Beyond Tort Reform

The Inherent Limits of Downstream Solutions to Upstream Problems

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The Inherent Limits of Downstream Solutions to Upstream Problems

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I. Executive Summary

If insanity is doing the same thing over and over and expecting a different result each time, then continuing the battle to pass national tort reform legislation qualifies for a psychiatric diagnosis. The failure of the U.S. Senate to pass a tort reform bill for medical malpractice liability on May 8, 2006, leaves the problem to the states, where the plaintiffs' bar will attempt to hold the line on the status quo and the reformers will offer Texas' 2003 statute as a model for controlling costs. Stewardship of the lobbying dollar argues for a review of what is going on here, and whether the end results are worth the fight. The issue is critical for American businesses and consumers. According to a 2006 report by PriceWaterhouseCoopers, liability insurance and defensive medicine eat up 10% of annual health care costs in America. If the tort reform solution proves itself worthy, health care costs for employers go down. If not, these costs continue to threaten the very existence of some businesses. Moreover, the $32.6 billion health care liability expenditure each year for medical malpractice claims and expenses is only one part of the total allocation to the tort industry, which a 2005 Tillinghast study reported to be a $246 billion annual item in the American budget.

In this paper we first examine how tort reform saves money, and then describe three tests that tort reform fails. We will argue that tort reform falls short primarily because it involves "downstream" tinkering with the system (caps on awards if the case should ever reach the courthouse), ignoring the real opportunities for cost control that exist upstream (prevention of incidents and, most important, early collaborative resolution of potentially compensable events that preserve provider-patient relationships and goodwill).

For hospitals, elder care facilities, and physician groups in states that do not have legislative tort reform, and for these same groups in states that have tort reform but wish to save additional money and reduce complaints to investigative bodies, we offer an "upstream" alternative. Based on precedent in other industries, the upstream alternative promises 50% savings in attorneys' fees annually, eliminates the need for defensive medicine, and puts the saved dollars back on the bottom line for hospitals, elder care institutions, physicians and other providers, as well as consumers.

II. Counting the Costs

By any standard of measurement, the costs of professional liability (expenses and payouts to injured parties) in health care are high:

- $32.6 billion is spent annually for professional liability claims and expenses for hospitals, elder care facilities, and physician groups.[1]

- Total annual allocation to the tort industry is $246 billion per year or $845 for each American citizen (Tilllinghast, 2005).

- Dollar amounts for filed medical malpractice claims growing 7.5% annually (Aon, 2004).

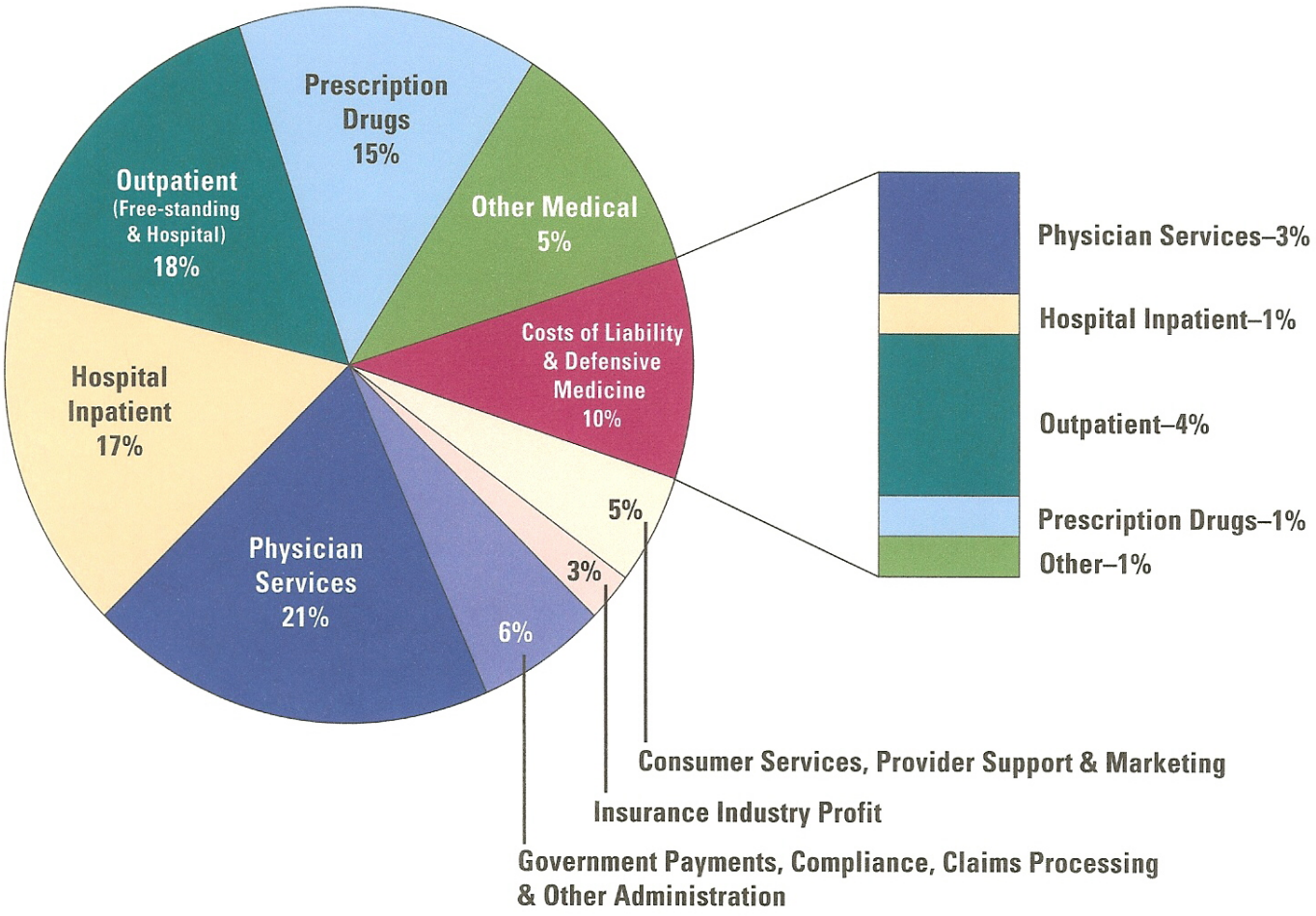
- The median settlement in out-of-court cases nearly doubled from 1997 to $700,000 in 2003 (Insurance Information Institute, 2006).

- Ten percent of the annual expenditure for health care goes to medical liability and defensive medicine (PriceWaterhouseCoopers, 2006).

[1] Estimate based on CHORDA analysis of data from: (a) 2004 Best's Aggregates and Averages – Property and Casualty; (b) Best's Review, July 2004, p. 12; (c) Best's Review, May 2005, p. 103; (d) 2006 AHA Hospital Statistics; and (e) 2004 Aon Hospital Professional Liability and Physician Liability Benchmark Analysis.

EXHIBIT 4

Estimated Breakdown of Insurance Premiums With Medical Liability and Defensive Medicine Extracted, 2005



Sources: Adapted from Centers for Medicare & Medicaid Services, National Health Accounts, 2005 and Midwest Business Group on Health, April 2003.

From: PriceWaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2006."

III. Defining Terms

Before showing how tort reform saves money, it is important to define key terms:

1. Incidents, Potentially Compensable Events, Claims, and Lawsuits

Incidents – An incident in professional liability that could be a documented medical error or an unanticipated event that the patient or other party perceives to be an error.

Potentially Compensable Events – Events that are judged by one party or another as warranting compensation of some form owing to the fact that someone may be shown to be liable for an error for which there are damages associated with the error.

Tort – A wrongful act, inaction, injury, or damage (not involving breach of contract) for which a civil action can be brought.

Claims – Formal filings by patients, family members, and/or plaintiffs' attorneys to hospitals, elder care facilities, or physician insurance carriers.

Lawsuits – Actions initiated by plaintiffs' attorneys seeking resolution through the courts.

2. Prevention

This refers to initiatives by hospitals, elder care facilities, and others to achieve high quality care so that errors or mistakes do not occur. Patient safety initiatives in hospitals include a wide range of programs including improvements in communication among providers aimed at preventing errors.

3. Upstream Versus Downstream Solutions (Early Resolution versus Late Resolution)

Downstream or late resolution refers to resolution by judges and juries in the court system. Upstream or early resolution refers to steps taken by the parties—patients, families, hospital personnel, insurance representatives—to prevent incidents and to resolve cases after incidents have occurred and after one or more of the parties has judged

that an incident is a potentially compensable event or is believed to be such by the other side, before claims are filed. Claims can be considered a part of the upstream phase if they are resolved by attorneys who specialize in negotiation only, though claims are considered to be a part of the downstream phase if the parties are represented by trial attorneys who will be representing the clients in court.

4. Dimensions of a Tort Case

In order for a case to be compensable according to the law, liability must be established (one or more parties committed an error as judged by comparison of the care given with an objective standard) and there must be damages associated with the error (such as lost wages, lost function).

5. Standard Solutions

Experience with dispute resolution suggests that there are four standard solutions that the parties may draw from to resolve a case (Slaikeu, 1996). These are: acknowledgement/apology associated with the event (this can be offered by one party to another or requested by one party from another); restitution (typically money paid to rectify a wrong or compensate for damages; this may also include "punitive" damages which are punishment for having committed the wrong); corrective action (steps taken to prevent future occurrences, typically framed in light of the recent negative event); forgiveness (a party who forgives another agrees to no longer hold the matter against the other, which is often possible only when the previous three standard solutions are in place).

In negotiations on application of the standard solutions, the parties may either request one or more of the standard solutions to be delivered from another person or they may offer to provide one or more of these solutions to the other side.

6. Collaborative versus Higher Authority Processes

Collaborative processes include negotiation (the parties discuss the matter directly with one another or their attorney advocates discuss the matter with a view to achieving a resolution that can be accepted by all parties) and mediation (where a third party assists

the negotiators in achieving a resolution). Higher authority resolutions are those in which a third party renders a decision or award with arbitration being one form of higher authority (an arbitrator makes the decision). Litigation is the best known form of higher authority resolution in the American justice system (judges and juries render awards).

In higher authority methods, the solution most frequently used is monetary restitution; in collaborative methods, the parties typically draw from all four standard solutions.

7. Tort Reform

This refers to adjustments made in the justice system, such as capping the non-economic portion of awards, or limiting attorneys' fees. The bill that failed in the U.S. Senate on May 8, 2006, is an example of standard tort reform provisions (S.22): (a) cap on non-economic damages at $250,000, with a total of $500,000 from all institutions; (b) limitations on plaintiff's attorney contingency fees (e.g., 40% of the first $50,000, 33 1/3% of the next $50,000, and so on), and (c) clarifying requirements for credentials for expert witnesses. These and other features all relate to what will happen if a case reaches a judge or jury, and hence are intended to have a direct impact on the filing of cases (prevent frivolous cases being filed), and in other cases to influence the negotiations (for example, if the parties know at the very beginning about the caps on non-economic damages, then the amount offered by the defendant will be lower).

IV. How Legislative Tort Reform Saves Money

Tort reform saves money by making it unprofitable for contingency fee-based plaintiffs' attorneys to file some cases. By putting a cap on non-economic damages (for example, $250,000 per case in Texas), plaintiffs' attorneys who work on a contingency fee basis (35% or more of the award) know that there can be no large award for the case and hence decline some cases that they otherwise might have taken. Fewer cases filed means less money paid out to patients, plaintiffs' attorneys, and defense attorneys.

Data from Aon risk consultants reveal that while the severity of medical malpractice claims against hospitals is "still on the upswing in many states,…Texas has seen a dramatic reduction in the number of claims" due to amending the constitution to cap damage awards in 2003 (Poling, 2006).

Reports from Texas indicate that physicians and insurers have responded favorably to these reductions in cases. Texas Medical Liability Trust, the largest medical malpractice insurance carrier in the state, which had doubled its rates from 1988-1993, cut them by 12% in 2004, 5% in 2005, and another 5% to date in 2006 (*Insurance Journal*, 2006). Physicians have apparently evaluated these reductions favorably as evidenced by 3,000 new doctors entering the state since 2003.

V. Three Tests That Tort Reform Fails

1. *Negative Patient Relations*–Tort reform caps, and other features such as legislated limits on attorneys' fees, leave patients who want representation unable to get it, but their cases, and the perceptions that they have been hurt by their providers, do not go away. This means that unrepresented patients and their families create a pool of unsatisfied customers who take their business elsewhere, and tell others to do the same. One parent whose son died as a result of a medical error refuses to even drive by the hospital where the incident occurred. In America, physicians, hospitals, and elder care facilities compete with one another for business. Even one dissatisfied patient who tells the tale of woe to 15 others, and perhaps files a complaint with the State Board of Medical Examiners or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), detracts from positive marketing and future business. Anecdotal data from Texas physicians and insurers indicate that complaints to the State Board of Medical Examiners have increased significantly since tort reform legislation in 2003.

   Tort reform caps give physicians and other providers an expensive tradeoff: "We'll keep cases from entering the pipeline and, in return, you will likely have some unsatisfied customers and some bad 'word of mouth' public relations." The deal looks less appealing to providers when patients take their complaints to state boards of examiners, thereby challenging the provider's good name and adding additional stress to medical practice.

2. *Money Left on the Table* – The most telling critique of tort reform is the money that it leaves on the table.[2] Research shows that in payouts made by self-insured hospitals, elder care facilities, and insurance companies every year, 50% - 80% of the awards go directly to attorneys' fees—defense and plaintiffs'—and administrative costs. The math goes like this: approximately 25% goes to defense costs (called Adjusted Loss Allocation Expenses or ALAE Paid) and the rest goes to injured patients. Of the latter number, 35% - 50% goes to the plaintiffs' attorney(s) as a contingency fee award. Tort reform leaves these percentages untouched. While tort reform keeps cases from entering the pipeline, for any case that does enter the pipeline, 50% or more still goes to plaintiffs' and defendants' attorneys' fees.

[2] See Sage (2005) for a critical review of tort reform in the broader context of medical malpractice insurance reform.

This is especially telling since experience in other industries shows that with the use of early resolution systems as an upstream solution, the benchmark can be reduced to 20% of the total award going to attorneys on both sides.[3]

The difference between the 20% benchmark for attorneys' fees and the current 50% or more for health care litigation costs represents the money left on the table by tort reform.

It is important to note that the 50% to attorneys' fees holds even if mediation and arbitration are in full force, owing to the fact that in traditional claims resolution plaintiffs are represented by contingency fee trial attorneys, and defendants are similarly represented by trial attorneys whose revenue goes up with trial preparation. Mediation and arbitration typically occur late, after the lion's share of money has been spent on adversarial discovery and other trial preparation.

3. *"Not on My Kid You Don't!"* – The final test that tort reform fails is the "not on my kid, you don't" test. The question is this: "If there were an error with your own child or other family member, would you want an arbitrary cap on one part of the award (pain and suffering, for example, or punitive damages against an intransigent defendant), with no consideration given to the facts of your particular case?" If the answer is "No" on the individual case basis ("my case"), then why apply this solution to others' cases? The answer, of course, is to "bring down prices" for insurance, which is a tradeoff similar to the one for negative patient relations.

[3] The 20% benchmark is based on results from outside health care (e.g., Toro (Aronson, 2002) and Halliburton (Slaikeu and Slaikeu, 2002) reporting 50% - 80% savings in defense costs through early resolution), with extension of these same principles to plaintiffs' attorneys' fees through use of the ***Two-Track*** model (see Section X. in the current paper).

VI. Key Psychological and Other Interests of All Parties

Separate from the financial failure of money left on the table, if we peel the onion on the second of the two tests listed above, we see that the reason tort reform fails on these is that it does not address the psychological needs and interests of patients and care providers following an "unanticipated outcome" (Banja, 2004; Berlinger, 2005).

- Patients want to know what happened, without having to file a lawsuit to find out. They want "justice," which means that when all is said and done they want to perceive that the "right thing" was done on the matter.

- To address their underlying hurt, sense of fairness, and concern for others who might go through the same ordeal, they want access to a full range of standard solutions, not just money; this includes acknowledgement and apology for errors, corrective action, and the opportunity for forgiveness.

- And they want this to happen with a minimum of stress, time, and disruption to their lives.

- Most important for the tort reform debate, providers who may have committed a medical error—whether as a one time event or, less frequently, a repeated occurrence—need their own version of the same solutions: understanding of what happened/acknowledgement/ opportunity to apologize; opportunity for appropriate restitution, corrective action, and the receiving of forgiveness from a patient or family, admittedly often possible only after the other solutions are in place.

The snag occurs, of course, in finding a safe forum to address these interests, especially when the parties may have legitimate differences of opinion on the basic elements of every case: liability (did anyone do wrong?), damages (how much, to what extent) and remedies (acknowledgement/apology, restitution, corrective action, and forgiveness).

VII. The Hidden Culprit in Medical Malpractice Costs: Adversarial Litigation

The current system of issue resolution in medical malpractice says this to providers and patients after there is an unanticipated outcome: "You may have been cooperating with one another in all aspects of care up to this point, but now you must stop that; you are now adversaries and therefore positive and constructive communication between you will cease as this matter is put in the hands of your respective trial attorneys."

- The adversary model of justice calls for the attorney advocates to position the case for a favorable verdict from a higher authority (not the parties themselves, as is the case in interests-based negotiation and mediation). This is usually a judge or jury and, in some variations on this theme, the higher authority is an arbitrator, or a medical panel of experts (Common Good).

- Even though over 90% of these cases will settle without ever getting to court, the fear of being found "wrong," with a possible large damage award handed down as the result, makes it hard for defendants to offer a simple acknowledgement of wrong done, reasonable restitution, and, if appropriate, other corrective action to resolve cases.

- Trial attorneys on both sides, who are required to "zealously" represent their clients, must juggle the often contradictory roles of negotiator (diplomat) and litigator (warrior) when they represent the client in both phases.

- If alternative dispute resolution is used, it occurs late in the process, after expensive discovery and heightened financial and emotional investment, so that the best the parties can achieve is often a courthouse-steps compromise satisfying to neither side.

Under the current system, hospitals, elder care institutions, and insurance carriers as defendants have no way to keep a patient or plaintiff's attorney from launching this expensive process. From the patient and family point of view, they have no choice in the kind of attorney representation they will get. It will be a contingency fee attorney who will take the case for no up-front money, with the understanding that the fee will come on the back end from a substantial percent of the award or settlement. The system is wired—even with tort reform in place—to be all about money. "I'm Sorry" laws aimed at allowing doctors the human expression of regret have little or no effect on the ultimate focus of the case: to pay or not to pay.

While health courts streamline the evaluation process by experts, they provide win/lose solutions that give no relief to physicians and patients in addressing all of their key interests: speed, justice, and preservation of the provider-patient relationship.

VIII. Upstream Solutions Save Money

Unlike downstream solutions that involve tinkering with what will happen to the case when it reaches a judge or jury, upstream solutions focus on prevention of incidents through patient safety initiatives, early disclosure of errors, and the use of confidential, protected and collaborative forums for early resolution of cases, prior to lawsuits being filed.

The precedent outside health care is impressive. Toro, Halliburton, and other corporations save up to 80% annually in litigation-related costs and expenses by rewiring upstream procedures to resolve cases before the adversarial litigation processes begin, and General Electric reports "double digit millions" saved in avoided litigation through its "early dispute resolution system" (Slaikeu and Slaikeu, 2002). Coca-Cola Enterprises, Shell, and others use legal consultation plans for employees to hire attorneys on an hourly fee basis to represent them in mediation and arbitration, instead of litigation (Slaikeu and Hasson, 1998).

Elsewhere we have shown how hospitals can modify tools from employment and commercial dispute resolution to create early resolution systems that pass the tests that tort reform fails (Slaikeu and Slaikeu, 2002) and others have also reported on programs that address the advantages of early detection, disclosure and early resolution of professional liability claims (Arnst, 2006; COPIC, 2000; Kowalczyk, 2005). Based on lessons learned in a wide range of organizations and industries, best practice for the early resolution component of upstream solutions includes the following: (a) linking of a "preferred path" (collaboration first, higher authority second) to the organization's mission, and integrating this into all procedures that govern resolution of issues for patients/residents/families and staff; (b) skills training to resolve issues at the staff level through the use of constructive communication and collaborative approaches; (c) support for all parties through an ombuds function (confidential, off-the-record assistance); (d) change in use of attorneys, with negotiation specialists engaged first and trial attorneys as backup, to be used only if needed; and (e) rigorous evaluation of the relationship between these systems changes and reduced costs (legal expenses and indemnity) and increased satisfaction of the parties.[4]

[4] For information on tools that apply these features in organizational settings, including hospitals, elder care, and physician practices, contact kslaikeu@chorda.com or call 512.482.0356.

IX. The Role of Attorneys

Of special interest in the upstream model is how to resolve disputed claims without a litigation battle. Since most cases, even the very large ones, settle without ever going to trial, the issue is not settlement, but *when* the case will close and at what cost: after expensive unilateral discovery and billable hours on two or more sides (which makes 50% or more of the award go to trial attorneys), or much sooner after disclosure of a potentially compensable event.

There are several hopeful solutions on the horizon that provide an answer to the problems that tort reform thus far leaves untouched. Collaborative Law (Chanen, 2006) and the ***Two-Track*** model of attorney representation (www.twotracklawyers.com) both draw on the British distinction between solicitors (non-trial) and barristers (trial) in order to control legal expenses and, most important, increase the satisfaction of the parties by addressing the underlying interests of both plaintiffs and defendants.

In these models, medical malpractice cases go first to collaborative attorneys whose goal is to address the human and legal requirements of each party, and resolve the case without the expense, stress, and broken relationships that occur in adversarial litigation. Using confidentiality protections currently available in the law—attorney/client, joint defense, settlement talks, mediation—the aim is to create a safe forum for patients/families, physicians and institutional representatives to conduct cooperative discovery, which meets the needs of all parties to achieve an understanding of what happened and the dimensions of liability. They then turn to a range of both economic restitution and non-economic acknowledgement/apology and corrective action to resolve the case. By providing for consultation with a litigator on each side, the ***Two-Track*** version protects the parties' rights to litigate if the collaborative efforts fail, and allows for informed choice before final settlement of a case.

The outcome of a Track 1 collaborative event is either closure of the case or transfer to litigation. Closure can occur anywhere along the standard solutions continuum, from no payment (the

parties agree that there was no liability or compensable damages, or settle on a non-economic solution), to a negotiated package that includes all four elements (acknowledgement/apology, compensation, an agreed upon corrective action to prevent future occurrences, and forgiveness). In contrast to traditional litigation, the parties cooperate with one another to fashion remedies that address the interests of all. Participation in a Track 1 collaborative event commits the parties to nothing more than cooperative discovery under rules of confidentiality, and interests-based negotiation or mediation, in order to reach a mutually agreeable solution.

Especially important for psychological healing, these structured collaborative processes allow the parties to debrief on critical elements of the case, moving through the resolution steps expeditiously, with the option of using mediators to achieve the benefits of a facilitated conversation on complex matters that have psychological, legal, professional and economic implications for the various parties.

In ***Two-Track***, attorneys who take the case for their clients through the Track 1 collaborative processes of negotiation or mediation are paid on an hourly basis. Contingency fees are preserved exclusively for Track 2 events, where attorneys represent their clients in the adversarial processes of arbitration or litigation only if Track 1 negotiations are unsuccessful. Also, any real or perceived attorney conflict of interest (more billable hours in litigation than in Track 1 collaboration) is eliminated. A ***Two-Track*** Procedures Manual (www.twotracklawyers.com) can be customized by agreement of the attorneys and the parties to address their unique requirements. Evaluation protocols allow comparison of outcomes on the key dimensions of user satisfaction and—most important for actuaries who set premiums—total payout and the portion that goes to patients and families as opposed to the transaction costs of legal representation.

X. Who Loses and Who Gains with Upstream Solutions?

Trial attorneys lose revenue in the upstream model. Attorneys who specialize in negotiation/mediation advocacy, paid hourly, gain new billable work. Litigation (Track 2), including contingency fees, is protected in the ***Two-Track*** model, though used as backup only.

Patients and families, physicians and other clinical practitioners are the primary benefactors since they are provided with a safe forum to communicate and negotiate with one another about unanticipated outcomes, and to fashion interests-based solutions, while retaining their rights to litigation. The cooperative patient-provider relationship is preserved throughout. Hospitals gain a safe early resolution forum which complements patient safety initiatives to prevent errors, and disclosure initiatives that heretofore have meant, "Get ready to be sued."

American businesses and society as a whole gain since the upstream model eliminates the need for defensive medicine and reduces the portion of total claim dollar payouts to attorneys from the current level of 50% or more down to a benchmark of 20% of the total.

XI. Tort Reform Without Legislation

All of which raises the question: instead of continuing the tort reform battle, why not move upstream and implement solutions that will reduce to a trickle the number of cases that end up in litigation? Thinking of the known interests of patients, physicians, and provider institutions for solutions that allow them to continue as partners even in the face of an unanticipated outcome, why not invest in systems that address these human needs and professional interests while also reducing the inordinately high litigation expense component of medical malpractice insurance?

XII. Frequently Asked Questions

1. How can I be sure our institution needs early resolution tools for professional liability?

The diagnostic test is this: Do you typically negotiate with a plaintiff's attorney who is paid by the hour, or is there a contingency fee? It matters little if a hospital uses mediation, arbitration, or any other process as long as the patients and defendants are represented by the same trial attorneys who will ultimately prepare for and take the case to court if there is no closure through a collaborative process. Extensive experience in other settings indicates that having trial attorneys in the lead role for the upstream phase of negotiation drives costs up so that the total attorney allocation will be 50% or more, instead of the benchmark 20% of total payout.

2. How does this fit with mandatory disclosure of errors?

Mandatory disclosure is incomplete if it is not accompanied by an early resolution capability. As Dr. John D. Banja (2004) has indicated, even when done well, in most hospitals mandatory disclosure leads to the "get ready to be sued" phenomenon. In order to save money and improve satisfaction, mandatory disclosure must be coupled with an early resolution system upstream.

3. Does early resolution work on complex and large cases?

Yes. Large cases settle in the current system on the courthouse steps, so *settlement* of large and complex cases is not the issue. *When* these cases settle is the key issue. The early resolution model orchestrates all procedures and activities and works with dedicated professionals (who are excluded from court activity) to unbundle these complex cases and resolve them early.

4. **But some of these cases take years to determine damages, so how can they be resolved with an early resolution event?**

   Skilled Track 1 attorneys can use outside experts to calculate potential future financial needs and reach agreement on financial settlements even before the case has played itself out entirely, or they can build in provisions for escalators based on specific features. Furthermore, Track 1 attorneys in consultation with Track 2 attorneys can negotiate private and binding contractual agreements that address issues such as statute of limitations or other legal requirements.

5. **How do we know that the early resolution solution is in fact responsible for the result and not something else we are doing in the hospital?**

   The use of a control group with a comparison of cases allows the determination of which intervention leads to which outcome.

6. **In evaluating this, we have old cases and new cases. Does the new system apply to both?**

   It is possible to apply the new system to new cases only and compare these with a control group or with comparable cases from the historical loss runs. It is also possible to structure a specific convening event for existing cases and close them with a Track 1 approach.

7. **If we settle 80% of our cases without paying anything at all, how does this program help us?**

   The key metric is not how many cases are settled with no payment, but rather the percentage of the total dollar that goes to attorneys' fees and to patients/families. As an example, for one insurance carrier, over 80% of claims were settled with no payment at all though 70% of total claim dollars went to attorneys' fees on both sides.

8. It seems like our claims manager is actually our Track 1. Can this work?

Yes. The claims manager may be the lead negotiator with outside defense counsel in the Track 2 role.

9. If this works for professional liability, how about other issues such as employment conflict or nurse-physician relationships?

The same early resolution tools used for professional liability can be customized for these other areas as well. Precedent from other industries has proven the financial effectiveness in employment and commercial relationships, even before their application to professional liability (Slaikeu and Slaikeu, 2002).

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XIV. About the Authors

Karl A. Slaikeu, Ph.D., founder and CEO of CHORDA Conflict Management, Inc., is a psychologist, mediator, and internationally recognized author. He formerly held a tenured faculty position in the Department of Psychology at the University of South Carolina, followed by teaching in the Department of Psychology at the University of Texas at Austin. Dr. Slaikeu is the author of *When Push Comes to Shove: A Practical Guide to Mediating Disputes* (Jossey-Bass, 1996), and co-author with Ralph H. Hasson of *Controlling the Costs of Conflict: How to Design a System for Your Organization* (Jossey Bass, 1998), as well as other books and articles on crisis and conflict management. His formal education includes a B.A. from the University of Nebraska-Lincoln, M.Div. from Princeton Theological Seminary, and M.A. and Ph.D. from the State University of New York at Buffalo. Dr. Slaikeu is known for his innovative application of conflict principles to help individuals and organizations capture the benefits of collaborative conflict resolution. Clients include health care institutions, insurance companies, and organizations such as GE, Shell, Coca-Cola Enterprises, and Coors, as well as governmental, religious and non-profit organizations.

Diane W. Slaikeu, J.D., Executive Vice President, CHORDA Conflict Management, Inc., is a graduate of the University of Nebraska-Lincoln (B.S.), and the University of Texas School of Law (J.D.). Ms. Slaikeu is the co-author of "Confidential From General Counsel to CEO: 'I'm Fed Up, and We're Not Going to Take This Anymore!'" (*Journal of Health Care Law and Policy,* 5:2, 2002). Her professional experience includes legal work in the Texas and South Carolina state legislatures, and a general civil litigation practice, which evolved exclusively into a negotiation and mediation practice. Ms. Slaikeu also has extensive experience as a trainer in communication skills and mediation for managers and in-house dispute resolution specialists. A member of the State Bar of Texas, the South Carolina Bar Association (inactive), the Association of Family and Conciliation Courts, and the Association for Conflict Resolution, Ms. Slaikeu has recently served as adjunct faculty at the Strauss Institute for Dispute Resolution of the Pepperdine School of Law, Abilene Christian University, and Austin Presbyterian Theological Seminary.

Katherine A. Stewart, M.A., M.B.A., Vice President Client Services, CHORDA Conflict Management, Inc., has over 15 years of management experience, including international assignments, in a wide range of industries. She has taught conflict management, intercultural communication, organizational communication, and courses focusing on the Arab-Israeli conflict for numerous corporate clients as well as the University of Texas at Austin, Jacksonville University, and Tec de Monterrey, Mexico, and The Art and Science of Negotiation in the Graduate School of Business, the University of Texas at Austin. She is a graduate of the University of Florida (B.A.), and University of Texas at Austin (M.A. Middle Eastern Studies, M.B.A.), where she is currently completing a Ph.D. in Communication Studies. Her research interests focus on organizational and intercultural communication and collaborative processes. Ms. Stewart is a practicing mediator and experienced mediator trainer.