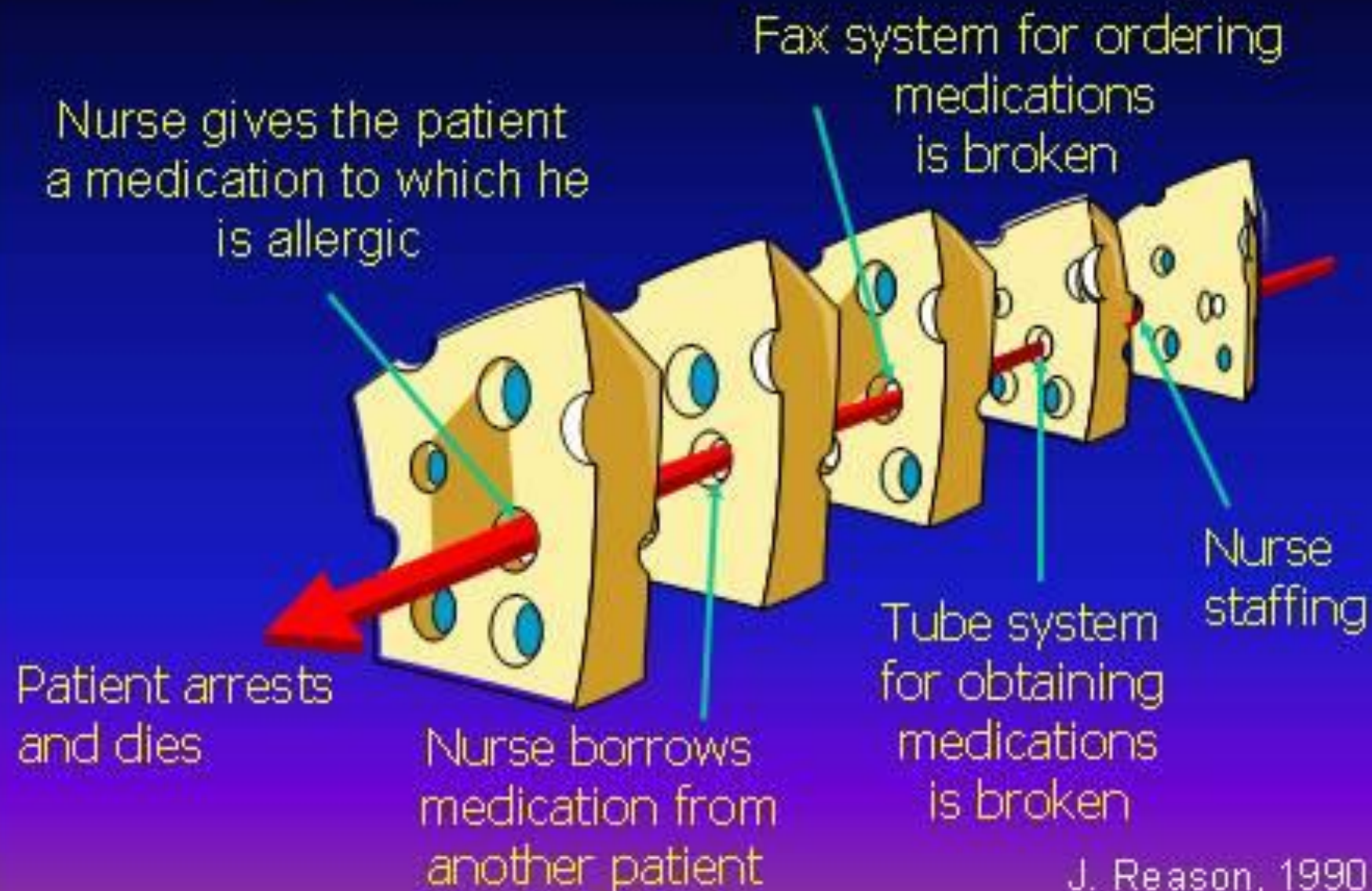


## **The Framework for Patient Experience Management**

Society for Health Care Advocacy 2012 Annual Conference

Source: <http://www.shca-aha.org/shca-aha/events/speakers.html>

# A Medication Error Story







HEALING  
WORDS

**the power of apology in medicine**

*Second Edition*

MICHAEL S. WOODS, M.D.

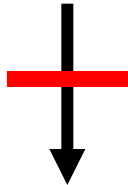
***Recognition***  
***Regret***  
***Responsibility***  
***Remedy***  
***Remaining engaged***

# DAO of Apology

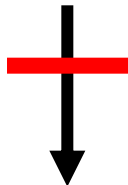
- **Disclosure, Apology, Offer** programmes in Massachusetts benefits both the liability system and patient safety ( Milbank Wuarterly 2012, 90(4): 682-705)
- Harvard in 2006 released a document addressing useful responses to adverse events; including formation of a programme specifically designed for the needs of involved physicians, flexibility in physicians' schedule following an adverse event, clear debriefing and documentation, assistance communicating with patient's families and instruction for physicians regarding peer review.  
( Lippincotts Case Manag 2006; 11: 193-194)
- 3 basic principles: (1) patients should be quickly and fairly compensated when medical error results in injury; (2) clinicians should be vigorously defended when an injury is not caused by unreasonable care; and (3) mistakes provide learning opportunities ( JPPNN)

# From Retroactive to Proactive

Communication  
(Front-Line)



Conflict Resolution &  
Complaint Management  
(Mid-Management)



Incident Management  
(Top-Management)

1) *Culture:*  
Patient Relation Matters

2) *Skills:*  
Applied Mediation  
Skills in communication and  
conflicts

3) *Protocol*  
Immediate management and  
Risk Reduction





# ER



HOUSE  
FOX.COM/HOUSE

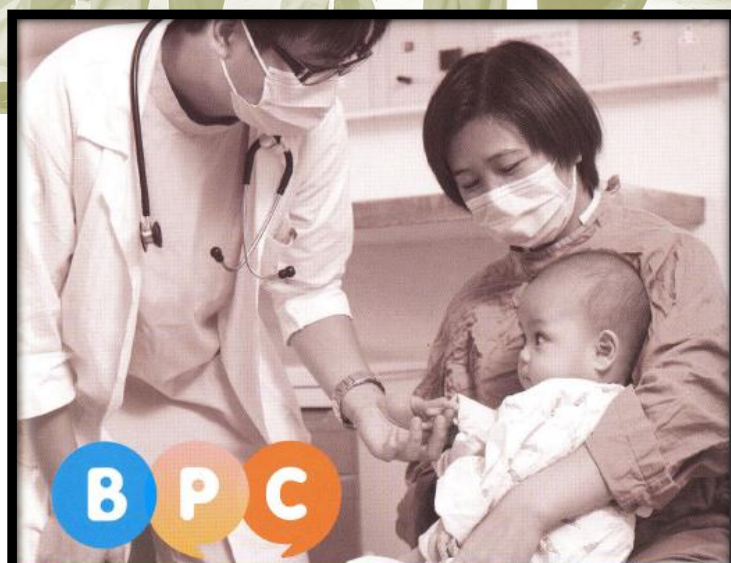


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# 白色巨塔



B P C

## Better Patient Communication Training Program

- | Healthcare Professionals at HA  
傷病檢控・醫護幫忙
- | Patient Communication Attitude  
從內而外・以心為心
- | Patient Needs  
明白所需・理解所求
- | Effective Service Steps  
掌握要訣・步驟有序
- | Communication Toolset  
會上溝通・新創智慧





Thank you