

EDUCATION AND LEARNING

Conflict management: a primer for doctors in training

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Conflict in the health arena is a growing concern and is well recognised for doctors in training. Its most extreme expression, workplace violence is on the increase. There is evidence that many conflicts remain unsatisfactorily resolved or unresolved, and result in ongoing issues for staff morale. This paper describes the nature of conflict in the health care system and identifies the difference between conflict and disagreement. Using a conflict resolution model, strategies for dealing with conflict as it arises are explored and tips are provided on how to effectively manage conflict to a satisfactory resolution for all parties.

It is widely recognised that human interactions have the potential to develop conflict.¹ The situation in health care is not different. In its most extreme expression, workplace violence is also well recognised as an area of concern for doctors in training.² In a study that sought to identify the range of work related conflicts experienced by doctors, disagreements between residents and attending physicians, patients or families, and other residents were cited as important area of concern.³ Many of the conflicts mentioned in the study were aggravated by the hierarchical structures implicit in residency training.³

There is evidence that many of these conflicts remain unsatisfactorily resolved or unresolved and result in ongoing issues for staff morale. In a study of family medicine residents, role conflict was negatively associated with satisfaction.⁵ While recognised as an important aspect of competence in clinical communication, little work has been done to address this issue. As recently as 2002, consensus meetings to determine standards of communication skills for the vocational training of doctors did no more than identify this proficiency as an area for further study.⁶ In practice, interpersonal competence for physicians is usually obtained through a hidden curriculum of on the job training, or not at all.⁷

This paper uses a series of exercises and case studies to assist individuals and groups of doctors in training to recognise and manage situations involving conflict. Through understanding the elements of conflict and mastering the processes associated with managing conflict to resolution, doctors will be able to more effectively deal with the conflicts that arise in their workplaces.

WHAT IS CONFLICT?

Conflict can be defined as a disagreement within oneself or between people that causes harm or has the potential to cause harm. There is some confusion between the definitions of conflict and disagreement. Disagreement may be a precursor to conflict. However, expressing a different opinion does always lead to a situation where damage can occur. Underlying factors usually precipitate the transition from a disagreement to a conflict. These can include differences in:

ideas, perspectives, priorities, preferences, beliefs, values, and goals.⁸ Organisational structures can also contribute.

A range of misconceptions about conflict exist. They centre on the notion that conflict is immutable. For example, that harmony is “normal” and conflict is “abnormal” or that conflict is the result of “personality problems”. These fixed ideas are often a barrier to resolving conflicts.

CONFLICT CASE STUDY

The resident: You have been newly assigned as the medical resident on the gastroenterological surgical team. You attended a handover session from the outgoing resident whom you are replacing. He went through all your tasks in meticulous detail and you took copious notes. The outgoing resident assures you that the registrar and consultant have always been supportive to him. He suggests if you have any questions, you should ask the registrar. During the first few weeks on this rotation, you want to double check everything you do with the registrar, just to make sure you are getting everything right. The registrar is always unavailable and says he is “too busy, but you seem to be going just fine”.

The registrar: You always hate the changing rotations. It means more work for you as the residents get up to speed. This time you are happy though because the new resident has a lot of experience in gastroenterology and it should make the transition easier. However, during the first few weeks of this rotation, you feel the resident is insecure and too demanding of your time.

The consultant: You thought everything was going well when the registrar and resident seemed to be getting along at the start of the new term. So you can't understand why the ward staff have now started to complain about them. They both seem very nice and pleasant people to you, but apparently the registrar is upsetting other staff by the dismissive way he talks to the resident. You decide to ask the human resources department of the hospital for advice.

WHAT IS THE NATURAL HISTORY OF CONFLICT?

A conflict goes through at least four phases in which thoughts and emotions interact with actions. In the first phase, one or more parties involved in the conflict will experience frustration. Frustration is a strong, imperative, and yet undirected emotion that almost always demands our rapid attention. We have to find a cause.

Conceptualisation of the cause is often the second phase. This rationalisation is usually rapid and may not be accurate. The main purpose of the process is crystallising our painful thoughts and feelings into a plan of action.

Phase three represents the expression. We direct a series of behaviours at our constructed “cause”.

The conflict situation is formalised when these behaviours result in a series of destructive outcomes in phase four.

In his book *The 7 Habits of Highly Effective People* Steven Covey describes this process in detail and suggests that while the stressors responsible for conflict may be unavoidable or inappropriately conceptualised, the behaviours and outcomes

Box 1 The escalation of conflict

- Phase one
 - Stimulus occurs
- Phase two
 - Cause is attributed
- Phase three
 - Behavioural response is directed at cause
- Phase four
 - Response results in a less than optimal outcome

can be modified by prolonging the time between phases two and three (see box 1).⁹

In the case study, there is a stimulus for conflict every time the staff rotates. The cause of the conflict will be attributed differently by the each of the players.

Less than optimal responses arise when this conflict precipitates other conflicts in the ward and the situation escalates.

EXERCISE ONE

Identify a conflict situation that you experienced recently at work. What was the stimulus?

In medical practice there are a range of common sources of conflict. Differences between people can result from diversity of values, skills, priorities. Prohibitive environments and organisational structures can also play a part. Some examples are given in box 2.

In the case study a number of these sources come into play. There are clearly issues with communication skills and value systems. The organisational framework has resulted in a less than optimal resolution with the consultant assuming responsibility for resolving this conflict.

Using your example, make a note of what differences caused the disagreement. Describe the phases of the conflict and whether it involved differences of values, skills, priorities, or organisational structures.

WHAT CAN ACCELERATE CONFLICT?

Some authors suggest that role and identity issues act in consort to accelerate the intensity of conflict for physicians.¹¹ Performance, function, and process factors are frequently the determinants of role conflict.¹² Differing goals and individual differences, problems with communication and feedback, power and rivalry, lack of support and collegiality, and the absence of role modelling and expertise can all contribute in the long term.¹³

Identity conflict is of a more personal nature. It arises when there is a mismatch between the insights physicians have of themselves and others and vice versa. While both play a part, it is not clear whether role or identity is more significant in hastening conflicts. In a study of residents, over one quarter stated that they had been required to do something during the year that they believed was immoral, unethical, or personally unacceptable.¹⁴

HANDLING CONFLICT: FOUR MAIN WAYS

The recognition that conflict is a part of every day life and not a rare occurrence means that mastering effective conflict management strategies is essential for all of us. The ways we are taught in medical school to deal with conflict with patients may not be suitable for other conflict circumstances. In dealing with our patients we are in a position of power and

Box 2 Common sources of conflict for physicians¹⁰

- Information mismatch:
 - “The results you gave me were for the wrong patient” (skills)
- Inadequate information:
 - “I don’t have the patient notes in front of me” (organisation)
- Information overload:
 - “The patient has three large files!” (organisation)
- Ambiguous jurisdictions:
 - “I don’t know who has the sign off on that issue.” (prohibitive environments)
- Ambiguous instructions:
 - “The duty registrar told me not to do that” (skills and environment)
- Communication barriers:
 - “They never return phone calls.” (skills)
- Unresolved prior conflicts:
 - “We always have a problem with the trust about the final report.” (priorities) Over dependency of one party:
 - “We will have to wait until our budget is handed down.” (priorities)

knowledge that gives us a degree of control. This is not always the case; junior doctors in training have few opportunities, if any, to feel in control of their hospital work.

There are four main ways to deal with conflict (see fig 1):

- Avoidance or denying the existence of conflict;
- Accommodation or letting the other party totally decide;
- Competition or aggressively pursuing ways to achieve your win; and,
- Collaboration or actively looking after your own interests but not losing sight of the interest of others.

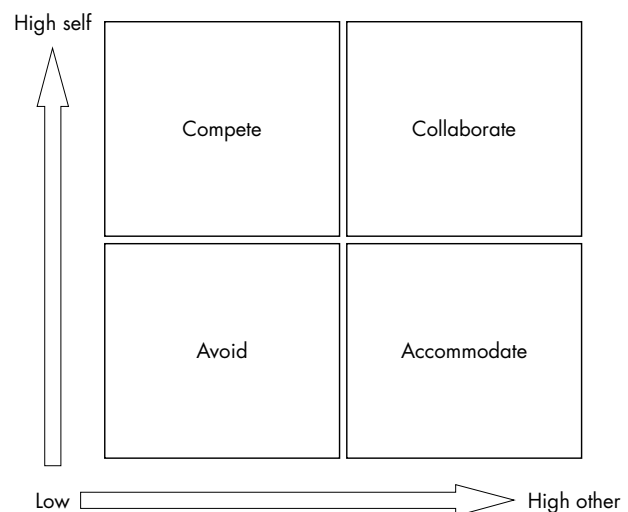


Figure 1 Ways of handling conflict.

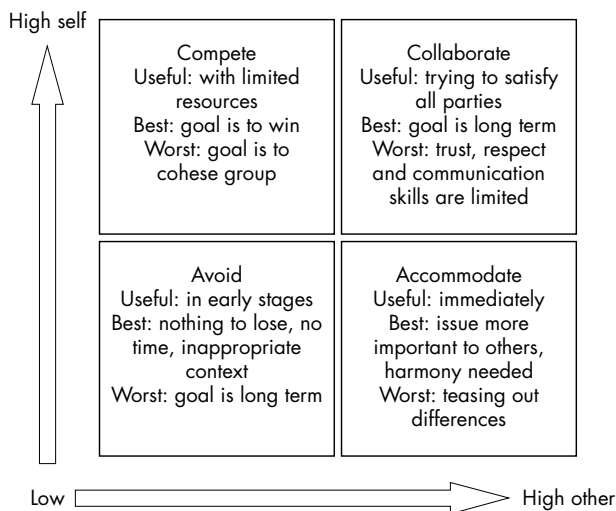


Figure 2 Comparing ways of handling conflict.

Avoiding a conflict usually involves no declaration or statement from one of the parties to the other and therefore no cooperation from the other party is sought or gained. It is useful as a short term strategy when there is a lot of “heat” in the situation, but rarely works to achieve long term change.

In the case study, the responsibility for the management of this conflict has been appropriated by the consultant who reassigns it to the human resources department of the hospital. The strategy is one of avoidance. The consultant just wants someone else to work to make the problem to go away. A temporary worker in the ward would see no advantage in a prolonged negotiation and may seek to avoid the conflict for as long as possible.

Accommodating someone else’s point of view places the emphasis on achieving the other party’s desired outcome. It is often seen as a “female” way of doing things. Like avoidance, it is expedient; but accesion is unlikely to result in a successful strategy in the long term because the accommodating party’s needs may never be exposed.

In the case study, the resident, as temporary worker in the ward, would see no advantage in a prolonged negotiation, so she has chosen to accommodate the person she sees as her direct superior, the registrar.

Competing is another conflict management strategy that entails little, if any, cooperation. It is similar to any contest where the goal is not to work with other parties but to win. Where outcomes are most important and resources are limited, rivalry is often seen as the best strategy by a potential victor. Obviously, contest works against any attempts to cohes a group or forge an alliance with someone. It is often interpreted as a “male” way of doing things.

In the case study, the problem can be viewed as a competition between the registrar’s time against the values with the ward staff who are asserting their view.

Collaboration is by far the most time consuming conflict management strategy. The process of trying to satisfy all parties can also be very draining of energy and other resources. While best suited as a strategy to effect sustainable change, it may be of limited use where the parties have longstanding mistrust or limited capacity to communicate in-depth with each other.

In the case study, by involving human resources, the consultant may hope to do more than just avoidance, rather to enlist their skills in negotiating a more enduring resolution.

Each technique entails a different level of assertion and cooperation. The use of each technique had its advantages and disadvantages and no one technique is best for all

situations. Figure 2 outlines the unique features of each method and highlights when each technique is most and least useful.

In your example, describe the way you handled your conflict. How did others handle it?

OUTCOMES OF CONFLICT

In the ideal situation, achieving a win for you and for the other party is the most effective outcome when viewed from both perspectives. Other end points at best will only favour one party; at worst nether. The fourth phase of conflict involving the outcome can either be constructive or destructive.

In constructive conflict:

- Growth occurs
- Problems are resolved
- Groups are unified
- Productivity is increased
- Commitment is increased.

Unsatisfactorily resolved conflict is generally destructive and:

- Negativism results
- Resolutions diminish
- Groups divide
- Productivity decreases
- Satisfaction is decreased.

In the case study, evidence of constructive outcomes of the conflict may include a negotiated understanding between the resident, registrar, consultant and other ward staff.

WORKING TOWARDS POSITIVE OUTCOMES

While conflict cannot always be avoided, much work can be done to minimise its destructive effects and maximise the constructive outcomes. Preparation for post-conflict interactions is essential. Use goal setting techniques to ensure that your goals are short term and flexible enough to keep a dialogue open with the other party.

Remind yourself of the background behind the conflict: how it occurred and why. Often these factors pre-date the actual event. You should be aware of the “worst and best case scenarios” and what you are prepared to accept. Rehearsing the negotiating process with a friend or colleague can help tease out the options.

The timing, setting, and who is in attendance is also significant. While it is important to have a safe and neutral environment in which to negotiate a solution, removing the discussion from the setting in which it occurred or allowing the negotiation to be run by a third party can also have pitfalls.

In the case study, relying on an human resources person to manage a conflict, no matter how skilled, will not achieve a satisfactory end-result unless the stakeholders are fully engaged in the process. It is akin to dealing with symptoms without treating the underlying problem. Effective conflict resolution depends on the degree of resonance between the subsequent actions of the various participants.¹⁰

Positive outcomes of this conflict could include: a renewed commitment by the consultant to review human resources policies on the management of staff with his team in the induction period for new staff; scheduled updating process on a regular basis; commitment by the registrar to modify his behaviour; and a timely review of the practices put in place to assess whether they have improved outcomes in the ward.

Box 3 Some tips

Preparation

- Set realistic goals and prepare to be flexible.
- Revisit the circumstances behind the conflict.
- Rehearse your interactions.
- Schedule specific start and finish times for the meetings.
- Find a neutral ground for holding the meeting.
- Minimise distractions.
- Ensure break-out spaces for all.

Interaction

- Agree on the rules of engagement at the beginning. For example, use a third party to outline critical issues and external influences. Establish a time frame, if possible, for resolution.
- Allow each participant to say what would satisfy them.
- Define common ground for agreement, for example, good patient care.
- Delineate disagreement, for example unresolved differences, clarify lingering ambiguities.
- Identify and try to expand on small agreements.
- Avoid communication freezers, for example, negative personal comments or interjections

Follow up interactions or summation

- Highlight points of agreement and progress.
- Develop and agree on a work plan for working on issues. Clarify rules and tasks for participants.
- Work at reframing continuing issues in a more palatable way.

Prevention

- Best of all—try to prevent conflict occurring.

In your example, describe the outcomes achieved? Were they constructive or destructive or both?

CONFLICT NEGOTIATION STRATEGIES

Effective conflict management entails the recognition that in modern health care, differences and conflicts are always present.^{16, 17} A range of strategies that can assist in the preparing oneself to successfully manage a conflict are listed in box 3.

CONCLUSION

When involved in a conflict, a doctor should be able to assess the situation and employ skills and processes that move the conflict dynamic towards a positive outcome for themselves and others involved.

Despite our best efforts, some structural conflicts, such as those that exist between different health care providers,

cannot be resolved by just a personal approach. Structural change must occur. Differences in perception, identity, and role between professional groups can be the source of continuing conflicts within a health care organisation. The resolution of these problems will require a broader approach.

While the diversity of people involved in the delivery of health care services may create opportunities for conflict, the shared common vocation of effectively meeting patients' needs provides a solid, ethical basis for conflict resolution.

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