After the strike: using facilitation in a residency training program

Education

Éducation

Deirdre Andres, MD; Daniel Hamoline, MSW, LLB; Mark Sanders, MD; Judy Anderson, MSW

Dr. Andres is with the Department of Family Medicine, College of Medicine, University of Saskatchewan, Saskatoon, Sask.; Mr. Hamoline is a mediator, counsellor and lawyer in private practice, Saskatoon, Sask.; Dr. Sanders is with the Faculty of Medicine, University of Manitoba, Percy E. Moore Hospital, Hodgson, Man.; and Ms. Anderson is a counsellor and mediator in private practice, Saskatoon, Sask.

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Abstract

METHODS OF ALTERNATIVE DISPUTE RESOLUTION, including facilitation, can be used to identify and resolve areas of conflict. Facilitation was used by the University of Saskatchewan's Department of Family Medicine (Saskatoon division) after the strike by residents in July and August 1995 so as to allow optimal use of the remaining educational time. Through facilitation, experiences of the strike and areas of potential conflict were explored. Participants had a broad range of responses to the strike. Specific coping strategies were developed to deal with identified concerns. Although outcomes were not measured formally, levels of trust improved and collegial relationships were restored. Because so many changes occur in health care and medical education, conflict inevitably arises. Facilitation offers one way of dealing with change constructively, thereby making possible the optimal use of educational time.

Résumé

ON PEUT RECOURIR À D'AUTRES MÉTHODES de règlement des différents, y compris la facilitation, pour définir et régler des conflits. Le département de médecine familiale (division de Saskatoon) de l'Université de la Saskatchewan a utilisé la facilitation après la grève des résidents en juillet et août 1995 de façon à permettre l'utilisation optimale de temps de formation qui restait. La facilitation a permis d'explorer les expériences vécues au cours de la grève et les conflits éventuels. Les participants ont réagi de toutes de sortes de façons à la grève. On a mis au point des stratégies particulières pour faire face à des préoccupations définies. Même si l'on a pas mesuré officiellement les résultats, les niveaux de confiance se sont améliorés et les relations de collégialité se sont rétablies. Comme les milieux des soins de santé et de l'éducation médicale changent tellement, les conflits sont inévitables. La facilitation offre un moyen de faire face aux changements de façon constructive et de permettre ainsi l'utilisation optimale du temps d'éducation.

Group facilitation and mediation are processes of alternate dispute resolution that identify areas of actual or potential conflict, provide resolution of differences and handle multiple constituencies[1] (Appendix 1). Two of us (D.H. and J.A.) had previously been involved with an employee assistance program, where facilitation was used after strikes to enhance communication and reconcile differences in perception between parties.

A process of facilitation was used by the University of Saskatchewan's Department of Family Medicine (Saskatoon division) at the end of the residents' strike in August 1995 for the department's faculty members and the residents. Its purpose was to identify areas of conflict between the participants and to encourage the restoration of functional educational and collegial relationships within the teaching program.

The residents' strike in July and August 1995 came after several years of cumulative change in such areas as licensure requirements, physician quota systems imposed by district health boards and examination requirements. In the spring of

1995 the University of Saskatchewan, in an attempt to cope with the financial crises facing postsecondary education, decided to charge the residents tuition. When residents were unable to negotiate any change to this decision, the majority of them, including all family medicine residents, went on strike.

The strike ended after 6 weeks because both the College of Family Physicians of Canada[2] and the Royal College of Physicians and Surgeons of Canada[3] have strict limits on the amount of time residents can miss from their programs before suffering education penalties. However, the issues that had precipitated the walk-out had not been resolved, and new layers of anger and frustration had accumulated.

Faculty members' concerns

Faculty members had to identify and deal with their own varying reactions to the strike. They wanted to maximize the educational time remaining, especially for the final year residents, by identifying areas of difficulty and developing effective interventions. Their concerns included the possibility of resentment, anger and demoralization on both sides that might affect faculty members' ability to teach effectively and the residents' ability to pursue their training. Faculty members also wanted to offer constructive support to the residents. They therefore approached the residents to suggest facilitation as a way to address these concerns.

Residents' concerns

The residents felt varying degrees of anger, resentment and apprehension at the end of the strike. They were disappointed at being forced back to work without any resolution of the key issues leading to the strike. Many were concerned about the loss of 6 weeks from a relatively short training program. There was anger at administrative staff, hospital staff and faculty members who had publicly disapproved of the residents' actions. There was some fear regarding the unavoidable confrontations with these individuals. Residents were apprehensive about encounters with patients who did not understand or accept their actions. They were concerned about patients' inevitable comments and questions.

Among the residents commitment to the strike had varied. This generated resentment and divisions within the group. Residents were also disappointed that faculty members had not intervened on their behalf with the school.

The facilitation process

When the strike ended, the residency training coordinator contacted the facilitators and the chief resident. The facilitation took place within 2 days after the strike's end. This key feature ensured that intervention could take place before negative reactions could solidify.

Faculty members and unit administrative staff were invited to attend by the residency training coordinator; 2 of the senior residents contacted all the residents. Voluntary participation was another key feature, especially because some people had expressed hesitation about attending. To reduce barriers to attendance the 3-hour session was planned for the regular academic half-day. No records were kept during the process so as to encourage participants to speak freely and to ensure confidentiality. For the same reason, attendance was not recorded, although it is estimated that most of the faculty members and half of the residents came. None of the residents who were on out-of-town rotations returned for the facilitation.

Initially, the facilitators worked from prepared written exercises and questions (Table 1). They began by asking participants for their expectations and reasons for attending, then moved to a more direct exploration of the effects of the strike on individuals. The role of the facilitators was to ensure that everyone had an opportunity to participate and to guide discussion. The ensuing structured discussion revealed varying points of view about the effectiveness of strike action in general and about this strike's importance.

Participants with differing viewpoints were able to discuss these differences clearly and respectfully and arrived at a better understanding of other peoples' positions. They were able to articulate concerns about any academic penalty or loss of educational time, and how that fear influenced their participation in the strike. Those who had been concerned about lack of solidarity discovered some of the reasons underlying that issue. Residents talked about their expectations of faculty members during the strike and how they had perceived faculty members might intervene. Faculty members discussed their feelings of powerlessness to intervene effectively. As the dialogue became more spontaneous, new areas of concern appeared, including those about how to address and respond to patients who often expressed strong feelings about the strike. Concerns about morale were found to be less serious than feared.

Table 1: Facilitator's prepared questions

How do you want to use this meeting? (written answer)
How has the strike affected you? (written answer)
How will you focus your anger?
How are you coping on a personal level?
How do you think your coping strategies will affect your functions?
Why do you think people are participating in this meeting?
How can you refocus so that you can continue to address issues while dealing with patient care and collegiality?

The development of options was another key feature of the process. Participants developed concrete strategies for dealing with areas of concern they had identified. For example, they developed a list of possible responses to patients' concerns. The group also developed strategies for identifying other sequelae of the strike and for coping with and solving problems in these areas. The facilitators offered the options of follow-up for the group as a whole and for individuals if a need was expressed.

Outcome

Outcomes reported are based on observation during the facilitation process and in the weeks that followed. Formal outcome assessments could not be undertaken while the residents who participated in the process were still in the program.

All those who attended took part in the discussions. As dialogue took place, participants' comments revealed that they were gaining new insights into others' actions and opinions. Specific coping strategies were developed to deal with identified concerns. Residents were able to discuss ways of pursing their various goals of education, patient care and administrative change. Faculty members were able to develop a better understanding of the underlying issues prompting the strike, including the residents' unmet expectations of them.

The facilitation appeared to provide reassurance that all participants could work toward common goals of teaching, learning and patient care. The strike became a common experience that could be discussed openly, instead of an "elephant in the waiting room" that everyone tried to ignore.

Conclusions

A main tenet of family medicine is patient-centredness. Good clinical medicine includes identifying and incorporating the patient's beliefs, feelings, expectations, level of functioning and previous experiences into the treatment or management plans.[4–6] Learner-centred models of education allow the learners to identify their needs and expectations, which are incorporated into the educational plan.[6] The facilitation process incorporates many of the same principles, parallels the exploration of experiences, needs and expectations and has as its goal an improved level of functioning. Any decisions made during facilitation are based on common ground.

After the strike, it was apparent that experiences, perceptions and needs of both residents and faculty members had changed. The facilitation encouraged mutual understanding and enhanced use of the remaining training time and resources.

Little literature exists on the outcomes of facilitation. More formal assessments are needed to corroborate the observed outcomes.

Although the strike was an extreme example of the effects of external stressors on education programs, a significant number of the precipitating stressors still exist in Saskatchewan and across Canada. This has the potential to affect postgraduate training and education. Facilitation can allow groups of people with differing points of view the opportunity to explore differences, identify concerns and find common ground. This becomes increasingly important at a time when medical education and practice are changing rapidly and in profound ways, where the changes are often not within the control of those affected and where the resulting stresses can interfere with faculty members' and residents' ability to function.

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Reprint requests to: *Dr. Deirdre Andres, Academic Family Medicine, Royal University Hospital, 103 Hospital Dr., Saskatoon SK S7N 0W8; fax 306 655-6822*

Appendix 1: Alternate dispute resolution

Alternate Dispute Resolution (ADR) refers to various processes that can be used to help participants resolve conflict without resorting to the courts. The advantage of ADR is that the interested parties retain higher levels of personal control over the outcome, and the focus of the resolution is less on win/lose decisions and more on solutions that meet the mutual needs of the people involved.[7] The process is often faster, less expensive and more private than traditional legal channels.

ADR is being used increasingly in all facets of society, including law,[8,9] business,[10] public school education,[11,12] labour-management, environmental issues and public policy matters.[9] Mandatory mediation has been introduced in some jurisdictions for civil and family law cases.[13] Several provincial colleges of physicians and surgeons use ADR in selected patient–physician disputes, and are participants in the process. The Saskatchewan college, for example, uses both informal and formal mediation to deal with patients' complaints. A few cases of ADR are noted in patient care.[14,15]

The principal tenets of ADR are:[7]

- voluntary participation when parties believe they can no longer resolve the conflict on their own;
- the involvement of an impartial third party who has no authority over the outcome; and
- the prevention of the process and outcome from being open to public scrutiny.

Facilitation is the least well-defined term in ADR literature. The *Concise Oxford English Dictionary* (7th ed, 1982) defines "facilitate" as to "make easy, to promote or help forward." In usage by one of us (D.H.), facilitation assists parties in addressing communications, interactions, roles, attitudes or stressors. Reaching agreements on substantive matters is incidental or not an issue. The process excludes producing written or oral recommendations to any outside parties.

Mediation assists parties in reaching agreement on disputed issues. Changes in communication, attitude, perceptions or interactions may also occur as a result of the process.

Conciliation involves an attempt to mediate, with written recommendations or reports to an outside party if an agreement is not reached.

Arbitration is used when the disputants ask the third party to make a decision for them. The decision may be divisory or binding. The arbitrator controls the outcome.