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Mediation – a treatment for stressed health care services?

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Introduction – some underlying issues

Health workers today need considerable agility of mind to accommodate the constant changes being driven by demographic change, scientific and technological developments, budgetary constraints and organisational adjustments, all of which can disrupt established fiefdoms, loyalties, and ways of working, and pull individuals in different directions. In all too many cases, these pressures can result in debilitating stress or even mental health problems. A workplace mediator called in at this stage will often find the interpersonal issues involved are being driven by deeper underlying issues, some of which are touched on below.

Diversity of attitudes. The NHS probably has the most diverse, multicultural workforce in the UK, some of whom may be recent arrivals and unfamiliar with the UK's equality legislation and resulting expectations of their co-workers. Where attitudes reflect a more hierarchical than collegiate approach, especially in the flatter, multi-disciplinary structures being adopted for the delivery of modern health services, this can result in diminished contributions from colleagues or, worse, to antagonistic interpersonal relations with all their potential for causing poorer outcomes for patients.

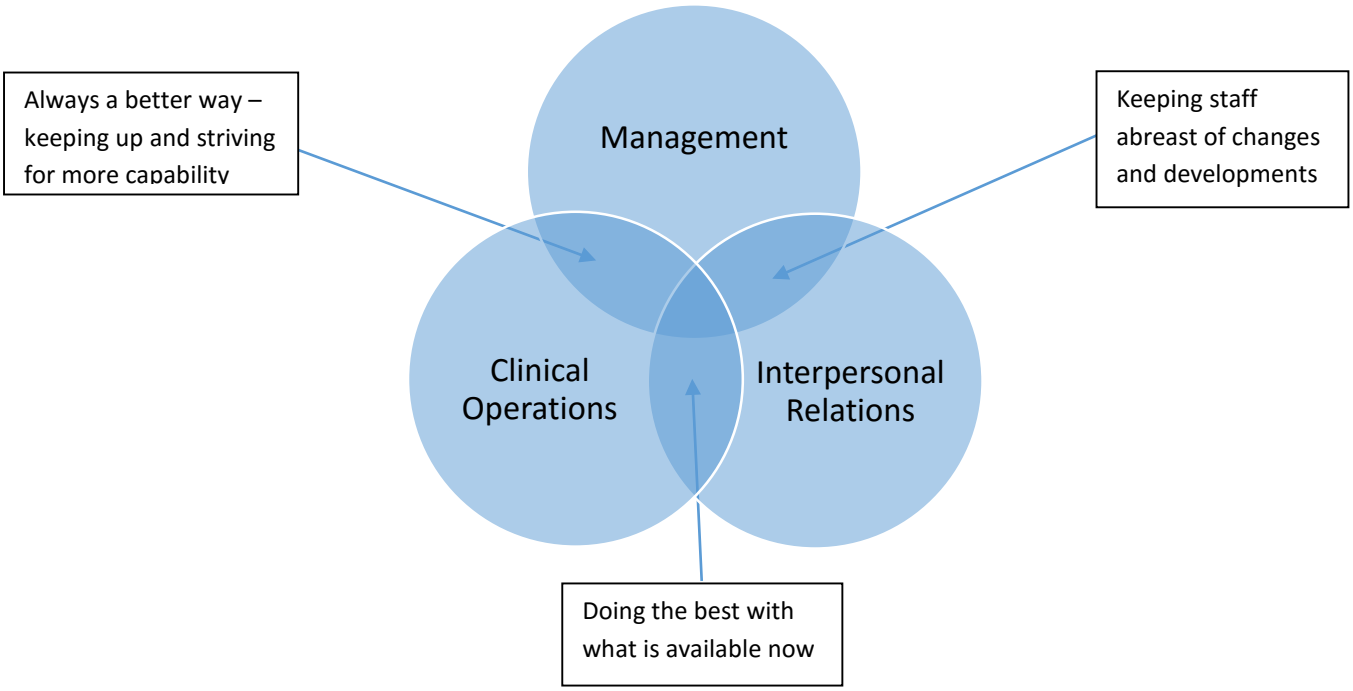
Fewer, better Centres of Excellence. The development of centres of excellence that combine specialists in fewer multi-disciplinary teams (MDT) to handle certain complex conditions, rather than retaining less capable teams at every hospital, requires the integration of various specialist clinical pathways and adoption of agreed protocols to provide a coherent new pathway with sufficient standardisation to enable effective inter-disciplinary working at all levels. This can be demanding, need a collegiate and highly co-operative approach and may involve breaking new ground. The process can push the bounds of compromise for some disciplines and, for some individuals, may appear to threaten or diminish their hard-earned status and authority.

Furthermore, the clinicians leading the development of these new centres will often identify a requirement for new or additional facilities, equipment and trained personnel, which will often encounter constraints from management, due to the unanticipated cost and competing demands for resources elsewhere. This can lead to friction between management and clinicians, especially where early expedient solutions start becoming institutionalised, thereby diminishing achievement of the level of excellence intended and potentially putting patient safety and outcomes at risk.

Decentralisation to Community Health. Meanwhile, efforts to limit the scope of hospitalisation to the acute phase of treatment only, with more pre and post-acute treatment being decentralised to community health providers, can give rise to different, often stress-related workplace tensions. Community-based clinicians may feel isolated from some mainstream developments and be constrained by the capacity and quality of care available in the community. In particular, the absence of joined-up communications systems and trained staff needed for a seamless transition to and from hospitalisation, are constraining the transition to more community health care and imposing considerable stress on those working there.

Friction Points. Ensuring patient safety and continuity of appropriate treatment in these diverse, continually changing and often fragmented arrangements places considerable strain on the interpersonal relations of those involved. When a mediator is called in to handle what appears to be an interpersonal dispute they will all too often find that the real problem lies at one or more of the systemic frictions points shown in the diagram below and the question then is: how can mediation help?

Systemic Friction Points



How can mediation help?

Almost invariably, a referral to mediation arrives based on concerns about interpersonal relations between individuals but as the mediator starts 'taking the story' from those concerned, it quickly becomes apparent that the real problem lies at one or more of the Venn Diagram interfaces. Establishing the true nature and cause of the dispute is seldom straightforward as participants are concerned about the implications for their career, that there is some implied failure or wrong-doing on their part, and that they are facing judgement by some unknown third party.

The strong ethos and loyalty binding health professionals will often be a further barrier and a mediator will usually need to overcome the participants' strong inclination to procrastinate and avoid having to become engaged. Providing a full and reassuring explanation of the protected status of the mediation process and how it works has proved to be an effective key to unlocking full participation.

The provisions for privacy, confidentiality and without prejudice discussion afford the essential safeguards participants feel they need to protect their careers. In particular, the provision for confidentiality between an individual and a neutral, external mediator with no organisational loyalties provides a basis for trust, which once achieved, becomes the tipping-point that allows participants to unburden themselves of professional concerns and buried resentments without fear of professional or

organisational retribution. Any sanitized, releasable version of what emerges in this initial investigation phase frequently comes as a considerable surprise to management and colleagues alike.

All referrals, be they for a dispute between individuals, within a small, single discipline team or involving a large MDT pose a unique challenge for the mediator. Very few will follow a predictable path and most will require the development of a bespoke process to handle them. In some cases, the mediator's initial investigation will uncovered problems that management recognise they need to handle themselves, usually leaving the mediator to repair some one-to-one personal relationships that have broken down when those concerned pursued, with considerable professional passion, different solutions to the problem(s) that have been reclaimed by management for resolution.

Recently, mediation has also been used successfully to resolve disputes between clinicians and patients/relatives, with access to this quick, relatively stress-free, inexpensive, private and confidential process being much appreciated by all concerned.

There is an element of management consultancy or, perhaps more accurately, "helping the organisation to see themselves as others see them" involved in most referrals and the following case studies provide a flavour of how a mediator and the mediation process can help resolve these often multi-faceted disputes.

Case Study 1

The local Clinical Commissioning Group called for a review of the arrangements for a large MDT that handled acute cases in the hospital and less severe cases in the community, with a view to making savings through more emphasis on health provision in the community. This led to friction between the hospital based and community based elements of the MDT, with hierarchically inclined Principals based at the hospital resisting any changes, which they saw as potentially resulting in some diminution of their status. This provoked a response from specialists working in the community, who could see the benefits of the proposals and felt constrained by hospital-based consultants whose focus seemed to them to be too immediate and confined to whether chemical or surgical intervention was required at the acute stage rather than on developing a longer term treatment plan tailored to each patient's needs, for delivery by an optimum combination of specialisations such as physiotherapy, occupational therapy, psychology and nursing.

To save time and as an experiment, the mediator asked the participants to produce a short statement of what they felt was wrong or needed to

be addressed, and circulate it by email to all the others – and then, to ensure all the voices were heard, to be prepared to deliver their statement to colleagues at the mediation. After a slow start and some prompting, the exchanges occurred.

The mediation was attended by over 20 people, from the MDT, Contracts/Finance, HR and Service Support. During the arrival coffee stage, 4 attendees, selected at random, were shown an office binding machine from different, view-limiting angles, and then asked to draw what they had seen. These diagrams were then used in an opening by the mediator to show how different, narrow perspectives influence perceptions and the importance of communication if everyone is to see the bigger picture. Even then, of course, everybody will retain their own perceptions of the bigger picture's implications for them and others.

This was followed by an active listening phase in which the statements were read out and no responses other than questions of clarification were allowed. During the refreshment break that followed, participants were required to cluster similar issues from different statements into a consolidated list of the issues affecting the MDT.

On re-convening, the participants read out their lists for comparison with those of colleagues and the subsequent discussion resulted in a broadly agreed list, which was disputed in part by some.

Participants then broke for lunch during which they were tasked to develop their solution to the issues and/or identify and prioritise the demands they would make if they were to support a solution proposed by someone else. The plan for the afternoon was to allow potential leaders to come forward with proposals for negotiation with colleagues – and by accommodating their demands, to build a constituency of support until a clear majority emerged for a solution that would be acceptable to all, and would then form the settlement agreement. Fortunately, the mediator had remembered to expect the unexpected.

The participants stood in a circle with a mediator in the middle – and well outside his comfort zone! Earlier, the finance/contracts representative had revealed a broad and balanced understanding of the situation so the mediator had primed him to open with a proposed solution. After a slow start, and with the mediator engaging some of the more reticent attendees, the discussion got going - but not along the lines the mediator had anticipated.

During the debate, the issues coalesced into three interconnected areas: behaviour, the hospital/community divide, and the need for a more comprehensive clinical pathway. Community-based specialists were frustrated by having to refer upwards to the hospital-based consultants on matters for which lateral referrals would seem to be appropriate, for example, allowing a physiotherapist to refer a patient

to a psychologist to establish between them the extent to which a particular problem may be physical or mental, before reporting back to the rest of the MDT. Proposals to develop the clinical pathway to accommodate more efficient arrangements were resisted by some consultants and led others to raise the issue of arrogant or overly hierarchical behaviour, which was also seen as contributing to the hospital/community divide.

The turning point came when the mediator asked why the team did not simply adopt the behaviour set out in the 'GMC - Management for doctors', paragraph 50, that had been issued before the mediation. The Clinical Lead, effectively '*primus inter pares*' among the consultants, asked the mediator to read the text – emphasising her request by repeating it firmly. This public exposition of how people should behave, including to some who seemingly had not bothered to read it, yet alone comply with it, shifted the balance of the debate, overcame some blocking tactics and quickly led to agreement to the formation of three working groups, one of which would draft a Team Charter covering the team's objectives, values and behaviour, for the adherence of all; another to develop proposals responding to

the Clinical Commissioning Group's call for a review of how to shift more service delivery into the community; and a third to develop a more comprehensive clinical pathway, which would enable specialist expertise to be employed more readily and effectively, to the benefit of patients.

The three team secretaries each agreed to support a working group and the other participants then clustered onto the secretary for the working group they wished to support. Three weeks later, when the mediator called back to check on progress, the working groups each had their project plan in place, were meeting regularly and developing (and sharing) their respective solutions.

Reflections on this case study include:

- The importance of all the voices being heard in order to overcome established opinions and the selective use of evidence by some.
- The need to combine and refine multiple perspectives until an agreed picture of the problem emerges and can be addressed (cf. Narrative Mediation).
- The mediator being prepared for unexpected developments during a 'mass-mediation' and allowing them to flourish. This involves retaining control of (and faith in) the process whilst the participants provide the content and momentum towards a settlement, which may not be in the direction many had anticipated.

Case Study 2

A team of five consultants covering various aspects of the same specialisation, based in a mainly community health facility, had become of concern to management because they were operating as five separate individuals rather than a MDT, to the detriment of the service being provided. Although there were regular patient review meetings, these were perfunctory, could quickly become fractious and did not adequately address management and governance matters, which raised concerns at higher levels about patient safety. Rather than responding positively, the consultants seemed to want to distance themselves from management and just get on with doing things their own way, in their own little world.

The work schedules of those concerned meant that there was only one two hour slot each week available for mediation with all the consultants present. It was agreed that two slots would be allocated to the mediation, two weeks apart, with the first session being devoted to establishing the issues to be addressed within the team and the second to developing possible solutions.

There was some initial reluctance by the consultants to engage with the process and the mediator had to provide considerable advice and reassurance about what was involved to secure their full participation. There was also a distinct reluctance to expose the issues affecting interpersonal relations and so the mediator decided that rather than trying to take individual stories, he would use a version of the game of 'Consequences' to see what was revealed in the first session.

The mediator prepared 10 questions designed to draw out the underlying problems. The participants wrote their answer to each question in a note pad, turned to a blank page and passed the pad to their neighbour. Once all the questions had been answered, the notepads were shuffled and re-distributed. The mediator then read out the question again and the participants read out the answer in front of them. The mediator then facilitated a discussion of what had emerged to clarify the issues to be addressed at the next session.

Reflecting on the session, the mediator felt the outcome had been rather superficial, amounting to little more than a need for better communication and a latent 'them and us' hostility to management. Then, midway between the two sessions, the mediator received a telephone call from one of the participants to say that the main issue affecting the team had not emerged from the notepad passing exercise but needed to be addressed.

It emerged that one of the more outspoken members of the team had a personal relationship with a principal manager at NHS Trust level and the other members of the team believed that this conduit was being used by him for inappropriate discussions about the team and performance of individuals that affected their careers. Whilst discrimination was not alleged, it could be implied from the ethnic makeup of the

team and that of those in the personal relationship concerned. The mediator checked with the principal concerned, who admitted to one informal discussion in which he had drawn on the experience of his colleague working in the team to support his decision, and acknowledged the difficulty this could create.

With the agreement of the complainant the mediator warned the Team Clinical Lead *(primus inter pares)* and individual concerned before raising the issue at the start of the next session. It was quickly apparent that a boil had been lanced and the individual concerned was genuinely horrified by the impression created among his colleagues by his personal relationship. After much reassurance on his part, peace was restored and relations visibly improved. A draft Team Charter, provided by the mediator, was developed by the participants at their next two weekly meetings and the final version was then laminated and put up on the notice board for adherence by everyone associated with the MDT, which has been functioning very effectively since.

Reflections on this case study include:

- The importance of uncovering the real underlying issues when participants are hesitant about revealing them because of the wider implications and the danger that a simplified approach may turn out to be no substitute for taking each participant's story in a probing, face-to-face exchange.

- Mediators need to be prepared to probe sensitive issues uncovered during the mediation process with third parties, usually in higher management, and agree with those concerned how best to address them in the mediation.

Case Study 3

A Clinical Commissioning Group decided that a specialist capability being delivered by a multi-discipline team at two of their hospitals should be tendered and consolidated into a single centre of excellence at the hospital offering the winning bid. However, post-contract award, the service was disrupted by disputes between the clinicians concerned and the problem was referred to mediation with a view to resolving what was thought by management to be purely interpersonal differences. Over 20 clinicians from various specialisations and support staff made up the multi-disciplinary team (MDT) and their line management.

The protected status of the mediation process, especially the confidentiality between participants and their mediator, gave participants the confidence to open up and express their real concerns, which turned out largely to be about the appropriateness of the contract award. The winning hospital had included facilities in their bid which had not subsequently been provided, and without which patient safety was at risk. This undermined efforts to reach agreement on the clinical pathway, protocols and associated arrangements between the two merging clinical teams, because some saw such efforts as seeking to institutionalise a sub-standard solution instead of fulfilling the tender requirements and delivering a fully compliant, excellent service.

Having heard everyone's story, the mediator felt that this was as much a commercial, financial and infrastructure problem as it was an interpersonal one and the clinical excellence aspired to could only be delivered when these associated matters were addressed. The mediator consolidated the issues raised in interviews, without attribution, into a report that was then discussed with the NHS Trust Chief Executive and Medical Director. They placed the

mediation in abeyance, pending the outcome of a Royal College inspection that confirmed the mediator's findings and gave clear guidance to the Trust on what needed to be done.

The mediator then handled a number of one-to-one mediations with clinicians whose professional relationships had broken down, to enable them to reconcile their differences now that the appropriate developments were being put in place. Thereafter, the MDT were able to develop an agreed clinical pathway and associated protocols to underpin the smooth integration of the various specialist and support staff, with everyone comfortable that they were conforming with best clinical practice and meeting key patient safety standards.

Reflections on this case study include:

- The protected nature of the process and use of an independent external mediator gave participants the confidence to speak candidly without fear of damaging their career prospects.
- What were thought to be interpersonal issues were actually deeply held concerns about patient safety and the way in which delivery of the service using best clinical practice was being constrained by management.
- The lack of agility in implementing changes and extent to which management can become blinkered by financial and resource constraints without realising it.
- The strain placed on professional relationships as clinicians handling full treatment schedules struggle to win priority for the

resources required from management and for safe interim clinical arrangements with colleagues.

- The extent to which the mediator must be prepared to address organisational, commercial and clinical frictions behind the interpersonal issues, when handling this type of mediation.

Case Study 4

The provision of a particular specialist treatment is split between an in-house NHS team of consultants and specialist nurses, and a contracted private health provider. Renewal of the contract is overdue and the tender preparation has highlighted differences between the team and management over what should be provided by whom. Two of the in-house consultants are at loggerheads over the role of the unit and scope of the service to be provided. Patient pre-operative and post-operative care and monitoring is patchy and treatment at home is not currently being provided. There are capacity constraints across the board, including in the contracted portion of the treatment. Interpersonal relations are fractious and angry outbursts not infrequent due to differences over treatment protocols, which disrupts the smooth functioning of the Unit, both within the in-house element and between them and the contracted private provider.

Despite acknowledging, during the mediator's story-taking, that capacity constraints and clinical differences were major contributors to their interpersonal differences, all three in-house consultants saw no opportunity in the renewal of the contract to make improvements.

Perhaps unsurprisingly, the private provider's local manager held the opposite view, citing as one example that the in-house nurses felt their antiquated IT system tied them to data inputting at the expense of other clinical work, and was causing both of them to look for job opportunities elsewhere, whilst the contractor was providing a modern IT system and handling the data inputting in a similar facility in an adjacent hospital.

Reflecting on the story-taking sessions, it seemed to the mediator that the differing views on the role of the specialist unit and scope of its service, the blurred interface between contracted and in-house provision, capacity constraints, and clinical differences over patient handling, combined to generate a debilitating level of stress throughout the unit.

As a result, the mediator sought assurances from the management team, which were provided, that they would ensure the contract tender document would reflect the entire clinical requirement and give bidders the opportunity to offer a new service delivery model, together with modern facilities and the resources to deliver it, provided they remained within the available budget. The organisation and roles of the

NHS in-house team would then be adapted by the NHS Trust to cover requirements not included in the contract.

The mediator was then able to share this assurance with the participants at the subsequent mediation, which involved three two sessions of two hours each, some two-three weeks apart. In the first session, the consultants agreed that they could handle their clinical differences without any external input and all participants accepted that they needed to stay close to the tendering process to get as much as possible from the contract. They also agreed that there would still need to be an in– house team as the private provider would only do what was in the contract and there were always other requirements to be addressed.

During subsequent exploration of the extent to which misunderstandings and upsets resulted from their tendency to communicate on a one to one basis from their own, rather than any collective team, perspective, the closed 'hub and spoke' style of team management by the Clinical Lead came under discussion. Whilst it was recognised that this style of management insulated individuals from wider distractions and left them free to concentrate on patient requirements, it also insulated the Clinical Lead from and discussion or disagreement over

how developments affecting the Team were being dealt with. One effect of this was that the unit was functioning as a group of individuals each fighting their daily battle and with little or no incentive to spare time or effort for colleagues. Another effect was creeping stagnation, with individuals becoming institutionalised and accepting mediocre standards because reaching for excellence alone was too difficult. Realising this both energised and empowered the Team and they committed to holding a weekly Team meeting at which developments and improvements to their service would be discussed and implementation measures agreed, to provide the Team with common goals and a collective approach to achieving them. Perhaps unsurprisingly, this settlement left the Clinical Lead feeling isolated and having to adapt to a much more inclusive approach in which discussion and communication will be the norm, rather than the exception, in future.

Reflections on this case study include:

- NHS staff are in danger of becoming institutionalised and so immersed in struggling on in the face of organisational and resource constraints that they do not see or feel empowered to explore innovative options for improvement, especially where contracted third party external providers are involved.
- Mediators need to judge when and how to engage higher management to address underlying issues within their ambit, to provide for an holistic approach that would make a settlement sustainable, without losing the trust of participants by exposing their confidences.

- Mediators must be prepared to 'speak truth to power' and expose deep seated issues revealed to them for handling by management if they are to facilitate sustainable solutions, rather than just pursuing a superficial 'sticking plaster' approach to provide a temporarily fix, which sometimes seems to be what management would prefer.

- Hard-pressed clinicians focusing on patient care can have little patience for management matters that add to their workload. But differences between individuals over clinical practice, the scope of the service to be provided and the developments required to achieve it, can quickly impact on the performance of the Team, stress levels and the state of interpersonal relations. To minimise differences, and optimise their performance teams need an inclusive approach in which all voices are given a sympathetic hearing before accepting collective responsibility for the outcome – and despite the tempo and pressures of everyone's work, this does require an investment of time and personal involvement in team meetings.

Conclusion

The constant dynamic change that is characteristic of modern healthcare provision imposes heavy demands on those working in the system and ready access to mediators who understand the context and can intervene early to minimise emerging friction would contribute significantly to the smooth operation of these essential, specialist services. However, when working for health service providers, mediators must develop an understanding of the context and be prepared to handle some wider underlying issues giving rise to referrals if they are to be fully effective. In particular, mediators will need to remain aware that:

- Interpersonal relationships are often aggravated by systemic friction at the Clinical and Management interfaces, with hard pressed clinicians juggling full treatment schedules with management requirements involving competition for resources and the demand for efficiency measures that may impact on established regimes and habits. Mediators should expect to encounter organisational, budgetary and clinical frictions behind the interpersonal issues giving rise to the referral to mediation.

- All voices need to be heard and a common picture developed that reflects the multiple perspectives concerned if a sustainable solution is to emerge. Mediators should be prepared to exploit the confidentiality of the process and their independence from the organisation, and dig deeply in the one-to-

one sessions to uncover underlying concerns that participants may hesitate to reveal, especially any involving patient safety.

- In large Team mediations the mediator needs to trust the process and allow unexpected developments to flourish – remember that the mediator handles the process whilst the participants decide the direction and content.

- Mediation may become multi-dimensional, depending on whether - or which, management representatives are participating, as the mediator may need to make higher management aware of underlying issues, especially any involving patient safety, and establish with them the extent to which there is scope for any organisational, budgetary or infrastructure changes being mooted by the participants as part of the emerging solution.

Bio:

Tom is a widely experienced mediator who has been involved in conflict and dispute resolution in one form or another for most of his working life, at community interfaces during peacekeeping operations in the Armed Forces, during high-level diplomatic negotiations in NATO, policy development and budgetary management in Whitehall, and ten years of business negotiations in the City.

Tom is Managing Mediator of Greater London and East Anglia Mediation LLP and his previous appointments include Chair of the Dispute Resolution Panel, NHS South East Coast Strategic Health Authority, Fellow of the Institute for Democracy and Conflict Resolution at University of Essex, and Chair, National Mediation Helpline Provider's Forum. He is a Member of, and is Registered by, the Civil Mediation Council and is currently a member of their Government Relations Committee and Standards & Registration Committee. He also participates in the American Institute of Mediation, ADR Conflict Resolution Group, and Mediation Exchange Group.

Tom is an experienced and effective mediator - 4 cases did not settle in his last 50 mediations.