
CONFLICT MANAGEMENT IN SURGERY: THE IMPACT OF THIRD PARTY CONSULTATION

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Abstract

This one-year study describes the impact of a third party consultation intervention in an operating room of a major medical center. The results show statistically significant levels of improvement on all six subscales of the Group Behavior Inventory, as well as improvements in group effectiveness, honest communication, comfort discussing organizational problems, and interpersonal trust. Additional results include an increase in the availability of surgical supplies and equipment, a 95% decline in physician abuse of scheduling privileges, a decrease of verbal abuse of nurses by physicians, the reconvening of the OR Standards Committee, and a decrease of nursing turnover from 30% the previous year to zero.

Conflict Management in Surgery: The Impact of Third Party Consultation

Conflict is inherent in all relationships and can arise from a variety of sources (*Walton, 1987*). For example, it can result from such substantive issues as task orientation, pay rates, work methods, conditions of employment, and competition over scarce resources. Conflict can also develop from interpersonal issues, such as personality differences, misunderstandings among group members, a lack of interpersonal skills, and the emotional baggage people bring to relationships. Third party interventions focus on conflicts that arise between two or more people in the same organization and are designed to address and resolve conflicts that disrupt effective task accomplishment and work flow (*Golembiewski & Rauschenberg, 2000*).

In an exhaustive study of conflict, negotiation and third party models, Lewicki, Weiss and Lewin reported that, historically, research on third party consultation has been categorized according to style and the social context in which it occurred. Unfortunately, it was not until recently that researchers began to reference one another's work, so most third party research developed in relative isolation. This unfortunate circumstance also "led to a general failure to contrast various party styles within the same context, and a failure to compare the impact and effectiveness of styles across contexts. Both consequences have hampered model development" (*Lewicki, Weiss & Lewin, 1992, 230-231*).

Nevertheless, several models have emerged as dominant paradigms. For example the Process/Decision Control model (*Thibaut and Walker, 1975*), the Matrix model, (*Sheppard, 1984*) and the Process Consultation Model (*Walton, 1987; Schein, 1969*) provide theoretical frameworks for practitioners and researchers alike. In addition, attempts have been made to apply third party processes in a variety of different problem-solving contexts, including problems with racial tension in Rhodesia (*Burton, 1969*), a border dispute in East Africa (*Doob, 1970*), religious conflict in Northern Ireland (*Alevy, Bunker, Doob, Foltz, French, Klein and Miller, 1974*); Arab-Israeli relations (*Kelman, 1976; Cohen, et.al., 1977*); and community organization disputes (*Fisher, 1983*).

The model used in this study is derived from Walton's (I) research and includes preliminary interviewing, structuring the confrontation, facilitating dialogue between the parties, encouraging problem solving, and planning for the future. Specifically, the study describes a third-party intervention between an operating room director and the chief of surgery in a major medical center. (1) The results indicate that this intervention both improved the relationship between the two parties and had a wide-spread impact on the surgery department as a whole.

Background

Practicing physicians have ties to specific, and often multiple hospitals whose specialized facilities they use. Surgeons, for example, depend on access to operating rooms and, therefore, tend to associate with multiple institutions. Some have enough clout to demand from their hospitals special or extra resources and privileges. If such privileges are denied, they often threaten to move their patients to a different hospital more willing to meet their demands. Furthermore, a physician who has ties to high levels of authority within the hospital administration can use these connections to bring pressure on the staff to comply.

Such was the situation faced by Lincoln Hospital, a for-profit hospital that had several hundred beds to fill. The hospital's administrators, including its previous president, had usually complied with the demands of its surgeons, even reassigning or dismissing staff members with whom some surgeons did not like to work. The hospital's current president felt similar pressure but was reluctant to satisfy unreasonable demands or to lose control of hospital administration and policy to surgeons.

One specific challenge illustrating the problems faced by this president was the conflict between the hospital's operating room (OR) director and an orthopedic surgeon who enjoyed hospital privileges. Mary, the strong-willed OR director, was a conservative, no-nonsense administrator, who strictly followed all the hospital's policies and procedures. She felt that her consistency and impartiality in her dealings with both staff nurses and surgeons were personal and professional strengths, and that her decade-plus history of trust from the administration, respect from the OR staff, and good interactions with at least some of the

physicians justified her management style. Other physicians, however, disliked Mary for her strong will and what they saw as inflexibility.

Don, an orthopedic surgeon, had long and often spoken critically about the hospital. The hospital administrators, while recognizing his professional competence, had strong misgivings about his generally abrasive manner toward professional staff. The nurses' reaction to him was fear.

In contrast, Don's physician peers valued these same abrasive qualities. Don was articulate; moreover, he had access to the president and went to bat for his fellow surgeons. His peers perceived that these qualities, together with his aggressive approach to everything he did, would help represent them in dealings with the hospital's administration. Also, Don's large practice provided him with professional security. So he felt free to engage in, and powerful enough to win, battles with the administration that his peers were reluctant to take on. Finally, Don shared the other physicians' dislike of Mary and wanted her removed as OR director. For these and other reasons the physicians saw fit to elect Don chief of surgery.

Still, the president himself was unwilling to remove Mary from her position. Satisfied with her performance generally as he observed it, he had concluded that responsibility for the problems in the OR rested on the surgeons as well as the nurses, not just on Mary alone. Furthermore, finding a new OR director would not be easy. Therefore, he directed Mary and Don to come together and resolve their problems; the status quo was simply not an alternative.

Mary felt that it was futile to expect any positive outcome from meeting with Don. For his part, Don could see only loss of power and influence if he yielded any ground to Mary. The hospital's president had made it clear that they must reach a resolution, and the situation itself demanded a change, but the total lack of trust between them made it unworkable for them to meet alone. Accordingly, Don and Mary agreed to have three hospital vice presidents participate in their meetings as neutral observers to help them resolve their differences. But the first meeting only worsened the situation. The two parties wasted the time defending themselves and attacking each other, with much shouting and no actual listening. All attempts by the three observers to defuse the situation and

move toward compromises were only seen by each party as taking the side of the other.

As a result of this first disastrous meeting, a skilled consultant was brought in as a neutral third party. He interviewed first Don and Mary and then 25 surgeons, nine surgical nursing managers, three vice presidents, and the president. Now the real problems, extending well beyond the personal difficulties between Mary and Don or issues in the OR, came to light for the first time.

Two positive findings emerged about Mary and Don, personally. One was that technical competence in their respective professions was not at issue. The other was that each saw that the problems were major, and did want to resolve them. Nevertheless, differences in personality and perceptions were enormous. Don wanted to make an example to the rest of the medical staff by firing Mary, even though he admitted that only some of the OR problems were due to her shortcomings. Mary, to her credit, did focus on Don alone; but she saw him as an abusive, arrogant, egotistical clod unwilling to actually listen to input from anyone else. Each had a strong need to control others, coupled with a strong unwillingness to be controlled. Their only meeting ground was a desire to resolve their differences.

It further emerged that the conflict between Don and Mary was only the tip of the iceberg. During the previous eight months, for various reasons, but at least partly in response to verbal abuse of nurses by physicians, more than a third of the OR nurses had quit, and the OR was still short seven surgical nurses. Because of this turnover, and the replacements' lack of training and experience, the general level of skill among the staff had been compromised--and with it, patient care.

Don, in voicing his own feelings, spoke also for many of the other surgeons:

I don't think the administration has a clue as to how urgent this matter really is. It takes at least five years for a surgical nurse to gain the necessary skills to be useful. In the last two months, we have lost some of the best nurses I have ever worked with in my life. As a result, I have had to start the training process all over again. It

has seemed like I've been working with a group of student nurses! This turnover has cut my productivity by more than 50 percent. (Boss, 1989, pp. 29-30.)

Management of the OR also suffered serious problems. On not just a few occasions nurses had failed to provide equipment needed for surgery. Orthopedic surgeons had found in the middle of an operation that the needed prosthesis either was the wrong size or had not even been ordered. This, of course, caused needless pain and stress to the patient, and great loss of time and resources on the part of the surgical staff and hospital.

But many frustrations voiced by physicians were directed not at OR nursing staff or general hospital staff, but at other physicians. More than a third of the surgeons were labeled by their own peers as perfectionist prima donnas who took no responsibility for their own dysfunctional behavior, even while complaining about the same behavior in their peers. Blind to their own selfishness, most of the surgeons felt that their own time was far more important than anyone else's, and complained bitterly when their schedule was delayed or things didn't generally go according to their wishes. Scheduling in the OR had become a great problem; the tardiness of whoever was scheduled first bumped all the subsequent surgeries for that operating room and also forced postponements of surgeries in other rooms because the scheduled nurses were still tied up with earlier operations not yet completed. Curiously, the loudest complainers were often the greatest offenders.

Rather than changing their own behavior and working constructively to resolve problems, the surgeons mostly just engaged in gossip and backbiting. Much of their hostility was directed unjustly at the nurses. Consequently, morale was very low. Physicians and nurses ignored each other rather than cooperating, and both groups saw the administration as ineffective in doing anything to relieve the situation. Worse yet, two groups of surgeons were planning to build their own outpatient surgical centers.

Because of Mary's responsibility for the OR, and Don's position outside the formal authority structure of the hospital (which meant he couldn't be forced to do anything), the first step in problem resolution was for the consultant to see whether Don and Mary even shared any commitment to improving their working relationship. They did. Both Mary

and Don privately defined the kind of help they wanted and explained how they wanted it to be given; they pledged to do all they could to make things work, on condition that their basic values be held inviolate.

The Intervention

The strategy for helping Don and Mary improve their working relationship rested upon (a) sharing perceptions, (b) identifying problems, and (c) following-up (*Fordyce & Weil, 1971*). Specifically, Mary and Don responded in writing to three questions:

1. *What does he or she do well?*
2. *What do I think I do that bugs him or her?*
3. *What does he or she do that bugs me?*

Then Mary and Don each explained their responses to the consultant while the other listened. To negotiate around their mutual hostility, the consultant first had them talk only to him. Their responses are shown in Figure 1.

Figure 1
Participants' responses to questions in the third-party consultation model.

- 1a. What does Mary think Don does well?
 - He is very concerned about patient care.
 - I admire him for his skills as a surgeon. I would have no problem sending a member of my family to him.
 - He is interested and wants to work out issues that we have with each other.
 - He can be very gentle and considerate at times.
 - He is well respected for his skills by his peers and by the OR nursing staff.
- 1b. What does Don think that Mary does well?
 - She is honest in her work.
 - She has met my needs in orthopedics in getting us the instruments and equipment we need.
 - She has a lot of external pressures on her and she has handled them well.
 - She deals well with the various groups that are pulling at her: patients, staff, administration, and physicians.
 - She manages the overall picture very well in the OR.
- 2a. What does Don think he does that bugs Mary?
 - I am impatient. (Mary agrees)
 - I am demanding of personnel in surgery, but everyone can't always get what they want, when they want it. (Mary disagrees)
 - She is uncertain about how much I am willing to support her this coming year. (Mary agrees)
 - I am not the best listener. (Mary agrees)
- 2b. What does Mary think she does that bugs Don?
 - I don't listen to him. (Don agrees)
 - I appear defensive at times. (Don agrees)
 - My response to some directives is too detailed. (Don agrees)
- 3a. What does Mary do that bugs Don?

- She is difficult to communicate with. I can talk to her, but I am not sure that she is listening.
- She doesn't assume the responsibility for some specific problems, such as not being able to do an operation without a full set of prostheses available.
- She doesn't effectively manage the personnel that she supervises in OR. Specifically, there is a great deal of disruption that is going on. And there are also morale problems among employees, caused by their lack of trust of her and her lack of trust of them in the OR.

3b. What does Don do that bugs Mary?

- He generalizes and is not very specific with examples, even when questioned.
- The staff labels him as a whiner, in terms of nothing is ever right; his complaining, etc. This also relates to laying out problems and then walking away.
- He sometimes says one thing but means another; he gives mixed messages. For example, I ask him how things are going, he says fine, but I then find out that he has problems later in the day.
- I do not feel a full measure of support from him, and that bugs me.
- He doesn't always listen (*Boss, 1989, pp. 32-33*).

An essential benefit of this design was that the writing down of specific liked and disliked behaviors introduced an element of rationality into an otherwise emotionally weighted process; subjective statements, value judgments, and gross generalizations were unacceptable. By listing their observations, each realized that the things that actually bothered them about each other were not permanent and irremediable, as they had imagined. Also, the simple act of writing things down diffused hostility by guaranteeing that each would be able to tell his/her own story without interruption; afterwards, each was more willing to listen respectfully.

By allowing both participants to concentrate on the positive aspects of their relationship, the design helped each to dampen hostility toward the other's negative traits and to begin cooperating. Don later commented:

I was stunned to hear her say those positive things, particularly the part about me taking care of her family. For a long time, I had seen her as my enemy, and I expected only the worst. I was amazed that

she had so much respect for me. As a result, many of my negative feelings for her began to disappear. It is really tough to stay angry at someone who says so many nice things about you. I also found that I was much more willing to listen to what I do that bugs her. Somehow, criticism is always easier to take when it is accompanied by something positive (*Boss, 1989, p. 34*).

The second question forced them to examine their own inconsiderate behaviors in detail, as neither had been willing to do earlier. Mary explained:

It had never really occurred to me that I may be doing something that caused Don to react that way. Vaguely I suspected that I may be doing something that he didn't like. But I was hard pressed to identify what it was. I really had to stand back and say to myself, "What is it that I am doing that is making this working relationship go sour?" I had spent so much time concentrating on what he was doing that bugged me that I hadn't looked at myself (*Boss, 1989, p. 34*).

Once they discovered that they had been far less hard on each other than on themselves, the subsequent criticisms they did pronounce upon each other seemed, by comparison, much less offensive. This question also helped each come to appreciate for the first time that neither had been intentionally causing problems for the other. Consequently each became willing to begin giving the other the benefit of the doubt.

Mary and Don's responses to the third question were listed on a large sheet of paper. Each then indicated the intensity of his or her dislike for a particular behavior by an arrow whose length indicated the perceived magnitude of the problem.

Both were surprised to realize that some behaviors offensive to the other could be corrected immediately, even though others might take longer. Each discovered major barriers that needed to be removed to improve their working relationship. And this cooperative process continuously helped each to begin to trust the other. Both came to realize that neither could improve their mutual relationship nor resolve problems in the department without full cooperation from the other.

Each was asked to develop action items in response to the following questions:

- *What will I do to help resolve this problem?*
- *What will the other person do to help me succeed?*

Through this process, both participants changed from competing to collaborating. Each defined the specific behaviors he or she wanted the other to change, and also negotiated those behaviors he or she personally was willing to address. In effect, each informally contracted with the other to reduce or eliminate identified problems. The consultant documented their decisions. At the meeting's end each received a copy of the agreements.

The consultant and the three observing vice presidents met with Mary and Don every three months for one year. Before each meeting, the consultant interviewed each of the five people privately to evaluate progress. The agenda for each meeting began with a review of commitments made and kept. The follow-up included a status report on how Mary and Don were improving their interaction and what was happening in the OR. Each reported specific behaviors of the other that he or she noticed and appreciated, as well as positive things that had taken place in the department because of those behaviors. Where commitments had not been kept and progress was less than desirable, plans were made to ensure future follow-through. To their credit, both Mary and Don had in almost all instances acted as they had agreed to do. This adherence to agreements from one quarter to the next continued to build interpersonal trust and strengthened the foundation for further identification of problems and planning of new or continued action.

Methods

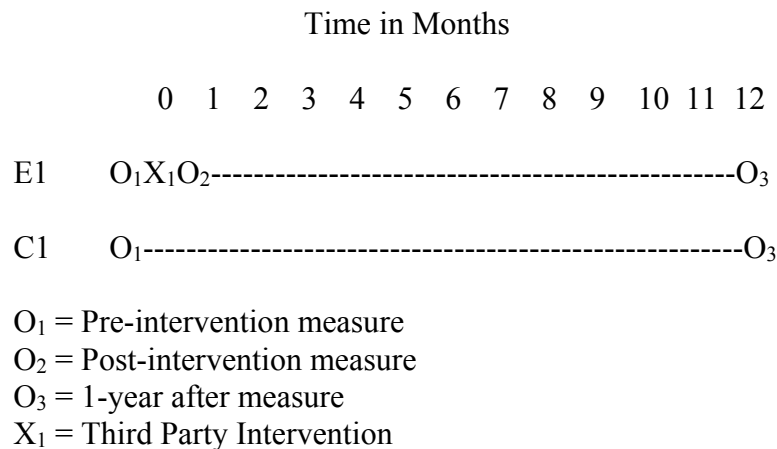
The major instrument used to measure the effectiveness of this intervention was Friedlander's Group Behavior Inventory (GBI). All subjects were asked to complete the instrument with the other person in mind, and some of the questions were slightly modified to reflect a group of two people. The GBI (Friedlander, 1968) measures group performance and group interaction in an organizational setting. The six dimensions or

subscales include Group Effectiveness, Leader Approachability, Mutual Influence, Personal Involvement and Participation, Intragroup Trust, and Worth of Meetings.

The participants also responded to four additional questions designed to measure the degree to which they worked effectively together, the honesty of their communication, their comfort in discussing organizational problems, and their trust for one another. Respondents rated these questions from 0= *Not At All* to 10= *Completely*. The questions were phrased as extremes (e.g., "The degree to which you trust [the other person].").

Mary and Don completed the instrument three times: immediately before and after the intervention and one year later. The Comparison Group members, made up of an OR director and chief of surgery in a sister hospital in the same health care system and located in the same general geographical area of the U.S., completed their questionnaires one year apart. All data were analyzed by one-way ANOVA (analysis of variance) (Winer, 1991). (2) The design of this study is shown in Figure 2.

Figure 2
Design for data collection.



Results

Several factors suggest that the third party intervention reported in this study played a significant role in improving both Don and Mary's working relationship and the effectiveness of the department as a whole. First, Table 1 contains the one-way ANOVA results on the six GBI subscales for Don & Mary and the Comparison Group.

Figure 3

Presents the mean GBI scores for each subscale in a graphical format, and Figure 4 shows the same information for the Comparison

After - 1 Year After	1	7.02	11.56	4.00	169.0**	2.78	4.50
Error	5	(7.34)	(4.71)	(8.49)	(7.05)	(6.33)	(7.74)

Comparison Group

Source	df	F					
		Group Effectiveness	Leader Approachability	Mutual Influence	Personal Involvement	Intragroup Trust	Worth of Meetings
Between Subjects							
Before - 1 Year After	1	0.007	0.012	0.077	0.024	0.040	0.077
Error	3	(0.003)	(0.003)	(0.010)	(0.010)	(0.010)	(0.004)

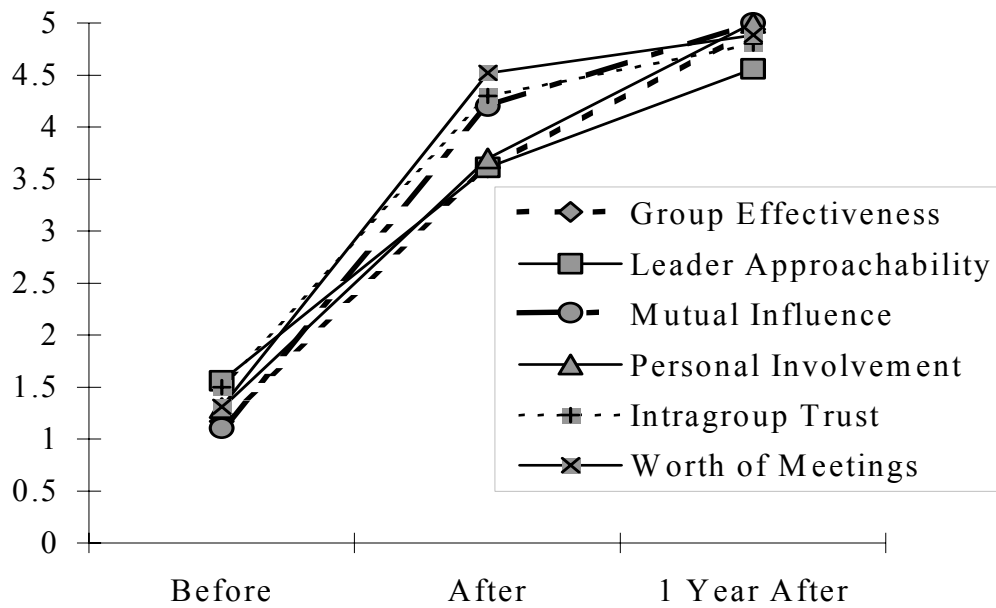
Note. Values enclosed in parentheses represent mean square errors between subjects.

* $p < .05$. ** $p < .01$.

Group. The data show a statistically significant improvement between the Before and After measures and a continued improvement during the

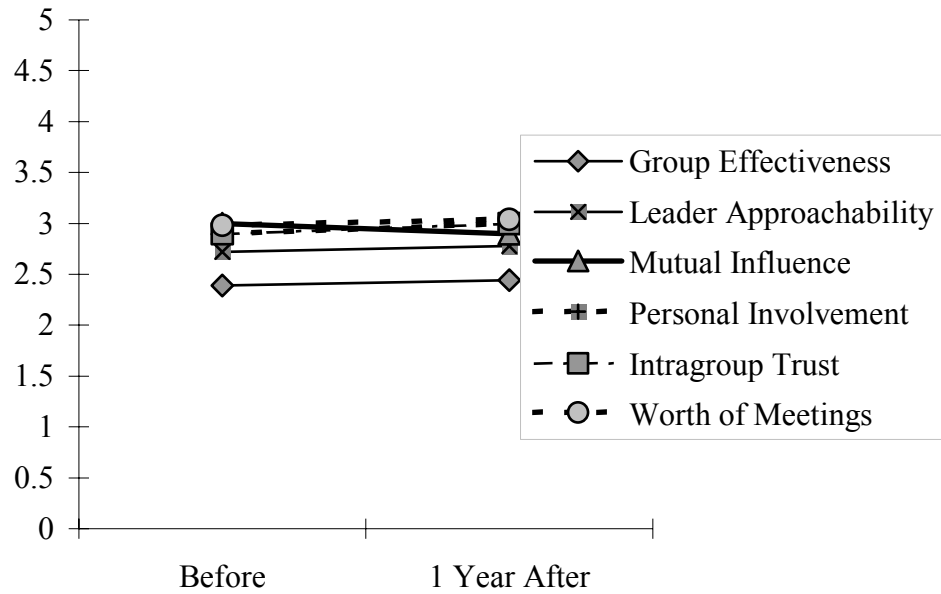
Figure 3

Don and Marv's average Before, After, and One Year



following 12 months, while the Comparison Group shows no statistically significant differences during the 12 month period.

Figure 4
Comparison Groups' average Before and One Year After GBI



Second, Table 2 shows the one-way ANOVA results for the four additional questions about group effectiveness, honest communication, comfort discussing organizational problems, and interpersonal trust for Don and Mary and the Comparison Group, while Figures 5 and 6 present the graphs of Don and Mary's mean scores, and the same information for the Comparison Group. In each case, the results approximate those from the GBI in direction and significance. The data show statistically significant improvement between the Before and After measures on each variable for Don and Mary, and that level of improvement was sustained for the subsequent 12 months, while the Comparison Group showed no statistically significant changes between measures.

Table 2
Analysis of variance for four measures of group effectiveness

Don and Mary

Source	df	F			
		Team Functions Effectively	Honest Communications	Organizational Problems are Discussed	Trust For Other Person
Between Subjects					
Overall Model	2	85.33**	41.17**	97.33**	35.17**
Before - After	1	128.0**	98.00**	162.0**	98.00**
After - 1 Year After	1	0.00	1.80	2.00	0.20
Error	5	(42.67)	(41.17)	(48.67)	(35.17)

Comparison Group

Source	df	F			
		Team Functions Effectively	Honest Communications	Organizational Problems are Discussed	Trust For Other Person
Between Subjects					
Before - 1 Year After	1	1.000	0.200	1.000	0.077
Error	3	(0.250)	(0.250)	(0.250)	(0.250)

Note. Values enclosed in parentheses represent mean square errors between subjects.

* $p < .05$ An Interaction
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Figure 5
Don and Mary's average Before, After, and One Year After scores
on four measures of group effectiveness.

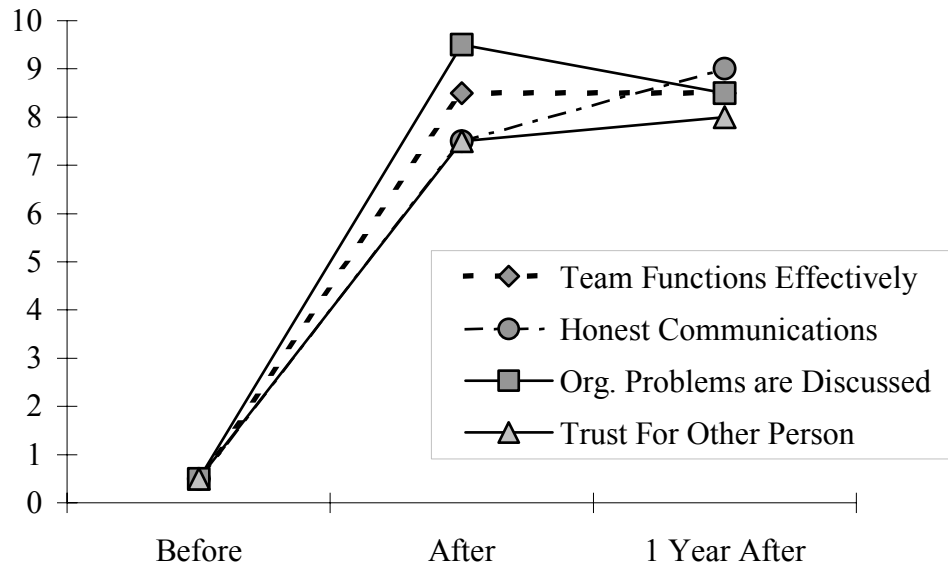
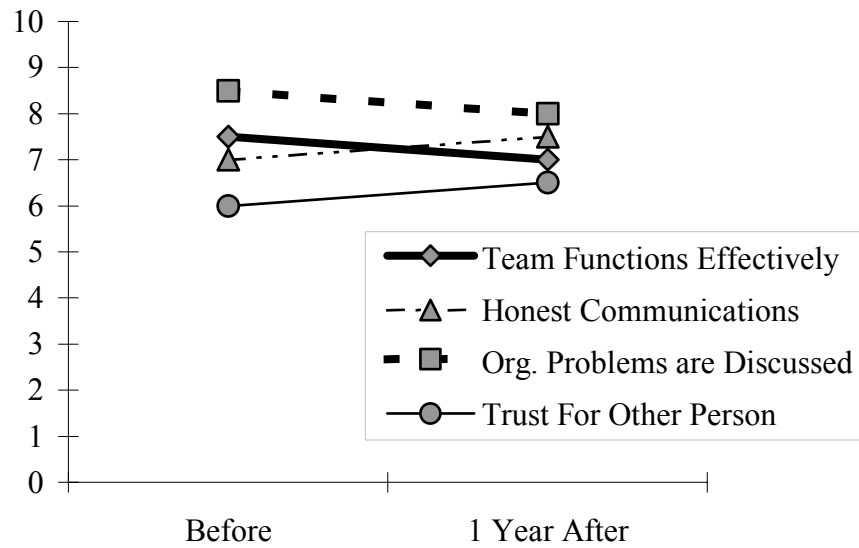


Figure 6
Comparison Groups' average Before and One Year After scores on
four measures of group effectiveness.



Third, significant improvements were realized in surgical services, including improved management of the OR. During the twelve months following Don and Mary's first meeting with the consultant, no problems were reported with regard to any prosthesis needed for scheduled orthopedic surgery. Other surgeons also reported significant improvements in availability of surgical supplies and equipment.

Fourth, three months after the project began, Mary initiated regular meetings with her staff to develop ways to improve their working relationships with each other, as well as with difficult physicians, and to address improvements needed in the OR. Through the concerted effort of all concerned, who were willing to take personal responsibility for their own actions, the morale and working climate among surgical personnel, as well as hospital medical staff in general, were significantly improved.

Fifth, Don took the initiative in helping the OR physicians address scheduling of the operating rooms. Surgeons who abused their scheduling privileges lost their priority times for surgery. Within a few weeks, their behavior changed significantly, and by the end of the study period, abuse of scheduling privileges declined by 95 percent.

Sixth, physicians committing verbal abuse were confronted and held accountable for unprofessional behavior. During the last half of the year, no physician was reported to have verbally abused a nurse.

Seventh, the hospital OR standards committee, which had not functioned for more than six years, was revived. This committee, which included Mary, as the OR director, and six surgeons, was responsible for

- (a) approving all proposed changes in procedures, supplies, and equipment;
- (b) monitoring the scheduling practices of physicians; and
- (c) following changes in patient care.

With this stimulus the leadership of the OR became proactive and focused on problem prevention and planning, rather than simply reacting to crises after they erupted.

Eighth, even the ongoing shortage of qualified nurses was resolved. All seven vacant positions were filled by experienced nurses. Equally important for hospital finances, the turnover rate (and recruitment costs) for surgical nurses dropped to zero. This translated into a savings to the hospital of more than \$300,000, compared to the year before.

Ninth, the two groups of surgeons, who had planned to build their own outpatient surgical centers, scrapped the idea. The hospital had improved their services to the point that they saw no need to proceed with their construction plans.

Summary

Although this study provides no long-term data on the effects of the intervention, the results reported here provide evidence of the positive impact a third party design can have on both a dysfunctional interpersonal relationship between two people and the ineffective department in which they worked. In this case a turbulent and destructive relationship between an otherwise valued staff member and an accomplished surgeon changed into a productive and regenerating relationship between two highly competent professionals who willingly cooperated to resolve the serious problems facing the OR. Although the problems between Mary and Don were only the tip of a figurative iceberg involving the whole OR as well as attitudes and behavior of the hospital staff in general, Mary and Don's interpersonal conflict had profoundly affected how well surgical services as a whole functioned. The problems could not have been resolved without their cooperation and support. Significant improvement occurred early, and continued throughout all four quarters of the project. As Mary and Don kept their commitments, they developed enough trust in each other to concentrate less on what they disliked about one another and more on what they could cooperatively accomplish in improving surgical services. Thus, in the short-run, the project appears to be highly successful. The long-term impact of the intervention will depend on the continued commitment of both parties and the continued support of the administration and the medical staff.

Notes

1. This version adds material to and corrects inaccuracies in the following: Boss, R. W. (1989). Organization development in health care. Reading, Mass.: Addison-Wesley, pp. 27-37; Boss, R.W., Boss, L.S. & Dundon, M.D. (1990). Lincoln Hospital: Third party intervention. In A. Glassman & T. G. Cummings (Eds.), Cases in organization development (pp, 203-212). New York: Irwin; and Boss, R.W., Boss, L.S., & Dundon, M.W. (1990). Lincoln Hospital: Third party intervention. In A. Glassman & T. G. Cummings (Eds.), Cases in organization development instructors manual (pp. 75-77). New York: Irwin.
2. All data in this study were analyzed by a researcher who was not involved in the intervention.

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