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Conflict in Health Care Organizations

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CONFLICT IN HEALTH CARE ORGANIZATIONS

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I. INTRODUCTION

Health care delivery occurs within a complex system of institutional environments, multidisciplinary professionals, technology, financial reimbursement, legal and regulatory requirements, and patient, family and community based needs. Competing priorities within this structure of health care often result in personal and professional conflicts between health care providers. Strong philosophies and personalities often collide under the pressure of critical decisions, time limits to accomplish tasks, varying levels of understanding, and the need to come to closure not only for present issues but for the impact on future decisions.

Issues giving rise to conflict involve a range of circumstances and professionals in health care settings. Disciplines most frequently include physicians, nurses and administrators but may extend to other health care professionals such as social workers, pharmacists, dietitians, and physical therapists.[2] Some key areas of conflict include: perceived lack of interpersonal or inter-professional respect and recognition; treatment protocol or intervention disputes; and, administrative issues such as competition for scarce resources.[3]

The approach to better understanding conflict among caregivers requires an understanding of the health care environment in which care is provided, the way conflict exhibits itself in the health care setting, the means by which disputes are currently handled, and potential means of improving conflict resolution. The extent to which conflicts can be avoided or disputes expediently resolved to each parties mutual satisfaction, the more positive the health care environment will be for patients and providers and the greater opportunity to develop high performance multidisciplinary teams.

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2. THOMAS GILMORE, MANAGING HOSPITALS 204 (Shelton Rovin & Lois Ginsberg eds., 1991).

3. *See* Jeffrey T. Polzer & Margaret A. Neale, *Conflict Management and Negotiation, in* ESSENTIALS OF HEALTH CARE MANAGEMENT 136 (Steven M. Shortell & Arnold D. Kaluzny eds., 1997).

II. HEALTH CARE ENVIRONMENT

Health care exists in a complex environment partly as a result of dual organizational systems and due to rapid advances in health promotion, disease prevention and treatment possibilities. Health care institutions operate on a base of both a formal bureaucratic organizational structure and on a professional structure.[4] The bureaucratic structure is the legal entity that holds corporate responsibility for the organization and includes the Board of Directors and senior administrators such as the President or Chief Executive Officer, Vice Presidents of services as medicine, nursing, operations, finance, human resources, and information management. Expert members of the care delivery team as physicians, nurses, radiologists, and social workers represent the professional structure. These members work across departmental and hierarchical lines based on expert referent power. The degree to which they control decisions and formulate patient care actions is independent of the formal structure as long as corporate policies and procedures (including regulatory guidelines) are adhered to.

When an integrated health care system exists by virtue of expansion and corporate mergers and consolidations, multiple care settings are interconnected as an enterprise.[5] This creates a complex system of communication, referrals and treatment plans based in expertise.

A. Financial Reimbursement

At one time, the health care environment was composed principally of the general practitioners' office, the hospital and ambulatory clinics.[6] Reimbursement was based on fee for service or health care insurance.[7] In the present, health care is delivered in more diversified settings including physician offices, group practices, primary care and ambulatory settings, hospitals, rehabilitation institutions, long term care, hospice, and home care.[8] These settings may be independent operations or part of an integrated health care system in which a variety of settings, often forming a continuum of care from primary care to acute, rehabilitation, long term and home care, are part of one

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4. Talcott Parsons, *Introduction* to MAX WEBER: THE THEORY OF SOCIAL AND ECONOMIC ORGANIZATION 60 (A. M. Henderson & Talcott Parsons trans., 1964).

5. *See* James C. Robinson & Lawrence P. Casalino, *Vertical Integration and Organizational Networks in Health Care*, 15 HEALTH AFF. 7, 9 (1996).

6. *Id* at 8.

7. *See id.* at 9.

8. PETER I. BUERHAUS, HEALTH CARE RESOURCE MANAGEMENT 265 (Sylvia Price et al. eds., 1998).

corporate management structure.[9] In this environment, the incentive is to keep clients within the health care organization for purposes of efficiency in cost control, revenue generation, resource use and continuity of care. Co-existing with these changes is a regulated rate environment with set reimbursement levels for federal payment through Medicare and Medicaid.[10]

The evolution of managed care has created a shift in focus to case based reimbursement in which patient care services are rolled together into an episode of care with a fixed fee based on contracted per patient allowance.[11] In this system, a flat fee is identified for patients based on their diagnosis and key co-morbidity indicators.[12] For example, a patient with pneumonia who is over 65 years of age and has chronic obstructive pulmonary disease would have a longer approved length of hospital stay than a similar patient under 65 years of age without a second contributing and complicating diagnosis.

Changes in financing have increased pressure on professionals in health care settings.[13] The term "quicker and sicker" prevails since many patients defer treatment until they are sicker and because limits on reimbursement create pressure to treat and discharge more quickly.[14] Fixed reimbursements mean that no matter how the care is delivered or over what period of time, the amount of payment for services has been predetermined.[15] The use of fewer resources will lead to increased revenue while the use of more resources will lead to decreased revenue and possibly system financial deficit. The effort to maintain a reasonable operating margin produces policies and procedures of treatment oversight and required permissions that are often a source of conflict between physicians, health care administrators and nurses regarding resource allocation and treatment philosophy.[16]

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9. STEVEN K. KLASKO & GREGORY P. SHEA, THE PHANTOM STETHOSCOPE 75 (1999).

10. *See id* at 114.

11. *See* Kevin Devine, *Health-Care Financial Management in a Changing Environment* 48 J. OF BUS. RES. 183, 184 (2000); *see also* AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS (1999).

12. *See* Devine *supra* note 11, at 184.

13. Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited,* 20 HEALTH AFFAIRS 9, 11 (2001).

14. *See* BUERHAUS, *supra* note 7 at 14; *see also* Jane A. Zanca, *Patients Going Home "Quicker and Sicker"*, CANCER NEWS, Summer 1990, at 15.

15. *See* Devine *supra* note 11 at 184.

16. *See* BUERHAUS, *supra* note 8, at 82.

B. Legal and Regulatory Requirements

The realm of health care has become increasingly litigious with consumers expecting perfect outcomes at each point of care and for each presenting diagnosis.[17] Requirements, however, extend even beyond the obvious of care and treatment to include regulations for health care organization accreditation,[18] licensure,[19] privacy of health care information,[20] and insurance authorization. These requirements permeate daily practice and create a framework around which care is provided.

The Joint Commission for Accreditation of Healthcare Organizations is a private not-for-profit agency, which surveys institutions providing health care and awards accreditation if its standards are met.[21] Standards are available for most types of institutions including, for example, hospitals, long term care, ambulatory care, rehabilitation, hospice, home care, and integrated systems.[22] Standards are divided into the following three categories:

(1) patient-focused functions such as patient rights, ethics, assessment of patients, care of patients, education and continuum of care;[23]
(2) organization-focused functions such as organization performance, leadership, management of the environment of care, human resources and information, and surveillance, prevention and control of infection;[24]
(3) structures with functions including governance, management, medical staff and nursing.[25]

An average accreditation visit involves three to four surveyors for a period of three to five days depending on the size of the organiza-

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17. Evelyn Bradford, *Jot Got Hit With A Malpractice Threat? Cool It!*, 99 MED. ECON. 99 (1998).

18. Joint Commission on Accreditation of Healthcare Organizations, *Facts About the Joint Commission on Accreditation of Healthcare Organizations* (2002), *available at* http://www.jcaho.org/aboutjc/facts.html (stating that the Joint Commission on Accreditation of Healthcare Organizations is the nation's predominant standards-setting and accrediting body in health care).

19. JONATHON S. RAKICH, MANAGING HEALTH SERVICES ORGANIZATIONS 268-69 (1992).

20. *See generally* Mary K. Wakefield, *Legislating Patient Privacy*, 17 NURSE ECON. 222 (1999).

21. *See* Joint Commission on Accreditation of Healthcare Organizations, *supra* note 18.

22. *See id.*

23. Joint Commission on Accreditation of Healthcare Organizations, *Guidelines for Document Review Session* (2002), *available at* http://www.jcaho.org/accred/hos/hapdocreview.html.

24. *See id.*

25. *See id.*

tion being surveyed. Accreditation, although voluntary, is important since accredited organizations have "deemed" status that entitles them to federal reimbursement for services to Medicare and Medicaid patients.[26] Medical residency programs must be operated only within accredited organizations[27] and only these agencies may receive federal grants for research including clinical trials of new pharmaceutics and treatment interventions.[28]

Individual licensure requires that providers including physicians and nurses, as well as other licensed professionals, function within their identified scope of practice.[29] This means that professionals may also have practice restrictions. For example, unlike a registered nurse, a licensed practical nurse may not administer intravenous medications.[30] Likewise, physicians may be credentialed in specific areas of practice through Board Certification in specialties such as internal medicine, thoracic surgery and obstetrics.[31] Health care institutions require verification of credentials and competency-based evaluation specific to treatment interventions and skills. Medical and Nursing Boards at the State level also maintain oversight as to complaints against providers by consumers or employers and may take action as part of quality of practice review.[32]

Federal regulations also direct the management of health care information through the Health Insurance Portability and Accountability Act.[33] The intent of these regulations is to ensure the appropriate transmission of health care information between legitimate health care agents and agencies and to protect individuals from having health information used to deny insurance.[34]

Insurance authorization has become a complex issue with the growth of managed care. Each institution and physician practice must

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26. Joint Commission on Accreditation of Healthcare Organizations, *Federal Deemed Status and State Recognition*, (2002), *available at* http://www.jcaho.org/govt/deemstat.html.

27. *See* RAKICH, *supra* note 19, at 269; *see also* Accreditation Council for Graduate Medical Education, *About the ACGME*, (2002), *available at* http://www.acgme.org.

28. *See* KLASKO & SHEA, *supra* note 9, at 65.

29. *See, e.g.*, MD. CODE ANN., HEALTH OCC. §§ 8-702; 8-311 (2001); *see also* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 76 (3d ed. 1997).

30. MD. REGS. CODE title 10, § 10.27.20.05 (2001); *see, e.g.*, MD CODE ANN., HEALTH OCC. § 8-311 (1957); *see also* U.S. Department of Labor Bureau of Labor Statistics, *Licensed Practical and Licensed Vocational Nurses* (2002), *available at* http://stats.bls.gov/oco/ocos102.htm.

31. *See* U.S. Department of Labor Bureau of Labor Statistics, *Physicians and Surgeons* (2002), *available at* http://stats.bls.gov/ocos074htm.

32. MD. CODE ANN, HEALTH OCC. §§ 8-316, 14-401 (2001).

33. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat 1936 (1996).

34. *See id.*

understand the regulations of individual insurers and managed care companies that provide reimbursement. Differential reimbursement is made for services depending on the company providing coverage.[35] Insurers will have specific reimbursement levels for approved interventions and may restrict the type and frequency of treatments to be made available.[36] When a company changes its contract or decides to no longer cover a particular geographic area, providers and institutions may no longer be eligible to receive reimbursement for services. This may require clients to change providers or seek other sources of payment. When a co-payment is required, the amount will vary by insurer.[37]

The regulated health care environment often provides an unseen source of conflict between administrators, physicians, nurses and other caregivers. Restrictions on what can be done, or requirements of what must be done, when and by who pervade the practice environment. As more and sicker patients are treated, and pressure on time and choice increase, sources of conflict grow.

One example is of an elderly woman who had become dizzy and fallen in the lobby of the hospital. She was taken to the emergency department and evaluated through a battery of diagnostic tests that indicated a possibility of syncope related to cardiac disease. She was admitted to the hospital but since her condition did not justify continued admission she was scheduled for discharge although she was not able to independently care for herself. Although the treatment team felt she should remain hospitalized until additional treatment could be assessed and post-hospital support obtained, the decision was that she should be discharged following the second day. This occurrence created conflict between the treating physician and the hospital utilization review department that served as the oversight for approved length of stay. The physician discharged the patient with referral to the cardiac service clinic. On further follow-up the patient was readmitted for a pacemaker insertion. The result was two admissions and medical risk as well as continued future conflict between the physician and utilization review.

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35. *See* Carole P. Jennings, *The Evolution of U.S. Health Policy and the Impact of Future Trends on Nursing Practice, Research and Education*, 2 POL'Y, POLS. & NURSE PRAC. 218, 220 (2001).

36. *See id.* at 220.

37. Bruce A. Strombom et. al., *Switching Costs, Price Sensitivity, and Health Plan Choice*, 21 J. HEALTH ECON. 89, 96 (2002).

C. *Technology*

The level of technology afforded by automated systems such as computer-based patient records, monitors, lasers, endoscopy, genetic intervention, imaging scanners and transplantation has expanded the possibilities of treatment and care management.[38] Technology has also created more opportunities for treatment, monitoring and evaluation of patients over the continuum of care.[39] Medical advances have increased patient and family expectations for immediate and effective care and extended the range of treatment choices that have served as the source of debate among professionals as well as between providers, patients and families. For example, should elderly debilitated patients be aggressively treated with cardiac surgery and extensive rehabilitation? The possible disputes are legion.

An example of this involved a ninety-year old man with cardiac disease and lung cancer admitted to the hospital for respiratory distress. His wife and daughter insisted that he be offered surgery to remove his lung and given chemotherapy and post-surgical radiation in an attempt to treat him. There was a disagreement among the surgical team as to whether this treatment was valid given the likelihood that the patient would not only not survive the surgery but would lack quality of life in his remaining years due to the post-surgical regimen. Following much debate, the patient was treated conservatively and returned home without surgery.

D. *Multidisciplinary Professional Teams*

Care giving teams are expected to represent the multiple disciplines on which patients depend for health services.[40] The team includes key members of the provider staff such as nurse, physician, social worker, physical therapist and others as appropriate.[41] While each member brings specific knowledge and skill to care planning and delivery they often represent different perspectives on what that care should include and how it should be administered. Anything can be a source of conflict from the actual deliberation of treatment plan

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38. *See* Amy Bernstein et. al., *Trend Data on Medical Encounters: Tracking a Moving Target*, 20 HEALTH AFF. 58 (2001).

39. *See* Roger Taylor & Leeba Lessin, *Restructuring the Health Care Delivery System in the United States*, 22 J. HEALTH CARE FIN. 33, 42-43 (1996); *see also* Kenneth I. Shine, *Impact of Information Technology on Medicine*, 18 TECHNOLOGY IN SOCIETY, 117, 118 (1996).

40. Lillian M. Simms & Margaret M. Calarco, *Maximizing People Potential in Empowered Environments*, *in* HEALTH CARE RESOURCE MANAGEMENT: PRESENT AND FUTURE CHALLENGES 165, 170 (Sylvia Anderson Price & Maryland Wade Koch eds., 1998).

41. *See id.*

to the impact on staffing resources or the ability to provide necessary services.

In one residential mental health facility for children a fourteen year old girl had been admitted for obsessive-compulsive disorder. She had run away from home while in outpatient treatment and had also run away from another psychiatric facility. After a four month course of treatment conflict ensued between the psychiatrist, nurse staff and psychiatric social worker who each had a different opinion as to the disposition of the child. The nurse felt the patient should be further treated in the acute setting, the psychiatrist was intent on having the child admitted to a long term residential treatment facility and the social worker had promised the parents that their daughter would be placed in a residential therapeutic school. Over the period of a month, the conflict continued to develop with each of the team members taking action to pursue their own option of choice, investigating placements and talking about them as certainties with both the child and parents. Team members confronted each other and verbalized that the other members were not behaving appropriately. At the end of this month of conflict, the parents, now expressing disgust for the system, decided to have the child discharged to home and arranged for a day program at a therapeutic high school.

This situation called for an evaluation of the treatment team process and the quality of assistance given. The evaluation of the quality of care is the responsibility of this team as is the development of a plan of corrective action. This requires a close- and honest- working relationship based on respect and recognition of professional expertise.

E. Ethical Considerations

There is a need for careful consideration of ethics in working with patients and their families as they make critical decisions. While there is a requirement for patients to be informed about the opportunity to create an advanced directive[42] to make their treatment preferences known should a medical condition render them unable to convey their wishes, there is no way to avoid conflicts with family and providers who may disagree. Not all treatment decisions take on the same importance as end-of-life choices. Sometimes it is a matter of what information should be conveyed to a patient or family and how that communication should take place. It may be offering palliative

42. *See generally* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388 (1990).

care in place of aggressive treatment or "watchful waiting" in place of any treatment. In each case, preferred options are based on personal attitudes, beliefs and values in addition to professional education and experience and, as such, they become sources of conflict between individuals.

Ethical conflicts may also surround organizational decisions that are in conflict with an individual's personal philosophy. While these decisions may not be unethical, they may be directly in opposition to the direction an individual feels is the "right" choice for them. The following vignette describes a political ethical conflict faced by a nurse manager. The manager was aware that a staff nurse had confronted a physician regarding the need to have a mentally retarded ten-year-old requiring critical care admitted to the pediatric intensive care unit. The physician wanted the patient to go to an adult unit because of her size and limited mental status. The nurse called the chief of service and the patient was admitted to pediatrics. After that event, the physician went to the manager and berated the nurse's performance on many levels. He insisted that the nurse be terminated and that he would report the manager as a poor administrator if she did not support him. The manager knew that the nurse had not acted inappropriately but she also felt her own position was in jeopardy. She decided not to terminate the nurse and reported the incident to her administrator and to the chief of service. This infuriated the physician who was subsequently confronted by the chief of service. The working relationship became more difficult. Eventually, the staff nurse transferred to another unit and the nurse manager left the institution for a position elsewhere.

III. SOURCES OF CONFLICT

Conflict between caregivers rarely requires legal recourse. Most often there is a need for more immediate and local dispute resolution. Conflict often arises surrounding a mix of personality, professional opinion and perceptions of power.

A. Interpersonal and Interprofessional Respect and Recognition

Collegiality grows from working relationships that result in respect for another's ability.[43] This requires consistent collaboration and critical decision making between caregivers. Conflict arises when

43. *See* Harriet Van Ess Coeling & Penelope Laing Cukr, *Collaboration in Practice in* HEALTH CARE RESOURCE MANAGEMENT: PRESENT AND FUTURE CHALLENGES 185, 186 (Sylvia Anderson Price & Maryland Wade Koch eds., 1998).

mutual respect and recognition are lacking.[44] Some examples of conflict include the following:

- physician demanding something be done when it is obvious the nurse is doing something equally important
- berating a nurse in front of patients and family members
- throwing objects down
- blaming for perceived poor outcomes- as when a patient signs out of the health care facility against medical advice and the physician demands to know why the nurse "let the patient leave"
- whistle blowing by a nurse regarding some perceived misstep by a physician

In each of the examples, the behavior leads to an escalation of conflict. One of the parties feels injured through misunderstanding and hurtful behavior while the other feels anger and equally misunderstood. The parties may not be able to resolve this conflict by themselves since each is now in a reactive stage of waiting for the next event to occur. In fact, the conflict does not stay limited to the original two individuals but often spreads to other team members who "side" with one or the other. This situation multiples the conflict to include others or to heighten the perceived need on the part of the original participants to prove their superiority.

In one event a nurse administrator with line authority over nursing to hire, fire and promote, made a decision to promote a nurse to a middle management position. The physician in charge of the service voiced a complaint that he did not feel this nurse should be promoted. The nurse administrator initiated a discussion with the physician regarding his position on the promotion. At the conclusion of the meeting he voiced his willingness to support the change. However, the following day he wrote to the president of the organization that he would not support the decision. The president supported the physician. The nurse to be promoted was very well respected by the nursing staff. On hearing of the decision, the nurse staff in the patient care units of the specialty service began a petition and complained to the Board of Directors. The decision of the president was supported in deference to the medical staff. Within one year, the nurse administrator, all four nurse managers and several staff resigned to take positions elsewhere citing a lack of professional respect. The physician eventually left as well for another position. The cost in

44. *See id.*

human resources to the organization due to lack of appropriate conflict resolution and mediation was significant.

B. Treatment Protocols

Decisions regarding treatment protocols are a matter of professional judgment and intervention options based on the outcome experiences of other patients with similar conditions. While many interventions are relatively standard such as surgery for ruptured appendix, other treatments may be subject to debate surrounding different experiences on the part of nurses and physicians or between physician specialists. Adding to the selection of interventions are personal and social characteristics of the patient and dynamics between family members as well as the patient and the care providers.

Examples of treatment protocols that may serve as the basis for conflict between caregivers are:

- Do not resuscitate orders
- Palliative care versus aggressive therapy
- Radical surgery or intensive therapy for debilitated patients
- Genetic testing for illnesses having no effective treatment

The most frequent cause of conflict in these circumstances is the disagreement of what constitutes effective and appropriate care for an individual.[45] Much of the conflict centers on ethical and moral principles of what is right or good for an individual patient based on scientific advances that may offer new possibilities for an effective health outcome and on the possibility of the patient achieving that outcome with reasonable quality of life.

When treatment options are dictated without discussion or multidisciplinary team involvement, the opportunity for disagreement increases and conflict arises. Caregivers form opinions and may try to prove the merit of their argument by gathering support from other caregivers or through documentation in the patient record of information supporting their position.

An example of this is the decision regarding the level of medical support to give an infant that had no expectation for survival. The physician decided to with-hold all but basic intravenous fluids while the nurses felt that this was neglectful and should include more supportive nutritional care and medical intervention. Conflict between

45. *See* Polzer & Neale, *supra* note 3, at 136-39.

physician and nurse care-givers led to dispute resolution at the patient unit level mediated by in-house counsel.

C. Resource Allocation and Resource Leveraging

The ability to acquire resources and the possession of resources is important both as statements of position and power and the means by which action can be pursued.[46] Resources in health care may include physical, fiscal or human capital.[47] Physical resources encompass buildings, plants, space, and equipment.[48] Fiscal resources include funding through service revenues, grants, contracts, stock, and incentives.[49] Human resources involve persons such as staff personnel, colleagues, and contractual employees.[50]

Conflict arises when individuals perceive resources to be inequitably distributed, inadequate to accomplish the task, or at a level that fails to recognize ability or is non-competitive with other similar situations or settings.[51] Conflict can occur directly between individuals or indirectly through intermediaries who have a related but different interest in representing others. An example of the latter case is when nurses go to physicians to complain about inadequate staffing in order to leverage power within the system by having medical staff seek additional resources on their behalf. In doing so, nurses do not follow the chain-of-command, setting up conflict not only between themselves and nurse administrators but also between physicians, nurses, and administrators.

Inequitable resource distribution is frequently the result of strategic planning that identifies centers of excellence or strategic priorities.[52] In this case, a conscious decision is made by the Chief Executive Officer and senior administrators to develop specific services that will expand health care service capability and market niche.[53] These services are identified as "centers of excellence" building on the expertise of professional staff, current resources and future possibilities to develop a cohesive program for patients having specific types of problems.[54] Programs may include services such as women's

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46. *See id.* at 137.
47. *See* RAKICH, *supra* note 19, at 14-16.
48. *See id.*
49. *See id.*
50. *See id.*
51. *See* Polzer & Neale, *supra* note 3, at 136-37.
52. *See* JOEL E. ROSS, TOTAL QUALITY MANAGEMENT 99, 100 (1993).
53. *See id.* at 100.
54. *See* Bernard P. Wess, Jr., *Defining Centers of Excellence*, HEALTH MANAGEMENT TECH., Aug. 1999, at 28.

health, neurotrauma, ophthalmology, and orthopedics. Commitment to these strategic priorities entails over resourcing the selected centers and maintaining other services at current or lower levels.[55] This situation can create a perceived environment of "haves" and "have nots" and lead to conflict between service chiefs and other professionals not affiliated with the strategic service priorities.

Perceptions that resources are inadequate to perform necessary tasks also leads to conflict with other caregivers and administrators.[56] For example, the expectation that all hospital beds and patient care services will be fully operational in the face of nurse staffing shortages leads to conflict between nurses, administrators and physicians. Pressure on nurses to maintain high quality and efficient services, on physicians to maintain referrals and to meet the expectations of patients for rapid treatment, and on administrators to provide the environment for a continuum of quality, cost-effective care leads to demands and conflict between all groups.

Non-competitive resources such as salaries, equipment, buildings and plant space that are not equal to similar services offered by other institutions lead to internal conflict.[57] Under these circumstances, the conflict involves dissatisfaction and demands for upgrading that may or may not be possible given the availability of additional resources for the services in question.[58]

Resource leveraging in the context of conflict is the use of a third party to obtain resources that would otherwise not be available to the principle participants. Caregivers or administrators may use this technique by forming coalitions with others who also stand to gain by the acquisition of the resources. For example, a chief of service may support another chief of service in obtaining different space so that he may acquire the space that has been vacated. If the administrator does not support the change in physical space for the service in question, there are now two powerful individuals to deal with instead of one.

IV. CONFLICT RESOLUTION

While conflict can make a situation uncomfortable, it can lead to changes in policy and procedure that can strengthen an organization and move it to a position of increased strength. Functional conflict

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55. *See* STEVEN A. FINKLER, BUDGETING CONCEPTS FOR NURSE MANAGERS 144, 145 (2d ed. 1992).

56. *See* Polzer & Neale, *supra* note 3, at 136-37; RAKICH, supra note 18, at 13.

57. *See* RAKICH, *supra* note 19 at 11-12.

58. *See id.*

may be referred to as constructive conflict. This type of conflict increases individual and unit efforts, directs attention toward organizational goals, and synthesizes differing viewpoints. Some levels of conflict can facilitate critical thinking among group members, make a group more responsive to the need for change, and provide similar benefits that can enhance group and organizational performance. Conflict, can however, also create negative interpersonal relationships that reduce the quality of communication and hinder the ability to obtain meaningful outcomes. Dysfunctional conflict, or destructive conflict, leads to organizational and personal stress, distortion of unit goals, and game playing.

How conflict is managed and ultimately resolved is critical to the effective functioning of the organization and its ability to creatively move forward. Frequently, conflict is not managed or resolved under the assumption that intervention is uncomfortable. This only makes matters worse and will ultimately involve more people with no resolution.[59] Unfortunately, inaction rarely improves the situation. Instead, it continues to deteriorate until action must be taken or it reinforces the original behavior as one that achieved its goal of creating a stalemate or of validating the power of an individual to not acquiesce.[60]

Another method of dealing with conflict is to accommodate or allow others to have their way. This strategy can imply that one individual is more powerful or it can be used to gain the respect of another party.[61] Accommodation involves coming to the conclusion that the other person has the better approach, the outcome is not important enough or the repercussions are too great to engage in lengthy negotiation or mediation.[62] An example of this may include times when two supervisors are giving staff different directions and on query from the staff member, one supervisor gives instruction to follow the direction of the other supervisor. This strategy often implies that one individual is more powerful or is used by one party to gain the respect of another.

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59. *See* Mary Ann Brandt, *How to Make Conflict Work for You*, NURSING MGMT., Nov. 2001 at 32, 35; *see also*, Polzer & Neale, *supra* note 2, at 144.

60. Tony L. Simmons & Randell S. Peterson, *Task Conflict and Relationship Conflict in Top Management Teams: The Pivotal Role of Intragroup Trust*, 85 J. APPLIED PSYCHOL. 102, 103 (2000).

61. *See* Brandt, *supra* note 59, at 35; Kenneth W. Thomas, *Conflict and Conflict Management, in* HANDBOOK OF INDUSTRIAL AND ORGANIZATIONAL PSYCHOLOGY 889 (Marvin D. Dunnette ed., 1976).

62. *See* Polzer & Neale, *supra* note 3 at 142; Thomas, *supra* note 61, at 901.

Compromise, however, requires that each individual or group give up something that they would have liked.[63] While not always presenting the best solution, this method may be the option of choice rather than continuing conflict and risking damage to the professional relationship.[64] In the previous example, the two supervisors could have compromised by meeting and deciding to alter both of their directives to develop a new initiative with components of each of the previous ones.

Collaboration is the most desirable resolution to conflict in that it involves designing a mutually acceptable solution to the problem and allows both individuals or groups to win.[65] The goal of the collaborative process is to have individuals work out a better alternative than either had before,[66] and negotiation skills can be helpful in this process. For example, the development of a triage strategy for emergency patients might replace the two alternatives of seeing patients on a first come first serve basis or having them go to designated specialty service areas without referral.

Disputes between caregivers may be addressed directly between individuals or may be taken by one or both parties to the next level administrator to be mediated.[67] A higher level administrator may be accessed to broaden the discussion and to seek resolution.[68] The success of these actions depend on variables such as the personalities of the individuals or groups in conflict, the level of importance assigned by the individuals to the issue around which the conflict revolves, and the ability to change the conditions which originated the conflict in the first place.[69] Of key importance is the ability of the mediator to manage the process of conflict resolution through a facilitative approach that takes an informed but neutral position.

Conflict resolution may occur at several levels- interpersonal, inter-professional or organizational. Figure 1 shows how similar methods may be used at various levels of conflict resolution.

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63. Brandt, *supra* note 59, at 35.

64. *Id.*; Thomas, *supra* note 61, at 901.

65. *Id.*; *see also* ROGER FISHER & WILLIAM URY, GETTING TO YES: NEGOTIATING AGREEMENT WITHOUT GIVING IN 73 (Bruce Patton, ed., 1991).

66. *See* FISHER & URY, *supra* note 65, at 74.

67. *See* Polzer & Neale, *supra* note 3 at 154-55; Richard Wendell Fogg, *Dealing with Conflict: A Repertoire of Creative, Peaceful Approaches*, 29 J. CONFLICT RESOL., 330, 335-36 (1985).

68. *See id.*

69. *See id.* at 155.

FIGURE 1: CONFLICT RESOLUTION METHODS AND LEVELS

Method	Interpersonal Level (One on one)	Inter-professional Level (several individuals & professions)	Organizational Level (Administration)
Tension Reduction	Discussion one on one. Humor.	Discussion and listening	Introduce nature of the conflict
Knowledge Building	Clarification of facts. Seeking additional information	Review of information from formal sources	Obtain information from system level re. issue of conflict
Issue Generation	Identifying the source of the issue	Mutually determine the underlying issue	Explore system basis of issue
Negotiation of Issues	Detailing possible alternatives and evaluation criteria.	Seek key outcomes sought by each person & win-win	Include system-wide resources within negotiation
Agreement and Plan of Action	Discussion of possible alternatives and implementation	Select alternative and action for short and long-term	Explore broad applicability of resolution and action

The difference in levels of conflict resolution is reflected in the scope of resources that can be drawn on to impact the situation.[70] At the interpersonal level, resources are largely dependent on building relationships between individuals and mutually finding means of working through conflict.[71] Even the decision to avoid confronting the issue of conflict is an action, albeit not usually an effective one. In healthcare settings the dynamics between caregivers combined with pressures to take definitive action surrounding patient care or the organization of patient care services takes on heightened importance.[72] As a result, working with conflict is more often the outcome. When conflict is resolved it generally involves taking time to identify the underlying issue and identifying measures and actions that will preclude its recurrence.[73]

Inter-professional conflict may involve nurse-physician, nurse- administrator, physician-administrator dynamics.[74] Positional authority and disagreements surrounding decisions being made from different perspectives often influence these conflicts. Issues of resources as well as management of patient care services and care protocols serve as the subject matter.[75] Review of information and exploration of multidis-

70. *See* Polzer & Neale, *supra* note 3, at 139.

71. *See* Van Ess Coeling & Laing Cukr, *supra* note 43, at 185-86.

72. *See id.* at 187.

73. *See* Brandt, *supra* note 59, at 32-33.

74. *See* Paula S. Forté, *The High Cost of Conflict*, 15 NURSING ECON. 119, 119-20 (1997); *see also* Van Ess Coeling & Laing Cukr, *supra* note 43, at 186 (discussing the inevitability of conflict that arises when " strong and talented persons with diverse abilities come together in a complex health care and economic structure.")

75. *See* Polzer & Neale, *supra* note 3, at 137.

ciplinary perspectives can be useful in expanding the discussion to include alternatives for resolution that may not have presented themselves when viewed from parochial vantage points.[76]

Organizational level conflict includes not only the dynamics of individuals within and between professions but encompasses other levels of the healthcare system such as directors and department heads. When occurring at this level, internal mediation may be necessary and a systems perspective must be represented.[77] The broad picture of issues generating conflict needs to be clarified and discussed, alternatives developed and actions prioritized in meetings with key participants.[78] Internal conflict at the organizational level can include limited numbers of individuals or entire departments such as the department of surgery and the emergency service. An example of the latter case might be when the emergency service continually has to turn patients away for lack of ability to send patients to surgery as needed resulting from backed up surgical schedules. In identifying the source of the issue, it might be determined that surgeons are under-estimating the time it takes for them to perform scheduled surgery, staffing shortages causing a reduction in the number of operating rooms available or poor triage in the emergency department itself.

Current management of disputes often does not include a thorough examination of the processes that are at work and the underlying source of issues around which conflict develops.[79] Direct intervention assistance is generally not available when it is most needed and individuals, multidisciplinary teams and organizational units are frequently left to their own devices to work out problems. Poorly managed, the result may be staff turnover, underlying hostility, and counterproductive tactics.

V. IMPROVING CONFLICT RESOLUTION

Conflict resolution in the healthcare setting requires a top down approach of setting expectations and providing mechanisms by which disputes can receive early attention. Before professionals complete their formal academic preparation, there should be interdisciplinary education and opportunities to practice team oriented patient care.

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76. *See* Forté, *supra* note 74, at 122.

77. *See* ANN MARRIENER-TOMEY, GUIDE TO NURSING MANAGEMENT AND LEADERSHIP 329 (N. Darlene Como ed., 5th ed. 1996).

78. *See id.*

79. *See* Deborah Terry, *Effective Employee Relations in Reengineered Organizations*, J. NURSING ADMIN., Sept. 1999, at 37 (discussing the importance of a comprehensive analysis of the current system from the patients perspective).

Within this interdisciplinary preparation should be clearly defined scopes of practice, roles and responsibilities for each member of the team to promote an understanding of realistic expectations and practice orientation. Interdisciplinary case analyses would provide a means of practicing collegial problem solving and resource utilization.

Cross-professional orientation should take place in the patient care setting to inform all professional members as to the system of organization, breadth of patient care services, resource availability, working constraints and opportunities. This orientation should be designed to expand working relationships and to identify mentors wherever possible. These mentors should be able to facilitate the progress each team member makes in developing their knowledge, skills and career opportunities within the healthcare system and in the larger professional career network.

Although healthcare professionals depend on good interpersonal abilities in working with patients and their families, communication as a content area may receive little attention in the formal academic program. This especially extends to interpersonal skills in working relationships. Attention to principles of negotiation and conflict resolution during the academic program and especially within interdisciplinary education is essential.

In the workplace, there must be an investment in team building. Many organizations, in a search for cost efficiencies have undertaken process re-engineering, a technique by which operational processes are evaluated and re-designed. For example, a surveyor may follow one or more patients through the emergency department treatment system and record each interaction related to care. This would include the welcome a patient receives, triage procedure, number of individuals seeing the patient and interacting with them, diagnostic tests, management of specimens, communication and documentation of results, treatment interventions, education, referrals and transportation within the system. This evaluation is intended to lead to system redesign including the reconfiguration of services and use of team members. It can also change the dynamics of the current system and create conflict with changes in roles and authority. The development of the team will depend on planned time to listen to staff and to respond to the information given. The team should be involved in operational planning leading to system's evaluation and change and supported in its development through discussion, assessment and positive feedback.

Workplace mediation should be made available – especially for inter-professional and organization level conflict. Mediation can be

organized through in-house counsel or through individuals or teams prepared in negotiation and conflict resolution. It is important that this service, if offered, is available informally as well as formally and that all healthcare professionals are made aware of the service when they begin to work within the system. The service must be clearly non-punitive and organized only to assist, not dictate, results generation. Senior management must support mediation and mediators must be prepared through conflict resolution education. This should include the development of principles and rules by which the mediator can deal with conflict early in the process before positions become entrenched and individuals rally supporters. If the dispute will not be able to be resolved in the short term, another tactic might be to delay the resolution while building trust with the participants. This latter action is difficult in healthcare settings since an unresolved dispute will generally spill over to other activities and interactions. The close proximity and frequent contact of care-givers and of administrators demands that disputes be resolved or contained in a way that precludes their having a negative impact on day to day operations.

Creative approaches to conflict resolution seek "to satisfy the needs behind the demands."[80] There is a distinction between concentrating on demands and solving the basic problem.[81] Conflict resolution can be organized by varying what, why, when, where, how and who are involved.[82] In healthcare this may mean identifying the interests that individuals and groups hold in common, generally quality of care and well-being of the patient. By starting at this point, disputes can, on occasion, be broken down to more basic elements that allow a new pathway of action to be established that resolves the conflict. In this process, language is very important since words and phrases take on different meanings to individuals with different backgrounds. For example, when discussing "access" to healthcare, care-givers immediately think of the means by which patients can locate and obtain healthcare. Policy-makers and some administrators, on the other hand, think in terms of the patient's ability to obtain insurance coverage, allowing them entry to the healthcare system. As a result, it is important to clarify words and terms throughout the process of communication.

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80. Richard W. Fogg, *Dealing with Conflict*, 29 J. CONFLICT RESOL. 330, 332 (1985).
81. *Id.*
82. *Id.* at 333-34.

Effective interpersonal and group dynamics are based in good working relationships built on equality of respect, if not position.[83] For this reason, healthcare institutions must pay particular attention to assessing the climate of the organization to determine if the environment is healthy or if there is unresolved conflict.[84] Some indications of a healthy environment include open communication, perceived control in decision making, low staff turnover, few complaints by staff, recognition of excellence, and ability to form effective interdisciplinary teams to meet unexpected challenges such as high patient volumes and care emergencies.[85]

VI. PARADIGMS OF LEADERSHIP – CONFLICT, NEGOTIATION AND RESOLUTION

One means of providing a creative approach to improving skills in negotiation and conflict resolution is the use of a leadership module in interdisciplinary education. Under grant funding from the American Nurses Foundation, Mills, Tilbury and Proulx developed a leadership module designed to build specific conflict negotiation and resolution skills among nursing students. The module was designed to prepare the student to: identify potential sources of conflict; anticipate the potential impact of unresolved conflict on the work and patient care setting; preplan logical strategies to manage conflict; and, take positive action through negotiation to resolve conflict.

In brief, the method involves participants preparing a brief narrative describing a conflict situation in which they were a participant and how they responded. A simulated exercise focused on cooperation and interdependence and use of a conflict management self-assessment instrument provided a foundation for skill development in addressing the connections between theory and situations. Common themes include a perceptions of the parties in conflict, concepts of opposition, blockage of interests and incompatibility of goals. A theoretical lesson addresses the nature and progressive process of conflict, strategies for conflict resolution and/or management, and negotiation. Group exercises related to several case studies featuring a conflict scenario are used for students to diagnose the problem and negotiate outcomes. Also included are cases as examination material plus questions requiring the student to apply theoretical content in an

83. *See* Amy Edmondson et al, *Speeding Up Team Learning*, 79 HARV. BUS. REV. 125, 131 (2001).

84. *See* Brandt, *supra* note 59, at 35.

85. *See id.* at 35 (quoting Mary Ann Brandt et al., *How to Make Conflict Work for You*, Nov. 2001, NURSING MGMT., at 32, 35).

analytical and critical manner. The interactive leadership module, is designed to better prepare students to resolve issues in a productive and positive manner that can contribute to the management of complex health care delivery environments and their own career success.[86]

In a health care practice setting there are several instruments available to measure conflict.[87] These measures evaluate interactions such as: organizational conflict within and between groups; perceptions of conflict between individuals, groups and departments; organizational climate; conflict management behaviors; and interpersonal relationships.[88]

The purpose of the leadership paradigm is to promote the development of collaboration so that conflict can become constructive.[89] Communication is key to this process and requires active listening, objectivity, mutual problem solving and creation of options and action plans.[90]

VII. CONCLUSION

Health care is offered in complex environments of multidisciplinary professionals: physicians, nurses, social workers, pharmacists, administrators and others. The combination of legal and regulatory pressures, health care financing, and demands placed on interdisciplinary teams have created high pressure work settings. The nature of health care delivery also creates tension as professional care-givers seek to meet the needs of patients and their families as well as the sometimes competing demands of the system itself. Differences in perspectives based in the educational socialization to their professions, position, authority and power often lead to conflicts in the health care arena.

Sources of conflict emanate from inadequate interpersonal and inter-professional respect and recognition, differences in opinion regarding optimal treatment protocols and competition over fiscal and human resources. There are also ethical dilemmas whereby protocols may be contrary to individual values. While individuals can, and do, actively resolve conflicts without intervention, often times there is an avoidance of dealing with the conflict. The result frequently leads to additional problems. Care-giver to care-giver conflicts such as those

86. *See* Edmondson, *supra* note 83, at 132.

87. *See* Diane L. Huber, et. al. *Evaluating Nursing Administration Instruments,* 30 J. NURSING ADMIN., 251, 259 (2000).

88. *See id.*

89. *See* Brandt, *supra* note 59, at 35.

90. *See id.*

between physician and nurse or physician and physician occurs when communication fails to achieve a mutually satisfactory result.

Conflict can be constructive if enacted in a positive way to stimulate the accomplishment of goals and to synthesize differing viewpoints and promote critical thinking. As a result, the management and resolution of conflict is critical to the effective functioning of the organization. Active steps should be taken to promote interdisciplinary team building during academic preparation for the chosen professions rather than expecting dynamic teams to develop spontaneously in the work environment. Academic institutions should implement some measure of interdisciplinary course work involving clinical practice and team case analyses of patient problems and formulation of plans of care. Healthcare organizations should attend to interdisciplinary team development from the outset of employment and should consider preparing in-house mediators to facilitate dispute resolution. Mentoring of new physicians and nurses would further provide counsel in selecting means of dealing with conflict as well as building a valuable professional, and hopefully, multi-professional network.

As shortages grow in the health professions and labor unrest increases, conflict resolution will become a priority to building a strong healthcare system and a quality environment for patient care. Even more valuable will be the regular assessment of organizational climate and the implementation of measures that will serve to prevent conflict or facilitate individuals to resolve it at the interpersonal level.