

## Mediation Training Enhances Conflict Management by Healthcare Personnel

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### Abstract

**Objectives:** Mediation training can prepare healthcare professionals to manage conflict effectively in today's changing healthcare system. The primary purpose of the study was to measure the perceived comfort level of healthcare professionals with conflict before and after mediation training and to determine the extent to which mediation principles were applied within and outside the work setting. Secondary objectives were to observe firsthand transfer of skills and to identify subjects' perceptions of the impact of mediation training.

**Study Design:** A cross-sectional, descriptive experimental design was used.

**Patients and Methods:** Over a 3-year period, 173 healthcare personnel, chosen from a community not-for-profit hospital, a health maintenance organization, a managed care insurance company, and a skilled nursing rehabilitation setting, received 25 hours of mediation training; of the personnel who underwent training, 130 participated in the pre- and posttraining survey. A Likert scale with a Cronbach alpha of .82 was used to measure perceived differences in comfort level with conflict before and after the training intervention.

**Results:** The comfort level of healthcare personnel with conflict increased significantly ( $P < .01$  or

$P < .001$ ) for all groups of participants after training. The mean pretraining score was 5.92, compared with a mean score of 7.57 after training. Active listening, summarizing, and reframing were the mediation skills most often used by participants after training. Skills were transferred to interactions with patients and peers, and participants noted that they were able to intervene successfully early in problem cases.

**Conclusions:** Mediation training significantly increased healthcare workers' comfort level with conflict, and the skills were transferable to the healthcare workplace. Mediation training in healthcare settings can help resolve conflicts with clients at an early stage and prevent progression to costly litigation.

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Tensions created by a market-driven healthcare system remain a major social policy issue.<sup>1</sup> Changes in medical technology, organizational structures, payment mechanisms, financial resources, and societal expectations create complex issues and challenges with no readily available solutions.<sup>2-4</sup> Consumer dissatisfaction with the healthcare system exists despite advances in healthcare such as better cancer detection rates and improved outcomes for open heart surgery.<sup>1</sup> Forté suggests that unresolved conflict may cause patients to worry that healthcare is "worse than even the media portray it as being" and that consumers may "fail to ask questions because the provider is too busy, thereby lowering their expectations of health-

care providers.”<sup>5</sup> Widespread consumer dissatisfaction has led to legislative proposals to assure patients’ rights and reviews of appropriate lengths of hospital stay after delivery or mastectomy. Employers and patients are increasingly scrutinizing consumer reports on healthcare organizations, physician performance, quality of care, and customer service.<sup>1,5-8</sup>

The authors have conducted innumerable mediations to reduce conflict in managed care settings. A consistent finding among patients who participate in mediation is a feeling of vulnerability and weariness with the disease process, which tends to render them incapable of self-advocacy or of using their insurance company’s internal procedures to seek redress for perceived wrongs. Denial of care because of perceived arbitrary decisions further intensifies patients’ anger. We have further discovered during our mediation sessions that we were often dealing, not with individual ethical issues, but rather with a serious breakdown in communication throughout the system. Mediation offers all parties an opportunity to open communication channels, solve problems collaboratively, and resolve a conflict to everyone’s satisfaction.

Mediation first gained popularity in labor-management disputes and is now widely used in fields such as psychology, psychiatry, law, and social work.<sup>2</sup> It is also increasingly used in healthcare institutions and by healthcare ethics committees.<sup>9-11</sup> Rush-Presbyterian-St. Luke’s Medical Center in Chicago is now using mediation to resolve selected medical malpractice cases,<sup>12</sup> and the United States Post Office is using mediation to resolve sexual harassment cases.<sup>13-14</sup> Mediation is a well-established problem-solving model that emphasizes dialogue and whose success derives from the involvement of all significant stakeholders in the process.<sup>2,9,11,14,15</sup>

An individual’s response to conflict within a work setting is part of an intricate web of overt and covert messages about how conflict is managed at all levels of the organization.<sup>16</sup> The skills necessary to manage conflict can be learned.<sup>17</sup> Although it is acknowledged that conflict management should be part of the curriculum for health professions,<sup>11</sup> these skills are rarely taught.<sup>18-19</sup> Inability to manage conflict can be costly, and Kushell and Ruh caution organizations not to underestimate the power of positive communication in saving the organization time, and ultimately, money.<sup>20</sup> Although unmanaged conflict impacts people at all levels of an organization, the adverse effect of unresolved conflict between pro-

fessionals on patient care outcomes is an even greater concern.<sup>21</sup>

As organizational consultants, we value what Weisbord calls “third-wave management and consultation.”<sup>22</sup> This approach recognizes that learning strategies should include self-awareness, interpersonal group and technical skills, economic knowledge, and social responsibility. Weisbord further suggests that an imperative in contemporary organizations is to pay attention to open-systems thinking that considers economic realities, technologic changes, and notions of dignity and responsibility for the common good.<sup>22</sup>

This article describes the findings of a study that measured the impact of mediation training on the perceptions of the level of comfort with conflict by healthcare personnel. It reports the specific mediation skills that were transferred to the work and home settings and describes actual situations that were resolved by the application of mediation training.

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... BACKGROUND ...

### **Conceptual Foundations of the Training Intervention**

Adults learn best when the context for learning addresses relevant concerns and when they are actively engaged in the learning process. For work-based training to be effective, it should be linked to business needs.<sup>23-24</sup> Therefore, in-depth discussions were held with the respective clients to determine current workplace issues. Workplace issues were translated into scenarios. These specific scenarios, along with other scenarios generic to healthcare and applicable across all settings, were used for mock mediation and communication exercises.

One conceptual base for this research was Festinger’s theory of cognitive dissonance, which suggests that people are motivated to change their conflict management style when (1) presented with new information, (2) there is a change in the environment, or (3) perceptions of an event are altered.<sup>25</sup> An individual’s tolerance for dissonance varies according to the importance of the issues and the number of positive or negative elements.<sup>26</sup> In addition, Deutsch suggests that the outcome of any conflict is influenced by the size and number of issues; number of motives, goals, and values of participants; size and number of principles and precedents; emotional and financial costs; enemy image and loss of face; investment in a position; and time.<sup>27</sup> Therefore, the training intervention taught the sub-

jects how to (1) identify the parties' perceptions of events; (2) listen for an understanding of the perspectives of all participants in a conflict; (3) clarify and prioritize the number of issues presented by the parties to a vital few; (4) acknowledge emotions;

(5) convert positions to mutual interests; (6) reduce the "enemy image"; (7) save face; and (8) evaluate the emotional and financial costs of remaining in conflict. We also used communication theory, ethical guidelines, and the mediation

#### A Case History to Illustrate How Mediation Works

Jill, a 31-year-old, 5'3" Caucasian woman, is considered by MediCal standards to be "disabled" due to morbid obesity. From 310 pounds, Jill's weight dropped to around 275 pounds, the best weight reduction she had ever attained. However, because of a work-related injury and depression from being house bound, Jill was still 75 pounds over the ideal weight recommended by her physician. A friend encouraged her to investigate Roux-en-Y surgery, a safe procedure and the therapy of choice for morbid obesity. Jill's physician was supportive and believed her to be a good candidate, but her insurance company denied her request, informing her that "she did not meet the criteria for this surgery." Angered by the denial, Jill submitted an appeal with the full support of her physician. After consultation with the Corporate Medical Director and Legal Counsel, the case manager called Jill to request that she and her physician consider mediation as the next step, a suggestion they acquiesced to.

As part of the first stage, the mediators heard the narratives from all parties and an agenda was developed that addressed relevant content or substantive issues, emotional concerns, and areas of agreement. Relevant content issues included (1) criteria for denial, (2) ethical issues such as autonomy (including informed consent), (3) fairness for Jill, and (4) the interests of the organization. All parties were concerned about MediCal standards, implications of the Americans with Disabilities Act, and the medical prognosis, including the risks associated with surgery. Emotional concerns included (1) Jill's anger related to the denial, (2) the insurance company's frustration with Jill as a surgical risk, and (3) Jill's physician's frustration at not being able to provide his patient with the best care available. During the mediation, Jill also clearly expressed her desire to lead a normal life. Despite the parties' differences, the mediator uncovered several factors that were held in

common. The parties did come together in good faith to seek a resolution to their differences and there was general consensus that medical care was necessary for Jill and that appropriate care should be initiated as soon as possible; furthermore, all participants wanted to avoid outside litigation.

In stage 2 the mediators facilitated communication between the parties in order to decrease the enemy image and to build understanding of the interests, rather than the positions, of all parties. When empathy was expressed for Jill's life and the impact of obesity on her lifestyle, and once Jill fully understood the HMO's concerns for her safety, solutions began to emerge. Even though Jill failed to meet all of the criteria for the Roux-en-Y procedure, it was apparent that her weight posed greater danger for potential complications from high blood pressure and diabetes, and the case was resolved to avoid these undesirable consequences. The parties agreed to the following: (1) Jill agreed to have fasting blood sugar and blood urea nitrogen tested the following day; (2) Jill's physician agreed to order protein supplement as soon as laboratory results were available; (3) Jill agreed to a psychiatric consult to deal with anxiety attacks that accompanied attempts at exercise and agreed to begin a supervised protein supplement program and continue until the anesthesiologist certified that she was not at risk for postoperative respiratory problems. In addition, the group medical director agreed to a second mediation in 2 months to review the psychologist's and anesthesiologist's assessments of risk. The medical director agreed to the Roux-en-Y procedure after the psychologist and the anesthesiologist indicated that risk was minimized. (It is not possible in the space of an article to reflect the dynamics of the entire mediation process or its attendant agreement.<sup>27</sup>)

process itself as the foundation for building these new skills.

**The Mediation Process**

Mediation can be defined as a process by which a neutral or impartial person(s) assists parties in isolating the issues or concerns that comprise or surround their dispute. The mediator facilitates the communication process so that the parties are able to develop options, evaluate alternatives against mutually agreed-upon criteria, and reach a consensus that addresses their expressed needs and interests. Mediation acknowledges that the responsibility for making decisions rightfully belongs to the parties involved in the conflict. The process is forward looking and is not a fact-finding mission. The mediator holds no significant stake in the conflict, but rather listens for what the parties have in common, pays attention to the emotional and objective nature of the problem, and reflects these observations back to the parties in less volatile language.<sup>28</sup> The mediator facilitates a 3-stage process (Table 1), in which participants have an opportunity to express concerns, fears, expectations, and goals. Ground rules help establish a balance of power between the par-

ticipants, and emphasis is placed on mutual interests rather than on adversarial positions. The agenda developed in stage 1 serves as a starting point for stage 2, during which the parties improve their understanding of the other's perspective, leading to an agreement in stage 3. In the context of this study, mediation addressed interpersonal, interorganizational, and bureaucratic conflicts. We did not deal with any court-ordered mediation that would be part of the litigation process. The preceding fictionalized case history illustrates how mediation works.

... METHODS ...

**Subjects**

One hundred and seventy-three persons participated in a 3-day training intervention called "Building Conflict-Positive Systems." A community-based not-for-profit hospital, a health maintenance organization (HMO), a managed care insurance company, and a skilled nursing rehabilitation company were the sites for the study. Participants' roles and professions were diverse and included nurse case managers, nurse educators, quality improvement staff, social workers, doctors, lawyers, and business, customer service, and finance staff. Telephone calls, E-mail messages, and messages from secretaries and managers were used to encourage subjects to return completed questionnaires.

**Training Intervention**

Participants preferred to be away from work for no more than 2 days at a time. This 25-hour training program was scheduled over a 2-week period (dates and times were established at the mutual convenience of the researchers and participants) and consisted of 11 hours of didactic content, 10 hours of mock mediation exercises and simulations, and 4 hours of homework. The training, conducted both on- and off-site, was highly interactive and experiential and consisted of lectures supplemented with discussion, case study analysis, practice sessions, simulations, outside reading, and assign-

**Table 1.** The Mediation Process

<p><b>Stage 1—Introduction and Narratives</b></p> <ul style="list-style-type: none"> <li>• Mediator requests that participants briefly address all key concerns, speaking directly to the mediator.</li> <li>• Participants recess for a brief period while the mediator constructs an issue agenda and reframes positions into areas of interest.</li> </ul> <p><b>Stage 2—Exploring the Issues</b></p> <ul style="list-style-type: none"> <li>• Mediator facilitates the participants in talking directly to each other regarding all issues on the agenda.</li> <li>• Mediator may call for private meetings (caucuses) to explore issues more fully, thereby reducing participant's vulnerability.</li> <li>• Participants explore common areas of interest and shift from positions to a problem-solving mode.</li> </ul> <p><b>Stage 3—Decision Making</b></p> <ul style="list-style-type: none"> <li>• Participants are assisted by the mediator in brainstorming options, determining objective criteria by which options will be selected, and finally, in building a SMART agreement for settlement.</li> </ul>
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Adapted from reference 2.  
SMART = specific, measurable, achievable, realistic, and timed.



ments. Each aspect of the mediation process was learned in small, sequential steps. Attention was paid to cultural sensitivity and competency. Finally, the participants were oriented to a values history instrument developed by us to enhance cultural competency and ethical decision making in catastrophic and end-of-life cases. Specific content and time allocations for the training intervention are shown in Table 2.

### Measurement of Outcomes

*Comfort Level Before and After Training.* We developed a Likert-scale instrument to measure perceived differences in comfort level with conflict before and after training and the transfer of mediation skills to other settings. The pretraining test was administered immediately before training. The posttraining test was completed 2 months after the training. The scale's reliability, as measured by Cronbach's alpha, was .82, indicating a high level of internal consistency.<sup>29</sup> Subjects ranked their comfort level with conflict, pre- and posttraining, on a Likert scale that ranged from 1 (low) to 10 (high).

*Transfer of Mediation Skills to the Workplace.* Transfer of skills to the workplace was analyzed in several ways. Posttraining, all subjects were asked to review a list of mediation skills and to indicate, on a Likert scale ranging from 1 (seldom) to 5 (frequently), the extent to which they used a particular mediation skill with patients, coworkers, others at work, and their families. Two months following training, all subjects were asked to indicate on a Likert scale ranging from 1 (not useful) to 5 (useful) the extent to which mediation skills were useful in the workplace, with coworkers or patients, and at home.

*Observation and Interviews.* The managed care insurance company allowed the researchers to observe staff at their work sites and to identify the mediation skills used by the case, benefit, risk, and quality improvement managers. Plan members gave permission to have an educational consultant listen in on their conversation. In addition, subjects were asked about specific ways in which the training had made a difference in their work lives. Each investigator spent approximately 30 minutes with each of 16 subjects; approximately 16 hours of data were collected.

### Statistical Analyses

Paired Student's *t* test was used to analyze the difference in comfort level with conflict before and after the mediation training. Analyses of pretraining comfort level with conflict according to gender and managerial status also used the *t* test.

## ... RESULTS ...

### Participant Profile

Of the 173 participants, 130 returned the post-training surveys, a return rate of 75%. A 100% return rate was attained in the managed care organization in which the researchers were on-site. For the other study sites, participants were dispersed throughout the organization and were at numerous locations. Demographic data on the participants are presented in Table 3. Thirty-seven (28.6%) of the participants were nonmanagers, 57 (43.84%) were midlevel managers, and 36 (27.69%) were upper-level managers. A majority of participants (82.9%) were women.

### Comfort Level With Conflict Before and After Training

A significant increase in comfort level with conflict was reported for all subjects after mediation

**Table 2.** Mediation Training Intervention

Content	Hours
Changing paradigms in healthcare	1.25
Communication principles	1.45
Bioethics	1.45
Organizational ethics	0.50
Conflict theory	1.00
Alternative dispute resolution models	0.50
Mediation—description, stages, process	1.50
Cultural sensitivity and competence	0.50
Ethical case analysis and tools	1.00
Values history instrument	1.00
Personal biases	0.50
<b>Summary</b>	
Didactic sessions	10.65
Practice session, debriefing, simulations, and discussion	10.00
Homework	4.35
<b>Total</b>	<b>25.00</b>

**Table 3.** Demographics of Participants

Institution	Sex*		Posttraining Survey Returned			Work Role
	M	F	All	M	F	
Community not-for-profit hospital	8	23	21	6	15	Midlevel managers
HMO (nonmanagerial)	7	33	37	6	31	Membership and benefits staff
HMO (managerial)	1	20	18	1	17	Managers
Insurance company case,	1	17	18	1	17	Physicians and risk, benefit, and quality intervention managers
SNF rehabilitation	9	46	36	8	27	Upper-level managers

\*One participant did not respond. Gender statistics are based on a group of 129 rather than 130.  
HMO = health maintenance organization; SNF = skilled nursing facility.

**Table 4.** Comfort Level with Conflict Before and After Mediation Training

Sample	n	Pretraining Mean Score	Posttraining Mean Score	t Test
Community hospital	21	5.38	7.47	7.610*
HMO, all	55	6.20	7.64	7.347*
HMO, nonmanagers	37	5.89	7.51	7.039*
HMO, managers	18	6.83	7.89	2.959*
Insurance company (1)	6	5.33	8.0	4.00 <sup>†</sup>
Insurance company (2)	12	4.75	7.25	5.99 <sup>†</sup>
SNF rehabilitation	36	6.11	7.51	4.047*
All nonmanagers	37	5.89	7.51	2.59 <sup>†</sup>
All managers	93	6.83	7.89	5.61*
All subjects	130	5.92	7.57	7.89*

\* $P < .001$ .

<sup>†</sup> $P < .01$ .

training at either the  $P < .01$  or  $P < .001$  level (Table 4). The mean pretraining and posttraining scores ranged from 4.75 to 6.83 and 7.25 to 8, respectively. Aggregate data for all subjects showed that the mean pretraining and posttraining scores were 5.92 and 7.57, respectively ( $P < .001$  for both).

When pretraining scores were analyzed by gender, a significant difference was observed, with women scoring lower than men, ( $P = .025$ ). However, after training, the comfort level scores increased significantly for women ( $P < .001$ ), whereas with men, the scores showed no significant increase ( $P = .058$ ). The posttraining scores did not differ significantly between men and women ( $P = .123$ ).

An analysis of pretraining scores by managerial status showed a higher level of comfort with conflict management among managers (mean score of 6.83) compared with nonmanagers (mean pretest score of 5.89). After training, the mean test scores were 7.89 for managers and 7.51 for nonmanagers, a statistically significant difference ( $P < .01$ ).

### Transfer of Mediation Skills to the Workplace

Aggregate data revealed that the transfer of particular mediation skills ranged from a low of 2.42 for SMART (specific, measurable, achievable, realistic, and timed) agreements to a high of 4.42 for active listening (Table 5). The skills used most often (in order of

decreasing scores) were active listening (4.42), summarizing (4.10), reframing (4.09), neutrality (3.69), balancing power (3.65), and the common positive (3.61). Skills used least (score less than 3.0) were SMART agreements (2.42), reality testing (2.90), and BATNA (best alternative to a negotiated agreement) (2.95).

An analysis of the usefulness of mediation skills in the workplace, with coworkers and patients, and at home reveals a range of usefulness from 3.60 to 4.25 on a 5-point scale (Table 6). Skills were applied most often in the workplace (score of 4.25), specifically with health plan members (score of 4.12).

**Direct Observation of Posttraining Skill Transfer**

In addition to asking participants about the transfer of skills to the workplace, we observed 16 subjects at their workstations. A telephone headset was used to listen to the conversation between the professional and the consumer. We were interested in the following items: (1) the presenting issue(s); (2) the underlying or real issue(s); (3) the mediation skills identified and used; and (4) the final outcome. At the conclusion of the telephone conversation, our observations of their skill application and care issues were validated with those of the case managers. The general consensus was that consumers found it very frustrating to repeat their "story," having already told it to several others in the system. The training participants used their newly acquired mediation skills to acknowledge and empathize with this frustration and to assure the consumer that they would help resolve the problem. In all cases, the study subjects began to look beyond the actual presenting issue and to more clearly identify issues that had consequences not only for the individual plan members but for the organization as well. We have selected 3 cases to demonstrate the issues confronted by the subjects. In a fourth case, the situation was complex and beyond the capability of the case manager; however, because of this training intervention, she requested and received the organization's permission to refer the case to formal mediation.

**CASE 1**

The first case involved a phone conversation with a plan member who perceived he was being denied his choice of doctor. Probing further, the case manager discovered that the patient's physician had moved to a medical group outside the insurance plan's panel. The case manager recog-

nized that the real issues had to do with continuity of care and preserving trust during this transition. She acknowledged the member's frustration at having to change doctors and stated their common goal of continuity and his being satisfied with a new physician. She asked the member for his criteria for selecting a physician, offered names of several alternative physicians in the appropriate medical group,

**Table 5.** Transfer of Mediation Skills

Mediation Skill	Score*
Active listening	4.42
Summarizing	4.10
Reframing	4.09
Neutrality	3.69
Balance of power	3.65
Common positive	3.61
BATNA	2.95
Reality testing	2.90
SMART agreements	2.42

\*Scale ranged from 1 (not used) to 5 (frequently used). BATNA = best alternative to a negotiated agreement; SMART = specific, measurable, achievable, realistic, and timed.

**Table 6.** Application of Mediation Skills

Transfer Site	Score*
Workplace in general	4.25
Patients (plan members, customers, clients)	4.12
Coworkers	3.82
At home	3.60

\*Scale ranged from 1 (not useful) to 5 (very useful).

and urged him to interview them before making a selection. Finally, she assured him that she would facilitate communication between the physicians to assure continuity of care.

#### CASE 2

A family perceived that their loved one was being denied skilled nursing facility (SNF) care. The case manager was empathetic and suggested that it would be important for her to obtain input from the nursing facility as well. She discovered that the patient did not qualify for skilled care, but rather required custodial care. Furthermore, the case manager recognized that the real issue was the declining health of the patient, which would require a major adjustment for the family. The family needed help to accept that their loved one neither needed, nor was eligible for, skilled nursing care. Understanding the family's need for dialogue, the case manager scheduled an on-site case conference within the following 2 days and allowed up to 4 additional SNF days for the patient, making it clear to the family that this was an intermediate plan. Later, the case manager revealed to us that the case conference helped the family accept hospice care, rather than custodial care, as the appropriate level of care.

#### CASE 3

A high-ranking official of a municipality that contracted with the insurance company for employee healthcare called on a Friday afternoon at 4:35 PM to complain angrily about "denial of benefits" for one of his employees. He gave the case manager "until midnight to straighten it out, or else!" She acknowledged his anger and frustration and the importance of caring for the patient, asked where he could be reached during the evening, and proceeded to apply problem-solving skills. She discovered that the patient had metastatic cancer and had reached the capitated limit of his home health benefit. She authorized a home health visit on the weekend for an assessment of the situation and indicated that if further home care was needed over the weekend, the cost would be divided equally between the medical group and the insurance company. The case manager informed the town official about the home health visit and conveyed her commitment to appropriate follow through, which satisfied the official. The patient was ultimately referred to hospice care.

#### Subject Interviews

When interviewed, subjects indicated that mediation training had bolstered their confidence, helped

conserve emotional energy, encouraged a proactive approach, rendered them less judgmental, and made them better listeners. These new skills contributed to successful problem solving. Nurses reported that rather than avoiding angry clients and emotional issues, they identified the emotions, acknowledged them in less explosive terms, depersonalized the interaction, and no longer felt under attack. Once emotions were acknowledged, plan members calmed down and were more reasonable and willing to engage in problem solving. Case managers acknowledged a greater ease with facilitation and collaborative problem solving that allowed them to intervene early in a conflict. Common themes expressed were: "The anger at the other end of the telephone no longer feels like a knife in my ear"; "I don't want to run away from anger, fear, or frustration. I can step back and acknowledge its presence without getting entangled in it. I don't feel beaten up"; "Mediation training helped me to get to the heart of the matter, not just what first presents itself"; and "In a time when hard savings are harder and harder to identify, customer satisfaction is an area of growing importance for our organization. I can now deal with an irate client quickly and effectively."

The case managers also recognized their limitations. Situations that were highly complex or potentially volatile or had the potential to be destructive for the patients, their families, the medical group, or the insurance company were referred to mediation and successfully resolved. One such case involved a 36-year-old woman who had been injured in an accident and been left a quadriplegic dependent on a ventilator. She was in a SNF recovering from severe pressure ulcers incurred while at home, but needed to be transferred because the SNF would no longer be providing ventilator care. The patient and family wanted her transferred home, whereas the medical group wanted her transferred to another SNF. Litigation was threatened. This conflict in goals and values between the family and the medical group led to reduced trust and poor communication. The parties were informed about mediation as an option, and the patient, medical group, and insurance company and their respective attorneys agreed to mediation. Fourteen persons attended the mediation that took place approximately 1 week prior to the need to transfer. The parties had differing opinions regarding quality of life, and the patient's family expressed their frustration and anger with medical care. The mediators also tested the parties' willingness to mediate because the patient and medical group were going to have a long-term relationship; it



was imperative that the mediation process also address the rebuilding of trust and improving communication between the parties. No short- and long-range goals were established for the patient at this meeting. After a 6-hour mediation, the parties agreed, as an interim plan, to transfer the patient to a rehabilitation facility. The patient, her husband, and the medical group submitted recommendations for rehabilitation facilities; selection criteria were to be developed by the case manager. The case manager who initially worked the case and who requested that it be referred to mediation was present at the mediation and had an important role in the development of criteria by which the rehabilitation was chosen. As part of the decision-making process, the patient's husband was asked to visit each of the facilities and, if criteria were met, given the authority to choose a facility. Ultimately, the patient was transferred to a rehabilitation facility, realistic goals were established and met, and the patient was subsequently discharged home. With the availability of adaptive computer equipment and the Internet, the patient is now working part-time at home.

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...DISCUSSION...

This study demonstrated that mediation training significantly increased health workers' comfort level with conflict. We speculate that the higher level of comfort with conflict expressed by managers, as compared with nonmanagers, is an acknowledgment that dealing with conflict is an inherent part of the managerial role and the reality of the workplace. The differences between men and women related to comfort level with conflict are also consistent with the literature and our training experience.

The skills associated with mediation were transferable to the healthcare work setting and were not merely applicable to a formal mediation session, as found in the private sector among dispute resolution personnel. In our study, the participants used these skills in interactions with coworkers, patients, and families. In interactions with clients, caseworkers were more sensitive to clients' needs and emotions, without sacrificing the needs of the organization. The subjects in the study recognized that conflict prevention generally required less time and energy than conflict avoidance.

The current cost-constrained healthcare environment makes it difficult to conduct a longitudinal study or an experimental or quasi-experimental study. For example, during the course of this 3-year

study, 2 organizations reorganized and 1 was involved in an acquisition. Ten study participants were either transferred or laid off. Work demands made it difficult for personnel to be off-site. The sample size of participants who could be observed directly in the work setting was small and confined to case managers. However, the themes expressed were similar to those expressed by all participants in this study, and as a result of this study, mediation as a formal and informal process is being used in the work setting in which the on-site observations were held.

This is the first reported study to measure the effectiveness of mediation training. We chose a descriptive, nonexperimental design rather than a quasi-experimental design<sup>29</sup> because it was difficult to have a control group similar to the participants. The participating organizations did not want to deprive employees of the potential benefits of the training. A potential area for future research would be to determine which aspects of the training accounted for the differences. For example, can the differences be attributed to neurolinguistics, communication, or other aspects of training? This could be done by establishing 3 groups—a mediation training group, a group exposed to neurolinguistic programming as a communication skill, and a control group that receives only the communication component of the training.

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...CONCLUSIONS...

The tensions and stress in healthcare will undoubtedly continue, and conflict will remain an inherent part of this industry. Because of the inadequacy of preprofessional education in basic conflict management techniques, it is imperative that healthcare workers be educated in these techniques. Mediation training should be part of the curricula that prepare healthcare professionals, with the curriculum content including, at a minimum, the elements outlined in the training intervention. Teleconferencing, CD-ROM, computer-assisted instruction, e-mail, and the World Wide Web are some creative means that should be used to bring mediation training to the workplace as part of ongoing staff development or continuous quality improvement efforts. We recommend, however, that distance learning be balanced with on-site small group experiential, interactive training.

Studies similar to this one should be conducted on additional populations and participants should be

followed on a longitudinal basis to determine the effects of training against organizational standards or desired outcomes. For example, does mediation training change the level of customer satisfaction? Is there a difference in the types of complaints or grievances filed with internal or external agencies? And, is there an impact on job satisfaction and stress levels for employees before and after such training?

Finally, where appropriate, we recommend that mediation be used prior to arbitration or litigation to resolve healthcare disputes. When people are wronged, mistreated, cheated, or violated in some manner, their typical response is to hire an attorney. When seeking justice, few take into account the various costs associated with litigation or arbitration. For example, a lawsuit of \$100,000 can easily result in pretrial bills of \$35,000 or higher for preparation of interrogatories, depositions, motions, and pretrial conferences. Costs for arbitration are also high since preparation for a "demand" for arbitration is costly and time consuming. The scheduling delay in obtaining justice is another cost that is often miscalculated. The high cost of litigation thus often makes mediation the first choice for resolving disputes. Furthermore, the solutions rendered by a judge or an arbitrator are imposed on parties, whereas in mediation, the parties have the opportunity to fashion their own solution.

Although it is difficult to estimate the savings in using mediation as opposed to litigation, there are also costs associated with conflict and stress on patients. Forté cites a large body of literature that enumerates the impact of anxiety and stress on the patient.<sup>5</sup> Forté suggests that patients fail to ask questions because the provider is busy. If he is right, this current time-sensitive healthcare environment is a disaster in the making. The ability to manage conflict when it is small and manageable is highly desirable. Mediation skills empower employees at all levels of the organization to act in a way that is prudent and respectful of the customers they serve.

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