

Managing Conflict in an Urban Health Care Setting: What Do "Experts" Know?


Kenneth Kressel

Cheryl Ann Kennedy

Elise Lev

Louise Taylor

Follow this and additional works at: <http://digitalcommons.law.umaryland.edu/jhclp>

 Part of the [Dispute Resolution and Arbitration Commons](#), and the [Health Law Commons](#)

Recommended Citation

Kenneth Kressel, Cheryl A. Kennedy, Elise Lev, & Louise Taylor, *Managing Conflict in an Urban Health Care Setting: What Do "Experts" Know?*, 5 J. Health Care L. & Pol'y 364 (2002).

Available at: <http://digitalcommons.law.umaryland.edu/jhclp/vol5/iss2/5>

This Article is brought to you for free and open access by DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized administrator of DigitalCommons@UM Carey Law. For more information, please contact smccarty@law.umaryland.edu.

MANAGING CONFLICT IN AN URBAN HEALTH CARE SETTING: WHAT DO "EXPERTS" KNOW?¹

KENNETH KRESSEL, PH.D.*
CHERYL ANN KENNEDY, M.D.**
ELISE LEV, ED.D, R.N.***
LOUISE TAYLOR, PH.D.****
JONATHAN HYMAN, J.D.*****

PART I: THE NATURE OF HOSPITAL CONFLICT

I. INTRODUCTION

Conflict within and among health care institutions is increasing as the result of major structural and economic shifts in the health care sector. The vast majority of these conflicts never reach the threshold of formal mechanisms for dispute management (such as litigation, formal grievance procedures, or hospital bioethics committees), yet there is reason to believe that they are a major source of stress and concern for health care workers.² Despite their ubiquity and importance, such conflicts have been very little studied. Recent efforts to

* Professor, Department of Psychology, Rutgers University (Newark Campus) and Director, Certificate Program in Conflict Management.

** Associate Professor, Departments of Psychiatry and Preventive Medicine and Community Health, UMDNJ - New Jersey Medical School.

*** Associate Professor of Nursing, College of Nursing, Rutgers University (Newark Campus)

**** Lecturer, Department of Psychology, Rutgers University (Newark Campus)

***** Professor of Law, School of Law, Rutgers University (Newark Campus), and Associate Director, Certificate Program in Conflict Management

1. We gratefully acknowledge the support provided for this project by the Joseph C. Cornwall Center for Metropolitan Studies, Rutgers University - Newark Campus, and The Office of Research and Sponsored Programs of Rutgers - The State University. We are deeply indebted to the health care professionals whom we interviewed and to whom we gave assurances of anonymity and confidentiality. Their thoughtful attention to our questions and generous sharing of their experience made this study possible. We would also like to thank the following individuals for their valuable help in the planning stages of this project: Lorraine Little Bell, Department of Human Services, University of Medicine and Dentistry of New Jersey; David H. Dixon, Manager, Guest Relations, Jersey Shore Medical Center, Neptune, New Jersey; Joseph Savage, Vice-President for Marketing and Development, St. Michaels Hospital, Newark, New Jersey; and Joanne Stevenson, Associate Dean, College of Nursing, Rutgers University. Shilpa Reddy, of the Department of Psychology of Rutgers University - Newark, conducted two of the interviews reported in this study.

2. Susan Lees & Nick Ellis, *The Design of a Stress Management Programme for Nursing Personnel*, 15 J. OF ADVANCE NURSING 946, 951-53 (1990); see Thomas I. Chacko & John K. Wong, *Correlates of Role Conflict Between Physicians and Nurse Practitioners*, 54 PSYCHOL. REP. 783, 785 (1984); Gunnell Elander & Goran Hermeren, *The Autonomy of Nurses in High*

address health care audiences about them have depended largely on anecdotal evidence and on extrapolating from research on other forms of social conflict.³

The current study seeks to increase our understanding of the nature and dynamics of health care conflict by focusing on a group of health care professionals within an urban teaching hospital with a reputation as skilled, if informal, conflict "mediators." While there is compelling evidence that the use of third party mediators is an effective tool for the constructive management of conflict,⁴ little of this research has occurred in health care settings, and even less of it has focused on persons who do not formally occupy the mediation role.⁵ In many workplace settings, however, such emergent mediators appear to be a large, if untapped, source of social wisdom about conflict and its management.⁶ We assumed that this would be true about health care conflict as well and that by making this knowledge explicit it could be more easily harnessed to important purposes, such as the

Dependency Care: Conflicts of Loyalties and their Consequences for Patient Care, 5 SCANDINAVIAN J. CARING SCI. 149, 152-53 (1991).

3. See PHYLLIS BECK KRITIK, *NEGOTIATING AT AN UNEVEN TABLE: A PRACTICAL APPROACH TO WORKING WITH DIFFERENCE AND DIVERSITY* (1994); see also LEONARD J. MARCUS ET AL., *RENEGOTIATING HEALTH CARE: RESOLVING CONFLICT TO BUILD COLLABORATION* (1995).

4. Kenneth Kressel & Dean G. Pruitt, *Conclusion: A Research Perspective on the Mediation of Social Conflict*, in *MEDIATION RESEARCH: THE PROCESS AND EFFECTIVENESS OF THIRD-PARTY INTERVENTION* 394, 395-400 (1989) (explaining the effectiveness of mediation in conflict resolution as compared to other dispute resolution forums); see also Kenneth Kressel, *Mediation*, in *THE HANDBOOK OF CONFLICT RESOLUTION: THEORY AND PRACTICE* 522, 523-24.

5. See LISA FELD & PETER A. SIMM, *MEDIATING PROFESSIONAL MISCONDUCT COMPLAINTS* 1-13 (1998) (discussing the advantages and disadvantages of complaint resolution by mediation versus discipline); see also Thomas B. Meltzoff et al., *Empirical Perspectives on Mediation and Malpractice*, 60 LAW AND CONTEMP. PROBS. 107, 107-09 (1997) (examining an initiative in North Carolina to implement mandated mediation and alternative dispute resolution as an alternative to malpractice litigation); Evert van de Vleirt, *Helpless Helpers: An Intergroup Conflict Intervention*, 6 THE INT'L J. OF CONFLICT MGMT 91 (1995) (reporting a case study of his structured intervention to assist two warring mental health teams); Johanna Shapiro, *A Visit to the Doctor: An Illustration of Implicit Meanings in the Doctor-Patient Relationship*, 6 FAM. SYSTEMS MED. 276 (1988) (discussing her efforts to assist a third year medical resident to develop a more effective way of helping a conflicted married couple care for their disabled, chronically ill child); Jean Ann Seago, *Culture of Troubled Work Groups*, 26 J. OF NURSING ADMIN. 41, 44 (1996) (reporting a survey of 115 nurse managers and administrators on the strategies they used to manage "troubled" nursing work groups).

6. Deborah M. Kolb, *Labor Mediators, Managers, and Ombudsmen: Roles Mediators Play in Different Contexts*, in *MEDIATION RESEARCH: THE PROCESS AND EFFECTIVENESS OF THIRD-PARTY INTERVENTION* 91, 99-107 (1989) (examining how individuals take on the role of mediator of work place conflict either voluntarily or because of the position that they hold in the company); see also Blair H. Sheppard, et al., *Informal Thirdpartyship: Studies of Everyday Conflict Intervention*, in *MEDIATION RESEARCH: THE PROCESS AND EFFECTIVENESS OF THIRD-PARTY INTERVENTION* 166 (1989) (examining how informal mediators have more stress on them than transient third parties because they usually have a relationship with the parties, are a part of the dispute themselves, and have more options available in conflict resolution).

training of health care professionals and the design of effective intervention programs.

Our investigation focused on individuals with a reputation for being skilled conflict managers within a single, 450 bed urban teaching hospital in the Northeast. The hospital is staffed by approximately 300 attending physicians and has about 600 residents in numerous training programs. The total number of staff, excluding physicians, is approximately 2700. The hospital serves a largely minority, lower socioeconomic population. It is just such hospitals which have been most negatively impacted by the many changes currently roiling the delivery of health care services in this country. While focusing on a single institution places obvious limitations on generalizability, it has the compensating advantage of providing an in-depth perspective about conflict dynamics in an important type of health care institution.

We were interested in answering three major questions: (1) What types of conflicts do informal hospital conflict managers attempt to resolve? (2) What do they perceive to be the causes of destructive conflict in the hospital? (3) What strategies of intervention do they use and what concepts guide their interventions?

II. METHOD

The investigation took the form of a series of in-depth, semi-structured interviews with individuals who had a reputation among their colleagues for expertise in handling conflict in the hospital setting. We began the process of locating respondents by offering a generic workshop on conflict management. The 14 attendees were primarily from middle level management positions. At the end of the workshop we explained the goals of our study and asked the participants to nominate individuals who would be appropriate informants because of their knowledge and skill at handling conflict within the hospital. This procedure generated the names of three individuals who were nominated by two or more workshop participants. From that point forward, additional respondents were located by asking each successive interviewee to identify other individuals who they felt matched our criteria of being skilled in dealing with hospital conflict.

This "snowball" approach ultimately yielded a total of 24 individuals of whom at least two other members of the hospital community thought were skilled at managing conflict within the institution. We stopped seeking additional respondents when new queries yielded familiar names. We were able to conduct interviews with 17 of the 24 individuals (71%).

Thirteen of the respondents were women; four were men. The informants had worked at the hospital for a median of 13 years (range, from 2 to 22 years) and were in their current positions an average of 5.75 years (range, 7 months to 15 years). Seven were nurses, five of whom were managers either of hospital units or large hospital patient care services, such as Emergency Medicine or Surgery. Three respondents were physicians (a neurosurgeon, an oncologist, and a physician director of a medical service), and seven were non-medical personnel who had significant managerial responsibilities in a variety of hospital departments, such as social work, legal management, ambulatory care, and rehabilitation.

Interviews lasted from one to one and a half hours and were tape recorded for later transcription. The interview began by defining conflict as "any general state of tension or opposition between two or more individuals or groups, whether or not that tension is openly expressed." With this broad definition in mind, respondents were first asked what types of conflicts they had found to be the most vexing at the institution. For each such conflict the respondent was asked whom such conflicts were between, what they were about, and what the biggest obstacle was to managing that particular type of dispute.

We then asked the respondent to select, for more extended discussion, a "vexing" conflict in which they had recently been involved. Respondents were encouraged, although not required, to select a conflict in which their involvement had been that of a mediator who had attempted to assist the disputing individuals or groups to resolve their differences. We also asked them to select a case which was unique to health care (e.g., could not just as easily have happened in a school or a business setting), was difficult to handle, might well have overwhelmed a novice, and was of interest to them because of what happened during the conflict or how things turned out at the end. We did not insist that the respondent select a case in which their intervention had been "successful." Pilot interviews had indicated that health care professionals were able to identify vexing conflicts which met these criteria and were comfortable with the case based format of the interview. Respondents were then asked to describe their intervention and the thinking behind it in three discrete passes. This interview procedure is based on the "critical decision-method"⁷ used to study expert decision-making in real world settings. The concrete details

7. Robert R. Hoffman et al., *Use of the Critical Decision Method to Elicit Expert Knowledge: A Case Study in the Methodology of Cognitive Task Analysis*, 40 HUM. FACTORS 254 (1998) (describing the Critical Decision Method implementation and use); GARY KLEIN, *SOURCES OF POWER: HOW PEOPLE MAKE DECISIONS* 189 (1998).

elicited by this method often provide a richer and more nuanced picture of how experts approach a problem-domain than is provided by less structured interview formats.

In the first pass, respondents were asked to provide a brief description of the parties to the conflict, the nature of the dispute, how they had become involved, and the eventual outcome. The second pass instructed the respondents to describe their actions and thoughts from their first involvement to the last. This pass generated a detailed chronology of conflict episodes. The final pass took the respondent over each of these episodes and probed for the respondent's thinking behind any actions taken or decided against, and any assessments they made about the parties or the dynamics of the dispute. After the final pass, respondents were asked to briefly summarize the major lessons they derived from the case; whether in hindsight they would do anything differently; what mistakes a novice might have made; whether they had any important unanswered questions about the case; and the degree to which the case was typical of their experience.

The interview ended with questions on several broad topics, including the respondents' views on the extent to which the hospital's urban environment affected either the nature of the conflicts they had to deal with or the skills needed to be effective; their views on the importance of training in conflict management for health care professionals, and aspects of their personal background which they felt might have influenced their thinking or approach to conflict in health care.

III. TYPES OF HOSPITAL CONFLICT

Our respondents represent an important, if hidden, social resource for the hospital. How does the hospital make use of them? Judging by the types of conflicts which our informants selected to discuss during the interview, their expertise appears to be harnessed to four basic types of conflicts: end of life disputes, conflicts over treatment planning, interpersonal disputes between two individuals, and organizational conflicts. For each type of conflict we provide a brief general characterization and illustrate it with one or two case examples. We begin with the two types of conflicts which are unique to the health care setting.

A. *End of Life Conflicts (3)*⁸

These are conflicts which occurred around terminal illnesses. Two of the cases in this category were "classic" bioethical conflicts, in which the parties held opposing views as to whether or not extraordinary measures should continue. The conflicts involved either a physician and family members or a disagreement within a family. Our informants, serving either as the hospital bereavement specialist or a member of the hospital's bioethics committee, mediated resolutions designed to insure that the wishes of the patient or legally empowered guardian were respected. The final case was a much condensed variation of a bereavement intervention in which a nurse manager defused a volatile situation involving an angry group of teenage gang members who had come to the hospital to see a dying comrade.

All three cases were handled successfully in the sense that our respondents were satisfied that they had helped find a resolution in which the dignity and wishes of the dying person and family were respected. In comparison to the other types of conflicts described to us, interventions in end of life conflicts were more clearly structured, generally took less time, and relied upon interveners with more clearly articulated ideas about the dynamics of the conflict and what was required of them to manage it successfully.

The Unwilling Daughter. The parties in conflict were the attending physician and medical staff and the adult daughter of an 89 year old woman with advanced cancer. The daughter repeatedly pressed the medical staff to take extraordinary measures to keep her mother alive against medical advice. The mother had an advanced directive which named another daughter as her health care proxy. The proxy daughter agreed with the physician that extraordinary measures should be stopped.

Over the course of two or three days our respondent, in her role as an advanced practice nurse bereavement specialist, was able to get all the parties to agree to the cessation of extraordinary measures. Her major interventions involved a meeting with the attending physician who had called for her help; two bedside meetings with the daughter who was insisting that all measures be taken; a meeting with the proxy daughter and her husband; and a final group meeting involving all family members, the physician, and a clergyman who had been invited to provide emotional support to the daughter who was unwilling to have the extraordinary measures ended. At this final

8. Numbers in parentheses indicate the number of cases in each category. The details of cases have sometimes been changed to protect anonymity.

meeting a plan for terminating the extraordinary measures was worked out in deference to the medical realities of the situation and the medical directive. The daughter who had been against this step was given an important measure of emotional support and was involved in deciding how to say "goodbye" to her mother.

The Gang in the Surgical Intensive Care Unit (SICU). A group of more than 20 angry and unruly teenage gang members had come to the hospital to see a comrade who had been fatally wounded in a gang fight. The gang's presence on the unit was preventing the grieving family from being with their dying son, upsetting the SICU staff, and creating a potentially explosive situation.

In the span of about 20 minutes, the respondent, a trauma nurse who had been called from her work in the ER by the anxious SICU secretary, developed a plan for the orderly departure from the hospital of the gang members. Her major intervention involved an impromptu meeting in the visitors lounge with the gang members. At this meeting she provided sobering information about their friend's fatal wounds and enlisted their cooperation and the cooperation of the angry SICU nurses in a plan for the gang to say a final farewell to their friend and to exit the hospital gracefully.

B. Conflicts Over Treatment Planning (4)

These are conflicts which occurred when major decisions had to be made about patient care. Two were conflicts about transferring a patient to another facility and two were about recommended treatments in the hospital. The conflicts surfaced when there was sharp disagreement involving the family or patient on one side and the hospital on the other. One of these conflicts also involved a disagreement among several hospital services over who should be responsible for the patient's care; and another involved two physicians with very different medical opinions about how to treat an active drug abuser with advanced cancer.

Although they acted as third parties in these conflicts, the respondents did not serve as mediators. In three of the disputes the respondent's role was to coordinate communication or decision-making among the affected parties or to serve as a consultant to a hospital department. In the remaining case the respondent physician was herself one of the disputing parties.

The treatment conflicts went on for extended periods – weeks to months – and were relatively complex, involving many parties and numerous interventions on the respondents' parts, from the drafting of memorandum to the scheduling of meetings and the relaying of infor-

mation by phone. The outcomes were varied. Two cases were settled successfully in the sense that a discharge or treatment plan was finally worked out that made medical or economic sense for the hospital and/or was accepted by the family. Another intervention was a failure in the sense that the patient was discharged at his own insistence, but without adequate medical treatment according to the hospital treatment team. One case had mixed results. The physician respondent reluctantly consented to administer palliative chemotherapy to an active drug abuser who lacked family support, but used the case to raise the medical staff's awareness of the need for close consultation with the oncology service before making such a referral.

The Adamant Duo. The disputing parties were a 30-year-old quadriplegic male shooting victim and his mother versus the hospital Social Work Department which is responsible for discharge planning. The Social Work Department wanted to send the patient to another facility for long term care and rehabilitation. The patient and his mother were strenuously opposed to this plan. The mother was planning to move to another state but had no means to care for her son and he was refusing to sign a release which would discharge him to any other facility in the state.

Over a period of several weeks, our informant, a member of the hospital's legal department, served as consultant to the social worker in charge of the case. In this capacity he helped her think through the practicality and legality of various alternative treatment plans (e.g., whether to seek to have the courts appoint the hospital as legal guardian) and consulted on her behalf with other relevant sources of information (e.g., the hospital's Risk Management Department on the advisability of transporting the patient to a distant state). The case was resolved successfully with the enactment of a plan to transport the patient by plane to a rehabilitation facility in the state to which the mother was moving.

C. *Interpersonal Conflicts (5)*

These were personal conflicts involving misunderstandings and the use of poor interpersonal skills. Four of the five conflicts in this category involved physicians embroiled either with patients or with clerical or nursing staff. The fifth case was between two nurses.

The respondents functioned as mediators, typically using highly directive tactics, after concluding that one of the parties was being difficult or unreasonable. In two instances, the parties' stopped fighting and ended on a note of better understanding; in the three other cases the immediate conflict stopped, but no genuine rapprochement

seems to have occurred. Although the respondents functioned as mediators, unlike the mediators in end of life conflicts, they intervened not because they defined mediating as a primary part of their role, but because the conflict was interfering with patient care or department morale and they felt administratively compelled to intervene.

Power Trip in the ER. The conflict was between two nurses who were friends but had had a falling out over time-off schedules. The older of the two was demanding that her colleague give her some of her allotted time-off on the grounds that she deserved it more. Our respondent was a nurse manager in the ER and the younger nurse sought her help, complaining of unrelenting "harassment" from the senior nurse about the time-off issue.

The respondent attempted to mediate a resolution, first by speaking to each party separately, then through a few joint meetings. She also tried coaching the younger nurse to be more assertive and developed a clear impression that the older nurse was being coercive. When her efforts at bringing the parties together failed, she used her power to make clear to the older nurse that she was behaving inappropriately and would have to stop her aggressive tactics. She told both parties that she would have one of them transferred to another department if the conflict between them did not stop. The fighting did stop, but the respondent noted ruefully that the nurses were no longer friends.

The Demeaning Doctor. The disputing parties were an authoritarian female doctor and a very angry nurse who worked on the same unit. The physician had a reputation for treating subordinates in a disrespectful and coercive manner. The nurse objected to how she was being treated by the doctor and complained to our respondent who had managerial authority over the unit in question.

The respondent functioned as a not so neutral mediator who brought pressure to bear on the physician to desist from her more coercive behaviors and on both parties to work out a plan of mutual accommodation. This was accomplished in a series of meetings, including sessions with each of the participants and separate meetings with the hospital Medical Director and the physician's department chairperson. These sessions culminated in a meeting, chaired by the respondent, involving the parties and the two high level physicians. The doctor and the nurse were instructed to clear the air by telling each other of their respective complaints and to work out a plan of professional co-existence. This objective was attained. The physician

agreed to be more respectful and the parties were able to work together more constructively.

D. Organizational Conflicts (5)

These were conflicts resulting from organizational mandates or needs or competition with other health care institutions. All of them were fueled by a scarcity of resources of one kind or another. Two of the cases were among the longest conflicts described, extending over many months.

Our informants played contrasting roles and experienced contrasting results. Two were advocates, either of their department or the interests of the hospital against those of another institution. Both of them achieved their primary objectives – e.g., a physician department chief was able to leverage the considerable financial resources his unit brings to the hospital to get the medical director of another service to provide him with the surgical personnel he was seeking to improve the performance of his unit.

The other three respondents served as third party intermediaries in an organizational conflict but in ways that were not purely mediational in the traditional sense. Thus, one was a nurse administrator intent on insuring that staffing needs and procedures were being observed; another was an administrator charged with enacting directives from above her to merge two groups of nurses; the third was a semi-volunteer, drafted into “facilitating” a multi-department task force charged with addressing a hospital wide problem. Those who played the third party role in organizational cases reported some success in dealing with the focal problem, but all of them expressed an awareness that the underlying source of the conflict remained very much unresolved.

The Merger of the ER Nurses. The hospital administration had decided on a merger of the psychiatric and general medical nurses in the emergency room, who, until then, had worked separately and did not cross-cover each other. There was much resistance to this plan from the two groups of nurses and there were strong personal animosities between the two groups. (“It was like the Hatfields and the McCoys,” according to our respondent).

As a manager in the ER, the respondent was assigned the task of effectuating the merger. She first met separately with each group of nurses to inform them of the coming change and to get their buy-in. In the meeting with the psychiatric nurses nobody would look at her. She acknowledged their dislike of the plan and said that the merger would be tried for six weeks, at the end of which time she would ask

them for suggestions for improvement. She also developed a structured "education" plan, covering the psychiatric and general medical competencies the nurses would need to know.

Throughout the several month transition period the respondent remained highly directive, but willing to listen to complaints. The merger was effectuated and, according to the respondent, the tensions between the two groups of nurses was greatly reduced. However, the majority of the psychiatric nurses eventually transferred out of the ER or left the hospital altogether.

The Missing Medical Supplies. A common hospital problem is that a variety of medical supplies are frequently not available when they are needed (e.g., oxygen canisters). The respondent was asked by a hospital executive to serve as the team leader of a task force to address the problem. He was asked to do this because he had facilitation experience and was known to enjoy organizational problem-solving.

The respondent convened a task force of the most directly concerned departments, none of which had wanted to assume responsibility for tracking the supplies in question and being accountable for their availability. He then organized a year long problem-solving process with this group involving distinctive stages of fact-gathering, planning, piloting, and evaluation. There was also outreach to other groups in the hospital to explain the pilot program and get feedback on its feasibility.

The task force eventually formulated a pilot procedure for tracking the most important supplies and one of the task force departments agreed to accept responsibility for that task. The pilot was successful in significantly reducing the incidents of missing supplies. However, the process "fell apart" because key people on the task force left the hospital and one of the task force departments became immersed in internal problems of its own. At the time of our interview the task force had been reconstituted and was beginning to implement and evaluate its plan again.

IV. SOURCES OF CONFLICT

As the institution's unofficial conflict managers, our respondents are particularly well-positioned to provide insight into the causes of destructive conflict within the hospital. To be sure, their perspective does not encompass the entire landscape of health care conflict. They are best thought of as direct observers of "ground zero" – the terrain upon which large social and economic forces impact the daily transactions of medical care in a particular type of health care organization.

From their unique vantage point, our informants identified four major sources of destructive conflict within the hospital: (1) Aspects of health care culture, practice, or training; (2) organizational dynamics within the hospital; (3) resource scarcity; and (4) characteristics of patients and families associated with the particular problems of an inner city environment. It is also important to note that for many of the respondents, "conflict" referred to suboptimal medical intervention or decision-making (e.g., failing to provide emotional support to a grieving family) as well as to outright danger or hostility.

A. Health Care Culture, Practice, or Training

The most frequently mentioned source of conflict within the hospital, alluded to by approximately 70% of the respondents, was some aspect of "health care culture," broadly defined. Problematic physician characteristics were most often elaborated on, along with certain aspects of medical practice. Other important sources of conflict included aspects of nursing culture, the problematic climates of certain medical services, particularly the emergency room and the trauma services, and "value" differences arising either within the hospital or between the hospital and other health care institutions.

1. The Physician and Aspects of Medical Practice

Physician Power. The physician is a primary source of authority and influence in the hospital. From our informants' perspective, this power, while necessary and legitimate, can corrupt. Because they have so much power, physicians often try to impose their wishes on staff members or families, sometimes in ways that not only create tensions but also compromise patient care. For example, even the clearly expressed wishes of patients or families for a dignified death can be frustrated by physicians who insist on remaining in control. Said one physician: "Sometimes I think that docs become docs just so they can be substitute gods. The white coat is both a cloak of honor and a protection. In very interesting ways it protects you against having to confront some of the humanity you otherwise would."

Paradoxically, relinquishing control can be difficult because of the strong attachments the physician has formed with the dying patient. The same respondent commented:

The better a physician is, the more intensely they value the doctor-patient relationship. One of my first cases as a medical student was a fellow almost exactly my age who had a malignant melanoma with metastasis everywhere and in the most horrible pain. His brain had herniated one afternoon

from one of his brain metastasis, and that paralyzed one side of his body. But, he could still talk. I resuscitated him from that. He woke up and I was talking to him and holding his hand and he said, "Doc, you've got to let me go." His wife, who was a wonderful lady, said, "You are holding him too hard. You're hurting his hand. He has metastasis there." That's not what the patient was saying. He was saying, "It's too much. All that is left is pain. Let me die of my disease." And the next time when he herniated, he did die. I had done him a disservice by bringing him back when I did.

At other times, medical power is a liability because there is a disjunction between the official authority of the physician and his or her actual knowledge. Thus, nurses often know more about case management than the medical residents who are in charge. In addition to being less knowledgeable than the nurses, residents often lack skill at collaborating. A respondent with more than 20 years of nursing experience put it this way:

I think they are taught that they make the decisions for the patient. When they write orders its going to be done. But they're not taught to collaborate with the health care team. They're taught that they are an entity in and of themselves Residents start that behavior very early in their residency. You'll see it in their first year when they are just new babes out of the womb and they don't have all the expertise. I used to have fun seeing them tell me these things and I used to say: "Do you really want to give that medication?" And they'd say, "Yes, what did I write?" I'd say, "Well, this is what you wrote and according to what you wrote, if you gave that to this kid, this is what would happen." He'd say, "You're a smart aleck." I'd say, "No, I tried to work with you but you didn't want me to ask questions. That's my job - to make sure that you are writing the right thing." But they don't want you to ask questions for clarification because they "know it" and they're first year residents and they "know."⁹

9. See Lees & Ellis, *supra* note 2, at 955-57. In a study of the stresses reported by experienced British nurses (n=20), "conflict with doctors emerged as a large problem, mentioned by 40 percent of the sample, and accounting for the second most commonly mentioned stressor for trained staff." Elander & Hermeren *supra* note 2, at 151-53. The authors queried 17 British nurses working in intensive care settings about "their principal and most awkward ethical dilemma" Although the authors report their results impressionistically, of the 19 examples they provide of nurses' "ethical dilemmas," 11 involved physicians. The preponderance of these involved the unwillingness of doctors to admit a patient was dying while insisting on more aggressive treatments. See also Chacko & Wong, *supra* note 2, at 785-87. In surveying 361 nurse practitioners about their "role disagreements" with physicians, the authors found that nurse practitioners working in hospitals reported

A significant source of doctors' power is economic. Among the most powerful in this regard are surgeons. A nurse administrator commented:

Physicians tend to be very temperamental and surgeons even more so. With a surgeon, they get upset with you and they walk out. That affects you tremendously in your pocket book. If they don't show up you've got patients, you've got staff, you've got ORs, that are not used and patients that are not serviced. That costs you money and time – a lot of money.

To complicate matters further, the economic self-interest of doctors is often opposed to the economic interests of the hospital. Another nurse administrator with years of ambulatory care experience observed:

The physician is the entity that generates revenue. As a consequence there is a mind set, whether deliberately taught or learned in medical training, that pits everybody against them. For instance, a physician wants to see a patient who hasn't had the pre-registration and clearance that would allow us to identify the payor source. They just say, "Bring the patient in the room. Forget registration." But, in order for the hospital to collect its piece of that fee, information has to be in place for the visit, because if the visit is not documented, then there's no fee for the hospital. Somebody is

significantly more role conflict than nurses working in public health or doctors' offices. The higher the number of physicians in the hospital the higher the reported role conflict. See also Seago, *supra* note 5, at 44. Providing evidence that doctors are a significant source of conflict for nurses, a survey of 115 nurse administrators' views on the characteristics of "troubled" hospital units reports that "doctors with poor attitudes" was a relatively infrequent response, 18th most frequently cited on a list of 25 items. Nonetheless, 32 percent of the respondents made this choice. There is also considerable evidence from studies of physician-patient interaction that physician "communication" behaviors can have important positive effects. See also Sandra K. Joos & David H. Hickman, *How Health Professionals Influence Health Behavior: Patient-Provider Interaction and Health Care Outcomes*, in *HEALTH BEHAVIOR AND HEALTH EDUCATION* 216, 228, 234 (1990). The authors summarized the results of 41 observational studies thusly: "[T]here is a positive effect on patient care outcomes when the provider establishes rapport, encourages patients to express their concerns and points of view, and provides information. Good interpersonal skills facilitate these tasks and are related to improved patient satisfaction and compliance and outcomes of care." In six experimental studies, comparing physicians who had received some form of training in patient communication with a control group of doctors with no such training, all but one found a measurable impact on patient care. Of these investigations, the authors observed that, "... only three of the six interventions specifically included interpersonal skills training. However, the content of all the interventions incorporated information-giving skills, and all promoted conflict resolution by encouraging the physician to elicit the patient's perspective." *Id.*

responsible for seeing the individual's insurance card, making sure that they validate the address and phone number, keying in the information. This might take 15 or 20 minutes. [For the physician] that is wasted time. They want the patient in the room so they can see them and get on to the next patient. It's a process conflict.

The excesses of physician power are not entirely of their own making. Several nurse managers noted that much depends on the communication strategies of other hospital personnel. Two strategies that work are empathy and responsiveness.¹⁰

A physician came in and pounded on the desk screaming that he wants a nurse fired. I usually have the "wave" on [a soothing visual display] and some music, and I start asking some questions: "What happened today? Were you on call last night?" "Yes, I was and I had a really bad night. They brought in a child and he died." You kind of get to the real issue and they're just letting off steam because the nurse didn't give a med or gave it late or didn't answer them appropriately.

* * *

If the person who is trying to get the physician to see a differing point of view is able to engage them in a dialogue, have them hear them, it will work . . . "boom, boom, boom." The "boom, boom, boom" means, "just give me the facts and make it happen." That's it. That's all they want. They want things to happen.

Aspects of medical practice. Respondents spoke of a number of characteristics of medical practice which contributed to dysfunctional conflict. The fear of malpractice litigation is one such factor. In *The Unwilling Daughter*, the respondent commented: "I had a sense they [the physicians] were doing all this stuff for the daughter at the bedside, which happens all the time. You get a family who asks questions or raises things which makes the physicians very defensive [because of fear of being sued]."

The culture of medicine also favors active intervention. This can cause conflict if everyone does not agree that active treatment is the proper response. An oncologist commented:

10. There are a variety of structural mechanisms which serve as a check on the power of physicians such as the hospital bioethics committee and the related legal statutes which empower families and patients when faced with a doctor who opposes their clear wishes. We discuss the positive role of such mechanisms later.

Just the other day in Tumor Board we talked about a patient with advanced laryngeal cancer. We were talking about different treatment modalities. I raised the issue again: We can't just give treatment in a vacuum. In cancer, when we are trying to cure people, then I would definitely consider taking somebody home with me, almost, if it means that they could be cured of cancer. We would pull out all the stops. But palliation, which is much of what we do here, that's a whole other ball game. It's not clear to me that we have to do everything all the time when we palliate people. A lot of palliation is about doing less, not doing more. But its hard for doctors. People want to do things all the time. You always have to do something – not doing is a sign of weakness or ignorance. It's been a problem in the medical profession for a long time.

The fragmentation of care can also cause difficulty. Particularly at a teaching hospital, with its plethora of specialists and research and educational obligations, effective communication may be thwarted because each person has only bits and pieces of the medical puzzle. These difficulties played a role in several of the cases described to us, particularly those involving treatment planning.

The problems introduced by the fragmentation of care can be exacerbated by the very different treatment vantage points of the involved health care specialists. This was the main theme in a case we have labeled *A Clash of Medical Perspectives*. The respondent oncologist described the conflict created between herself and the referring radiologist about the treatment of a drug addict.

They [radiology] weren't seeing things through my eyes. They were just seeing it though their eyes. I wasn't involved at all in the decision-making. I was unhappy about that. I just told [the referring radiologist], "I have bad news for you. I am sorry but I don't want to treat Susie Jones. I just don't see how I can do it. She's actively withdrawing now. She needs drugs and I'm supposed to give this woman chemo, and then what? She's going home to what? Have you thought this through?"

Later in the interview she amplified:

Radiation oncologists don't admit people to the hospital. When people get sick they are kind of stuck. They have to rely on internists or medical oncologists to help them out. Sometimes its okay, but other times I feel like we get called in a little late in the game. We should have been apprised sooner that there were problems developing, rather than get-

ting a Friday afternoon surprise. . . . We're in it for the long haul, so we're worried about what's going to happen. How they are going to die? Who's going to be there? Much more so than the radiologists are.

Differing vantage points may also create tension between nurses and doctors in end of life situations. A physician noted that nurses are often much closer to patients and their families than the treating doctor. In such instances nurses may feel inclined to "go behind the back" of the physician to make the families' wishes known. According to our informant, this does nothing good for nurse/doctor relationships.¹¹

2. *Problems in the Culture of Nursing*

It is not only physicians whose behavior or attitudes can be problematic. Nearly half of our respondents were nurses or nurse managers and several of them discussed characteristics of nursing subculture which promote conflict. For example, in *The Gang in the SICU*, the trauma nurse respondent observed:

Many nurses don't like visitors at all and would be happy if none of us had extended families, because they don't want anyone watching their routine, commenting on their routine or giving feedback on their routine. We've had a lot of issues in our ICU with going from strict, limited visitation to open 24 hour a day visitation. Huge conflict.

In the case in question, the nurses' dislike of "outsiders" was associated with a corresponding desire to use coercive measures to forcibly extricate the gang members from the hospital – a strategy our respondent was convinced would have made things much worse.

Another respondent felt that nurses are often poor at giving commands in an effective way and that this is frequently at the root of

11. Given the central role attributed to doctors in creating dysfunctional conflict, it is of interest that very few of our nominees for "conflict expert" were, in fact, physicians. This piece of information may simply confirm the finding. On the other hand, more interesting forces may be at work. When one of our respondents was asked to nominate other potential interviewees, she named no MDs. The interviewer told her that nobody else had either, and she was asked what she made of that. She responded that while she can think of "many" MDs who are very good at handling conflict, they may not be mentioned because "I think we try to protect their time." She then cited as an example, a physician who is "very good" at managing conflict but who is also "very busy." As it turned out, the physician in question was eager to be interviewed and gave one of the longest interviews in the study. This incident raises the possibility that one of the barriers to improved conflict management in health care may be the protective attitudes of others towards the very people who are most at the center of the conflicts and have the most power to influence them.

much of the conflict she sees in the hospital. "I have nurses that don't know how to delegate. So they ask somebody, 'could you please do this?' So the person has the opportunity to say 'no.' Okay, here's how you should have done that – and it needs to be timely. It needs to be live and real."

Perhaps the biggest source of difficulty is the nursing shortage.¹² Nursing used to be a primary career choice for women; it is no longer. Even within the nursing profession there are alternatives to hospital work, with its physically and emotionally demanding contact with patients. Nurses can now find less stressful work in clinics, managed care settings, and what one informant referred to as "doc in the box" operations. The results: fewer hospital-based nurses, older nurses (the average age of nurses has gone from 20 to 44), and much more conflict between nurses and hospital management.

Many of these conflicts are about staffing.¹³ For example, at many hospitals, where 60%-70% of admissions come from the emergency room, unit nurses want more staffing because patient care needs can escalate rapidly and unpredictably (what one respondent referred to as the "what if" phenomenon). Unfortunately, hospital administrators cannot satisfy such demands easily, even if funds to pay for such staffing were available. A nursing executive explained it this way:

Years ago I could have called up an agency. Let's say we needed three nurses [on a unit] instead of two. The agency would have sent in a nurse, sometimes within hours. There are no agency nurses anymore. We put out orders for maybe 100 agency nurses a week and may get five. They aren't there.

One approach to managing the staffing dilemma is the invocation by management of objective guidelines and regulations. There is no shortage of these in an industry which has become highly regulated. A nurse manager described the situation:

At our hospital, which is no different from any other hospital, we have manuals which have staffing plans. They are regulated by the Joint Commission. You need a plan for how you are going to staff and care for patients. So, if you looked in one of those books, you would actually see that this pa-

12. Cheryl A. Peterson, *Nursing Shortage: Not a Simple Problem - No Easy Answers*, 6 ONLINE J. OF ISSUES IN NURSING, at 1-3 (January 31, 2001), at http://www.nursingworld.org/ojin/topic14/tpc14_1.htm.

13. Lees & Ellis, *supra* note 2, at 951. Understaffing was the single most frequently cited source of stress by experienced nurses in a survey of 53 British nurses. *Id.*

tient care unit should have no less than x amount of nurses. It goes literally unit by unit. We know how many patients are on the floor and the level of care they require. An ICU is very different than a step-down unit, which is very different than a general medical unit. It is in black and white in a policy for everyone to see. It falls within the regulations of the Department of Health. When you benchmark, it falls within the parameters of what I would say is common practice. The nurse manager utilizes the guidelines as a tool in regards to scheduling.

But the invocation of “rules” can sometimes escalate the tension and create mistrust between nursing staff and hospital administrators,¹⁴ as our respondent hastened to point out. Thus, nurses often get angry when their intuition tells them they need more staff, but management tells them the regulations say “no.”

“You say we only need two nurses, and yes, you’ve got objective guidelines. I don’t trust your guidelines, even though they may be national guidelines. My gut tells me we should have three nurses. My nursing experience tells me I won’t feel good about the care I provide.” So management isn’t trustful that nurses will support their efforts of trying to improve efficiency and effectiveness, for the whole purpose of providing the right care to the right patients at the right time, as well as sustaining the financial viability of the institution so everyone will end up having a job.

There is more to the conflict than this. Even though an aging work force gets tired more quickly, nurses, paradoxically, also want to work longer hours. Unfortunately, management is driven by accountability standards and research that tells them that shorter work shifts are preferable. Our respondent described the situation plaintively:

Nursing is physical labor. Nurses are getting older. So what any of us used to be able to do in 8 hours and 12 hours they can’t; they get tired. And nurses like to work 12 hours because then they get four days off. Sometimes we’re our own worst enemies. And they’re pushing more for 12 hours; which all the literature says that with an aging work force we should be flexing down to 8 hours or 6 hours or 4 hours.

14. See *id.* at 952. The authors report that trained staff constituted 25 percent of the 53 subjects who believed that the worst source of stress arose from a perceived lack of support from higher nursing management. Moreover, “[f]rom the trained [nursing] staff’s point of view, the majority of inter-nurse conflict arose from conflict with nursing officers, feeling them to be far removed from the difficulties of managing a ward with inadequate equipment and staff.” *Id.* at 956.

There is a disconnect. . . . We're constantly being asked to go to 12 hour shifts and get more nurses. All the answers aren't in synch with theory and research on practice. How to align them so we can at least talk from the same page?

There is also a movement in organized nursing to eliminate mandatory overtime. The nursing shortage gives nurses more clout to make the demand a reality. But it further exacerbates the tension between nurses and hospital management, as well as taking its toll on morale, as an older nursing culture gives way to changing norms about work:

There's much lobbying right now within the state to eliminate mandatory overtime. I would never even have thought of bringing that subject up. When I was trained, it was "abandonment" if you left. You would lose your license. The work ethic was ingrained in me. I would have never thought of that. But decades roll on, there are ideas to look at things differently. We very rarely use mandatory overtime here, but let's just say that there wasn't a nurse. What do you do? How do you manage? Or let's say there are three nurses and one was to go home at 7 PM and you need the three? These are the conflicts in health care that you are dealing with. It's like a death in some instances.

3. *Departmental "Cultures"*

Nearly one third of the respondents commented on how aspects of the "culture" or ethos of a medical service unit could have a negative impact on its ability to deal effectively with conflict or even recognize that destructive conflicts are occurring. The Emergency and Trauma Departments were singled out in both regards.¹⁵

The Emergency Department. Two nurse managers with long experience in emergency medicine noted that the emergency room is "a world unto itself." This uniqueness is the result of never knowing the number and nature of the patients who will suddenly require treatment, particularly at a busy inner city hospital. The emergency room, according to our respondents, is also something of a "dumping ground" – the place where other medical institutions send patients with which they don't know what to do.

15. See generally *id.* at 947 (explaining that emergency rooms and intensive care units are frequently reported to be the most stressful work environments for nurses because of their unpredictable workloads, use of hi-tech equipment, high levels of environmental stimuli, such as heat and noise, continual possibilities of crisis, and frequent need for assessment and monitoring).

These medical realities foster a culture of great internal cohesion and self-confidence. One of the nurses remarked, "Its sort of like we're separate. We're on our own. We take care of everything we need to take care of." She went on to note that the unfortunate downside to such zeal is the inclination to deny or minimize the levels of conflict which are actually occurring.

The Trauma Department. Three respondents, all physicians, expressed the view that trauma units may also be less adept at handling conflict well because of the same inflated sense of power and infallibility, amplified perhaps by the appeal of the trauma unit environment for what one of them called the "surgical personality – brash and bold: maybe wrong, but never in doubt." Another physician described how this machismo culture sometimes plays itself out in the treatment of the poor and minority group patients:

Its okay to be a little more "cowboy" with "these" patients. The tendency toward that attitude exists in some services more than others. I would single out the trauma service here, not because they are a bad service, but because it's almost inevitable for "fire dogs" and "cowboys" to be fire dogs and cowboys. What makes the trauma service good is that they ride roughshod over everything. They charge into a situation with arms akimbo and devices flying. They take care of whatever has to be taken care of and to hell with nice interacting with human beings. You take care of medicine first and then worry about human beings. . . . The classic thing – "The patient was uncooperative so we had to paralyze and intubate them to get an evaluation." There is some validity to that because if somebody comes in sick and he might have a life-threatening trauma, if you don't get the information you need fast enough, somebody will die and most people that come through here don't want to die. But it means that if they are a little uncooperative, a little drunk, look a little bit cross-wise at the docs, the docs will feel more justified in saying, "The hell with you. We will simply make you unable to object to care by putting you out."

4. *The Lack of Needed Health Care Services*

In terms of generating conflict, not all the problems come from within the hospital. We have already noted this with regard to the effects of the nation wide nursing shortage and we will return to the theme when we examine our respondents' views on the conflicts provoked by shrinking health care budgets. The absence of appropriate

health care facilities was another external factor which has implications for the kinds of conflicts which break out within hospitals.

This was the driving theme in two disputes. In *A Clash of Medical Perspectives*, described earlier, the problem was the absence of facilities to which to send terminally ill cancer patients in need of chemotherapy who lack family or other social support. As our oncologist respondent put it:

Not everybody has a comfortable bed at home and somebody to feed them and stroke them. It's just not like that here, and you can't practice medicine in a vacuum. It's not like you can say, "You have a drug problem. Why don't you come to our drug rehab?" or "Let me get you a consult," or "Why don't you take a little detour into this wing?" It's very weak here. There's no place where you can say, "You've just been discharged from the hospital. You should go to this step-down, half way house."

In *The Patient Nobody Wanted*, described to us by a hospital social worker, the problem was similar. The patient in question was a 72 year old man with serious psychiatric as well as cardiac problems who was admitted to the cardiac care unit but was refusing all medical treatment. For eight days he remained in the CCU with no treatment. Eventually, he was transferred to Psychiatry where he agreed to take psychotropic medication but he continued to refuse all cardiac care. He was eventually discharged from the hospital after a frustrating two month tug of war between psychiatry and cardiology that also came to involve the Consultation and Liaison Psychiatric Service, the Medical Director's Office, the Assistant Director of Nursing, and the hospital's Legal Department. Our respondent noted that the sub optimal care rendered the patient was the result of the absence in the state of a single unit to treat patients dually diagnosed with serious psychiatric and medical conditions.

5. "Value" Conflicts

The culture of health care encompasses a variety of ethical, philosophic, and pragmatic values. Three of our respondents mentioned value related tensions as a source of conflict within the hospital. These include such things as the conflict between cost containment versus the rendering of the highest quality of medical care possible; conflicts between those who want to treat versus those who want suffering to end; and conflicts between the aims of research and those of clinical care.

The hospital also encounters value based conflicts with some of the institutions with which it interacts. One respondent described a conflict in which the hospital found itself in conflict with another hospital involving the patient's right to know versus intellectual property rights. In this dispute, researchers at the other institution, eager to protect their research protocols, were insisting that a patient sign an informed consent agreement lacking important medical details about the treatment. The patient felt she had a right to this information. Perhaps the most common inter-organizational conflict is with managed care companies, whose economic interest often leads them to pressure the hospital to agree to clauses in contracts that the hospital's Legal Department feels are not in the hospital's best interest.

B. Organizational Dynamics

More than half of the respondents (53%) mentioned some aspect of organizational dynamics as a source of conflict within the hospital. These dynamics seem characteristic of complex organizations in general, although many of the details were unique to health care. From the interviews, it is possible to identify three organizational variables that appear to fuel conflict and complicate the task of effective conflict management: (1) Coordination problems (2) "political" tensions within and between departments, and (3) ambivalent organizational attitudes towards conflict management.

1. Coordination Problems

A hospital is a complex organization of highly specialized disciplines and services. Meshing the component parts is often a challenge. In part, the problem stems from the difficulty any one person has of comprehending the language and knowledge of another specialty area, even one that he or she is supposed to manage. Said one nurse manager: "Because this is such a large institution, no one person can know everything. To give an example, my clinical background is in neuroscience. I'll tell you that when I go to the neonatal ICU, I can't make clinical judgments because it is not my area of expertise."

A more frequently mentioned difficulty was poor communication across departments:

A department can develop a policy that's department wide but really has a downstream effect for somebody else. But nobody talked about it and you'll see something and say, "But wait a minute!" So we need to do a lot more collaboration. . . . Historically, we have been a "silo" kind of organiza-

tion. We don't disseminate information among ourselves very well. We have some excellent programs that we, as individual employees don't really know about.

The hospital leadership is aware of these problems and has begun developing mechanisms to address the issue. The establishment of inter-disciplinary task forces is one such device. Another is the creation of new work roles. The respondent just quoted, for example, has a new position whose responsibilities include studying inter-unit coordination problems. Still another mechanism is the use of newsletters and internet technology to increase hospital wide information exchange.

Unfortunately, these mechanisms sometimes fall victim to the very problems they are trying to address. *The Case of the Missing Medical Supplies* illustrates the dilemma. The first problem faced by the multi-department task force being led by the respondent was designing a "one size fits all" process for tracking the supplies. "It got to be a problem, too, in finding a solution that was going to service all units because they are all a little different – medical, surgical, pediatric units. We had to make sure the solution we came up with would satisfy everybody."

After months of effort the task force had identified a lack of accountability as a significant contributor to the "disappearing" supplies and had drafted a pilot program to address the problem. A number of events intervened to frustrate the implementation of the pilot program. There was attrition in some of the key departments involved so that new individuals had to be educated about the pilot program; the department that was to play a key accountability role in the pilot got a new computerized scheduling system, which diverted a significant amount of their energies and attention; and the Joint Hospital Commission began a review of the hospital at large, which also drew attention and interest away from the program. At the time of the interview, some 18 months or more from the start of its work, the task force was once again gearing up to implement and evaluate its pilot plan.

It is in the operating rooms that the challenges of coordination in the service of quality medical care are most acute. One respondent described her role on a task force appointed to help deal with staff and patient complaints about the running of the ORs.

The OR is a large, revenue-generating department, but it also has a lot of issues. It is a multi-factorial, complex department because we have all the services that use the operating room: trauma surgeons, cardiovascular surgeons, open heart surgeons, neurosurgeons, plus anesthesia. All of them have

to learn to live together within the constraints of a 12 OR suite setup. How do we do that better?

The problems of coordination in the OR are complicated by the hospital's designation as the highest level trauma center that exists in the state.

We are a trauma center. Traumas come in and they go first. I don't care what's scheduled, unless it is open-heart. You can have patients scheduled for an elective and your elective cases get bumped because of emergencies. They [the surgeons] had concerns about the process in terms of how timely things get done in the operating room: equipment, staff ability to use the equipment, the lack of what they perceived as staff readiness and willingness to work with them and help them. The nursing staff and other staff felt that the surgeons were being abrupt, non-communicative, not willing to even listen to another person's or service's issues — the so-called "God syndrome." "I'm the surgeon. whatever I say — do it!" We've been working with the staff and physicians, the chairmen of the departments and the individual physicians on looking at the process.

2. "Political" Tensions

The difficulties of coordination frequently involve more than overcoming hurdles of communication and focus. Departments often have very different underlying agendas. These differences can create intractable dilemmas. This was an important, if secondary theme, in *The Patient Who Nobody Wanted*. In that instance, neither the psychiatry or cardiac services wanted to treat the patient for fear he would die on their watch and they would be held liable for providing inadequate care.

The Missing Medical Supplies provides the best illustration of how "political" differences can impede problem-solving and stir up divisiveness. Our respondent made it clear that much of his frustration in attempting to orchestrate a good problem-solving process by the task force he was nominally in charge of was the result of conflicts between two departments, neither of whom wanted tracking the supplies to become their job:

I get these two departments coming to me after meetings and the two of them are saying, "its not my job; I don't want to do it that way. . . ." Also when we were brain storming there would be barbs directed at the other service or comments about, "They call and ask us to bring equipment and we shouldn't be doing that." Always the "we shouldn't have

to be doing that" or "they should be doing that." There was a lot of finger-pointing during the meetings.

Effectively managing the inter-department rivalry on the task force was exacerbated by the strategy of the manager of one of the two departments:

The head of this department was not on the team. She had assigned a supervisor to the team and unfortunately, didn't empower the supervisor to make a lot of decisions. When the team would make a decision the supervisor felt it was appropriate but it would come back to the manager and she would say her staff wasn't going to do that or take that responsibility. It was a lot of time wasted.

3. Ambivalent Organizational Attitudes Toward Conflict Management

Students of organizational behavior have noted the ambivalent attitude which organizations often have about conflict.¹⁶ On the one hand, "conflict" with other organizations is often seen as a good thing and the source of much innovation and social progress.¹⁷ On the other hand, conflict within the organization is often viewed as a sign of disloyalty, dysfunction and a threat to the attainment of important organizational goals.¹⁸ These attitudes are rarely openly expressed, but they are clearly implied in the lukewarm support organizational leadership gives to the task of "managing" conflict within the organization.

Thus, a number of respondents noted that the Office of Employee Assistance (EA), which they would like to use as a place to effectuate problem-solving and conflict resolution, is generally seen by staff as a place they are being "sent to" to be disciplined for poor performance. The result is that EA is almost never used to mediate interpersonal conflict. Aside from various formal grievance mechanisms, which appear to be familiar venues in this heavily unionized hospital, there does not appear to be any clear place where managers or employees can go to resolve their differences in a non adversarial way. An occasional respondent expressed a wish that such a forum existed – and one even sought such assistance from outside the hospital for a dispute between two subordinates that she felt unable to mediate herself:

16. Kolb, *supra* note 6, at 99.

17. *See id.*

18. *See id.*

We do have – and I'm very familiar with them, I'm sorry to say – labor relations and grievance hearings and arbitrations. I was down at the EEOC [Equal Employment Opportunities Commission] last week and the month before that, too. We have an affirmative action office that reviews work place issues for employees that are classified. So we do have some formal processes. What we lack is a process for resolving conflict on a peer to peer level.

INTERVIEWER: There's no mechanism to help mediate disputes between individuals?

RESPONDENT: Not unless it goes through labor relations. I think that is late. It is very late in the process and it takes a long time. The one conflict that I described where we found a mediator from the mental health services unit of the hospital was actually a conflict between one of our paramedics and an ED nurse. The nurse complained to the nurse manager and the paramedic complained up through the grievance system. They are both good, valuable people and they're in different unions and we're in different unions. We could fight it out, director to director, but that's not going to solve the interpersonal problem down there. I'm proud of the fact that I was able to find someone to mediate that.

Ambivalent organizational attitudes towards the management of conflict were apparent in *The Missing Medical Supplies*. The respondent made it clear that he had mixed feelings about taking on the job of task force leader. He enjoys this kind of "organizational development" work, but he felt that he tends to get "over committed" to it. This sense of "over commitment" also appeared to be a reflection of the limited support he felt he got from the hospital executive who had asked him to take on the job. The executive had the authority to order the managers of the affected departments to free up staff time to give the task force the help it needed. This authority was never used. There were other problems:

My understanding of what [the executive] should have done was to outline the process as he saw it and give us more direction. I felt a lack of direction. It was like, "This issue came up; you take care of it." It came out of the blue so I was feeling a little dumped on. I felt the executive should have provided more direction if the hospital really wanted this issue worked on. Give me the background. Give me some information. It wasn't forthcoming. . . . I also invited the executive to our first meeting so that he could outline the expectation to the team. I felt we needed to hear it from the top. If we are being pulled together to solve a problem, tell

us the end product you are looking for. My feeling is, I still don't have the answers to my questions.

The respondents' perceptions of the hospital's posture regarding training in conflict management may be another sign of organizational ambivalence. Nearly all of our respondents thought it was "very important" that health care professionals get training in handling conflict effectively, whether for the purpose of improving the quality of patient care or to reduce the threat of law suits. However, only a few informants reported getting such training. Although we were told by one informant that the Human Resources Department offers such help, another felt that since training in managing conflict is voluntary, many people don't seek it out. In this vein, a nurse administrator wryly observed:

Several years ago we went through this big "Great Expectations" customer service training program. All of us had to have mandatory training – every department, every individual, every housekeeper, you name it. Not the physicians. Our patient satisfaction tool was saying it was everybody else; not the physicians. I started laughing.

INTERVIEWER: Would doctors come to a conflict training workshop?

RESPONDENT: It would have to be a different name. I think it would have to be called something different – something about "team building" or something else. But you sure couldn't call it "conflict resolution," because they don't have any!

Perhaps the most striking sign of organizational ambivalence toward conflict is the popularity of conflict avoidance. According to nearly two-thirds of the respondents this is the preferred strategy for dealing with hospital conflict.¹⁹

19. In six studies of nurses' approaches to conflict management, avoidance and compromise have been identified as the most frequently used conflict management styles, as opposed to the more robust collaborative and competitive approaches. See Patricia E.B. Valentine, *Management of Conflict: Do Nurses/Women Handle it Differently?*, 22 J. OF ADV. NURSING 142, 145 (1995). In a similar vein, a study employing an assertiveness inventory, reports that 75 percent of the nurse respondents were characterized by "dysfunctional" assertion repertoires (e.g., low assertion/hi anxiety). See Lees & Ellis, *supra* note 2, at 954. Only 25 percent of the respondents fell into a more functional assertion category (low anxiety/high assertion). The authors believe that the low level of assertiveness among nurses in their study may help explain the degree to which conflict with physicians and other nurses were experienced as such potent stressors by their respondents. *Id.* at 959. But see Patricia E. B. Valentine et al., *Nurse Educators'/Administrators' Ways of Handling Conflict*, 14 J. OF PROF. NURSING 288, 295 (1998). The authors assert a more positive interpretation of the female nurses' preference for avoidance and compromise and their

People do not like to handle conflict. If they can, they ignore it. Conflict makes everyone uneasy. People hold onto conflict. They are uncomfortable sitting down and discussing it. It amazes me. There is a way to do it that's not going to harm anybody. When there's conflict it makes them (medical staff) very nervous and many times they'll say: "Until this family is all in the same place at the same time we're not doing anything. . . ." When there is conflict that is their approach. In most situations in health care when there is conflict the doctor's come around when the family is not there. They don't answer their pagers. They withdraw and avoid.

The respondents expressed several ideas about the source of conflict avoidant inclinations in their colleagues. Two nurse managers noted that many health care professionals have never been taught how to deal with conflict. Conflict avoidance may also be a function of the lack of visible procedures and venues for bringing the relevant stakeholders together. We heard much about this, particularly in regard to conflicts over treatment planning.

A nurse with advanced practice training in bereavement counseling expressed the view that some medical services at the hospital were better at managing conflict than others. Oncology was good in this respect, she felt, while "the culture" of the ICU was more problematic. According to a doctor with much bioethical training, another potent source of avoidance is the difficulty doctors have talking to patients about death.

In a situation like this [end of life discussions] you're always talking to a patient about their anticipated demise, and that's something lots of doctors are intensely uncomfortable talking about You have to look mortality in the face and be as sure and confident as you can that the patient is looking their mortality in the face with as great a degree of steadfastness and awareness as possible.

Helping colleagues manage their conflict avoidant inclinations is an important role for many of our respondents. We will examine it more closely when we turn to the central topic of intervention.

A Positive Note on The "Anatomy" of Organizational Responses to Conflict. The hospital response towards conflict does appear to have a more positive side: One third of the respondents made reference to units within the hospital which function as places to resolve conflicts

disinclination to use competitive stratagems. They argue that women's strategic preferences may be a reflection of a distinctly female ethos of nurturing and connectedness.

and promote organizational learning, even though this is not their official purpose. We have already noted that our oncologist respondent used the Tumor Board to begin a dialogue with other medical services to establish clearer criteria for dealing with the terminally ill drug abuser.

The director of a medical department reported a similar strategy to deal with his frustrations in getting several other departments to provide better service to his unit:

We have a group that meets every other week. It includes myself, my nurse coordinator, radiology, all of the peripheral ancillary services in the institution. We deal with clinical and nonclinical issues. For example, I got admitting to finally show up consistently. Now we have someone who, after six years of hammering, is beginning to make changes in some of the admitting policies and procedures. This individual has decided to take accountability on herself, God bless her.

A nurse administrator described her assignment to improve the functioning of the operating rooms:

I spent weeks in the OR. I got into scrubs and actually sat there watching each function, because the OR is a microcosm all of its own. There's a board runner, if you can imagine; there is one person assigned to look at the board and if there are cases running over, they have to reassign rooms and reallocate staff. That in itself is a job: With the calls coming in and saying, "I need you to switch the order of my cases. I need you to do this. A trauma's coming up from the ED." That was something just to watch. Then I watched a scheduler. Then I watched some cases and saw how people interacted. I spent time with the OR staff; anesthesia; and medical equipment. Just watched the operation My assignment was not just for the expertise I brought for conflict. I was bringing another expertise too. I was doing that to understand the operation of the OR and then to develop, as a facilitator, some measures of process within that operating environment. I was to facilitate meetings, but I was also to document when interventions were made and what the outcomes of those interventions were, and then bring that back so that we could develop a feedback loop.

Other places which were mentioned as vehicles for addressing organizational problems included the Bioethics Committee; the Medical Prognosis Committee, the hospital's complaint hot line; the Professional Liability Committee; the Department of Social Work (which does the brunt of the work in interfacing with families and other units

in and outside of the hospital); and Human Resources, which does organizational development and offers a variety of workshops (including one on conflict management). To this list we may also add the Administrators on Call and the Lawyers on Call, individuals who are specifically charged with handling "emergencies" which arise, frequently on weekends, when the normal administrative staff are unavailable.²⁰ The effectiveness of these institutional mechanisms is, of course, another matter. Their existence indicates that institutional ambivalence towards conflict is very much a two-sided coin.

C. Resource Scarcity

The conflicts engendered by shrinking resources provoked some of the most pungent and detailed remarks of any subject covered during the interviews. Nearly one third of the respondents spoke directly about the negative effects of reduced resources on conflict within the hospital and between the hospital and other organizations. (All but one of these respondents was a director of a hospital department). Many other respondents made indirect allusions to negative economic impacts.

The flavor of the change in hospital economic realities is captured by the rueful reflections of one department manager:

In the 80s, health care was in a big growth spurt. So we could be creative and we didn't need to be productive and we were well paid and we grew. It was a growth industry – 14% a year. It was nice. And now we are challenged with managing health care like a business; managing people like a business; managing our clients like clients. And the financial restraints are phenomenal, especially for an industry that had been such a growth industry. I have vice-presidents that I am working with that say, "Why did you do this back then?" Because we could! No one asked us to be financially accountable. It was great in the 80s! Hospitals have operating budgets and they have budgets of money that they reinvest in capital and, of course, hospitals and health care people like to buy lots of technology; we love to buy the newest toy. And as an academic health center we should have the best equipment – we take care of the sickest people. However, as the budget shrinks, the work force shrinks. We've had numerous layoffs. We're going to have another layoff in the next couple of weeks. So we had a "work redesign." We've "re-

20. In our sample three respondents had served as Administrator on Call.

engineered”; we’ve “down-sized”; we’ve “reduced force.” I mean, we’ve called it everything.

The shifting economic circumstances have fueled conflicts with insurers, with patients and their families, with other hospital systems, and most significantly, within the hospital, as various hospital stake holders compete for shrinking resources.

1. Conflicts with insurers.

An obvious source of the economic constraints are the cutbacks in insurance reimbursement with the advent of managed care. Interestingly, relatively few of the respondents discussed this matter at any length, perhaps because a relatively small percentage of the hospital’s patients have private insurance. One physician referred to the conflict between the hospital and insurers as “the chronic, nagging push to drive patients out of the hospital.” He recognized that there is a genuine economic problem, but objected strenuously to the idea that it should be the insurance companies that get to make the decision on patient care. Another physician, commented with a wry laugh: “There’s no conflict resolution there that will work with the exception of dynamite and letter bombs. These people don’t want to pay or they make you jump through such hoops to be paid.”

2. Conflict with patients.

Two respondents noted that Medicare and Medicaid will not reimburse the hospital for rehabilitation of a patient past the period of active medical care. The hospital is thus under pressure to discharge the patient or get stuck with huge uncollectable medical bills. This can cause conflict between the hospital and a patient who refuses to be transferred or with a family which is unable or unwilling to cooperate in discharge planning. Several of the cases discussed during the interviews were of this type.

The changing system of insurance reimbursement can cause more mundane conflicts with patients:

A patient will arrive at the hospital for an outpatient appointment not having brought their insurance card. We are trying to verify the type of insurance. He does not understand the process because the managed care company has not educated their consumer about their program. The patient is thinking that we are just making them wait an inordinate amount of time, so they go another route – to the administration to make a complaint that they waited an hour, when,

in fact, four or five things needed to happen prior to that appointment.

Because so many of the hospital's patients are directly dependent on public funds for their medical care, government health care initiatives have sometimes caused major headaches in patient-staff relations. A respondent with long experience in ambulatory care services commented:

It is the way that managed care rolled out in our country. In this state, specifically, they started with the AFDC (Aid for Families with Dependent Children) population. That was the Governor's plan for Medicaid. A lot of the mothers who were receiving aid for their children were auto-assigned into managed care. They had an arbitrary auto-enrollment. The mothers didn't read the documents. They don't know that you have to call your PCP. "What's a PCP?" "Your primary care provider." That terminology is new to them. Calling someone before you go to the ER is a new concept. "I missed my doctor's appointment; I'm going to the ER." We have rules that say you have to treat them; establish a medical screening. We have all of that, but they don't understand all that. I think that with the socioeconomic class aspect, we haven't done a good job with our education as it relates to changes in how health care should be accessed. Our patients, woefully, don't understand that.

3. Conflicts with other hospital systems over "desirable" patients.

The shrinking economic pie has led to conflicts between the inner city hospital in which our respondents work and its sisters hospitals in the local area. In some cases, conflicts arise with many other hospitals in the state because of the hospital's status as a Level One Trauma Center and as the provider of emergency ambulance services for the region.

Sometimes the conflicts are directly over money. The hospital must compete with other hospital systems for state controlled "charity care" dollars, as well as for money from the city Health Department. At other times conflicts arise over patients; some are economically desirable because they have good insurance coverage while others are much less desirable because they are poor and lack such coverage.

For example, most trauma cases are attributable to automobile accidents and automobile insurance coverage is, in the words of one physician, "the best health care coverage out there." It is a common view of trauma centers that the community hospitals do their best to retain such patients rather than transfer them to the trauma centers

which are better equipped to render the appropriate medical care. Our respondent believed that this dispute could be resolved if there was accurate data on how many trauma patients were being inappropriately cared for at community hospitals, but he expressed skepticism that getting the data would be easy. The state health department has no funding to do the necessary research, so there is a great reluctance on the part of hospitals to supply the information. Even if accurate data could be obtained, it would then be necessary to assemble "political allies" to pass a state regulation, conformity to which would then need monitoring and enforcement.

Because the hospital's Emergency Medical Service is a state-wide operation, the hospital often becomes entangled in the strategic battles which hospitals wage to insure a tolerable flow of the economically desirable patients. Much of this warfare over patients is conducted in the shadow of state regulations. One respondent with a great deal of experience with this struggle had much to say on the subject.

The good news is that hospitals in the state cannot deny emergency care to anyone based on their ability to pay, that's the good news. However, hospitals can't continue to take care of patients without reimbursement They could be under-staffing their emergency departments because historically emergency departments lose money in an urban setting. So you under-staff your emergency department and this denies access to your inpatient beds [This strategy] causes a tremendous amount of stress for patients in the inner city, where EMS and emergency departments are their safety net health care because they don't have access to primary care doctors.

The regulations that are intended to impose limitations on the strategies hospitals employ for controlling patient flow can get quite detailed. These details are helpful, according to our respondent, but they by no means eliminate the strategic jockeying, or the stress this imposes on EMS workers.

We have these things called "bypasses and diverts." In the EMS and hospital industry there are articles and law suits about this all the time. A hospital goes on bypass and they announce to everybody, "We're bypassing because we don't have the capacity or capability to take care of patients." And they can divert certain kinds of beds. For example, we were diverting women in labor under 32 weeks. Our neonate nursery had been filled to capacity for the last 6 weeks They put these diverts out and they broadcast them through

the system and its just another piece of information EMS has to manage.

What we find with the hospitals is that it's a domino effect. One hospital calls a bypass and within hours the next hospital does; and there are certain times of day where you know bypasses are being called and you think its due to economics or deliberate staffing However, the 911 call volume is consistent. So we have the work product coming in and the responsibility to take them to hospitals and the hospital saying, "We can't handle them." And they're not allowed to deny care to people based on their chief complaint, and, in fact, if 8 out of 10 hospitals are calling a bypass, we get into what's called a rotation. It's a forced situation where the hospital has to take the next patient that comes out of their geographical area They're not great rules, but they protect the consumer. I believe in the rules; they're a whole lot better than anarchy. But, I think we can do a whole lot better job of taking care of patients.

4. Conflict within the hospital.

Economic retrenchment has perhaps had even greater effects on conflict among various groups within the hospital than with the hospital's external competitors. The respondents described three major types of conflicts within the hospital which are directly related to economic constraints: conflict between and among departments, conflicts between departments and the central administration of the hospital, and conflicts between an older, "slower" hospital ethos and a newer ethos of efficiency and cost containment.

The inter-departmental rivalries caused by economic necessities were well-captured by one department director:

In the shrinking pool, the competition is now between disciplines in the hospital. Nursing is looking for new beds; physicians are looking for new invasive monitors; the OR's looking for new high-tech operating equipment. Now we're all justifying it not just on the nice touchy-feely "we're going to save lives and babies," but now we have to justify it [in economic terms]: "Are we going to turn a profit on it? How's it going to impact our new budget? Are you going to be able to reduce another expense?" So you have to do all this financial justification and even after you've done that and you proved the value of it and you know you're going to save small children and old people, there's shrinking dollars and you might not get funded. There's a lot of frustration, a lot of inbred competition. The neonate nursery needs isolet-

tes but EMS needs ambulances. So now we have a decision-maker that has to balance out what's more important, the ambulances or the babies? These kinds of decisions are being made everywhere in health care every single day.

The conflict between the trauma service and admitting is another example of interdepartmental conflict fueled in part by economics. The Admissions Department lacks the sophisticated computer software and hardware that would allow for the rapid and automatic retrieving of Medicaid and other data from distant data banks. The consequences are reflected in the frustration expressed by one respondent:

I do trauma and surgical critical care. A seriously injured patient comes in, certain things have to be done. It's at times vexing to get the registration people to do their job in a manner such that we can get something as stupid as a medical record number and appropriate information To have a Continental Airlines employee hurt at the airport come in and be registered as self-pay with no insurance is a bit of foolishness At times people fail to recognize that the goal of this institution is to provide care to sick and hurt and injured patients – not to perpetuate a hospital on the corner!

Interdepartmental conflict is also exacerbated by the unpredictable and acute needs that abruptly arise in hospitals, and by what one respondent described as the tendency in any large organization to hoard, particularly during periods of resource scarcity.

It is an organizational problem in health care. People hoard so that you have it. You don't trust the process, so you hoard. If you went into closets around here you're going to find hidden wheelchairs and oxygen tanks – you're going to find stuff everywhere. It's the nature of big organizations – failure to trust that the process is going to work when you need. "When I have an emergency, I'm going to make sure that I have my stash."

Since departmental purse strings are ultimately controlled by administrators in the hospital, respondents occasionally expressed frustration with the hospital "bureaucracy." The Director of a hospital surgical center commented:

We put in a request to replace three computers that are over five years old, one or two of which are broken. I get 17 signatures; I sign it; the Medical Director of the hospital signs it. It goes. This is chump change. You're talking about \$5500.

It comes back to me from the head of Hospital Management Information Services saying, "They just got machines as part of their Y2K upgrade." What has one thing got to do with the other? So I just wrote back to the Medical Director, "This is unacceptable." "I don't care what happens. I'm not stealing the money."

As far as I am concerned, all those budgets are fanciful. They told me at one point that we overran our budget. The budget of this Center is somewhere between \$400,000 - \$500,000, of which 82% or more is fixed salaries. And \$50-\$70,000 worth of junk - phones, beepers You don't want me to pay for beepers? Fine, put it on someone else's budget. Phones? All right, we don't need any phones. Of the \$70,000 of junk, \$20-\$25,000 is related to the Center's network, our computer network, that we need for the Center. You don't want us to have it, we won't be a [major] Center. Just let me know. The amount of effort I need to spend on this activity and the fact that I have not one administrator that oversees the Center is the source of my angina and frustration. To me, that's conflict without resolution.

Another respondent also complained about administrative decision-making, but for a very different reason:

In the old days the process was very defined and clear. And people like me, who were assertive, could go in and influence the key decision-makers. In fact, I had a videotape that I played for these executives. I walked into their office and played this tape and said, "Look, we could do this here." It was a dispatcher telling a mother how to clear the air way of her infant. The next day I had the mom bring the baby into the hospital and we gave her an award. I can't tell you what kind of funding I got after that! It was so easy. And I was pretty good at it, bringing the mother and the baby and winning over people's emotions. And there are physicians that do similar. I mean, I learned that skill here; I didn't learn that in school. I learned that from very influential people. But now the process is not so well-defined. I don't even know exactly who all the key decision-makers are. And even if I did target the right person, I know they're limited in their ability to fund things because the budget has shrunk so.

The complaints are not all directed upward; management has its own frustrations with getting staff to accept the new economic realities. A nursing executive noted that the hospital had a \$60 million deficit last year. To eliminate the deficit, twelve work groups were formed to reduce costs and improve quality. These efforts succeeded

in eliminating the budget deficit, but they encountered a good deal of resistance from employees.

People don't react to change well, or to how change is managed. With the number of change efforts it is difficult to maintain an optimal sustaining of whatever change was supposed to take place There are many individuals who don't feel they need to change; don't want to change, so inherent in that is a conflict People are getting tired by trying to keep up the pace, but also anxious, in the sense that its not going back to what they were used to, which is also causing some conflicts. What they knew as learned behavior before – "accept change but go back to what you were doing before; its only going to be for awhile" – is not necessarily happening this time.

The economic constraints have also provoked within the hospital a conflict of a more general kind: The clash of an older, well established ethos of paternalism with a more recent business ethos that emphasizes efficiency and cost containment. These two "cultures" maintain an uneasy co-existence within the hospital, but the tensions between them have grown sharply with economic retrenchment. The tensions were evident in the remarks of several respondents.

The physician head of a major department:

There was a great conflict in the early and mid 1970s when this hospital was erected. There were great concessions made to the community, from employment to a lot of other things. There were many unions. It has taken 25 years to slowly move this institution out of an inner city, charity hospital mentality into one where health care has fortunately morphed itself into a business It has taken a generation to slowly move this institution forward. It's not that we haven't made progress; in places, we have made great progress. But bureaucracies are very good at self-perpetuation. The only thing that preexists bureaucratic survival mechanisms are the cockroaches I remember reading in *Time* or *Newsweek* that at General Motors there was something like 13 or 17 layers between the guy who put the ribbon into your car and the CEO. At Toyota there were five. We're General Motors.

He went on to note how gratifying it was to find an administrator who has been responsive to his needs. "She doesn't get defensive and she agrees that there is an issue and is trying to remediate it among her people. Not easy, because of the bureaucratic and inner city cul-

ture in this institution. If this was a private institution it would be easier to fire people.”

A nurse manager spoke in similar tones:

Things have happened over the past several years that have driven change; one of them is financial. It has forced action and the way the institution has to operate isn't the same as it had been historically. The culture before was more slow, in the sense that it allowed time; it allowed other ways to compensate. And those luxuries aren't necessarily in place, so its causing friction. I'll give you an example of the nursing staff. If, when you benchmark – because we are doing a lot of benchmarking – if other institutions can manage the same number of patients, the same level of acuity of patients with four nurses, we shouldn't be using six nurses. Previously we may not have focused the effort on looking at the performance or even how we organized the work. If we didn't organize the work well or have the right performance levels, there may have been no way that we could have done the work with four nurses. But now we're being forced to look at change and it is happening quickly.

She amplified:

Very often when something was introduced, sure there could be training; sure there could be, “Let's check this;” “Let's do inter-rater reliabilities.” But then the quality controls wouldn't be put in place long term, say a year from now: “There were 13 steps; are we still doing the 13 steps? Did we cut down to the 10 but we really shouldn't have?” There wasn't as vigorous quality checks or controls put in place over time. We're starting to focus on that more, particularly in nursing, and its a learning experience.

While the preference of these respondents is to make the new ethos work, the strain of doing so was evident, particularly in the interviews with individuals with significant managerial roles. There was also occasional skepticism about the new culture (combined with a tacit acceptance of its terminology):

It may be that I will be able to effect some of these bureaucratic changes in restructuring of the whole medical program as a product line with its own identifiable service. That may help or, “be careful of what you wish for; you may get it.” I'll trade one set of problems for another.

D. Characteristics of Patients and Families

In 40% of the interviews, patient or family characteristics were mentioned as an important source of conflict. If we include responses to our questions about the extent to which the inner city context was problematic, the number is nearly 60%. Respondents complained about what might be described as the "pathologies" of urban life. These included drug addiction, severe psychopathology, and disorganized or non-existent family support structures.

Another problematic category were inflexible individuals, including litigious people and those with religious values that forbid medical interventions. (One respondent commented, "It is very hard to counteract God. I am not that powerful"). At times the "rigidities" have to do with the family's unswerving demand that the patient continue to be treated in the hospital when medical judgment says that the patient would be better off at home or in another facility.

There are also times when the characteristics of patients and families are only problematic in the hospital context. For example, end of life conflicts are sometimes fueled by geographic distance among family members, so that a family member who lives far away will also be emotionally far behind other family members who have been at the bedside for many days and are thus more ready to "let go." It is also normal for patients and families to experience significant distress when medical news is bad. This distress can create conflict because it clashes with the busy pace of the hospital and the specialization in medical care, which may make it hard for the hospital to take the time to arrange an appropriate response to the emotional needs of the family.

1. The Inner City Environment.

A particular concern of this investigation was to explore the impact of the inner city environment on the dynamics of health care conflict and its management. Respondents were asked two questions on this subject: Whether the inner city setting affects the nature of the conflicts they deal with? Whether to be an effective manager of conflict in this particular hospital there are important things that it is useful to know or to know how to do?

Three respondents rejected the idea that the inner city context played any unique role in fueling conflict or making it harder to manage. Their perspective was that "conflict is conflict" wherever it occurs and that the problems of any city are likely to be similar. For these respondents "cultural diversity" can be an issue at the hospital (and

they approved of training staff to manage diversity related conflicts better) but this is an issue in most health care organizations.

The majority of respondents, however, felt that the specific inner city environment has a significantly negative impact on conflict within the hospital. Most of the problems arise from the "pathologies" of the urban environment noted earlier. In addition, less than a quarter of the hospital's patients have private insurance or Medicare. Medicaid and charity care are the major underwriters of patient services. As one respondent put it, "our demographics are bad."

Respondents described six negative consequences associated with the hospital's inner city location:

1. Reduced compliance with medical treatments.
2. The creation of pressures on staff to do things that are medically problematic or financially burdensome to the hospital (e.g., to give outpatient chemotherapy to a patient with no support network).
3. Staff emotional distress. Dealing with the very sick, very poor, and socially disorganized people can be very stressful, making it harder for the staff to be empathic and respond well under tension. Said one nurse manager:

I was on a nursing unit where there were many homeless patients and you don't realize the guards these individuals build up because of the environments in which they have to survive. I'm remembering how some of the nurses were trying to be nice to this one patient, but that patient would spit at them They don't want to know how it feels for someone to be nice, because when they have to go back to their environment they may need that barrier to survive. Even as a nurse in a very challenging environment where you get the sickest of the sick in academic tertiary care, its not just enough to go in to change your IV and change your chest tube; you have to also alter how you deal psycho-dynamically with each patient, so you are constantly on guard. Physically you are on guard; emotionally you are on guard. It's stressful.

A family's prior experiences with the hospital can also starkly impact the kind of communications directed at the staff. A trauma nurse noted that the crime and tensions of the street are brought directly into the hospital. In her view, this makes for a very different climate than the one in hospitals in more benign surroundings. She cited one example: Often families have had a good deal of experience with the trauma services. Some of those experiences have involved the death of a loved one, which triggers statements like, "My so and so was here and you killed him."

4. Patient distrust. The socioeconomic and cultural differences between patients and staff can create problems of trust. A physician commented:

When there is great educational disparity between doctors and patient family groups and where there is socio-cultural disparity that leads to an inherent distrust. Often patient families are worried that they will be abandoned by their physicians. That's a peculiarly public hospital mentality.

INTERVIEWER: The patients are worried that they may be abandoned by their doctors because of their socioeconomic status?

RESPONDENT: Yes, and because they are black and different in those ways; because they have been led all their lives to believe that they have no right to medical care, they have no expectation of adequate medical care.

Language differences can also reduce patient confidence that the hospital cares about their needs. A nurse who was born and raised in the city, remarked:

We've done a lot with our customer service training, but the culture [of the hospital] can be very punitive for a person who doesn't speak English. I want to be careful with this, but it is real, I tell you. If you don't understand my language flow and you seem to need more help, I'm already stressed about that and that conveys itself in how we deal with the patients. It could be English as a primary language or limited English proficiency, it doesn't really matter. We, as an organization, need to get ourselves in line with how we communicate because how we communicate is a factor in our ability to serve a person and meet their needs and have them walk away with their dignity, as opposed to how sometimes we talk down and we just belittle them. That is a culture that still needs a lot of work.

Because of the social and medical conditions associated with poverty, the hospital is also sometimes obliged to take actions which put it in direct conflict with patients. A nurse who worked in ambulatory care for many years commented:

You might have to invoke a social hold on a baby because the mother is not able to take care of the kid. You have to do it, right then and there. I've been there. "Call Public Safety and have them get social services up here. Now!" That's conflict. Here you have someone believing they have a right to do something and unfortunately, because other people are in-

volved, minors, we have to do what we have to do to protect them. Those things are big things.

5. Conflict between the hospital and the community. The mounting financial pressures on the hospital raises difficult issues with the community about what the hospital's priorities should be. A respondent with executive nursing responsibilities noted:

[Although] our hospital is no different than any other urban hospital, it has special characteristics because of the genesis of this institution on this site. It is very community based and helped with the growth and the rebuilding after the riots. That's very much alive; this institution is supporting the community. That, in and of itself, leads to conflict in terms of the direction of the hospital. Does it become an institution that serves only the community, or does it entertain other ventures that may bring business in to sustain itself financially? [But] the question comes up. "Would you be denying care? You were placed here for the community. You can't deny, even if they can't pay. You need to provide." But that's why the institution has to bring in payors, because you can't always provide, particularly if charity care is cut back. There truly would be limited resources and there wouldn't be any money left.

6. Conflict with other health care institutions or insurers. We have already discussed the struggle between hospitals for the well-paying patient. Our hospital, because of its location and its history of being a "charity care" institution, is often the place other hospitals try to send their non-paying patients. A nurse responsible for outpatient services noted:

We take care of the patients that other people don't want to take care of for whatever reason. We have some interesting dynamics with the [names another health care system]. They do some interesting things, yes they do. We have mechanisms to address that. If we think we have had a patient dumped on us by another facility, we go to the Medical Director's office who has the right to make a complaint to the state department of health and have it be investigated. So we have a process to get with those folks. You can get some hefty penalties if you are guilty of doing that. The thing is that on an out-patient basis, its hard to prove. Sometimes people say, "Oh, go down there. They don't charge." I have had patients tell me that they told her to drive down from [a neighboring city] to our hospital because you don't have to pay if you come here.

At other times the hospital's conflict is with Medicaid. A manager in the emergency department described a typical scenario:

Frequently [Medicaid] will say, "They didn't need an ambulance to get to the hospital and they certainly didn't need the ER." We have this fight with the Medicare/Medicaid denial people all the time. They'll say, "A child had an ear infection, why did the mother call the ambulance?" I'll have to debate with them to pay the claim. If my kid has an ear infection and I live in the suburbs, I have a car; I have neighbors; I can leave my house and take my kid to the doctor or to the emergency department by car. They don't have that resource here. A lot of times the only way they can get access to health care is through an ambulance because we do not charge them to come to their house like a cab does.

Although the respondents gave candid, and at times stark assessments of the demands and challenges of working in an inner city health care setting, the overall impression was of professionals with a deep commitment to the hospital and the patients it serves. The advanced practice bereavement specialist captured the flavor of this stance:

Everything I know about this stuff [how to help people deal with loss] I learned from the people in this city. Moms and grandmoms here have taught me everything. You don't have to go to school and learn this. You just hang out with them. They are a remarkable people. This lady today – her son is 32 – he was on his bike going to visit her and he got hit by a car. Thirty-six hours later I am sitting in a room with her and she gives his eyes, his kidneys, his liver and she says to me, "I don't want another mother to hurt." Amazing! It just gives you so much respect for the human condition.

We have described in detail our respondents' accounts of the types of conflicts in which they intervene and their perceptions of the forces that fuel those disputes. It is evident from these reports that there is no single or outstanding cause of the conflicts with which the hospital must contend. The blame certainly cannot be pinned on "difficult people," although there was no shortage of people behaving badly in the cases we heard about. However, from the perspective of our "ground-zero" observers, the source of the difficulties lies primarily in the complex and highly "flammable" health care environment in which people function. This environment is the product of a number of complex and interacting social forces, including aspects of medical and nursing culture which work against collaborative problem-solving, dysfunctional organizational dynamics, including signifi-

cant organizational ambivalence about conflict itself, an increasing scarcity of resources, and the interpersonal and practical challenges posed by a poor, culturally diverse, patient population.²¹

However, our respondents are much more than observers of this problematic terrain. They are also key agents in the hospital's efforts to deal with its conflicts. It is to this central topic which we now turn.

PART II: STRATEGIES AND CONCEPTS OF INTERVENTION

I. INTRODUCTION

The interviews provided rich details about the activities and strategic thinking of informal conflict managers in a complex, urban health care organization. Before proceeding to these matters it will be useful to briefly review the intervention roles the respondents played in the cases that were discussed during the interview.

Our primary interest was to better understand the role of informal mediators of conflict in a health care setting. We therefore asked (but did not insist) that the respondents select a case to discuss in which they had played a mediation role. Ten (59%) of the respondents chose such a case. Five of them described disputes in which they had played the "classical" role of a mediator with no official authority over the disputants; five others discussed cases in which they mediated as administrators with clear organizational authority over the parties.²² Another respondent discussed a case of organizational problem-solving in which his role approximated that of the traditional mediator in the sense that he had no formal authority over the parties and was attempting to be the "honest broker" who kept the problem-solving process on track.²³ Six respondents (35%) described conflicts in which they did not mediate, but either served as a consultant or coordinator of the activities of others or functioned as a principal negotiator for themselves or as the representative of their unit.

Although none of the respondents were serving in a formal mediation role, their intervention strategies are well-captured by a typology which has proved useful in describing the work of professional third

21. See Michael L. Glenn, *Structurally Determined Conflicts in Health Care*, 5 FAMILY SYSTEMS MEDICINE 413, 414-16 (1987) (depicting a detailed account of the multi-dimensional nature of health care conflict from the perspective of a practicing physician).

22. This kind of intervention has been referred to as "authoritative" mediation. CHRISTOPHER W. MOORE, *THE MEDIATION PROCESS: PRACTICAL STRATEGIES FOR RESOLVING CONFLICT* 45-49 (1996).

23. His official role was that of team leader of an inter-departmental task force.

party intervention in conflict, such as labor mediation,²⁴ divorce mediation²⁵ or the mediation of medical malpractice disputes.²⁶ The typology classifies tactics into five major strategic categories: (1) establishing rapport (2) gaining an understanding of the conflict (3) improving the climate between the parties (4) addressing the issues, and (5) applying pressure for resolution.²⁷

The account we present of these five strategies is a composite; not every respondent talked about each of them. It is also important to bear in mind that while the typology is useful for descriptive purposes, it also introduces a number of distortions.

First, the typology suggests a separation of tactical behaviors into discrete strategic categories, when, in fact, it is often the case that the same intervention may have been undertaken with more than one strategic purpose in mind. We have quoted liberally from the interviews, partly as a corrective to this impression and partly to convey the richness, pungency, and occasional humor of the respondents' language.

Second, a description of the individual categories misses a crucial quality of the approaches to managing conflict of a good many respondents: Its holistic and structured nature. This important matter is considered at the end of our account of the strategies and tactics of intervention, under the heading of "Intervention Schema."

II. ESTABLISHING RAPPORT

Establishing rapport is a fundamental requirement of conflict management. It is among the first things that professional mediators describe doing.²⁸ So it is with our non-professional health care interveners. Respondents described four tactics for establishing rapport. These included active listening, being immediately helpful, validating the disputant's concerns, and relating to disputants empathically. A reputation within the hospital for competence in conflict management appeared to significantly augment rapport-building tactics.

24. See generally Peter J. D. Carnevale, et. al., *Contingent Mediator Behavior and it's Effectiveness of Third Part Intervention*, in Kressel & Pruitt, *supra* note 4 at 213-40; See generally KENNETH KRESSEL, *LABOR MEDIATION: AN EXPLORATORY SURVEY* (1972).

25. See Kenneth Kressel & Morton Deutsch, *Divorce Therapy: An in Depth Survey of Therapists' Views*, 16 FAM. PROCESS 413, 424-31 (1977).

26. See generally FELD & SIMM, *supra* note 5.

27. See *id.* at 37-40 (explaining various tactics of third party intervention in mediation).

28. Kressel, *supra* note 4, at 529; MOORE, *supra* note 22, at 90, 122-24.

A. *Active Listening*

Nearly half of the respondents noted the importance of giving the parties an opportunity to unburden themselves in the presence of a third party who is "really listening." Examples of active listening were described as coming very early in the respondents' involvement and for the purpose of providing an immediate outlet for anger and other powerful feelings. Listening was frequently described as a cognitive as well as an empathic activity. A high level administrator of ancillary care services described her first contact with an angry nurse:

Listening is a skill, because as I'm listening I'm thinking: "What's going to be my next step?" When the nurse walked into my office I could tell she was upset. Her face was all red and typically, she's a lovely lady. You could tell she was crying. She walked in and said, "I just can't take it anymore. What am I going to do? I'm going to kill her! [the doctor she was angry at]. This is the kind of written orders I get. This is ridiculous. How dare she or anybody else do this? I'm a very good nurse. How dare she demean me in anyway as unprofessional! I could take her to court." So I'm going to myself, "Oh boy. This is a handful here!" There are multiple issues: allegations of not doing her job, being unprofessional, sitting in the doctors' office with her feet up on the desk and a couple of other things. So, as I was listening I was writing down everything, which is what I usually do. I write down whatever they're saying. I'm looking at it . . . listening and looking. I'm thinking: "What is my next step?"

Several respondents noted that at their hospital, active listening and empathic efforts generally, are made more difficult by the socioeconomic and ethnic differences between staff and patients in an inner city hospital. A doctor commented:

You have to be willing to listen. You've got to look for nuance. You've got to hear not only what people are saying, but how they are saying it. You've got to look for "syntax." I'm not sure if that's more true here, except that in other hospitals there may be more shared socioeconomic expectations . . . Societies in which all of these assumptions are shared don't have to listen so hard for the answers.

B. *Being Helpful*

Responding to a person's immediate need, whether or not that need is connected to the dispute, was another popular rapport building tactic. It was a particular emphasis of respondents who had had

significant training in bereavement counseling. In *The Unwilling Daughter*, the respondent described her first contact with the daughter who was opposed to the cessation of extraordinary measures to prolong her mother's life.

I said [to the attending physician], "Give me a chance to meet everybody. Let me go 'schmooze.'" After 25 years of doing this, that is more important than anything else. Going in, sitting down, eyeballing people, and "making nice." I went into the room and said, "I'm so and so, I work with families. What do you need?" This is not about my agenda. I see so many people who screw this up by going in with their own agenda. She said, "I need help turning my mother." So we turned her mother. We rubbed her back a little bit. I got involved with her on that level.

The respondent noted that interventions of this kind are particularly likely to be effective because of the emotional vulnerability of people in the midst of a medical crisis: "It doesn't take a lot of time if you meet them where they are and you find out what they need. Within 20 minutes you can be very connected to a family member because they are in crisis. They are under such stress that they are wide open."

Coordinating such interventions with the normal rhythms of the hospital is also useful: "It was a quiet time – not busy and crazy. That makes a difference sometimes. All the chiefs go home and they'll often turn down some lights. Hang around here after 7 p.m."

Being helpful can also be a strategy to overcome resistance to a particular intervention. In *The Gang in the SICU*, the trauma nurse commented on her handling of the nurses' objections to her efforts to "mediate" between them and the milling mob of gang members. The respondent had devised a plan to allow the gang members to "say goodbye" to their dying comrade and then to exit quickly and voluntarily from the hospital.

There was only one nurse taking care of him but nurses can be like a gang. So there were six or seven nurses on that day and a couple of them had very strong opinions about how many visitors were coming in. With their manager there, I explained to them what we were going to do. They were all going to come in, two at a time, and pay their last respects. The nurses weren't real happy about it. They'd had enough visitors. "There [are] things they need to do. Don't I know there are medications they need to give? If these visitors are all in there, I can't get in there." [I said], "Then you won't go in there while we're in, and if you need to do something,

we'll step out. I'll be here." I went in with each of the groups and made sure and brought them down the hall.

Another respondent described how her responsiveness helped calm an angry surgeon. The respondent was a nurse administrator who had intervened in a complex treatment planning conflict between a surgeon and a psychiatric patient who was refusing, against sound medical advice, to consent to the amputation of his leg. She had inherited the case when she assumed her normal rotation as hospital Administrator on Call (AOC). The surgeon was angry because the previous AOC had been less than diligent in keeping him informed about the steps the hospital was taking to try to establish a legal right to do the surgery.

Once he met me and we sat down and he saw what I was doing and how fast I was responding to him that first day I found him to be very patient. He just wanted to get [the surgery] done by Wednesday, because he felt that would be reasonable considering that he had had this discussion with someone else [the prior AOC]. I assured him that I would do everything I could to work with him and get his patient care needs done. I told him I'd get back to him in one or two hours and I did. That was the one thing that was key. He knew that I was with him because I got back to him every time I said I would with new information or where I was in the process. It wasn't like I fell off the face of the earth.

C. Validating

Nearly one third of the respondents spoke of the importance of making it clear to angry or distressed people that their concerns are legitimate. Validation of this kind was viewed as an essential means of establishing the emotional and interpersonal conditions that make problem solving possible. At times this can be done straightforwardly. One nurse administrator of an out patient treatment unit put it this way:

You can't talk to people when they are yelling and screaming. So first you have to calm them down. I say, "You know what? I'm the person in charge. You should be talking to me. What's going on? What can I do for you? How can I make this better?" They begin to talk to me and tell me what they need to happen. Then I'm able to work it out. "I think I can do this, but I might not be able to make that happen. What do you think about X, Y, and Z?" I've usually found that most of the time people just want someone to hear them.

They want to know that somebody heard their issue and thought it was important enough to provide a response to it.

A similar theme was sounded in *The Unwilling Daughter*. The second daughter had been named by the mother as legal proxy in her advanced directive. This daughter had been stymied by her sister's opposition to ending extraordinary measures and the medical staff's avoidance of getting involved for fear of the legal implications. The respondent described her first meeting with daughter number two:

Both she and her husband came. We went into the conference room just to meet. I wanted to find out who they were and their connection with the other sister. She started out saying that she had the right to do this and I completely acknowledged that. "Absolutely, positively, you're in charge. But is there a way that we can 'win-win' this; not have zero-sum game? The other sister has to feel so devastated. Maybe there's a way to do this a little differently." She began to talk about it. Her agenda was to get mom off the machines. That was her agenda. I don't think she felt listened to. People were avoiding her because they knew she was right. I see her crying and her husband holding her hand. I watched her go from [makes an angry face] to "How sad this is." I think this happened because I completely acknowledged that she was in charge. She didn't have to fight.

Validation can also refer to acknowledging that people have a legitimate right to certain information and a legitimate role in an unfolding medical drama. The handling of the teenage gang in the SICU by the trauma nurse illustrates the point. Until her arrival on the ward, the gang members had been regarded by the staff as an unwanted and threatening presence.

I went around to all the groups in the hallway and told them that I needed to meet with them and that we were going to talk about their friend and I asked them to come into the waiting room. I introduced myself to them and my role at the hospital. I told them that I had seen their friend and met with the family and that I needed their help . . . I needed them to be on my team. They had a job to do and I was going to tell them what the job was and that they needed to do that job to the best of their abilities. The room was silent. They were looking at me. Some more angry than others, but nothing was being directed at me; it was directed outside of the hospital. They were quiet, listening to everything that I had to say. I think they needed somebody to talk to. They needed somebody to speak to them – not just ru-

mors or overhearing or a family member coming out with whatever information they were willing to share. I was somebody who represented the hospital and what we were doing for their friend and telling them what was happening with him: That he was critically ill and that this gunshot wound was going to kill him; that he was going to die; that it was going to happen probably that day. But this was also why they needed to respect the family. That the family was very happy that they had come in and that the family wanted to thank them for being there, but that the family wanted to spend some time alone.

INTERVIEWER: Had the family authorized you to say that?

RESPONDENT: No, but it felt like the right thing to say.

The manner in which concerns are validated can be crucial. In this regard, respondents emphasized directness and self-control. "I sat at this table. I never have a meeting from behind a desk. A desk is a barrier. I don't want any barriers when I talk to people."

A similar note was struck by another respondent:

My security staff says, "You're hopeless! When something is going on, you get right in-between. It's hard for us to protect you if you get right in there!" But you know what? Unless I get right there and talk to them, we can't resolve this. You standing in-between me and them isn't going to help. That just adds more fuel to the fire. I need to resolve this quickly and quietly.

The need for self-control, or more precisely, for not responding to anger with more anger, was a point made repeatedly during the interviews. The following was a typical comment:

One of the things I've learned is that if you don't fuel it, it doesn't get worse. Even if you're hollering, you're trying to say something – you're distressed; something is bothering you. People just don't act out because nothing is distressing them. There's something distressing them; you need to listen to that. I've learned to get quieter . . . I can hear you better when you're not screaming and I'm not concerned for my safety. We can talk. I can help you. I used to always say, "If you stop hollering I assure you that I can help you."

Given the upheavals occurring in health care, health care professionals also need to feel heard. In discussing the lessons to be learned from a case involving a dispute with shift nurses who were asking for additional staff, a nursing director noted:

Change is very difficult, and the more planning, the more communication at any given time, the better. Change is

something that we can't necessarily control, but we need to be cognizant of it and to support those individuals through that process. Even the element of fear. You can't take away the element of fear from someone. You can't say to someone, "Don't be afraid. It's ok," because they are going to be afraid. The more you discount their feelings and the legitimacy of those feelings, the more a communication barrier arises Take this example: The nurse-patient ratio might have been the symptom, but the cause could have come from fear and just not even knowing if we are truly addressing that.

D. Empathic Attunement

We refer to empathic "attunement," rather than empathy, because respondents described the challenge not so much of being empathetic, but of forming a positive image of individuals whom others in a conflict situation have presented in a negative light. Once again, this was a particular emphasis of respondents with training in bereavement counseling. Thus, in *The Gang in the SICU*, our respondent refused to see the gang members in the same negative way that the SICU staff did, but rather as young people in the midst of dealing with death and loss who needed help expressing their grief in a legitimate way. In the case of *The Unwilling Daughter*, the respondent was told by the treating physician that the daughter insisting on continued aggressive treatment was "crazy." The respondent did not want to see her in that negative light. Her brief visit to the bedside to help the daughter care for her mother gave the respondent the perspective she was looking for:

I got a sense of how alone she must have been and how much she must really love her mother. This woman is there all the time. She wants her not to die. How connected she is to her I felt sad. I really empathized with her because I heard her pain. She had lived with her mother since the day she was born and was very connected to her. This was going to affect her life more than anybody else's. Her whole life would be different. And I just remember being very sad.

This empathic reframing of the "difficult" daughter also appeared to derive from the respondent's understanding of how "out of control" most people feel in a medical crisis involving a loved one, and how easy it is for medical staff, especially inexperienced staff, to forget this:

When your ten year old gets hit by a school bus your whole world is out of control Novices usually are feeling so scared and threatened that one of the first things they do is get officious. It never works. You have to go in and sit down and say, "This is awful." You don't have to say, "I'm so important. I went to this and this school and I know all this." Who cares?

Another nurse gave a very different example of how important it is to master negative feelings in the interest of maintaining an effective professional connection.

Twenty years ago, when I was a nurse out there dealing with people who didn't want me to do things I needed to do for them, I had to figure out how to get a compromise. You have to figure it out. When it comes to adults, adults do have the right to tell you, "No, I don't want you to touch my body." I mean, a person said to me, "I don't want you to touch me because you are black." That's what he said. Now did it hurt? Oh yeah. I never heard that before in my life. But ultimately, I just figured out that it was his loss because I was better – the nurse in me took over.

E. Reputation for Expertise

In several of the cases discussed during the interview, respondents noted that a reputation for expertise within the hospital was an important element in establishing rapport. In *The Patient Who Refused Amputation*, our respondent noted that she was able to win the angry surgeon over partly because of her medical expertise:

A novice might not have gone back to the charts of old visits to see history. I think they might have been afraid to go on the psych unit and spend time with the patient and figure out where he was. I think that it would have been intimidating, because here was a surgeon saying, "I've got to do this." I quantified it by saying to him, "Are you telling me that if you do not cut the leg off immediately – today – that this man will die or that he will lose all of his leg?" He couldn't quantify that; so then I said, "It is not an emergency. It is urgent, but if you're still telling me there is time to work on some of these other aspects [such as] identifying next of kin and trying to get them involved, then you can take him." He heard me. I think that being a nurse made a difference, because not all the Administrators On Call are nurses. It made a difference in that I was able to be a little bit more credible

to him in terms of what I knew about policy and what I felt was the right way to manage this.

A similar dynamic was at work in *The Unwilling Daughter*:

I was an ICU nurse so I really know the physiology pretty well. That has been immeasurably helpful with credibility with the staff. I can work the machines if I have to. They are updated versions but I know what they do. It has helped me very much in explaining things to families. I understand it. When I go to the chart I can read the crazy notes and I know what it means.

She has several other sources of influence within the institution. She was among those who drafted the legislation in the state governing end of life medical decision-making and she helped train most of the senior medical staff on these issues when they were at earlier stages in their careers.

I was here 10 years ago when a lot of these guys were “babies” and just coming through. Now they are all in charge of trauma and the leaders of this and the head of that. They’ll say to whomever is under them, “Whatever she tells you to do, you do. You hear me?” That helps a lot – that informal and formal power.

II. COGNITIVE SCHEMA FOR ESTABLISHING RAPPORT

Although we have described a variety of tactics for establishing rapport, one or two respondents described rapport building in terms which make it plain that the individual tactics flow from an underlying cognitive schema. Here, for example, is a nurse describing what she means by “active listening:”

I think that people really need to listen. They need to be listening “actively,” as they say. Don’t try to solve an issue just by hearing it. Give that person the latitude to say it. Clarify if you don’t think that you heard everything or to be sure: “Are you telling me that . . . ?” Let them keep giving you that feedback. Then it changes the dynamics and people know that you are really listening and you’re hearing them. If you can’t resolve it, tell them that you’re going to get back to them. But be reasonable. People just need to know: “I couldn’t get it done right there and then, but in two hours somebody is going to give me a document or a call or something.” That is one of the things I would do – just listen more actively – I wish somebody would do it with me!

It is clear from this account that in the respondent's mind, "just listening" is a skill that is not only uncommon in her hospital experience, but one that involves an orderly progression of several different tasks: listening, clarifying through summary statements, and providing information on how she plans to be responsive.²⁹ We shall return later to the topic of intervention schema of a more encompassing kind and the crucial role they play in guiding tactical behavior.

III. GAINING AN UNDERSTANDING OF THE CONFLICT

These are interventions designed to "educate" the intervener about the nature of the dispute and possible directions for effective action. Failing to gather sufficient information about a conflict was listed as a significant mistake. A nursing supervisor commented:

I've learned over the years of being in administration that you've got to get the facts and listen to the stories first, because I myself sometimes jump to conclusions and make decisions based on things that I think or hear, instead of getting all the facts. I find that when I do receive all the facts, the decision is usually different than when I just respond. I try to step back and take some time and absorb the facts first.

In several instances, respondents described the important role which subtle visual or emotional cues played in giving them a clearer understanding of the challenges they would face in intervening.

In *The Demeaning Doctor* the respondent described the impression she formed in her first meeting with the physician:

This is a person who walked into the room clutching her chest – both hands folded over her chest – and never looked at me at all; looked at the floor, the table, the lamp; looked at everything but me. To me, this was a really angry, frustrated individual who, for some reason, hasn't had her needs met.

The visual impact convinced the respondent that the physician's rigid personal style was a major issue that would have to be factored into the management of the conflict.

29. In a pilot interview, a respondent with much experience in training health care professionals discussed his explicit teaching of a schema for handling patient complaints very much like the one quoted in the text:

RESPONDENT: "Listen. Repeat back to show you have heard. Empathize, apologize, tell them what you can do to rectify the situation. Don't tell them what you are not going to do! And thank them for bringing the problem to your attention."

The most dramatic examples of the diagnostic value of visual cues comes from *The Gang in the SICU*. The respondent described her first impressions of the unit from the office of the alarmed secretary whose phone call had summoned her:

She has this office that's outside the main hallway, so all of this traffic was going back and forth from her room. So it was a good place to start, because I could already get a sense of what was happening. Even without her telling me anything, I was already seeing it. You could sense the tension in people's voices. They were angry and upset. You could just hear the kids out in the hall and the fast pace up and back; yelling to each other. Every few minutes, the door would open and more kids would step off onto the floor.

INTERVIEWER: What were you thinking?

RESPONDENT: Who's down at the desk? Where's Security? They were just giving out passes and there was open access all over the place. If it wasn't controlled or resolved it was going to get out of hand. It was going to be, if it wasn't already, a dangerous environment.

On occasion, subjective "intuitions" served as diagnostic triggers. A nursing administrator used such cues in a conflict with nurses who were demanding additional staff. The respondent recalled that she had been with the nursing director of the unit in question an hour earlier and the director had said nothing to her about a change in patients that would require additional staff.

She and I were here until around 7 PM, so I knew if something was really wrong, she would have told me. My gut said, "I need to make sure that I didn't miss something. Did I miss a cue earlier that totally went over my head; that I should have responded to or heard differently?"

Based on this intuitive reaction she sent a clinical nurse specialist down to the unit to do a thorough review of the immediate staffing needs.

The respondent then became aware that she was angry; the same problem had occurred several times earlier in the week with the same group of nurses.

At that point I was kind of angry too. I think the anger was out of frustration. A smooth transition would have demonstrated that there is open communication [between the two nursing shifts on the unit]; there is the ability to have that open exchange. That's not something little; that's major. That something "major" didn't happen. We've got a bigger

issue at hand, because you are dealing with people whose perceptions aren't in sync.

The anger led her to review her experience with the nurses in more detail, which led to the outline of a plan for reengaging them in a new way:

Over the past eight months I've actually had six different meetings with the staff on this unit. It's a small group. Sometimes when you've got fewer people there are more interpersonal issues that come up There have been special meetings in regards to criterion [for staffing] for different patients. For this to have occurred [these efforts] weren't working. We may have to do something more tangible and actually have different case studies that they can do. Literally, instead of just talking about it, but having something more concrete; some objective measurement; trying different learning and educational strategies.

IV. IMPROVING THE CLIMATE BETWEEN THE PARTIES

An important aspect of our respondents' activities were attempts to modify the "context" surrounding a dispute in the hopes that the parties would be better able to work their own way to a constructive solution. This is a central strategy of professional mediators.³⁰ Ten respondents (59%) described such interventions. The tactics used to improve the climate were of three kinds coaching, consultation, and opening communication channels.

A. *Coaching*

As noted earlier, respondents identified conflict avoidance as a significant obstacle to the constructive management of conflict. Helping people deal more directly with their differences was therefore a frequently discussed intervention. One nurse manager described how she tries to coach physicians to deal with people with whom they disagree. First, she appeals to the doctor's ego (e.g., pointing out the central role the physician plays in hospital management); then she encourages the physician to deal directly with the person with whom they are in conflict; finally, she makes sure to praise any efforts that are successful. At other times, the conflict phobic physician may be coached in more directive ways. A respondent described how she assisted a director of a medical department to intervene in a conflict between one of his staff doctors and a nurse. The respondent had

30. Kressel, *supra* note 4 at 533.

formulated a plan to mediate the dispute. The director liked her plan, but he was worried about implementing it.

It was very difficult for him to be able to manage the conflict. For one thing, a lot of these medical guys don't know how to deal with this stuff. They rely on the administrator to do it. But he's an open, honest, forthright individual. He knew that this was his department to run, supervise, deal with; it's a very important department. Although he idolized both of them, he knew there was a conflict and he couldn't tolerate it anymore. He knew something had to be done. So when I came to him with the plan, he liked the idea I said, "What do you want me to be? Do you want to lead it or do you want me to do it?" He said, "No, you can do it." I said, "Why don't we do it together?" He agreed to that, but I did most of the talking (laughs)!

Nurses may also need help overcoming their inclinations to avoid conflict. An emergency room nurse-administrator described modeling for her nurse managers how to apply discipline fairly and how to analyze situations in terms of authority, responsibility, and accountability so that their inclinations to avoid giving negative feedback to their subordinates are minimized. At other times she teaches more directly:

I actually give managers some phrases to use, like "I'm really uncomfortable with your performance. You failed to document the vital signs that were required every hour." If they meet with the staff and the staff is just, "Well, I'm sorry," you have to go beyond that. "I hear that you're saying that you are sorry, but what will you do in the future? How will you handle this?"

B. Consultation

Although they are experienced managers of conflict, our respondents were not averse to seeking help from others. At times they reach out to confirm that their own strategy or position is sound. An Executive Director of a major outpatient service commented:

I like to collaborate with people. I don't like to do anything unilaterally. I like to be sure I have a consensus as much as possible before I go into a situation. I either consult with a human resources person or the director of the department or with the manager. "This is what I'm going to do. Do you see anything that may be a weakness in it?"

Consultation was a particularly prominent strategy in disputes over treatment planning. Our oncologist respondent consulted with a hospital bio-ethicist about her reluctance to accept the referral from radiology of a terminally ill drug abuser.

I was looking for some validation. Was it okay or was I totally off base? Sometimes you just wonder when you take a stand. "Am I nuts? Everyone else seems to be going along with it. Am I off my rocker?" He told me point blank that I didn't have to give this treatment. In his estimation, an active drug abuser was a patient to be concerned about. He just validated my concerns and that I was not ethically bound to give the treatment, especially since it wasn't life saving or life-prolonging at this point.

In *The Patient Who Refused Amputation*, our nurse Administrator On Call sought guidance from the hospital's legal department on a number of important issues, including whether or not to seek legal authority as the patient's court appointed guardian or to invoke a legal claim that an emergency or life-threatening situation was involved. Another respondent, who was a member of the legal department, described what he considered to be his most important role in treatment planning disputes:

I think it is being a sounding board. Making the social workers comfortable that they have covered the legal aspects and that they aren't missing something. So that they feel comfortable putting their plan into work. I think getting them to that comfort level is probably the most important contribution we make. Also, just having somebody else to discuss these issues with to make sure they are on the right track.

C. *Opening Channels of Communication*

Helping the parties share information is a well-documented activity of professional mediators.³¹ It was an important activity for our informal conflict interveners as well.

Controlling the flow of communication was a prominent activity in end of life conflicts, a field in which bereavement specialists and bio-ethicists typically "mediate" at meetings involving family members and medical staff. These meetings are often convened for the express purpose of overcoming the parties' anxiety and uncertainty about how to engage with each other that are typical in such cases, and to insure that all the relevant medical, practical, and emotional "facts" are put

31. Kressel *supra* note 4 at 533; MOORE *supra* note 22 at 166-68, 257.

on the table.³² Two of our respondents described end of life decision-making conflicts in which they played this role.

Respondents mediating interpersonal conflicts also described efforts to promote information exchange. The mediator of one such dispute explained her preference for joint as opposed to separate meetings with the parties. "Separate meetings never work, because no one is listening to the other person. You want to let them hear each other. Let them hear each other's anger. Let them go through the grieving process, whatever that is. And let them build their bridge at that point."³³

The important part that third parties can play in orchestrating the flow of communication in a complex health care setting came from conflicts around treatment planning. The most dramatic illustration is from *The Patient Who Refused Amputation*.

Serving as the Administrator On Call, and eventually, as the patient's legal guardian, the respondent became involved in a dizzying round of activities. These interventions began with a diligent search for next of kin. Ultimately the search disclosed that the patient had one surviving relative, a sister. Locating the sister was not easy, however, since brother and sister had lost contact with each other years earlier. Eventually, the respondent tracked down the sister and, since the woman had neither telephone nor means of transportation, arranged with a local police department to bring the sister to the hospital. The respondent then convened a meeting between the sister and the patient's attending surgeon and consulting psychiatrist to discuss the patient's medical situation.

The respondent described the moral stance that informed these activities:

Ultimately, I would not like to think that we're just going to do anything to anybody, even if the physicians are giving us medical reasons. I would want to be assured that we did everything that we could to find next of kin. It is a sad thing to call a next of kin and be told, "Well, I don't talk to them, so you're wasting your time talking to me." There's such strain in some families that that is a problem. You don't have a

32. See NANCY N. DUBLER & LEONARD J. MARCUS, *MEDIATING BIOETHICAL DISPUTES: A PRACTICAL GUIDE* (1994); See Mary B. West & Joan M. Gibson, *Facilitating Ethics Case Review: What Ethics Committees Can Learn from Mediation and Facilitation Techniques*, 1 *CAMBRIDGE QUARTERLY OF HEALTHCARE ETHICS* 63, 63-64, 69-70.

33. It is interesting to note the reference to the "grieving process." As we had repeated occasions to observe, in the health care field the most visible concepts about conflict management appear to come from the bioethical approach to end of life disputes. Health care professionals who have had this training apply it to other types of conflict situations.

proxy for health care or any of those things. It is difficult to figure out what's best to do in their interest when they aren't able to speak for themselves. That's one of the reasons patients' rights and advocacy are big things for me; and that's why usually I take the stands I do. Before I do anything, I'm going to exhaust every possible way, because I think that's right. I owe that person that before any decision is made.

When it became clear at this meeting that the sister was herself suffering from a neurological disorder which made her an unsuitable legal guardian, there ensued another, more complex round of activities aimed at getting the respondent appointed as the patient's legal guardian and identifying the patient's treatment options. To this end, the respondent convened several multi-party meetings and conference calls involving physicians, a deputy attorney general, the patient's court appointed lawyer, and a series of judges at higher and higher levels of appeal. She also insured that the appropriate documents were in the hands of these medical and legal actors and that the judicial instructions or decisions made at each meeting were carried out.

Once a final legally binding decision to proceed with the amputation was made the respondent was then charged with ensuring that the directive was carried out according to court order. This involved additional coordinating activities (e.g., enlisting the hospital Medical Director to insure that the surgery was performed on a weekend, per court order). After six weeks of more or less non-stop activities the respondent's arduous role was at an end – or, as she put it, with a satisfied laugh, “Yes, six weeks was over. My 52-year-old baby went home.”

V. ADDRESSING THE ISSUES

Although practitioners of formal mediation differ as to the appropriateness of the mediator expressing a point of view about the substance of the conflict,³⁴ addressing the issues in some fashion is an inevitable part of the third party role.³⁵ Two-thirds of our respondents described issue-related interventions in their accounts of the conflicts in which they were involved. These interventions were of

34. ROBERT A. BARUCH BUSH & JOSEPH .P. FOLGER, *THE PROMISE OF MEDIATION: RESPONDING TO CONFLICT THROUGH EMPOWERMENT* (1994); Leonard L. Riskin, *Understanding Mediators' Orientations, Strategies, and Techniques: A Grid for the Perplexed*, 1 HARV. NEGOT. L. REV. 7 (1996).

35. Kressel, *supra* note 4, at 533-34.

three major kinds: persuasive appeals, precipitating a decision, and monitoring agreements.

A. *Persuasive Appeals*

Although the persuasive arts are often described as essential to adroit mediation,³⁶ relatively few respondents described such activity (unless "arm twisting" is to be counted among the persuasive arts. Two respondents did, however, describe conflicts in which marshaling evidence and persuading others of its meaning were central activities. In these conflicts, however, the respondents functioned not as mediators, but as advocates.

For one respondent, the head of a medical unit, the issue was to improve the effectiveness of his service by convincing the chairman of another medical service to provide more timely surgical assistance to his physicians.

I think between the time I set up the meeting [with the other chief of service] I had data. I wouldn't have walked into that meeting without data in regards to: "Look, here are the pulmonologists. They're not doing great, but they're doing a lot better than you guys. I'm not happy with Dr. C's service but it is much better than yours." The part that was somewhat daunting is that this is early on in my tenure. There is deference to Dr. B because of age and stature. He is chairman of a department and I'm a division head. Academically I felt somewhat junior. On the other hand, I felt I had the moral high ground, which is always a good place to be.

The respondent was also keenly aware of the fact that the persuasiveness of his argument was greatly enhanced by the fact that his service provided much income for the department with which he was negotiating.

The most detailed account of the tactics of persuasion was supplied by an administrator with responsibilities for emergency medical services. At the request of very high-ranking officers of the hospital, she successfully refuted the accusation of another health care system that the hospital's EMS, through its region wide ambulance service, was diverting the patients with the best insurance coverage to itself. She accomplished this through a very detailed analysis of the data on hospital emergency admissions in and around the city and was able to demonstrate that the variability in patient admissions had nothing to

36. Christopher Honeyman, *In Practice: Five Elements of Mediation*, 4 NEGOTIATION J. 149, 154 (1988).

do with bias on the part of the EMS service, but was a direct function of a number of social, political, and economic forces over which EMS had no control (e.g., as a result of the increased use of automobile seat belts and the barriers to using the ER put in place by managed care, emergency room admissions were down everywhere, not just in the facilities that were claiming bias).

This was survival. They were accusing us of “cherry picking” patients. We’re in contract negotiations with the city. Timing is everything. I don’t think the timing of the allegation was an accident; in addition to the fact that we get the same pool of money for charity care that [the other hospital system] is competing for. Last year the state took \$9 million of charity care money from us and gave \$9 million of it to other hospitals. The redistribution of the pie. Maybe initially the people that made the accusation believed it, because on the surface when you looked at the numbers, the numbers of EMS patients to [the other hospital system] were down. Sometimes smoke screens are effective. In this case it wasn’t, because we killed them with the facts and the data.

She increased the impact of her persuasive message by gathering information about the “human” side of the drama.

I called in paramedics and EMTs and asked them: “Where are patients going? Why are you bringing them?” I talked to the people who are in the ambulances with the patients. Talking to the staff is so important. They can tell you what’s going on. They can tell you why a patient from this sector is going here and not there. They know! All you have to do is ask them – and we did.

The success of her effort paid a number of dividends. First, her stock went up with high level administrators:

As much work as this has been, it’s been positive for me and for my department, because the guy who was giving me the projects and is negotiating my contract with the city and is also a key decision-maker in possibly shrinking my service, is probably our best advocate as a result of this.

Second, the experience increased morale in her department.

I have people that are data people and I have people that are field people and I have a lot of people in between. There’s a whole lot of skill sets We really worked hard And I brought those people with me to the presentation. We all felt good when we walked out the door. We all knew; no one had to tell us. It was a success. We felt it; we knew it. It was

good for all of us as an organization to go through. I think it made us stronger.

B. *Precipitating a Decision*

Approximately 70% of our respondents had significant managerial responsibilities. Well over half of these individuals described interventions by which they acted decisively to bring a conflict to closure when practical, legal, or emotional circumstances were hindering the parties from embarking on a course of action. These interventions were enacted with varying degrees of pressure, ranging from mild to intense.

Among the milder interventions was that of a respondent who described his role as the hospital legal consultant, in assisting the social work and medical staffs implement a discharge plan for sending a quarrelsome patient to a facility in another state by airplane (*The Difficult Duo*). The plan, which had consumed long hours and weeks of work by many people, was still proving worrisome to some of the staff, who were concerned about liability issues and the patient's uncooperative mother. When asked what he saw as the major lesson of the case, our respondent replied:

The major lesson for me is that sometimes you just need somebody to make a decision as to how to proceed. In this case the social worker did an excellent job in making contacts and wanted somebody to say, "Let's go with this. Let's get this patient out of state. Let's send him to Florida. We have limited choices here. Let's make a decision on a practical basis. We've covered the legal issues" We took a little bit of a chance here because it could very well have been that if nobody was there to meet this person when the plane landed, we could have gotten this person back. People were creating all kinds of scenarios: "They're going to sue us because we weren't taking proper care." We did do everything we were supposed to do. I would say, from a lot of these cases, it comes down to a pragmatic decision. Sometimes we have had to talk to a patient's family as lawyers and say, "Look, if you don't do something to get this patient out, we're just going to transfer the patient." You sometimes have to take matters into your own hands.

A more vigorous application of decision-making pressure was described in the end of life conflict we have referred to as *The Unwilling Daughter*. A part of the respondent's strategy was forging a rapid emotional bond with the older daughter, which we described earlier. These actions, however, were only a necessary prelude to the heart of

the respondent's strategy, which played itself out in a bioethics committee meeting that the respondent had convened.

I opened with a time frame so that everybody heard the same thing. You're not sneaky. A time frame of when we're going to turn off the machines. We say that in front of everybody. We can do that with a plan, with the [unwilling] daughter right there so she doesn't feel left out And she asked for a half hour alone with her mother and we could give her that. Then she also asked that the rabbi pray with her at the bedside. So we were able to give her that. At the meeting when I went around and asked her what she needed, those were the three things. The first was, "I need my mother." Then I said, "I wish that we could do that, but we can't." And I remember saying, "if we are going to disconnect her from the ventilator this afternoon, what do you need?" "I need time with her."

INTERVIEWER: Why did you pick "this afternoon?"

RESPONDENT: It was time I think they [the medical staff] would have kept her there until her heart stopped because they think they're going to get sued.

C. *Monitoring and Follow-Up*

Several respondents observed that conflicts can reemerge if the agreements reached are not monitored. It is an important part of the third party role to see that this gets done. Thus, monitoring the impact of the task force's pilot plan was an explicit and formal part of the intervention in *The Missing Medical Supplies*. The administrator who mediated the conflict in *The Demeaning Doctor*, commented:

I always do follow-ups because it keeps things on the right track. It's the scientific process that I'm used to. You set up a plan, develop it, implement it, and then follow it up. [A month later] we asked how things were going. For the most part they both felt things were better. "Dr. ____ is giving me the orders appropriately. I don't have to go back and ask her a second and third time what she meant. She's not nasty. She's very professional and I'm happy with that." The doctor was a little quiet, but she said things are working well.

VI. APPLYING PRESSURE FOR RESOLUTION

The use of pressure tactics is among the more controversial issues in the literature on formal mediation. On the one hand, a prevailing ideology of mediation eschews such mediator behavior. In this view, the mediator's principal tools are reason and compassion. Ideology

notwithstanding, there is plentiful evidence that many professional mediators engage in considerable arm twisting, particularly when the level of conflict is intense, when values important to the mediator are at stake, and when the mediator has considerable formal authority.³⁷

The interviews indicate that what is true for the professional mediator is also true for the experienced, non-professional mediator of health care conflict. Of the eleven respondents who discussed a case in which they served as an informal mediator, all but two described the use of pressure tactics. The use of such tactics was associated with:

- unusually difficult circumstances, including conflicts involving extremely rigid, polarized parties or parties who were overly timid and avoidant.
- conflicts between individuals which threatened to spread and disrupt the functioning of larger units.
- conflicts which compromised medical care or had dragged on so long that important emotional or institutional needs were being blocked.
- disputes which raised the genuine possibility of a law suit.

The interpersonal conflicts, all of which involved feuding staff, were especially likely to provoke highly assertive interventions designed to help the parties "get along" for the sake of delivering quality medical care. Four major types of pressure tactics were described: Reminding the parties about "reality," insisting that they confront their differences, threatening transfer or dismissal, and compelling compliance.

A. Reminding the Parties About "Reality"

The intensity of the parties' anger and self-righteousness can lead them to lose sight of important "realities." It is the role of the intervener to bring such "realities" forcefully to their attention.³⁸ *The Demeaning Doctor* provides several excellent examples of this reality orienting function. The respondent described her tactic for compelling the physician to abandon her defensive posture and to participate in an informal mediation of the nurse's complaints:

She's a very negative lady. "Why do we have to meet? There's nothing to discuss." I said, "Your accusations have a potential for liability. We need to clear that up with the em-

37. Deborah M. Kolb & Kenneth Kressel, *The Realities of Making Talk Work*, in WHEN TALK WORKS: PROFILES OF MEDIATORS 479, 479-83 (1994); see Kressel & Pruitt, *supra* note 4, at 419.

38. Kolb & Kressel, *supra* note 37, at 479-83.

ployee and probably you need to apologize after this, but I want to hear what you have to say." That did it. She came in. She got scared because when you start making allegations about people's professionalism, people aren't afraid to go to an attorney.

Later in this initial meeting, our respondent again supplied a dose of "reality" in reacting to the doctor's continuing inflexibility.

It was a hard meeting because she felt she was absolutely right There came a point in the conversation where I said, "Doctor, there's going to have to come a point in time where you are going to have to understand that some of these things may damage you because you can't prove anything. I'm not asking you to not believe that you are right, but rather to understand that whether you are right or wrong, this person has the evidence that she's telling the truth. Either way, I'm here to tell you that if you're going to work together, you are going to have to change the way you deal with each other."³⁹

B. Insisting That The Parties Confront Their Differences

Since the respondents viewed the parties' tendency to avoid conflict as one of the major obstacles to the constructive management of hospital conflicts, it is not surprising that overcoming this inclination was an important challenge. At times, that challenge was met forcefully. *The Demeaning Doctor* provides another handy example:

We made them talk to each other. "I want you to tell Dr. ____ how you feel." And she told her. Dr. ____ listened and we asked her the same thing Each one of them had the opportunity to talk to the other with those of us in the room that were closest to them. The nurse expressed how deeply upset she was with this doctor for the way she talked to her and accused her, and just because she sat in the doctor's office with her feet up, that that's none of the doctor's busi-

39. A more extreme, not to say almost comical, example of the reality orienting function came from one of the pilot interviews with an administrator of an outpatient service. She described the following exchange with a physician about a patient who was complaining about the doctor's failure to appear for two previous scheduled appointments: DR. (to our respondent): "I just wanted to know, if I hit him you all will back me up, right?" RESPONDENT: "Excuse me! If you hit that patient we will nail your behind to the wall. We will be co-complainants with the patient to sue you. Do you understand?" DR.: "What are you talking about?" RESPONDENT: "To hit a patient? We will never agree for you to hit a patient! Do you know what the liability of that is - to tell you that it is okay to hit a patient! No. You can't hit a patient and a patient can't hit you."

ness. And the doctor said, "It is my business because I don't think it's professional. Maybe I didn't tell you personally." (Because what the doctor did was tell everybody else, which made for suspicions that there was something going on between the medical director and the nurse, which certainly wasn't true). I felt good because they were able to open up and express how pissed off they were with each other. They were really angry with each other.

INTERVIEWER: Did it make things worse or better?

RESPONDENT: It didn't make things worse. It made both of them realize that what they were talking about was inconsequential when it came to the big picture. It's about patient care and how we feel about each other and how we're treating each other, and, "you know what, maybe this is stupid."

C. Threatening Transfer or Dismissal.

Threats of dismissal were among the most coercive tactics described during the interviews. They were typically considered as last resorts with parties whose intransigent behavior posed serious threats to morale or competent care.

In *Power Trip in the ER*, our respondent first tried to coach the less assertive nurse to stand up for herself against the bullying co-worker who was demanding that she give up some of her vacation time. When that proved unsuccessful, the respondent tried to encourage mutual problem-solving in joint meetings. This too failed. The older nurse remained insistent; the younger nurse timid and unexpressive. Finally, the respondent felt obliged to play a stronger card. She told them both that if they did not resolve their differences and work "professionally," one of them would be transferred. This tactic ended the open warfare that had begun to permeate the ER, but the prior friendship of the two nurses was ended. Our informant was rueful, if resigned, about her intervention:

I felt disappointed that it hadn't gone the way I wanted it to and I was thinking, "This is it, though. Once something like this happens and starts involving other staff, it can really lead to other things and involve so many people." Before you know it, it's one side against the other side, over a stupid thing . . . Things don't always go as I plan or want or in the direction I'm heading. I wanted it to just settle nice and easy and everybody to be friends, but life isn't like that.

Actual dismissal of a kind was reported by two respondents in end of life situations. In both cases, the conflict involved physicians who refused to follow family wishes. For example, one respondent de-

scribed a situation in which a daughter's desire to have her dying father taken off life supports was opposed by a cardiologist in inappropriate and harsh language, "Why do you want to murder your father?" The physician's strong arm tactics so incensed our respondent that, in her role as a hospital bereavement specialist, she arranged to have the physician removed from the case. As she explained it: "When you hurt the family unnecessarily, I turn into a crazy Irish woman. You don't want to mess with me when you hurt the family."

D. Compelling Compliance: The Application of "Torquemada's Law"

At times, the intensity of the conflict and the mandates of the respondent's formal administrative role, led to the strenuous application of pressure to insure compliance with a solution of the respondent's devising. Most of these instances were in disputes involving physicians. In a pilot interview for this study, a respondent from another hospital who was responsible for handling patient complaints, described one such intervention. The conflict was between a cardiologist who told the patient that surgery was mandatory, and a pulmonologist who was opposed to the surgery. Because of this disagreement, the patient had been prepared twice, one day after the other, with no surgery taking place. The next day the patient's family came to the hospital, confused and "livid:"

I went to the nurse manager on the floor and I said, "What is going on here?" She said that it was between the doctors. I pulled the doctors together and I said, "I'm sorry to bring you in here, but something has got to happen I asked if she was on the schedule today to be operated on. The doctors said "no." I said, "What are you going to do about it?" The pulmonologist finally agreed that her lungs had cleared out and they took her into the operating room after they left my office. I went back up to the floor and explained the whole thing [to the family]. I said, "I'm sorry. It was a lack of communication. I pulled the doctors together and your mother will be operated on within the hour."

INTERVIEWER: Why did the physicians accept your presence?

RESPONDENT: Because [the hospital CEO] told them. I'm totally empowered to do what I need to do to set things straight. I have never had one time where [the CEO] did not support me.

In *The Demeaning Doctor*, our respondent described a similar "one-two" punch, pairing an explicit directive (the "plan of action") with the not so veiled power of the Medical Director:

I led off the meeting. The Medical Director said what he had to say and we presented what we believed would be a plan of action that would allow both of them to work in the same department and establish that they are both professionals It's hard to do that. Once you damage a relationship, it's hard to put it back together, and we said that. "Once you have a scar and you are hurt it's hard to start from scratch, but we're asking you to do that. We're asking you to start your relationship over, and whether or not you like each other, you need to put that aside and deal with the professionalism issue of learning how to work well together."

The most straightforward rationale for the application of pressure in the interest of compliance was provided by a physician administrator who was often frustrated by the countervailing power of other physicians, as well as the vagaries of dealing with the hospital bureaucracy. His case is instructive, because it illustrates both the appeal to the harried health care administrator of applying pressure and the limitations of this tactic.

From his perspective, one of the major problems in health care is "the failure of leadership to lead." He cited as a case in point the conditions which prevailed in his department just prior to his assuming the directorship. The system of transferring patient care from one physician to another "was a sort of free for all." When the admitting surgeon left duty, the case was passed to the next on-service attending and so on down the line. The result, in his view, was "poor care with not a lot of accountability." When he became Director he simply mandated a change in this policy and led it himself by following the new procedure which kept the patient under one doctor's continuing care. This was not a popular decision. Many on his staff did not "buy in" to the change (some resigned) nor did he try to negotiate with them:

I think at times the best way to mediate conflict is that people in authority should have the moral belief and vision and fortitude to persuasively argue their cause and hold people to a standard that they hold for themselves and follow it through. In fact, conflict resolution that requires a lot of mediation and dancing and negotiation is usually conflict among peers or near equals. There is also conflict resolution among unequals. In this case, and in any Fortune 500 company, your

boss does not mediate conflict with you. Your boss, if he or she is a good boss, sets a standard.

He summarized this philosophy, somewhat tongue in cheek, by invoking the Spanish Inquisition and what he referred to as the application of "Torquemada's Law:" "When you know you're right you have the moral obligation to bend people to your will." If this motto was followed more often in health care, he concluded, "there would be less angina and more time to sip cappuccino on the veranda."

E. Wariness About Pressure Tactics

Despite the appeal of pressure tactics, there is ample evidence that our respondents often had mixed feelings about their use. When asked for pitfalls that a novice might make in the case they chose to discuss, more than half the respondents cited the ill-advised use of pressure. Even the enthusiastic proponent of "Torquemada's Law" had his doubts. He phrased his reservations in terms of another motto which he found appealing, this one from the United States Navy Seals: "Lead from the front." To which he wryly added, "but don't get too far out in front or you'll be a target for your own people." Since becoming Director he has learned that "conflict resolution and getting people to agree is just hard work."

One thing that makes managing conflict "work" is that he does not always have the authority over others to make the application of pressure feasible; another is clinical ambiguity. He cited his monthly departmental meeting to which he invites physicians from other departments and which he instituted to "mediate" conflicts over clinical matters. It does not go easily. The problem extends beyond the fact that he has limited authority over doctors from other departments: "There's nothing in medicine that says you have to treat a patient a certain way. You have to come to these things slowly. These are much more akin to the Palestinians and the Israelis. These are the ones I can't use 'Torquemada's Law' on."

A primary solution to the dangers and limitations of pressure tactics is to attempt to establish rapport and a working alliance with the parties before attempting to overcome their resistance.⁴⁰ This approach does not always work; it seems to have failed, for example, in *Power Trip in the ER*, where the antagonistic nurses ceased overt hostilities, but lost their friendship. But when it does work it can be an effective combination. Reflecting on her role in *The Gang in the ER*, our respondent put it this way:

40. Kolb & Kressel, *supra* note 37, at 479-83.

As a younger me, I would yell right back at people. My anger would escalate with their anger just to prove who was in charge or who could push who around. At this point in my life, managing this one, I knew it wasn't about that. I can be in charge of the situation without pushing them around. I can get them to buy into a plan.

INTERVIEWER: What's the key to doing that?

RESPONDENT: I think a big part is communicating. I think they [the gang members] believed me. I was very sincere with them and very honest. I was going to tell them news that maybe nobody else had told them. "He was going to die. This is your last opportunity." I think being sincere is a big part of it. Talking directly to them. Not just sending a police officer with a message, but coming in myself.

VII. INTERVENTION SCHEMA

Categorizing tactical interventions into the strategic categories of establishing rapport, understanding the conflict, improving the climate, addressing the issues and applying pressure is useful for descriptive purposes. It does not, however, do justice to the organized and organic quality of our respondents' accounts of their cases. These accounts make it clear that the respondents were not simply picking and choosing tactics from among discrete categories of intervention. For a core group of respondents, strategic choice appears to have been driven by an underlying "blue print" or cognitive schema.

Given the small sample and the impressionistic nature of the data, this notion of conflict intervention schema is clearly provisional. However, the testimony of the interviews is consistent with research on schema in other studies of the third party role in conflict,⁴¹ and with more extensive literatures in social cognition,⁴² decision-making under difficult, non-routine situations,⁴³ and reflective case studies of professional practices as diverse as teaching and organizational consulting.⁴⁴ Broadly speaking, in these reports a schema functions like a "script," albeit frequently one which is only partly conscious, which directs the attention and guides the behavior of the actor, particularly at important decision-making "choice points."

41. Kenneth Kressel et al., *The Settlement Orientation vs. The Problem-Solving Style In Custody Mediation*, 50 THE J. OF SOCIAL ISSUES 67, 67-84 (1994); see Sheppard et al., *supra* note 6, at 186.

42. See SUSAN FISKE & SHELLEY TAYLOR, *SOCIAL COGNITION*, 96-179 (1991).

43. See KLEIN, *supra* note 7, at 15-30.

44. See DONALD A. SCHON, *THE REFLECTIVE TURN: CASE STUDIES IN AND ON EDUCATIONAL PRACTICE* (1991).

Earlier, we briefly described one respondent's schema for establishing rapport.⁴⁵ The schema we refer to here are considerably more encompassing. Four such schema can be identified from the interviews, corresponding to the types of conflicts discussed by our respondents. Schema can be identified for managing interpersonal conflict, organizational problem-solving, end-of-life conflict, and "crisis" grieving in a medical emergency.⁴⁶

In general, these are highly activist and directive conceptions. They are also implicit: None of the respondents spoke of their "schema" in so many words. The operation of the schema also appear to be partly "automatic," in so far as certain cues rapidly trigger a course of action with little or no conscious reflection.

We illustrate the notion of conflict management schema with two examples: one from the organizational domain, the other from crisis grieving. In each case the schema is characterized by ideas about what a good process of conflict management looks like, what can impede that process, and a clear conception of the third party role and its objectives.

A. A Schema for Organizational Problem-Solving: The Missing Medical Supplies

The respondent was an administrator of an outpatient department who was asked by a hospital executive to serve as the facilitator of an inter-departmental task force to improve hospital procedures for keeping track of medical supplies. As in most other hospitals in America, supplies of various kinds are in chronically short supply. The elements of the schema guiding his actions in this long and complex case can be described as follows:

1. A good process is defined by the logical steps of good problem-solving of any kind. In sequence, this means beginning with a careful fact-gathering stage, in which the current procedures for dealing with supplies is identified, both in this hospital and in other hospitals; this information is then used to develop a pilot plan, which is presented to relevant units in the hospital for comments and suggestions. The pilot is then implemented and carefully evaluated. The evaluation results are used to formulate a final, improved procedure.

45. *Id.* at 45-46.

46. No clear schema emerged for treatment planning conflicts, perhaps because our respondents in those cases did not serve as mediators, but as one of the disputants or as adjuncts to the problem-solving efforts of others.

2. The major obstacles to good process are the penchant in organizations for premature problem-solving, which cuts short or bypasses the all important fact-gathering stage; the normal resistance of departments to assuming accountability for a new procedure; and the tendency to ignore key stake holders.

3. The role of the team leader is to facilitate a sound problem-solving process and to keep it on track when obstacles arise. This means preventing premature closure by insisting on a thorough fact-gathering stage; identifying all the relevant stake holders and inviting them into the process; bringing people back to the table when there is evidence that the pilot plan is not working and people are trying to evade accountability; and being a voice against the press of self-interest. Thus, the respondent's comments to the task force when the pilot project they had agreed to fell apart:

I laid out our initial commitment to the process and what the process was supposed to be. Then I opened the table to what had fallen apart: "Where had we all failed? What weren't we doing that we agreed to? We had the commitment that this was going to be the solution what we all came up with. Now what's happening?"

His conception of his role comes partly from his formal training in organizational development and partly from experience in the hospital. At critical moments he relies on his intuition to guide him. For example, when members of the task force wanted to skip immediately to problem-solving his intuition told him that this was a mistake:

All they wanted to do is put a band-aid on and go on to do other stuff. It would have been so easy to do that. We all wanted to do that!

INTERVIEWER: Why didn't you?

RESPONDENT: Just experience. This issue had been here for years and years.

B. A Schema for "Crisis" Grieving in a Medical Emergency: The Gang in the SICU

We have already described this case in connection with various illustrations of tactical behavior. The underlying schema of intervention underlying these behaviors can be described thusly:

1. A good process is defined by the intersection of two concerns: maintenance of control and providing an outlet for the powerful emotions connected with grieving. The first step is to ascertain the extent of the threat which the gang on the SICU poses to the delivery of care and the maintenance of safety. That information is acquired rapidly

through visual cues at the site (e.g., the pacing and yelling gang members). Once the threat is determined to be significant, control becomes the central issue. Control is established by providing a focused but circumscribed outlet for the powerful emotions of pain and loss being experienced by the gang members (i.e., by gathering the gang members in the waiting room to acknowledge their right to be told what is happening to their comrade; the sudden emergence in the respondent's mind of the "two-by-two" plan for farewells; and the gang members' immediate exit from the hospital).

2. The major obstacles to good process are fear (that the gang will turn violent) and the concomitant press to use force (hospital security), a move that would only set off an explosion. This central realization is triggered instantly by an encounter with another nurse manager:

There was another manager out here in the hallway. She had a history of not managing crises or conflict. I've seen her escalate situations I already had a history with this nurse manager and to see her on the scene, I knew was not going to help things. She was already walking around telling me how she was going to call security and it was all going to be very confrontational – all of it. That was going to push buttons. These were, in my opinion, teenagers that were going to need a place to vent or a way to vent. If you didn't calm them down and let them deal with it either by crying or talking about it, you were just going to make a very labile group angry.

3. The role of the "mediator" is to orchestrate the grieving process in a way that is controlled, efficient, and takes into account the needs of other affected parties whose cooperation is essential (the family of the dying gang member; the SICU nurses). This is a highly directive role which is the result of the respondent having had much prior experience in similar situations (e.g., dealing with large numbers of police officers in the ER rushing to comfort a wounded fellow officer) and is made possible by the ability to establish authority firmly, but without undue force, and to rapidly formulate a plan that is responsive to the central emotional issue.

VIII. THE IMPACT OF FAMILY AND WORK ON SHAPING EXPERTISE IN CONFLICT MANAGEMENT

Because our informants represent a highly select and important resource for the hospital, we were interested in knowing about the personal experiences that might have contributed to their expertise

and interested them in the role of “peacemaker.” Toward the end of the interview respondents were asked if they knew of anything in their personal history that had helped make them esteemed managers of conflict in the hospital. The answers to this question indicate that certain family and work experiences were critically important. These sources imbued our informants with a small, but cardinal number of useful skills.

A. How to Make Decisions and Formulate “a Plan” Under Stress.

We have noted previously the view of several respondents that the “culture” of emergency medicine fosters both denial of conflict and overly aggressive strategies for managing conflict. Nonetheless, respondents with emergency room experiences credited it with providing invaluable training in managing conflict under stressful conditions. A trauma nurse commented:

I think the emergency room played a big part in how I developed to deal with conflict – this emergency room. You would have to know the emergency room. It is extremely busy, volatile. It goes 24 hours a day. In my earlier years down there you really had very little structure or oversight by management and attending physicians; so nurses really played an integral role in how decisions were made. The physicians who rotated through relied on the nurses to know what they needed to do and what the routines should be. You clinically had to be very astute. The conflict was always coming in through the street. You had up to 10 nurses on any given shift plus probably about five physicians, so you had a lot of different personalities that worked together in the same room. It really presented itself very much like a MASH unit. You needed instant response. There could be a bus crash and you could go from only having 15 or 20 patients in the ER to having 40 or 50 patients. You learned how to prioritize and decision-making, and how to delegate those ideas to people and get them to do it.

Another respondent with significant experience in emergency medicine made similar observations. She also hinted at the limitations of ER experience for conflicts with more extended time-frames. “People that are in the emergency medical profession are very good at categorizing things and managing a crisis; triaging things, prioritizing, delegating duties. We’re very poor at [long-range planning]. We can do disaster planning, but not strategic planning. We’re good at the incident, the crisis situation.”

B. How to Control One's Emotions and Channel them Effectively.

Four informants discussed critical losses they had experienced in their own lives or key figures from their families who modeled certain ways of being that made them more empathic to the pain of others or more patient and self controlled in difficult circumstances. A respondent whose mother died when she was 12, and who later lost a baby who was stillborn, said of her ability to manage angry people in non-confrontational ways:

It makes you aware of your own behavior and why you do certain things, and I realized that everyone has things in their life that affect how they respond and that they can't control It just gives me an understanding that sometimes you can go in the back door and maybe have a better relationship.

Two respondents felt that their ability to control their anger also had its roots in early, albeit very different, family experiences:

I rarely get angry I see a lot of people get angry and it's probably pretty healthy. I never really get angry at work.

INTERVIEWER: Is that an asset to you?

RESPONDENT: I think so. I see plenty of people who do get angry. I have "lost it;" maybe somebody pushed my button, but it's pretty rare. I'm really pretty patient and I think I learned that from my grandmother. She was my Presbyterian grandmother who converted to become a Catholic and became the best Catholic in the family. She just had this marvelous patience. There was probably plenty of conflict going on around her and family dynamics and everything. But she managed it well and I think I learned it because I spent a lot of time with her.

One thing I've learned is never personalize the response from other people. It is difficult to do, but you have to do that because you are always representing your organization; and secondly, you're not supposed to act like them. It's just part of me. I've been inculcated that you do not act up because somebody else is acting up I learned that in my home. My brother's a very argumentative man to this day. My response to him is to look him straight in the face, as if to say, "I don't hear you." He would get very angry with me because I would not argue, but he would walk away ultimately.

Another informant talked about how studying the grieving process and developing a satisfying personal approach to life had aided her in dealing with the pain of others.

Many years ago I had the absolute privilege of spending the summer with Kubler-Ross.⁴⁷ It changed my life. It was one of those “aha” experiences We spent most of the summer dealing with our own stuff. So when you face it that closely – your own stuff – you’re not afraid to relate to somebody else’s stuff. I don’t panic in the face of outrageous emotions. I don’t get threatened very easily There’s very few “if only’s” in who I am and how I live. There isn’t a whole lot I didn’t do when I wanted to. I’m heavy into “I want it now.” I’d like to hang around this earth a lot longer but I don’t have a lot of regrets. That kind of makes you open to other people’s stuff. There are days when I have to mop up a lot of grief, a lot of pain, but I can go home and leave it here. That’s a skill you have to learn. If you take the stuff home, you can’t come back . . . so the grief stuff is very important to me. I guess people don’t see a lot of conflict in grief but there is. A lot of conflicted feelings, a lot of “if onlys.”

C. The Capacity to be Respectful and to Respect the Autonomy of Others

Three respondents spoke of learning how to respect the “boundaries” of others from experiences in their families of origin. For one it was being the youngest of seven children. Another had a mother who was paraplegic for many years and who was dying with metastatic cancer. She was determined to die a dignified death and made him aware of her wishes. This helped him be respectful of the autonomy of others, especially in end of life conflicts.

A third respondent commented wryly about the role of family in regard to the hospital’s formal efforts at teaching staff how to interact with patients:

I had this eight hour training where I had someone tell me that I should smile, make eye contact and “yadda yadda.” I should do all these wonderful things – these new and exciting techniques. I said, “This is what my mother taught me when I was a little child – ‘Thank you,’ ‘Yes,’ ‘No,’ ‘How can I help you?’” I was basically taught that as a child.

IX. CONCLUSION

This investigation provides a portrait of one hospital’s conflicts and its struggles to cope with them. We make no claim that our findings are necessarily representative of the conflict dynamics in other

47. The psychiatrist Kubler-Ross did path breaking work in field of the psychology of death and dying.

types of health care institutions or settings. Even on its own terms, our portrait is inevitably incomplete. We have seen the institution through the eyes of people who know it well, but whose own subjectivity and position must inevitably color and, in some measure, distort the reality. Indeed, we cannot even be certain that all of our respondents qualify as bona fide conflict management experts or that this exhausts the ranks of those within the hospital who might so qualify.

Nonetheless, collectively, the respondents have given us an extremely valuable and provocative look at the manner in which large scale social, economic, and medical changes are roiling the waters of an important type of health care institution – the teaching hospital serving an inner city population. The interviews also describe how that institution and some of its most creative and dedicated professionals are struggling to navigate those waters. We summarize these matters with some observations about the hospital, the unofficial managers of its conflicts, and the training and research needs related to both.

The hospital in which our respondents work emerges in this collectively drawn portrait as an institution being buffeted by significant interpersonal, organizational and inter-institutional conflicts. The primary causes of these conflicts are not “difficult people.” Although physicians were often identified as culprits, and though there was an inclination to “personalize” the explanations for many of the conflicts we were told about, it is clear that dysfunctional conflicts within the hospital and between the hospital and other institutions are primarily a function of powerful, interacting social forces. These include aspects of medical and nursing practice and culture, organizational dynamics, the needs and characteristics of the hospital’s patient population, and above all, the hospital’s declining economic base.

In the accounts of our respondents, the hospital appears as an institution that is ambivalent or uncertain about how to manage its conflicts.⁴⁸ On the one hand, the hospital provides no highly visible, well-advertised places for handling conflicts in a non-adversarial manner. With the exception of the role of the bioethics committee in end of life disputes, formal conflict management is done primarily through adversarial structures provided by labor-management con-

48. The hospital’s ambivalence about conflict and at least some of its characteristic defects and strength in this regard appear to be common in many types of organizations. MAX J. BAZERMAN & ROY J. LEWICKI, *NEGOTIATING IN ORGANIZATIONS* (1983); DEBORAH M. KOLB & JEAN M. BARTUNEK, *HIDDEN CONFLICT IN ORGANIZATIONS: UNCOVERING BEHIND-THE-SCENES DISPUTES* (1992). Given the unique responsibilities of the hospital, the similarities to other types of organization may be of only modest comfort.

tracts or federal or state regulations. There is no ombuds office, no trained, widely available mediators, no developed mechanisms for defining and managing conflict in a non-adversarial way.⁴⁹ Conflict avoidance appears to be the norm for handling the daily irritations of work in the hospital, even about important matters of professional judgment or patient care.

The hospital's approach to conflict does have a more positive side. Although it may lack developed formal structures for mediation and mutual problem solving, its informal vehicles for so doing are notable. Not the least of these, of course, are the respondents themselves. As we have noted, they are a hidden but valuable human resource; serving at the least as an important safety-valve for anger and frustration and at best, as a means for managing change and for organizational learning.

There is also the hospital's hidden "anatomy" of conflict management: the committees, task forces, medical boards and inter-department meetings whose ostensible purposes are about medical decision-making or organizational "best practices," but which also appears to provide useful opportunities for people to raise and constructively confront important differences – especially people like our respondents who have the skill and good sense to create, use, and mold them.

There is also good and bad news about the unofficial managers of hospital conflict. The good news, apart from what we have already said, is that despite the fact that most of them have had limited formal training in conflict management, their approaches to dealing with conflict are, at least in broad outline, remarkably similar to those of professional mediators with years of training and experience.

Some of the respondents also appear to possess relatively sophisticated cognitive schema of intervention. The fact that these schema are often implicit and triggered automatically at critical moments in the unfolding of conflict suggests an efficiency and competence that has been found to be the hallmark of expertise in other challenging domains of life. Interestingly enough, given our initial interest in the role of the non-professional, emergent mediator, the study also tells us that there is more than one way to provide a useful service as a conflict manager: The role of impassioned and skilled advocate, or coordinator of or consultant to others can also be critical.

49. AMERICAN HOSPITAL ASSOCIATION, *MANAGING CONFLICT IN HEALTH CARE ORGANIZATIONS* (1995); K. Slaikeu, *Designing Dispute Resolution Systems in the Health Care Industry*, 5 *NEGOTIATION J.* 395, 398-399 (1989); see WILLIAM L. URY et. al., *GETTING DISPUTES RESOLVED: DESIGNING SYSTEMS TO CUT THE COSTS OF CONFLICT* (1988).

The bad news is that, with the exception of the end of life interveners, who can rely on a developed professional framework for conflict management and are accorded explicit recognition for their efforts, many of our respondents seem uncertain or ambivalent about their roles as conflict managers. At times, this seems to be a reflection of the hospital's own ambivalence, and the concomitant lack of formal recognition or support they get for their efforts. Several of our respondents, for example, expressed surprise that they were regarded by others as skilled conflict managers or dubious that they had any special knowledge in that domain. The trauma nurse who described her intervention in *The Gang in the SICU* began the interview with just such a disclaimer. By the end of the interview, to her surprise and apparent gratification, she admitted that she now realized she knew more about conflict than she had realized.

There is also the matter of pressure tactics. "Torquemada's Law" was popular, especially in the mediation of interpersonal and organizational conflict. Respondents felt obliged to rely on it for important reasons, but the results were often mixed. While pressure tactics seem popular among managers in other types of organizations and useful for producing immediate compliance,⁵⁰ there is good reason to worry about their long-term consequences,⁵¹ especially in an institution whose avowed purpose is nurturance and caring.

The informal mediation of conflict at the hospital also appears to be largely "woman's work." Three-quarters of our conflict experts were women, an over representation in the sphere of conflict management that appears typical in organizational life.⁵² There are many different explanations for this fact, including the social expectation that women are more skilled than men at the interpersonal "arts." But the disquieting theory has also been put forward that the prevalence of women as informal organizational mediators, and the fact that such activities often go unrecognized and unnoticed, suggests that behind – the – scenes peacemaking is a "devalued and gendered activity."⁵³

From a purely pragmatic view, the interviews suggests that health care professionals and health care managers might derive considerable benefit from more training in the management of health care con-

50. Blair H. Sheppard, *Managers at Inquisitors: Some Lessons from the Law*, in *NEGOTIATING IN ORGANIZATIONS*, 193, 203-04 (1983).

51. Jeffrey Z. Rubin, *The Use of Third Parties in Organizations: A Critical Response*, in *NEGOTIATING IN ORGANIZATIONS*, 214, 218 (Max H. Bazerman & Roy J. Lewicki, eds. 1983); see Kressel & Pruitt, *supra* note 4 at 418-20.

52. ARLE R. HOCHSCHILD, *THE MANAGED HEART: COMMERCIALIZATION OF HUMAN FEELING* (1983).

53. Kolb & Bartunek, *supra* note 48, at 88.

flict. The findings provide some hints about what such training might consist of and who should be taught. The "who" most certainly includes physicians, whose overuse of strategies of avoidance and aggression was a major theme (along with considerable skepticism that physicians would be interested in such training). Other prospective candidates for training may be in the area of emergency medicine, where there are indications that denial and over reliance on coercive tactics may be all too common. Two of the respondents with managerial responsibilities in emergency medicine were particularly receptive to getting such training for their staffs.

The "what" of training should not be limited to the handling of interpersonal conflicts, but should include material focused on conflicts over treatment planning and organizational conflicts, since these appear to be commonly occurring types of disputes. Mediation training for end of life conflicts is already a developed professional activity in bioethics and bereavement training, but may need more widespread dissemination.

Training should also be built around the notion of cognitive schema. The focus on schema would appear to be a more useful and important didactic tool than a mere enumeration and rehearsal of discrete strategic skills; it appears likely that it is the possession of the schema that makes the effective marshalling of those skills possible. It would also seem important to emphasize that there are different schema for different types of hospital conflict. Based on the current findings, while there are at least three key schematic elements for any type of conflict – the nature of a good process of conflict management, awareness of the primary obstacles to good process, and a clear conception of the third party role and its objectives – the nature of those elements is likely to be different from one type of conflict to another.

A final word about research. Like any in-depth, exploratory study, this investigation raises as many questions as it answers. More systematic empirical work is clearly needed in a number of important areas. For example, we could use considerably more study of what we have been calling the hidden "anatomy" of the organizational response to conflict – the internal boards and committees of the hospital in which conflicts often surface. What are the most influential of these venues? How do they work? How effective are they in regulating conflict and how well do they permit less powerful organizational voices to be heard?

We could also use more in-depth study of particular types of conflict, especially conflicts among physicians over treatment planning.

Only one such conflict was included in this investigation, yet in some way this is the type of conflict that is most directly connected to the substantive core of what hospitals do.

The concept of conflict schema is also in need of more systematic work. Can such schema be reliably identified with more objective empirical methods? If so, how important are they in distinguishing between the skilled conflict manager and the novice or the less skilled? Do different types of health care professionals have the same or different schema for handling conflict? Better and worse grasps of the schema they do have?

Finally, there is a need for research on the relationship between the ways in which conflict is dealt with and outcomes such as the quality of patient care, patient compliance with treatment, and staff morale and functioning. We have assumed that good conflict management contributes directly and positively to good health care outcomes. There is a need to test this proposition.

On the whole, however, we come away from this investigation with very deep respect for the important role our respondents play in the delivery of health care under often arduous and rapidly changing conditions and the important personal and social values which their efforts as conflict managers often express.