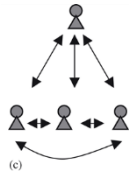
ACTIVELY USING CONFLICT ENGAGEMENT TOOLS AS CHAIR

Engaging conflict in all directions: up, down, and side-to-side



Hospital

HealthSystem

You are Chair of a medium-sized Department of Family Medicine which has a long and proud history of clinical service, education, research, and advocacy. For the past 40+ years the Department has been located in a cozy medium-sized academic community hospital in an underserved area (pseudonym – Flagship Hospital) that has been dedicated to the advancement of family medicine, primary care, and the health of the communities it serves. Unfortunately, the fiscal health of Flagship Hospital, which was never particularly solid, has been in ever increasing peril with ever growing budget deficits. After internal discussions with all hospital leadership, including the Family Medicine Chair, Flagship interviews potential suitors and is acquired by the second largest Medical School-affiliated health system (pseudonym – Northcoast). Sadly, this health system lacks the expertise to turn around the hospital (which cycles through 5 leaders in 3 years) and the economic plight worsens to the point of jeopardizing Northcoast's bond rating and nearly causing its insolvency. A new Northcoast CEO is brought in to "stem the red ink" and "get the house in order". In the meantime, the Medical School and University wake up to the threat posed by developments – and gets increasingly organized and involved. Events begin to unfold at an ever increasing pace:

1. The new Northcoast CEO fires nearly all of Northcoast's health system leadership – with movement from a culture of partnership to a culture of "command and control" – with rapid, sweeping staffing reductions in all areas and other radical cost-saving interventions.
2. Northcoast's new CEO and Board decides it cannot go it alone and it seeks bids from larger regional and national health systems to acquire Northcoast.
3. Flagship, Family Medicine's main hospital, is seen as a "dead albatross" weighing down the system and impeding the acquisition of the Northcoast system. Flagship is put out to bid separately from the other Northcoast hospitals in Northcoast's portfolio – and the only bidder is a legally and ethically-challenged West Coast for-profit that specializes in "distressed hospitals".
4. The Medical School and University propose their own plan which includes closing Flagship, transferring the Department of Family Medicine to another challenging West Coast for-profit system, breaking up the remaining pieces of Northcoast, and giving its most valued pieces to the largest medical school-affiliated system – which is Northcoast's direct competitor and antagonizer. This causes waves of unhappiness across all Northcoast units, including FM.
5. The Family Medicine and Internal Medicine residents at Flagship become increasingly irate at what they see as abandonment of underserved communities and neglect of their programs. They protest at public forums and make moves to unionize.

6. The Family Medicine faculty hold together, mostly, though they feel distressed and angry at the changes they see around them – and some depart for calmer waters.
7. Flagship's one suitor drops out and In order to make the Northcoast health system more attractive to higher quality suitors, the system announces the closure of Flagship Hospital and the elimination or transfer of more than 1000 employees (including physicians). Nearly all services are eliminated, with the exception of Family Medicine, which is expanded – much to the ire of other Flagship department chiefs, faculty, and staff.

At this point, the Chair is in conflict or potentially in conflict with the following individuals and groups, many of whom are in conflict with one another:

- Family medicine faculty, residents, and staff
- Flagstaff division and department chiefs, faculty, and community physicians
- Flagship nursing and other staff
- Northcoast leadership
- Dean, university president and provost
- City mayor and city council

Personality and Communication Styles of the Main Players:

- Chair: a consensus builder who mostly "decides with people rather than for people" and who tries to shape the environment by formally and informally creating strong relationship bonds, and working towards "win-wins" based on ideology and pragmatism
- Health System CEO: a strong centralist who seeks immediate results, clear power structures that emphasize decisiveness and their authority and who prefers data over opinions
- Dean: a complex mix of "change agent" and "stabilizer" who has left their comfort zone to pursue broad goals for the medical school and university. Wishes to shape the environment with the medical school in a more central role, bringing stability to the systems of care
- Family Medicine Chief Resident: Analytic by nature, and when pushed to the near breaking point, builds consensus for step-by-step contingency plans by all residents and staff that include use of social media, community-organizing, and non-violent protest

Questions for Case Discussion (3:55 to 4:40 pm with reporting out)

1. What are your strategies for engaging in the various conflicts (up, down, and side-to-side)?
    - Where do you start?
    - How do you proceed (simultaneously, sequentially, etc.)?
    - What conflicts do you avoid, manage, and engage?
2. With whom do you partner and with whom do you fight?
3. To whom can you reach out for support?
4. Given the personality and communication styles of the main players, how might you engage them and communicate with them going forward to be most effective?

Feel free to bring up examples from your own environment