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Abbreviations

Alternative dispute resolution	ADR
Health Service Executive.	HSE
Health Service National Partnership Forum	HSNPF
Irish business Employer Confederation	IBEC
Health Service-Employers Agency	HSEA
Psychiatric Nurses Association	PNA

Conflict resolution in the Health Service.

Is Partnership, mediation the way forward?

1 Introduction.

In this project the writer will discuss conflict resolution in the Irish health service.

The writer intends to do this by reviewing the literature on the many aspects of this subject.

The writer will look at the history of the health service in Ireland beginning in 1838 with the introduction of the Poor Law Act.

The writer will then progress to how the services have changed over the years; he will discuss the greatest change so far in the health service, the amalgamation of the eleven health boards, the voluntary hospitals, and the voluntary organisations into one executive namely the Health Service Executive.

The writer will look at the many causes of conflict as described in the literature

And will hope to get an understanding of why conflict happens and how it can be avoided

The Writer will discuss the various types of conflict present in the health service including staff/management, interpersonal /inter professional difficulties and customer relationships.

The writer will look at conflict describing the many ways that it can be resolved including, interest based problem solving, collective-bargaining, mediation and facilitation.

The writer will discuss the history of partnership in the health service in Ireland and review whether conflict resolution in the health service is moving towards partnership and mediation.

The writer intends to achieve this by:

- Literature review
- Interviewing Ms Anna Killilea HSEA and Mr Desmond Kavanagh PNA.
- A survey questionnaire presented to the 52 part-time mediators employed by the HSE.

2 The Health Service in Ireland

History.

(Hensey 1979) describes the introduction of the Poor Law Act in 1838 as the beginning of the health services in Ireland.

The Irish Poor Law Commissioners were appointed by the Queen in 1847. Their task was to ensure uniformity in the Poor Law service and their responsibility was to exercise very detailed control over the local authorities.

Local health services developed within the local government system during the 19th century, during this time each health service developed was the responsibility of the relevant local authority.

The final changes in the 19th century came with the introduction of the Local Government (Ireland) Act, 1898.

Under this act elected county councils, urban district councils and rural district councils were established.

The story of the health services in the 20th century falls into two sections.

The first period being up to the end of the Second World War 1945.

Under the Minister and Secretaries Act 1924 the Department of Local Government and Public Health under its own minister became the statutory central authority for the service. There were two important differences between the new central authority and the new board it replaced. Firstly it was now under a Minister of State and not under a central authority. Secondly it was responsible for all health services in the country including the lunatic asylums.

During this period up to 1945 a new preventative and hospital service was introduced as well as a dispensary and additional benefits scheme.

In the period from 1945 to 1960 the development of the Anti-Tuberculosis service and the Mental Treatment Act 1945 were the most noteworthy.

Up to March 1971 all of the health services were under the control of the relevant local authorities, with the introduction of the new Health Act in 1970. The health services in the Republic of Ireland became the responsibility of eleven health boards.

In the Eastern region the Eastern Health Board covered the counties of Dublin, Kildare and Wicklow until 1998, when this region was then divided into three area health board areas.

In 2004 all of the Health Boards plus the Voluntary hospitals and the Voluntary services became the responsibility of one health authority namely the Health Service Executive.

The HSE has responsibility for over 100,000 health care staff.

3 Conflict.

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(**Moore 2000**) discussed three main areas of conflict.

1. Latent conflict: this is when underlying tensions have not developed fully for example, staff cutbacks within an organization.
2. Emerging conflict: is where a dispute is identified and the problem solving process has not commenced.
3. Manifest conflict: is where parties are involved in an ongoing dispute and they have reached an impasse, the end result of this type of conflict may lead to a strike situation.

(**Jackmann. 2004**) Describes the conflict as a difference of opinion by two parties. She also states that managers dislike conflict because it gets in the way of the task they are trying to achieve. She further states that managers often ignore the conflict in the hope that it may go away. If conflict is not handled well it will inevitably get worse.

(**Beer 1997**) describes what happens when differences, disagreements and annoyances threatens something important in us, she calls this the 'conflict core'. Pg.11
When we study conflict, the conflict core is of great significance because it is very important for a mediator to realise that some parties may come to the discussion table with a lot of fears etc. and if these fears are not identified it may prevent them from resolving the dispute.

(**Cloke 2001**) Discusses conflict as a spiritual path. This includes our relationship with ourselves, with others and with life itself? He states that this is a very important issue in all our disputes.

Every conflict helps us to deepen our spiritual energy and this in turn connects us with life.

When we are able to empathise with people whom we've had disagreements with in the

past it opens unknown part of ourselves and we become more focused and true to ourselves.

In a study carried out by (**Daniel Dana 1984**) she cited 65% of performance defects are from strained relationships between staff members.

4 Conflict resolution.

In this part of the project the writer will discuss the many types of conflict resolution which are currently being used.

The first area that the writer will examine is Conflict Management Systems.

(**Tools for Change through Partnership 2006**) the author discusses how more organizations worldwide including the health service are developing conflict resolution systems to equip staff to deal with conflict in a positive manner.

The aim is to avoid disputes in the workplace and to get rid of the over- reliance on formal grievance procedures which can take up a lot of time and resources.

Each organization is best placed to design its own system in consultation with its staff and unions. These systems should include procedures for dealing with both formal and informal grievances.

In order to develop better conflict resolution systems, staff training and the development of appropriate policy documents is recommended.

(**Fisher and Urg 1999**) discussed a new system for people to deal with disagreements.

They began by looking at how people had negotiated their differences in the past, this involved adopting a position, arguing for that position and persuading the other party to agree or to find some kind of compromise.

The authors argued that splitting the difference between two parties does not have the same power as trying to find a solution to meet the legitimate needs and interests of both sides.

The authors also argued that starting from an extreme position and sticking to it, only making small concessions does not lead to a prompt or wise settlement.

The use of a soft approach or making an early offer or concessions does not work because the main issues are not resolved and this will lead to an unwise agreement.

(Fisher and Ury 1999) describe an approach developed to move on a dispute based on the following four principles.

- 1 Separate the person from the problem, be soft on the person and hard on the problem
- 2 Focus on interest and not on positions. It is very important to focus on why somebody adopts a particular position. There may be many reasons for this and getting to understand and deal with their interests will go a long way in reconciling the situation.
- 3 Invent options for mutual gain.

For every problem there can be more than one solution. It is important that we broaden the number of possible solutions and that we think creatively.

- 4 Insist on using objective criteria for the final agreement.

We often fear that we are negotiating a share of a fixed pie. If one party gets more, then we fear that we may get less.

(Fisher and Ury 1999) would argue “that it is important to reach a solution based on principles not pressures concentrating on the merit of the problem not on the merit of the parties be open to reason, but closed to threats”. Pg 86

Interest based Bargaining

(Barrett and O Dowd 2000)

“Interest based bargaining or interest based problem solving as it is sometimes called is an approach to collective bargaining or problem solving that is designed to help parties express, understand and build agreements around underlying interest or concerns

and desires”.Pg. 5

The skills used in interest based bargaining are:

- Active listening
- Converting positions into interests
- Brainstorming
- Joint data collection
- Facilitation.

Interest based bargaining is associated with expanding the pie, that is trying to make the pie bigger so that each party can get a bigger slice rather than accepting that the pie has to remain the same size in which case, one party’s gain has to be at the other party’s expense.

In traditional bargaining it was assumed by managers and also by employees and unions that management had sole responsibility for determining the size of pie.

Within this traditional approach, the role of trade unions was essentially to bargain over how the pie should be shared between management and employees.

Interest based problem solving or joint problem solving.

(Tools for a Change through Partnership 2006)

Joint problem solving is a collaborative process where the parties agree to approach an issue as problem solvers, not as an adversarial.

The parties acknowledge that there may be a real difference it seeks to work the common ground. There is agreement from both sides that neither party will seek to take advantage, therefore there is no need to adopt, defend or hide positions, as is frequently the case in adversarial bargaining.

The plan is to explore possibilities and create multiple options for mutual gain as a first step before deciding on the best option, the one that offers the highest level of mutual gain.

The central part of joint problem solving is to reduce the additional time spent in adversarial negotiation.

5 Alternative Dispute Resolution (ADR)

Alternative dispute resolution describes many methods of resolving disputes outside the conventional route of the law or formal investigation procedures. There are many techniques used in alternative dispute resolution. The most common form of alternative dispute resolution is mediation.

Mediation

(**Beer 1997**) describes mediation as any process for resolving disputes in which another person helps the parties negotiate a settlement.

This process is useful in a wide range of conflicts which arise in workplace, communities relationships.

The following describes the process used in a mediation session.

1 Opening statement.

The mediator meets both parties either together or separately, explains the process to them, agrees ground rules, and asks for their full co-operation in finding a solution.

2 Uninterrupted times.

Each person takes a turn to speak without interruption, this can be open-ended and they are allowed to talk about anything relevant to the situation.

3 The Exchange.

This is the part of the mediation process where arguing and discussion is allowed. Each party say's why they are upset and they also make there demands.

The mediator keeps the discussion centred so that each person is heard and their safety maintained.

It is not the mediator's responsibility to determine who is telling the truth or who is at fault, they listen for areas of agreement, and are on the lookout for a turning point

towards reconciliation.

4 Separate meetings.

These can take place at any time during a session and they have many uses including, checking out persons concerned and confronting unhelpful behaviour.

5 Setting the agenda.

This is where the parties look to the future and agree on a list of issues which need to be resolved.

6 Building the agreement.

The parties work through each issue generating a number of ideas, testing their suitability in order to reach a mutually satisfactory solution.

7 Writing the agreement and closing.

When the parties are able to come to a satisfactory conclusion the mediator writes a formal agreement containing the agreed solution.

The mediator complements all parties on their hard work and wishes them well.

In Ireland other examples of alternative dispute resolution is the use of the ombudsman, The Labour Relations Commission, Partnership forums.

The Irish Mediation Service use alternative dispute resolution techniques in helping couples negotiate separation agreements. The family mediation service contends that an agreement negotiated in this manner has a greater chance of being complied with by both parties as opposed to a judgement handed down by the Court's

Facilitation.

Facilitation is a change management tool used as a positive influence on how groups approach change.

Facilitators work independently to meet the needs of staff, management, unions, partnership committees and client groups within the Health Service taking into account their concerns, anxieties, goals and expectations.

(Moore 2003)

The author describes the role of the facilitator as increasing the involvement of team members in negotiation and decision-making, this in turn leads to greater ownership of the final solution.

6 Conflict Resolution Past and Present in the Health Service.

The writer will discuss conflict resolution in the Health Service in Ireland and he will also look at the changes that are occurring at present in order to have a greater partnership approach to conflict resolution.

(Labour Relations Commission Annual Report 2003) cited that the big success story of that year was the spread of industrial peace in the health sector in the second half of 2003.

The report states that 42% of the total days lost (15,800) occurred in the earlier part of year the 42% of days lost were as a result of a 10-week dispute by public health doctors. However, the Modernisation/Peace criteria agreed under Sustaining Progress had a major impact on the health sector thereafter, with no major disputes in the service.

The statistics for Industrial Disputes in Ireland during 2003 demonstrated that there were 24 disputes; of these three were in the health service.

(Schutte2003) describes the difference between conflict and dispute.

The author describes a dispute as an entrenched position which can be moved on following a successful negotiation.

The author on the other hand describes conflict as being more damaging and more difficult to deal with because it is below the surface.

In the writer's opinion the many legal changes introduced to the workplace in Ireland has set many challenging goals for both management and unions. The main legal

changes are as follows.

Safety Health and Welfare at Work Act, 2005.

Employment Equality Act 1998.

Equal Status Act, 2000.

Safety Health and Welfare at Work Act 2005 requires an employer to provide both safe place of work and safe systems of work.

The writer will now discuss two of the most common causes of interpersonal conflict in the workplace:

- Workplace bullying
- Discrimination.

The writer has chosen these two conflicts because in the writer's opinion they can be resolved through mediation.

In the Health Services in Ireland both of these conflicts are prevalent because of the history of a hierarchal management system and with the influx of migrant professional workers i.e. nurses, doctors and Allied professionals into our health service.

Workplace Bullying

(Schutte 2000) cites the landmark **Report of the Task Force on the Prevention of Workplace Bullying April 2001.**

This report defines bullying as "Repeated inappropriate behaviour, direct or indirect, whether verbal, physical or otherwise, conducted by one or more persons against another or others, at the place of work and/or in the course of employment, which could reasonably be regarded as undermining the individual's right to dignity at work." Pg.35

An isolated incident of the behaviour described in this definition may be an affront to dignity at work but as a once-off incident is not considered to be bullying.” Pg.35

The report proposed that the Health and Safety Authority should be the coordinating agency responsible for dealing with cases of bullying in the workplace

(Trinity College 2001) published the results of a survey commissioned by **The Task Force on the Prevention of Bullying in the Workplace.**

A summary of the results are as follows, out of 5,252 surveys.

- 7% claimed that they had been bullied at work;
- 81.5% experienced verbal abuse and Insults;
- The majority of those bullied were females;
- Lower professionals were most likely to be bullied;
- Prevalence was higher in the public sector;

Looking at the above results the writer is of the understanding that bullying is a major factor in the Health Service because three of the above criteria namely the number of females who were bullied, lower professionals and the prevalence of abuse in the public sector are all features of the health service.

Discrimination

Two of the most important pieces of legislation introduced to deal with discrimination in Ireland were the **Employment Equality Act, 1998 and the Equal Status Act 2000**, The purpose of these two acts was to put an end to discriminatory practices on a range of grounds.

The Director of Equality Investigations was also set up with a remit to investigate and to mediate on cases brought before it.

The nine grounds identified on which discrimination is unlawful are:

- 1 Gender.
- 2 Marital status.
- 3 Age.
- 4 Disability.
- 5 Family status.
- 6 Race.
- 7 Sexual orientation.
- 8 Religious Beliefs.
- 9 Membership of the Traveller community.

(Schutte 2003) defined Discrimination” If people are treated less favourably than another has been, or on any of the nine grounds” Pg 8. They may take a case against their employer on the grounds of discrimination.

(Schutte 2003) has cited in the annual report of the Equality Authority issued in June 2002 an increase of over 800% in 2001 in cases of Discrimination on gender grounds to the authority, this constituted the largest category of cases referred.

The presence of bullying and discrimination in the workplace presents an enormous challenge to employers and the writer believes that a solution may be found through mediation in some of these cases.

Collective Dispute Resolution in the Health Service

(Quality and Fairness 2001)

This document was developed following one of the largest consultation processes ever undertaken in the public sector.

It set out a vision for the health service. It recognizes that changes are required in how people are managed.

The report states that there should be more open manager / staff input into service

delivery.

The report defined seven key elements that need to be addressed in order to improve conditions for staff working in the Health Service.

- Manage people effectively.
- Improve the quality of working life.
- Devise and implement best practice employment policies and procedures.
- Develop the partnership approach further.
- Invest in training, development and education.
- Promote improved employee and industrial relations in the health sector.
- Develop performance management.

A timeframe of five years was agreed in order to progress these key elements

(Action Plan for People Management 2003)

The above document was published following the publication of the Government Health Strategy “Quality and Fairness”. “A wide and extensive consultation with all the stakeholders in the Health Service took place over a two year period”. Pg.9

Conflict resolution

The writer will now discuss how conflict is resolved in the Health Service in Ireland.

The writer will look at how successful national collective agreements have centralized pay and conditions agreements.

(Department of Enterprise Trade and Employment website) Since 1987 successful

national collective agreements have regulated the conduct of collective disputes, with the parties the disputee's being expected to comply with the various procedures contained in national agreements. In Ireland there are no regulations stating that collective disputes have to be referred to the dispute resolution channels. However if the parties are unable to resolve disputes in-house it is the usual practice for collective disputes to be referred externally to the Labour Relations Commission for conciliation. If this is unsuccessful the dispute is then referred to The Labour Court, which has the power to issue a binding resolution.

In the Health Service there are special regulations governing collective disputes in the form of a Conciliation and Arbitration Boards.

In addition during 2003 a voluntary code of practice on dispute resolution in essential services' were agreed in two key areas of the Public Sector Health and Local Government.

This code does not specifically rule out industrial action but it provides that extensive procedure must be exhausted for workers before they can engage in industrial action. For instance, unions must provide employers with three weeks notice of industrial action.

There is also a National Joint Council made up of senior management and union representatives which deals with collective disputes in the health sector.

With the introduction of national collective agreements and benchmarking in the last few years this has shifted negotiation on pay and conditions from the local arena to Central Government.

On a local level employers have to deal with disputes between staff members and disputes between staff and the general public.

In order to deal with these occurrences the HSE in consultation with staff and unions have prepared a Policy and Procedure book for its staff.

Grievance Policy.

(Policy and Procedures 2001) States that despite all the good practices associated with the employment of staff, an employee may have a grievance relating to work.

In this instance the following procedure will apply.

- 1 Staff member shall approach their immediate supervisor/manager in order to resolve the difficulty at the earliest possible stage.
- 2 If the matter remains unresolved or is not appropriate for the manager to deal with, it is referred to the next level of management.
- 3 If the matter still remains unresolved, it may be then referred in writing to the appropriate Director of Human Resources.
- 5 If the matter further remains unresolved it may be referred to an appropriate Third Party

During stages two to five staff may be assisted by the appropriate local or national trade union official.

Disciplinary policy.

If an employees standard of work or behaviour falls below an acceptable level their line manager must make them aware that this is unacceptable and point out how it must be improved upon.

If no improvement is noted then it may be necessary to invoke the formal disciplinary procedure.

The disciplinary procedure covers all Permanent, Temporary and Part-time staff working in the health service.

7 Conflict between Customers and Health Services. The American context

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(Suskind and Field 1996)

“The public is often treated like an angry mob rather than concerned customers or citizens with legitimate fear, concerns and needs. The practitioners’ role is to commit to nothing and admit to nothing”. Pg 9.

The above quotation is from a book written in 1996 which discusses the anger which the public felt towards unprofessional practitioners.

(Mediate.com Belak 2003)

The above author discusses that acknowledging a patients position or feelings should not be viewed as a fault or liability, but merely a step in the process of understanding and explanation.

The author also states that the challenge is to identify the interests that lie in the context of the complaints or the grievance, in such a way that the patient’s complaint is recognized.

In 1998 The Kentucky (USA) legislature enacted a law which encourages resolution of disputes through mediation.

(Belake2003) in his article comments that every state in the USA has laws encouraging or requiring mediation of patient disputes, none of the laws had been repealed, and more use of mediation is anticipated.

(Moore 2003) Discusses the increase in the number of disputes in the health care service in the USA.

Medical malpractice claims has cost the health industry roughly \$15 billion annually in preventative insurance.

“Studies on the motivation of malpractice plaintiffs in USA have shown that 40% of patients felt humiliated by their experiences with their doctor.

More than 50% of patients felt betrayed by their doctor and more then 80% of patients felt bitter by their doctor’s response to a complaint or question. More than 90% were very angry at their physician. In addition 24% felt the Doctor was dishonest or misleading them regarding their case or incident. 20% felt court was the only way to find out what happened, and 19% felt the need to punish the doctor” Pg 32.

The author cites (**Dauer, 1994**) survey on what could be done by doctors in order to prevent litigation. The findings were as follows;

- 35% of plaintiffs responded if they had received an apology or further explanation.
- 25% responded, correct the error.
- 16% responded, pay me compensation”.

(**Joseph 1994.**) Describes how there has been an 80% settlement rate in malpractice claims in Austen Texas since mediation was introduced to that state.

(**Moore 2003**) describes a number of other health care disputes where mediation is being applied or explored, these include conflict among doctors, administrators and hospitals, disputes between doctors and nurses, disputes between different health workers and also between customers and health providers.

8 The Irish context.

(Policy for the Management of Complaints in the Health Service Executive (HSE) 2006)

In February 2007 the HSE launched a new policy for the management of complaints. In its policy statement it states that the HSE welcomes the views of patients, service users, carers, visitors and the community about the services provided by the HSE.

The policy, states that complaints, criticisms or suggestions, whether oral or written would be taken seriously and handled appropriately and sensitively.

The HSE has a responsibility to ensure that the public are made aware of their rights in making a complaint and they must be kept informed on how their complaint is proceeding through the complaints management process.

The HSE has set out a timeframe for completion of the complaints process (**see diagram 3 in Appendix HSE Complain Management Process**)

The above process will be rolled out to the general public and the staff of the HSE during March 2007.

9 Partnership

The writer will now look at the new Partnership Agreement which sets out a framework, agreed by management and trade unions in the health service, within which a set of partnership principles, processes and structures link to shared interests and goals are to be applied.

(The Health Services Partnership Agreement 2006)

The above agreement was initiated in 1999 under the Partnership 2000 Agreement and it operates in the context of prevailing national agreements and the National Health Strategy- Quality and Fairness.

The Health Service comprises of acute, primary, community and continuing services and support services provided by the Health Service Executive to patients and other service users. In accordance with their obligation under the Health Acts.

(Health Service Partnership Agreement 2006) states that;

“Within the health sector, both formal and Informal arrangements have existed for many years which provide for a partnership approach to the resolution of difficulties.

Experience to date has shown that enhanced partnership between management, staff and trade unions, with a strong client focus, has led to services been continuously developed and improved” Pg 5

In this agreement all health service staff, their representatives and managers has agreed to participate in the modernisation agenda and to resolve difficulties at local level where possible.

This partnership approach does not replace National or local industrial relations systems and procedures, however it is hoped as an effective partnership approach evolves it will reduce the traditional adversarial approach to industrial relations issues.

The only area where this partnership approach cannot be used is in the area of clinical

responsibility, managerial accountability and statutory obligations.

It is also noted that the implementation of some partnership service/action plan issues may have to be referred to industrial relations procedures for conclusion or alternatively some issues may be channelled from industrial relations procedures to working groups in the partnership forum.

Health Service National Partnership forum. (HSNPF)

This forum comprises of equal numbers of management and trade union representatives and their role is as follows;

- To provide leadership to the Health Service partnership process;
- To champion partnership within Health Service management and within the trade unions;
- To provide a national level forum within which Health Service management and trade unions can agree the broad parameters within which partnerships are advanced at national, regional and local level;
- To assist the development of best practice and communication in the health service;

Local Partnership Working Groups.

The types of issues that this group will look at are:

- To integrate conflict management systems and mediation process;
- Getting to yes- joint problem solving- interest based bargaining;
- Team building and team facilitation;
- Supporting and assisting colleagues, facilitators, managers and trade unions in achieving partnership.

(Dignity at Work Policy for the Health Service 2004)

In this document which was produced on a partnership basis by a working group comprising of representatives from Health Service Employers Authority (HSEA) , Voluntary Hospitals and Intellectual Disability sectors, Health Service unions, and Irish Business Employers Confederation (IBEC).

The key objective of the new procedure is to ensure that all reasonable effort is made by local management to deal with complaints of bullying or harassment without outside intervention.

In the event that the complaint cannot be resolved locally, the procedure sets out an investigation process which is designed to deal with complaints expediently and with minimum distress for the parties involved.

The procedure also provides for mediation as an alternative to a formal investigation if all parties agree to participate in the process.

With the Introduction of the Health Service Partnership Agreement in late 2006 this offers a golden opportunity for conflict in the Health Service to move to a partnership approach.)

10 Interview with Ms Anna Killilea (Senior HR/IR Executive

Health Service Employers Agency (HSEA).

On the 14th of February 2007.

Ms Killilea commenced the interview with an outline of when partnership was first discussed with the unions.

In 1997 an anti-bullying policy was devised by the employers agency (HSEA) following a request from the Irish Nurses Organization. Previous to this time each health facility had their own anti-bullying policy. The HSEA brought together all the unions to discuss this policy and they jointly produced a document (Dignity at Work). This document became a template for dealing with bullying in all of the health services.

Following the introduction of Employment Equality Agency in 2004 The HSEA

convened a meeting of all union to revisit the bullying policy .in order to do a broader policy taking into account the legal obligations to prevent workplace harassment.

A joined working group including all the unions in the health board were invited to attend.

The mediation component come into it because investigations were been crashed because of procedural issues, this led to long delays which was of no benefit to either party.

Formal claims were not satisfactorily dealt with in the investigatory process, because a lot of the issues were due to a break down in working relationship and lack of clarity.

Other reasons why investigations had crashed was because staff felt that there managers had not responded adequately to the issues they had raised and also staff argued about the way the situation should have been managed.

Ms Killilea stated one of the main reasons why the HSEA wanted to introduce a mediation programme was in order to give greater power to local managers.

She continued by stating that line managers can get involved in local mediation because they are on the ground and they know that staff.

If the issue needs to go beyond the local managers she states that instead of a formal investigation a mediator would be called in.

The HSEA decided to appoint a local mediation panel to the Health Service because they believe that a local mediator would understand the local workforce. The HSEA also believed that it was more cost-effective.

She stated that from her own experience when she employed external mediators in some cases she was not happy with them because she believed that they did not seem to understand the local issues.

With the Introduction of the local mediators who had basic training she found that they had a very good knowledge of the local Health Service.

Following a tendering process they employed the Institute of Public Administration (IPA) to deliver a mediation training course for 80 people from all areas of the Health Service a total of 52 staff were invited to join a mediation panel.

Ms Killilea believes that the aim of mediation should be to get two people who have a problem to meet voluntarily with a mediator in order to resolve their differences. She

also states that in a lot of cases you have two very hard-working staff members who are very committed but who may clash over some issue. The fear is that other people may get involved thus escalating the situation.

An example given by Ms Killilea is with the arrival of many non-national staff to the HSE there is a greater chance of misunderstandings because of language difficulties and cultures. An example of this is if you come from the Philippines you are entitled to have your birthday off, this entitlement may not always be available on a busy ward by explaining to the staff member the rationale.

In conclusion I asked Ms Killilea what is the way forward for mediation in the Health Service?

Ms Killilea informed me that the HSEA were undertaking a review of (Dignity at Work Policy) commencing on Friday the 16th of February 2007.

The review body which includes members of the trade unions and management will look at this document in its entirety.

This group will examine in particular the role of mediation and how is it working?

How it might be improved upon and how can they promote mediation more effectively to the stakeholders.

The group will look at mediation panels to see if they are getting work and if not why not.

Finally the HSEA are going to consult with the Human Resource Managers in the HSE in order to promote mediation.

My final question to Ms Killilea was “how long she expects this review body will take to produce their report”?

She stated that she hoped to have the final report before the summer.

11 Interview Mr. Desmond Kavanagh.

(General Secretary of Psychiatric Nurses Association)

My rationale for interviewing Mr Kavanagh was as follows.

At present in the HSE there are four unions representing all of the staff.

The four unions are:

1. Irish Nurses Organisation.
2. IMPACT.
3. SIPTU.
4. Psychiatric Nurses Association. (PNA)

I put all of the above names in a hat and pulled out one The PNA.

I met Mr. Kavanagh on the 21st of February 2007. I started the interview by asking Mr. Kavanagh when he first got involved in the partnership process in the Health Service. He stated that he got involved with partnership about seven years ago and that he came to partnership with “a jaundiced eye” and he still would have some concerns because there is a natural friction between trade unions and management, he went on to say that he sees partnership as an element in the process that we can use.

He suggested that we will never get to a stage where we would not need arbitration, but his view is that there is now another alternative for example Partnership and Mediation .

Mr. Kavanagh stated that he had used partnership to resolve issues that in his opinion were intractable. He stated that he has used the services of partnership personnel to great effect an example being- In a hospital in the Midlands he had a very difficult situation between staff members and management regarding a move to a new premises, Following discussions with the management team they agreed to employ a person from the partnership forum to look at all the issues. He was glad to say that all issues were resolved satisfactorily.

Mr. Kavanagh also commented that he felt issues that were resolved within the partnership forum were “cleaner” because it resulted in a win- win situation for both sides. He contrasted this to arbitration which he found to be more adversarial and it always resulted in a winner and a loser and “sometimes when you win you lose”. He also commented that with arbitration a result is imposed on you. The two areas which Mr. Kavanagh believes that partnership can be best used effectively in the health service are:

- Ward closures
- Re-organization of services.

When you are dealing with any of the above situation you may start off with 20 issues of these 18 issues may be resolved by partnership and 2 may need to go to arbitration. When issues go to arbitration they are usually finely tuned and well defined.

Mediation.

Mr. Kavanagh stated that regarding a case of bullying, he would advise from a union perspective that it would be dealt with by a mediator if both parties agree. He gave me an example of a nurse who was out of work for four years following a bullying incident, this case caused a lot of polarization between staff in the hospital concerned and following many interventions it was still not resolved. In consultation with the management team a mediator was brought in. The mediator met with both party’s over a three-week period and produced an agreement.

Regarding the future of mediation in the Health Service Mr. Kavanagh feels because we have a partnership agreement with government which has a no strike clause, unions are now looking at different ways of resolving disputes, and this will include both partnership and mediation.

Mr. Kavanagh stated that The Psychiatric Nurses Association is part of the review body set up by the HSEA to look at the Dignity at Work Policy; this review body have just started their deliberations.

He further stated that at their last conference, some of the most militant branches of his association brought forward a motion asking the union to use mediation as a conflict resolution tool.

He concluded by saying that he certainly sees partnership and mediation as the way forward in the Health Service for certain “soft” issues.

12 Survey

Methodology

Following a search of the Internet I was unable to get a comparative questionnaire which would capture the type of answers I required for this project.

I compiled my own questionnaire and in order to check if my questions were appropriate I decided to compile a pilot study.

I randomly selected five people from the list of mediators sent to me by the HSEA and I sent the questionnaire to them, from the responses I received back I made appropriate changes to the questionnaire.

(Mason 1998) described the advantages and disadvantages of questionnaires.

The advantages outlined by the author were as follows” a large sample can be reached economically and greater anonymity can be provided by the respondents.”Pg. 300.

On the other hand the author states that” the motivation and commitment of the respondent cannot be assessed, although a large group may be sampled, getting enough

returns for a representative sample can be a problem” Pg. 301

Following communication with the HSEA regarding my project I was furnished with the full list of names and contacts for all of the 52 mediators.

I sent the questionnaires plus a cover letter (**Appendix 2**) via e-mail to 42 of the respondents. I posted the questionnaires to the other 10 respondents. Two weeks after sending the questionnaire I sent a reminder to all of respondents.

In order to analyse the results I used **Microsoft’s Excel 2007**.

Findings. Appendix 1

Circulation of Questionnaire.

81% of questionnaire was circulated by e-mail.

19% of questionnaire was circulated by post.

The main findings from the survey were as follows.

5 out of 28 respondents were Administrators.

4 out of 28 respondents were Accredited Mediators.

3 out of 28 respondents were Practising Nurses.

Regarding their belief on whether their training had adequately prepared them to work as mediators.

16 out of 28 said No

12 out of 28 said Yes.

Regarding the amount of clients they had seen in the last 12 months

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16 out of 28 had seen no Clients.

8 out of 28 had seen 1-5 Clients.

Regarding Contacts with each client.

12 out of 28 had 1-5 contacts with the Clients.

1 out of 28 had 6-8 contact with Clients.

15 out of 28 had no contact with Clients.

Main Referring Agent

7 out of 28 received their Referrals from the Human Resources Department

5 out of 28 received Referrals from their Line Manager

15 out of 28 did not Answer this Question.

Order of Presentation of Cases

10 out of 41 were of a Bullying nature.

7 out of 41 where from Interdisciplinary Dispute Situation

2 out of 41 where Customer Complaints

13 out of 41 did **not** Answer this Question.

Support received from their Line Manager/Organisation.

15 out of 28 replied Yes.

2 out of 28 replied No

11 out of 28 did **not** Answer this Question

Expertise being utilised by their employer.

16 out of 28 said No.

9 out of 28 said Yes

3 out of 28 did **not** Answer This Question

Personal Support System in Place.

22 out of 28 said No.

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3 out of 28 said Yes

3 out of 28 did **not** Answer

In the last 12 months how many of your Cases where?

18 out of 31 replied that there Cases where **Resolved Satisfactory**.

2 out of 31 were referred to **Another Agency**

11 out of 31 did **Not** Answer.

In conclusion the results showed that a majority of the mediators did not feel confident in undertaking mediation and they did not feel that their expertise was being utilised by their employer and a big percentage felt that they had no formal support system in place for them.

On the positive side the amount of contacts they had with their clients were very few and also the variety of cases presented to them was wide-ranging.

The mediator also felt more supported by there line manager/organisation. A high percentage of cases were resolved satisfactorily.

My recommendations for the future regarding the role of the mediators in the HSE is that a focus group would be set up so that the mediators would be able to discuss their future role and also a more detailed survey to be completed.

13 Conclusions.

The development of a Mediation and Partnership approach in the Irish health service could make a significant contribution to the smooth running of the organization.

An exciting development in the management of complaints in the health service was the

publication in February 2007 of the (Policy for the Management of Complaints in the Health Service Executive 2006). In this policy it states that the HSE welcomes the views of patients, service users, carers and visitors. The policy identified that a lot of complaints should be dealt with at the first point of contact and it also recommends that mediation should be used at an early stage if both parties agree.

Based on the reading undertaken for this project we have moved away from the adversarial type of conflict resolution to an alternative dispute resolution system. This includes Partnership Mediation and Facilitation.

The publication of (Quality and Fairness) by the government in 2001 which followed one of the largest consultation processes ever undertaken in the public sector it set out a vision for the health service, it recognized that changes are required in how people are managed.

It stated that there should be a more open manager/staff input into service delivery.

The follow-up from this report was (Action Plan for People Management). This report sets out a timeframe for the completion of the seven key elements which were identified following the consultation process.

The two key elements from the above plan which were discussed in this project were:

- .An alternative to the adversarial type of dispute resolution in the health service.
- Movement towards a more partnership model which included all the stakeholders.

The (Labour Relations Commission Annual Report 2003) cited that the biggest success story of that year was a spread of industrial peace in the Health sector in the second half of the year. In the first half of 2003 “15,800 “days were lost in the health sector due to industrial disputes.

In the next part of the year following the signing of the modernisations/peace criteria agreed under Sustaining Progress which outlawed wildcat strikes there were no days lost to industrial disputes, this was due to a voluntary code of practice on dispute resolution agreed in two key areas of the public sector health and local government.

In this code extensive procedure must be exhausted by workers before they can engage in industrial action, this includes referral to the Labour Relations Commission for conciliation. If this is unsuccessful the dispute is then referred to the Labour court which

has the power to issue a binding resolution.

With the introduction of benchmarking in the public sector in the last few years this has increased the use of alternative dispute resolution. Because in return for increase in salaries staff had to agree to a new set of work practices and a lot of these practices were agreed through partnership

In the (Partnership 2000 Agreement) the concept of working in partnership was initiated and in 2006 (The Health Servers Partnership Agreement) came into force. In this agreement all health service staff, and their representatives and managers, had to agree to participation in the modernisation agenda, and where possible to resolve difficulties at local level.

In my interview with both Ms Killillea from their HSEA and Mr Desmond Kavanagh from the PNA both had commented on the benefit of partnership and mediation.

In Mr Kavanagh's case he stated that he came to partnership with "jaundiced eyes" but was pleasantly surprised with the results.

As I write this project a review has commenced on the (Dignity and Work policy which covers all sexual harassment and any other harassment as outlawed by the (Employment Equality Act 1998) this policy also applies to bullying in the workplace.

The review body includes representatives of the HSEA (employers) and all of the trade unions.

When I started this project I was unclear whether there was a commitment from all parties to mediation/partnership in the Health Services.

Following a review of the literature and my interviews with Ms Killillea and Mr Kavanagh I have come to the conclusion that there is willingness from Government, HSEA and the unions to look at an alternative way of resolving disputes from the adversarial way to a more partnership/mediation process.

I feel that there are certain issues for example bullying, discrimination, interpersonal difficulties, re-organisation of services and customer dissatisfaction where partnership/mediation could be used effectively. As Mr Kavanagh stated in the interview "you may start off with 20 issues 18 of these may be resolved by partnership and 2 may need to go to arbitration, when these 2 issues go to arbitration they are

usually finely tuned and well defined.”

Some of the obstacles which are present in the HSE and militate against movement towards a full partnership/mediation are trust and the sheer size of the organisation. In the past there was a loss of trust between management and unions but with all the developments outlined above trust is being rebuilt again. A further area of mistrust which I observed while I was doing the research for this project is the lack of trust between customer (General public) and the HSE. With the publication of (**Policy for the Management of Complaint in the Health Service Executive**) in February 2007 this presents a more transparent ways of looking at complaints in the HSE. Results from the survey demonstrated some positive and negative results.

On the positive side

- 54% of the mediators returned their completed survey.
- Over 50% said their manager/ organisation were supportive of the mediation work.
- 18 out of 31 cases were resolved satisfactory.
- 16 out of 28 stated that they were not prepared adequately for their work in mediation.
- 16 out of 28 stated that their expertise in mediation was not been fully utilised by their employers.
- 22 of the 28 stated that there was no formal support system in place for them.

To conclude we have started the journey towards Partnership/Mediation in the Irish. Health Service and early indicators are positive, but there is a long road ahead

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15 Appendix.

Appendix 1. Questionnaire Findings.

Appendix 2. Survey Letter and Survey.

Appendix 3. Overview of HSE Complaints Management Process.

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