Conflict in Health Care: A Literature Review

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Citation

Abstract

Direct patient contact health care employees such as physicians, nurses, and technologists work in complex, stressful environments that are prone to conflict. Though some of this conflict may result in positive outcomes, much will have the opposite effect. Dysfunctional conflict has the potential to negatively affect the health care workplace on a variety of levels, including impacting the quality of patient care, employee job satisfaction, and employee wellbeing. Therefore, it would behoove hospital managers to learn to recognize the precursors to conflict in order to prevent any ill effects. The purpose of this literature review is to offer an overview of the antecedents and effects of conflict among health care workers. Both positive and negative effects of conflict are addressed. Also explored in this review are methods in which negative conflict can be adequately managed and resolved.

Although there is no universal definition of conflict (Cox, 2001; Katielidou et al., 2012; Kelly, 2006), it can be described as "a process in which one party perceives that its interests are being opposed or negatively affected by another party" (Kreitner & Kinicki, 2010, p. 373). As pleasant as it may seem at first glance, the total avoidance of conflict is more a fairytale than a realistic expectation. In fact, though there are multiple negative effects of conflict, there do also exist some benefits. This positive effect is often overlooked. Society tends to lend the term conflict a negative connotation. For example, the word war is synonymous with conflict. Wars are often viewed as events to be avoided at all costs, yet organizational conflict will occur more frequently and is expected by wise leaders. Repeated avoidance of conflict leads to dysfunction and is often based on various fears such as rejection, anger, failing, loss of relationships, and hurting others (Kreitner & Kinicki, 2010). Without conflict, problems develop. With chronic conflict, problems develop. Maintaining a delicate balance is the responsibility of organizational leaders.

Leaders of companies must inevitably face the issue of conflict in their workplaces. Health care leaders are certainly not immune. Hospital employees experience conflict quite frequently in the workplace (Berman-Kishony, 2011; Forte, 1997; Guidroz, Wang, & Perez, 2011) due to its high-stress environment (Chipps, Stelmaschuk, Albert, Bernhard, & Holloman, 2013) and the variety of stakeholders involved (Shin, 2009). This literature review will seek to answer key questions regarding conflict among direct patient contact health care workers, namely the following. (1) How are Kreitner and Kinicki's (2010) antecedents of conflict relevant to health care personnel? (2) What are the potential effects of conflict in the health care workplace? (3) What are some strategies that can be utilized in order to manage and resolve unhealthy conflict within the health care system? The implications for further research and the future of the health care workplace regarding conflict will also be discussed.

DYNAMICS OF CONFLICT

Conflict is a complex behavior. It can occur on various levels – intrapersonal, interpersonal, intragroup, or intergroup. Intrapersonal conflicts occur within the person, whereas interpersonal conflict takes place between people. Likewise, intragroup conflict happens within one group of people and intergroup conflict occurs between two or more groups of people (Forte, 1997). According to the definition of conflict, "one party perceives that its interests are being opposed or negatively affected by another party," perception plays an important role in conflict. The issues that arise to cause conflict may be genuine or illusory (Kreitner & Kinicki, 2010, p. 373). The subsequent conflict is real, nonetheless.

Dysfunctional conflict refers to the negative types of conflict that "hinder organizational performance" (Kreitner & Kinicki, 2010, p. 375). However, not all conflict results in

damage. Functional conflict involves the "healthy and vigorous challenge of ideas, beliefs, and assumptions" (Menon, Bharadwaj, & Howell, 2001, p. 303). Since conflict can result in necessary changes within an organization, Haraway and Haraway (2005) suggest leaders "not to try to eliminate conflict" but instead manage differences productively in order to increase efficiency and proficiency (p. 11). This is contradicted by Dougan and Mulkey (1996) who posit, "elimination of conflict is always the goal," even if the conflict seems constructive in the onset (p. 3). This latter view of conflict corresponds to the traditional understanding of conflict that stemmed from the 1930s that viewed conflict as destructive, dysfunctional, and disruptive. It was to be "avoided, suppressed, or eliminated" (Almost, 2006, p. 447). Only later, circa 1956, were the positive effects of conflict studied, beginning with Coser (Lewicki, Weiss, & Lewin, 1992). Nonetheless, Almost (2006) posits that resolution of conflict is necessary due to the fact that if allowed to be prolonged will eventually generate new causes of conflict.

ANTECEDENTS OF CONFLICT

What situations generate conflict? Conflict is more apt to take place under certain circumstances; by making themselves aware of these antecedents, organizational leaders can prepare for it and intervene when appropriate. Kreitner and Kinicki (2010) list the following circumstances as tending to create conflict: personality and/or value differences, blurred job boundaries, battle for limited resources, democratic decision-making, collective decision-making, poor communication, competition amongst departments, unreasonable work expectations (policies, rules, deadlines, time restriction), unmet and/or unrealistic expectations (regarding salary, advancement, or workload), more complex organizations, and unsettled or repressed conflicts. Most conflict research reveals that the majority of health care conflict arises from "interpersonal or professional communication difficulties" (Shin, 2009). Many of these factors are discussed in recent literature and will be reviewed in the subsequent paragraphs, along with findings from studies specifically limited to health care practitioners.

PERSONALITY DIFFERENCES

Almost, Doran, Hall, and Spence Laschinger (2010) noted that dispositional characteristics were found to be a major cause of conflict in the nursing field in three separate Canadian research studies. Incompatibilities between and amongst persons can include "personality clashes, tension and annoyance" (p. 982). Individuals have unique

personalities and vary in "attitudes, opinion, beliefs, culture emotional stability, maturity, education, gender, language, etc." (Jha & Jha, 2010, p. 77). Therefore, their reactions to specific stimuli also differ. These differences cause some individuals to perceive some matters as undermining their positions or refuting their worldviews or values. Oftentimes, individual differences can adopt moral and/or emotional undertones, turning a disagreement over who is factually right or wrong into "a bitter squabble over who is morally correct" (p. 77). Though Jha and Jha seem to suggest that differences contribute to situations of conflict, it is noteworthy to consider Mulford, Mulford and Wakeley's (1977) study that concluded, "conflict may be absent when organizations try to recruit members from different age categories (as cited in Dougan & Mulkey, 1996).

VALUE DIFFERENCES

Frederich, Strong, and von Gunten (2002) discuss a case of value differences resulting in micro-level conflict within a hospice inpatient unit. Physician-nurse conflict arose when a nurse refused to follow a physician-prescribed order to administer a potent sedative to a 47-year-old patient. The physician, the patient and the patient's wife had earlier agreed to initiate controlled sedation to the patient, who was seeking to hasten death. A nurse who worked during the previous shift felt uncomfortable with the order as well because it seemed excessive at that point in the patient's disease progression. Health care workers are able to refuse patient care assignments when they are "ethically or morally opposed to interventions or procedures in a particular case" (p. 156). The polarity of values on the hospice unit created conflict among the physician, the nurses, the patient, and the patient's family.

BLURRED JOB BOUNDARIES

Health care requires interdependence among its caregivers. This interdependence is often regarded as a "structural antecedent to conflict" (Wright, Mohr, & Sinclair, 2014). Multiple scholars reveal that conflicts among interdependent health care workers may occur from discrepancies about which professional is responsible for performing certain roles or making treatment decisions rather than disagreement over the procedure plan chosen (Jameson, 2003). Blurred boundaries between nurses and physicians lead to conflict when senior-level nurses, who are experts in their specialties, "frequently fail to observe the formal boundaries of nursing practice" (Bonner & Walker, 2004, p. 212). This corroborates with Kaitelidou et al.'s (2012) study of physician nurse conflict in Greece that

concluded physicians "reported having more conflict with nurses…with a higher (university) education" (p. 574). Nurse practitioners are advanced nurses who, in some states within the United States have prescriptive privileges and may set up autonomous clinical practices, much to the consternation of some physicians who at one time did not have to share that right. One nurse practitioner was opening her private practice and noted the following comment from a physician who objected to her new undertaking, "one radiologist stated that he would never accept a request from a nurse for an X-ray – funny he does now" (Norris & Melby, 2006, p. 259). The advancement of the nursing field creates inter-professional conflict between nurses and physicians who are unwilling to accept the evolution of the nurse practitioner profession. Many nurses today hold equal or increased academic qualifications as physicians (Ashworth, 2000). Norris & Melby (2006) explain that while this nurse advancement is more developed in the United States (U.S.) and Canada, in the United Kingdom (U.K.) the role of nurse practitioners is still in its early stages. This advancement is recognized as the relatively new challenge of blurring of existing barriers that was found in the authors' research that U.K. physicians "were more unwilling to accept that nurses should be allowed to undertake certain advanced skills" (pp. 260-261).

Ihemedu, Omolase, Osere, and Betiku (2010) also address these advancements of nursing roles in Nigeria. They note that the "boundaries between doctors as diagnosticians and prescribers of treatment and nurses as obeyers of orders and dispensers of treatment [are] less clear and more permeable" (p. 570). Ihemedu et al. assert that the contrasting reactions to these changes have led to conflict and poor working conditions.

In an editorial about this physician-nurse friction regarding advanced practice nurses, Caroll-Johnson (2000) relayed the story of a nurse practitioner in the U.S. that also worked as a clinical specialist and a university instructor was asked to leave a tumor board meeting when she arrived with a physician coworker. The decision to ask for her exit was catalyzed a week earlier when a different nurse filled in for an absent physician by presenting a patient case at the tumor board meeting, which infuriated the physicians. Eventually, the nurse received a letter from the Cancer Committee chairman stating that she was welcome to attend the meetings but could not present patient cases but could "add information and participate in the discussion about patients being presented from her physician colleague's office" (p.

885). The author conceived that many physicians preferred the hierarchical structure of the past and "refuse to acknowledge or value the contributions nurses can make during any phase of the patient care continuum" (p. 885).

BATTLE FOR LIMITED RESOURCES

Competition for resources in health care has grown significantly over the past few decades. With the exponential rising costs of health care, hospitals are forced to do more with less. Fewer employees, tighter budgets for equipment purchases, and workflow changes contribute to intergroup and intragroup conflicts (Tomajan, 2012). Financial resources are limited when considering physician payment as well. Health plans/managed care battle with physicians so frequently that Masterson (2009) referred to the two groups as "healthcare's Hatfields and McCoys" (para. 1). The health plans/managed care prefers paying physicians through the pay for performance model, while physicians disagree and believe that increased reimbursements would "improve payer/physicians relationships" (para. 3).

DECISION-MAKING

Discontent and frustration occur among health care workers when there are "constraints on the decision-making process" (Dougan & Mulkey, 1996, pp. 5-6). In the past, nurses had little to do with complex decisions in health care. However, the roles of nurses and doctors have changed significantly over the past two decades. This change to a more collaborative environment led to conflict in health care practices. Some physicians have a difficult time realizing that "nurses are now independent professionals" (LeTourneau, 2004, p. 12).

Coombs (2003) conducted an ethnographic study of intensive care nurses and physicians. Though much of the doctor-nurse interactions were "mutual or satisfying," clinical decision-making caused conflict between the groups of professionals. Both groups expressed disagreements concerning input with clinical decision-making but the disparate interpretations were noted. Physicians appreciated the fact that the nursing staff held patient knowledge. Coombs noted that this knowledge often was not considered as information in clinical decision-making, however. By ignoring or failing to take into account their knowledge, the nursing staff "felt frustrated and devalued" (p. 130). They also considered it "an insult to their clinical skills and professional experiences in intensive care" (p. 130). By feeling that they lacked a sufficient power base in making decisions, nurses believed that opportunity to offer valuable

input was limited. Some physicians failed to validate these feelings. One in particular stated that the working relationship between the two groups was collaborative. Yet, when discussing nursing concerns posited, "I think that some of the nurses may feel that there is a hierarchy, but I think that it's their problem. They're shit scared of medicine, but that's their problem" (p. 132).

In addition to the decision-making process as an antecedent in the aforementioned example, disrespect is noted. Almost (2006) expresses that interactional justice entails two factors, interpersonal justice and informational justice. The former is the extent to which individuals are respected; the latter involves how much the individual is provided justification for the decision-making process. These "perceptions of injustice or disrespect" are antecedents of conflict on an interpersonal level (p. 449). In concordance with Van Yperen, Hagedoorn, Qweers and Postma (2000), Wright et al., (2014) conclude that injustices yield more "outward-oriented" feelings, i.e., anger, that is apt to affect subsequent nursing behaviors (p. 32).

COMMUNICATION

Numerous studies include communication as a major cause of interpersonal conflict among nurses, including Almost (2006), Johnson (2009), and Warner (2001). Kreitner and Kinicki (2010) specifically mention "inadequate communication" (p. 376) as an antecedent, an element that corresponds with much of the literature (Wright et al., 2014). Other researchers, such as Almost (2006) point to the style of the communication within the health care field as lending to the development of conflict. That style could certainly consist of lack of communication, but can also include verbal or non-verbal communication. A high-stress workplace such as an operating room lends itself to conflict-producing verbal communication. This type of communication can include gossip, harsh language, rumor spreading, criticizing, bickering, and degrading comments (Chipps et al., 2013; Johnson, 2009; Rowe & Sherlock, 2005; Wright, et al., 2014). Conflict among nurses often results from sudden outbursts of anger (Duddle & Boughton, 2007). Rosenstein (2009) offers that some physicians create conflict inadvertently in the midst of making life or death decisions that may be "carried out with an autocratic domineering tone" that offends others (p. 14). Non-verbal cues such as ignoring, facial expressions, and body language can trigger conflict. According to Wright et al (2014), one nurse reported the following regarding non-verbal catalysts of conflict: "A nurse working in an adjoining department

consistently refrains form speaking to me. This seems deliberate as she speaks freely to others all around me. It just feels unfriendly and awkward" (p. 31). Bullying in the health care workplace is an example of dysfunctional communication that results in conflict (Chipps et al., 2013; Singh, 1991)

INTERDEPARTMENTAL COMPETITION

The general consensus among theorists "from Weber to Likert" suggests that intergroup conflict is inevitable (Dougan & Mulkey, 1996). The authors posit that department managers' roles demand "attention as itself an antecedent of perceived conflict" (p. 5). Department managers are required to lead their employees to continue necessary interaction between departments "in expected and often conflicting ways" (p. 15). Interdepartmental competition can arise when non-routine purchases need to be made. These are often not budgeted well on an organizational level and cause friction when more than one department requires large capital purchases that cannot all be accommodated (Cochran & White, 1981). Yet another interdepartmental antecedent to conflict involves issues with role boundary. "A lack of understanding of each other's roles was described as a source of conflict on [primary health care teams" (Brown et al., 2011).

EXPECTATIONS

Health care providers' expectations vary. Peers tend to get frustrated when their expectations for their coworkers are not met. This leads to nurses in conflict with other nurses, which an abundance of literature suggests is the most common form of conflict in the nursing field (Johnson, 2009; Rowe & Sherlock, 2005; Wright et al., 2014). Some speculate that nurse infighting may occur so frequently due to displaced aggression since "direct conflict with the real oppressor [the physician] is too risky" (Rowe & Sherlock, 2005, p. 243). Wright et al. (2014), as part of a larger study to identify nursing retention factors, studied interpersonal conflict through weekly surveys to 144 predominantly female nurses. The disparate work expectations produced conflict on the intradepartmental level. For instance, one nurse who was surveyed expressed conflict amongst her peers since she was injured on the job and later expected to "tough it out" by other nurses.

Leever et al. (2010) conducted an explorative qualitative study of the medical staff and nurses on one hospital ward. The authors relay that expectations of "communication, mutual respect, professionalism, climate of

collaboration, and quality of care" (p. 617) varied amongst the participants. Conflict, they discovered, "came about through a lack of compliance between the above-mentioned expectations and reality" (p. 618).

COMPLEX ORGANIZATIONS

Health care complexity such as pressures of time, life and death decisions, and heavy workloads contribute to the contextual causes of conflict (Almost et al., 2010; Bishop & Molzahn, 2004; Chipps et al., 2013; Haraway & Haraway, 2005; Rowe & Sherlock, 2005; Warner, 2001). The health care workplace is unpredictable, complex, and involves job ambiguity, which creates stress and results in macro-level conflict (Haraway & Haraway, 2005). Urban health care settings seem to increase the incidences of conflict when compared to their rural counterparts. The urban life environment adds stressors to the organization that are missing in rural life (Dougan & Mulkey, 1996).

Part of any complex organization is change. The health care system is quite complex and dynamic. In addition to the continuous changes normally occurring, the Patient Protection and Affordable Care Act (PPACA), informally referred to as Obamacare, was signed into law on March 23, 2010 ("Patient," 2013). The PPACA is a health care reform, which brings with it a plethora of changes to health care practitioners as well as all health care stakeholders. Cox (2001) notes that change is "likely to increase conflict in organizations" (p. 17).

UNRESOLVED OR REPRESSED CONFLICT

One example of repressed conflict among health care workers involves anesthesiologists and certified registered nurse anesthetists (CRNAs). There is much national discussion about the overlapping of skills and CRNA autonomy. Both professionals' associations rally for their disparate causes and lobby their legislators for reform. This inter-professional tension remains unspoken but "threatens to divide the groups and impede their ability to work collaboratively" (Jameson, 2003, p. 564). Two CRNAs commented on this repressed conflict:

CRNA #3 – We would never talk about American Association of Nurse Anesthetists of American Society of Anesthesiologists issues at work…if there wasn't [sic] some strain based on those two we could openly talk about those things, and we cannot.

CRNA # 7 – You know it's there but we don't talk about it. One CRNA is no longer here for that reason. She quit because she knew it wouldn't be tolerated. (Jameson, 2003, p. 572)

Wright, et al. (2014) found that a "downward spiral of interactions" occurs when nurses feel as though they are treated unfairly (p. 32). The researchers also note that the expectation of greater competence and responsibility led to conflict among the nursing staff. Almost et al. (2010) postulate that low morale lends itself to conflict. This often occurs when the nursing staff experiences unresolved conflict amongst each other and results in less commitment to the team and the workplace. The following section with elaborate on the effects of conflict among health care professionals.

EFFECTS

The consequences of health care workers' conflict are many. At best, conflicts result in beneficial changes in the workplace. At worst, it can impact patients' lives. This review will illustrate the effects across the continuum.

PATIENT IMPACT

Johnson (2009) cites an example of a worst-case scenario due to conflict. An intensive care nurse alerted the attending physician when a patient suffered post-operative complications. The physician verbally abused the nurse and refused to come to the unit to assess the patient. Later, when the patient's symptoms showed no improvement, the nurse again contacted the physician, which resulted in the physician becoming "even more verbally upset" (p. 9). The nurse declined to call the doctor a third time until the patient was beginning to hemorrhage internally. At that time, the patient was immediately returned to surgery, where the patient expired.

In an Internet survey of over 100 St. Louis nurses, the majority of nurses correctly answered textbook questions about physician-nurse scenarios of decision-making conflict that are commonplace in the labor and delivery department. However, they also noted that in the workplace, they would not respond according to those textbook ideals (Phillips, 2008). One of the scenarios involved a doctor ordering additional doses of oxytocin, a hormonal drug that increases contractions, when the woman was currently experiencing "too many contractions" (para. 6). A mere 23% of respondents stated that they would actually refuse the order, which most knew was the correct action. Another 23% replied that they would not increase the drug but agree to do so to the physician. The remaining 54% would increase the

hormone while monitoring the fetal heart rate and decrease the dosage if necessary" (para. 6). The latter choice would not only increase liability risks but also potentially harm the patient.

Though the respondents in this case were "highly educated and experienced nurses" (para. 4), many would fail to respond accurately due to "hospital hierarchy between doctors and nurses, fears of reprisal, belief that the hospital administration would not support a nurse who reported inappropriate behavior and a general desire to avoid conflict" (para. 13).

Fear of reprisal led to another case of impacting the patient in a case where a nurse was aware that a physician's "aggressive treatment plan" conflicted with a terminally ill patient's wishes. The nurse failed to request a review of the case from the ethics committee, which would have been the proper action to take, because of her worry of the repercussions from the doctor (Thrall, 2000, p. 32).

Besides immediate conflict and conflicting opinions of treatment, unresolved conflicts also have the potential of impacting quality patient care. Haraway and Haraway (2005) reveal that nearly every health care worker "can recall delays or inadequacies in patient care caused by a provider refusing to consult the 'on call' physician or group for a problem outside of their area of expertise because of some unresolved past conflict" (p. 12). In a U.S. survey of 213 nurses in a Philadelphia, Pennsylvania teaching hospital, 13% of respondents stated that being involved in verbally abusive encounters led them to "make a caregiving error" (Rowe & Sherlock, 2005, p. 245).

JOB SATISFACTION

In a study of 141 nurses working in 13 inpatient units within a hospital system, Cox (2001) found that the perception of better unit morale was associated with less intradepartmental conflict and lower expected turnover. Cox (2003) reported that increased levels of intragroup conflict led to less job satisfaction among nurses. Conflict in the nursing field is associated with higher job turnover, decreased job commitment, absenteeism, an increase in grievances, continual orientation of nursing staff, and considerations of leaving the profession (Almost, 2006; Jameson, 2003; Rowe & Sherlock, 2005; Tabak & Koprak, 2007). Recent studies conclude that Canadian nurses have decreased their working hours due to conflict and Japanese nurses left their current roles as a result to unresolved conflict (Almost, 2006).

Considering changes occurring in health care, job

satisfaction and retention is particularly important regarding health care workers. The PPACA is the "largest expansion of health care coverage since the passage of Medicare and Medicaid by President Lyndon B. Johnson in 1965" ("The effects, 2014, para. 1). With this expansion comes new patients seeking health care, which is anticipated to increase demand in health care workers, though a recent study noted that there was no significant patient surge in the first few months of 2014, though poor weather patterns in that time period may play a part in those findings (Chester, 2014). However, the aging population is expected to increase the need for health care workers. It is estimated that three million baby boomers are reaching retirement age each year for approximately the next twenty years (Barr, 2014). With this increased stress on the health care market, it would behoove health care managers to pay attention to retention efforts.

EFFECT ON INDIVIDUAL

Continued conflict results in stressed employees. Consequently, "interpersonal conflict has been noted as one of the major sources of stress for nurses" (Rowe & Sherlock 2005, p. 243). Research shows that stressed people have less ability to focus, memory lapses, slow healing, and diminished nutritional uptake (Forte, 1997). Stress can produce psychosomatic illnesses such as stomachache, headache, depression, and anxiety. Conflict educes fear, repugnance, and irritability (Almost, 2006). It can eventually undermine an individual's self-esteem and confidence level (Almost, 2006; Berman-Kishony, 2011; Johnson, 2009; Kelly, 2006). Some specific conflict consequences may involve failing to return telephone messages or emails from patients or colleagues, tendency to isolate oneself, charting by wrote to avoid criticism, taking everything personal, and victim portrayal (Forte, 1997).

COLLABORATIVE EFFORTS

Leever et al. (2010) assert, "Poor collaboration is likely to be caused by, or to result in conflict" (p. 613).Interpersonal relationships suffer with conflict, as negative emotions induce poor perceptions of the person who sparked the disagreement. It can create lack of collaboration as effects of conflict can lead to passively avoiding each other to confrontations and venting of emotions (Almost, 2006; Tabak & Koprak, 2007). This lack of collaboration results in lost productivity, reduced efficiency, increased medical errors, and the compromising of patient care (Almost, 2006; Rowe & Sherlock, 2005). In fact, Forte (1997) states that health care environments in which physicians and nurses

have a more collegial and respectful relationship demonstrate more beneficial outcomes that include "decreased patient morbidity and mortality" (p. 119).

COST

Conflict among health care professionals can be costly to an organization (Almost, 2006; Haraway & Haraway, 2005; Rowe & Sherlock, 2005). Not only does it decrease productivity, but also can lead to employee turnover. According to AARP, Inc. (2011), formerly the American Association of Retired Persons, the cost to replace a medical surgical nurse who earns $46,835 annually would be nearly triple the nurse's salary. Conflict can result in a hospital's litigation costs as well. According to the Equal Employment Opportunity Commission's 2004 data, about $168 million was awarded for legal cases of workplace conflict (Haraway & Haraway, 2005, p. 11).

POSITIVE OUTCOMES

Of course, as noted in the introduction, some effects of conflict may be positive. Reasonable degrees of conflict can lead to the generation of ideas as well as foster team cohesion. It can "lead to a sharpening of critical issues" and catalyze important changes that benefit the organization (Haraway & Haraway, 2005). Once conflict is resolved, those involved feel more united and capable (Almost, 2006).

CONFLICT MANAGEMENT AND RESOLUTION

With implications as potent as patient deaths and employee resignations, negative conflict must be effectively managed and resolved. Obviously, patient care is the mission of health care organizations and putting them as risk runs counter to that goal. Health care professional retention is currently at a premium since the PPACA's increased access to medical care is expected to increase the need for additional health care staff in the United States (Pearlman, 2013).

CONFLICT-HANDLING STYLES

There are five styles of handling conflict, according to the Rahim and Bonoma model: avoidance, compromise, obliging, dominating, and integrating (Kreitner and Kinicki, 2010; Leever et al., 2010). Avoidance and compromise are common styles used among physicians and nurses (Leever, 2010; Tabak & Koprak 2007). According to Kreitner and Kinicki, these two choices are temporary fixes. In certain circumstances, however, they may be useful (Rahim, 2002). Nonetheless, when dealing with complex issues, the preferred style of conflict handling is integrating (Kreitner & Kinicki, 2010; Rahim, 2002). Kelly (2006) reported that a

study of intensive care nurses revealed that they tended to use avoidance in order to protect relationships, prevent open arguments, act as proper role models in the presence of students and so they are not "branded [as] emotional or unfeminine women" (p. 27). Those who avoid conflict "neglect their own needs, goals, and concerns" in order to satisfy others (p. 23). This self-sacrificial approach may be considered an expectation in a career that ascribes to the philosophy of altruism. However, compromise was found to be the most prominent style of choice among doctors and nurses working in five Israeli hospitals, whereas a qualitative study done in a Norwegian hospital determined that physicians and nurses used avoidance, compromise, and dominating styles depending on the contextual factors of perceived interrelationship between the members, and the urgency of taking action regarding the situation (Leever et al., 2010).

ADDRESSING CONFLICT

Shin (2008) suggests that by increasing awareness about health care conflict may catalyze more useful approaches in conflict resolution within the industry. She continues that by addressing negative conflict early on, workplace relations are strengthened and a healthier environment is developed. Kelly (2006) concurs; she asserts that when conflict management is ignored, the team can dismantle and human potential is wasted.

CONFLICT RESOLUTION RECOMMENDATIONS

In order to resolve conflict, managers must first identify the source of the conflict. They learn this by engaging in "careful listening" (Shin, 2008, p. 26). Haraway and Haraway (2005) contend that the most important step in conflict management involves stopping the parties from trying "to make each other wrong" (p. 12). In order to do this, Rowe and Sherlock (2005) list four strategies that nurse managers should employ in order to reduce interpersonal conflict that results in verbal abuse among health care workers. They are: increase morale by utilizing creative strategies, institute strict policies regarding abuse while encouraging nurses to report cases as soon as they occur, educate the staff on these policies, and offer mandatory counseling for those nurses who have abused others. Cox (2001) and Wright et al. (2014) come to similar conclusions. The former recommends nurse managers creating a "team-oriented culture through collegiality and collaboration" in order to reduce the chance of conflict (p. 24). Wright et al. recommend interpersonal skills training to address nursing conflict, though admit that its success is inconclusive. In a

study of doctor-nurse conflict in pediatric hospitals in Greece, Kaitelidou et al. (2011) also suggest conflict management education for nurses as well as physicians. The authors note that there are "very few courses on conflict management" available in the country, however (p. 577). They suggest a basic course, aimed at early resolution that focuses on "negotiation, mediation, and the use of creative problem-solving techniques" (p. 577). Education is the recommendation given by Tabak and Koprak (2007) as well. They believe that nurses need to be apprised of the significance of cooperation and collaboration as well as be taught the most effective ways to resolve conflicts. The pair also advises nursing schools to include problem solving, conflict resolution, assertive behavior, organizational theory, and relationship building as topic of discussion in their curricula. In a similar vein, Shin (2008) that communication skills training be increased in medical and nursing schools.

Frederich and Strong (2002) addressed solutions to physician-nurse conflict that arises from nurses' hesitancy to administer a physician order. They note that nurses are more apt to use proactive conflict styles when they perceive the physician as typically managing nurse-physician conflict by integrating, compromise, or obliging, which are other-oriented styles. Nurses will tend to use avoidance to manage conflicts if they believe the physician is apt to respond to conflict by dominating or avoiding, which are self-oriented styles. The authors suggest that a discussion needs to occur when a nurse is either unclear or uncomfortable with a physician order. Training and development could help physicians with their active listening skills (to know when and how to listen) and help nurses communicate more assertively and effectively. They advise role-playing for the parties to understand how physicians can dominate without even realizing it and that nurses concede with the same lack of realization.

Ogbimi and Adebamowo (2006) reveal a more unique idea to help resolve the problems of physician-nurse conflict. They suggest that it is important to recruit more females in medical education and more males in the nursing field in Nigeria. The authors posit that by doing so, there will be "reduce[d] gender-role perception based conflicts and enhance[d] nurses-doctors working relationships" (p. 4).

DISCUSSION

Though workplace conflict can be positive, research indicates that prolonged, unresolved conflict is dysfunctional and can "hinder organizational performance" (Kreitner &

Kinicki, 2010, p. 375). Positive health care conflict is generally short-lived and can serve to generate ideas for needed change, aid in fostering cohesion, and improve relationships and the organization. Since negative, dysfunctional conflict among direct patient contact health care workers has the potential to harm the health care organization, it is helpful to reveal more about the topic.

This literature review applied Kreitner and Kinicki's antecedents for conflict to the health care conflict literature. Personality, value, and expectation differences often spur interpersonal conflict between health care workers. Employees' individuality can and does spark controversies. Blurred job boundaries and decision-making disagreements, especially those between advanced nurse practitioners and physicians, are problematic and conflict inducing. Just as inter-professional competition such as nurse practitioners and physicians occurs, so does interdepartmental competition. This antagonism prompts conflict. Communication, whether verbal, non-verbal, or lacking, can result in negative conflict. Battling for resources and the complexity of the organization are also antecedents of health care conflict on the macro level.

While functional conflict can help an organization make necessary changes, dysfunctional conflict bears negative results. It can lead to medical errors, job dissatisfaction, stress, psychosomatic illnesses, stress, decreased productivity, poor employee retention, and lack of collaboration. In order to mitigate these effects, education about different styles of dealing with conflict and conflict resolution processes is recommended.

LIMITATIONS AND FURTHER RESEARCH NEEDS

Many studies discussed in this literature review were limited in that the findings were self-reported. Future studies that included observation and interviews would considerably add to the body of knowledge (Guidroz et al., 2012; Leever et al., 2010; Rowe & Sherlock, 2005; Tabak & Koprak, 2007). There remains a large gap in the literature regarding health care professionals' conflict resolution training. A longitudinal study of conflict pre and post training would be helpful. Also recommended is a study that compares the prevalence of conflict between nurse practitioners and physicians in the U.S. versus countries like the U.K., where the idea of nurse autonomy is more novel.

Since allied health professionals collectively comprise the majority of the health care workforce ("Advancing," 2014),

studies using allied health care workers as participants in health care conflict research are warranted. Nurse and/or physician conflict is widely studied; however, there is a paucity of literature using allied health workers as participants. The allied health field consists of technologists, technicians, and therapists, (including physical therapists, radiologic technologists, and dental hygienists, to name a few) and is distinct from the medical and nursing fields ("What is," 2014).

IMPLICATIONS FOR THE HEALTH CARE WORKPLACE

The demand for health care workers is expected to significantly increase. The growth in the health care job market has twofold causes. First, the PPACA allows for more Americans to receive health coverage, therefore expected to increase the amount of patients in health care facilities. Second, the aging baby boomer generation will start to experience health decline and thus require more frequent health care visits. In order to retain the employees in the health care field, attention to their job satisfaction is necessary. Frequent, prolonged dysfunctional conflict adds stress to health care workers and quick resolution will help motivate them to retain their positions.

CONCLUSIONS

The purpose of this literature review included providing an overview of the antecedents and effects of conflict among direct patient contact health care workers and examining the management and resolution of dysfunctional such conflict. The vast majority of literature involves studies of nurse and physician-nurse conflict. Collectively, the studies suggested that antecedents of conflict include personality differences (Almost, Doran, Hall, & Spence Laschinger, 2010; Jha & Jha, 2010), value differences (Frederich, Strong, and von Gunten, 2002), blurred job boundaries (Bonner & Walker, 2004; Jameson, 2003; Kaitelidou et al., 2012; Norris & Melby, 2006; Wright et al., 2014), battling for limited resources (Tomajan, 2012), decision-making (Coombs, 2003; Dougan & Mulkey, 1996; LeTourneau, 2004; Van Yperen et al., 2000; Wright et al., 2014), communication (Almost, 2006, Duddle & Boughton, 2007; Johnson, 2009; Rosenstein, 2009; Warner, 2001), interdepartmental competition (Brown et al., 2011; Cochran & White, 1981; Dougan & Mulkey, 1996), expectations (Johnson, 2009; Leever et al., 2010; Rowe & Sherlock, 2005; Wright et al., 2014), complex organizations (Bishop & Molzahn, 2004; Chipps et al., 2013; Haraway & Haraway, 2005; Rowe & Sherlock, 2005; Warner, 2001), and unresolved or repressed

conflict (Jameson, 2003; Wright et al., 2014).

Though positive outcomes sometimes result (Almost, 2006; Haraway & Haraway, 2005), negative effects of health care worker conflict include patient impact (Haraway & Haraway, 2005; Johnson, 2009; Phillips, 2008; Rowe & Sherlock, 2005; Thrall, 2000), job satisfaction (Almost, 2006; Cox, 2001, 2003, Jameson, 2003; Rowe & Sherlock, 2005; Tabak & Koprak, 2007), impact on the individual (Almost, 2006; Berman-Kishony, 2011; Forte, 1997; Johnson, 2009; Kelly, 2006), collaborative efforts (Almost, 2006; Leever et al., 2010; Forte 1997; Rowe & Sherlock, 2005; Tabak & Koprak, 2007), and cost (Almost, 2006; Haraway & Haraway, 2005; Rowe & Sherlock, 2005).

Though elimination of dysfunctional conflict in the health care field is impossible, proper management of such conflict is feasible. Managers should keep themselves aware of the work dynamics and address negative conflict as soon as it is recognized. Education is advisable so that health care workers can learn effective conflict resolution techniques.

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