



Preventing and Managing Conflict: Vital Pieces in the Patient Safety Puzzle

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INTRODUCTION

A common theme in the recent patient safety reports *To Err is Human and Crossing the Quality Chasm* (IOM 2000 and 2001) and the Canadian Adverse Events Study (Baker and Norton 2004) is the need for healthcare organizations to create a culture of safety. However, as Lucian Leape (2004) has noted, it is an axiom still much in need of being adopted because the predominating culture of most healthcare organizations is not one of safety but of fear. Healthcare professionals fear litigation, professional discipline and coroner's inquests. Patients fear becoming one of the statistics of the unsafe system that they hear about in the media. Administrators fear bad publicity, lawsuits and increased insurance premiums. What this really means is that people fear being blamed and punished for making a mistake, and most of all they fear being seen as incompetent. Unlike the popular television show, this "Fear Factor" has no winner at the end, but only losers; losers in the form of healthcare professionals, administrators and most of all patients.

Fear creates anxiety and mistrust, which leads to failures in communication and a lack of collaboration and teamwork (Baggs 1992; Spears 2005). The inevitable result is high levels of conflict among and between healthcare professionals. And while conflict is a daily, often hourly experience for most healthcare professionals, it is rarely acknowledged, and even more rarely dealt with. As a result, mistrust persists, anxiety grows and conflict increases, creating and perpetuating an unsafe culture.

While the experts in the field of patient safety identify the need for culture change in order to improve patient safety (Baker and Norton 2001, 2004; Reason 2000; Leape 1994), little has been written about the fact that a significant contributor to unsafe cultures is the presence of unacknowledged and unresolved conflict. In this article, we will discuss how the prevalence of conflict in healthcare organizations is a leading cause of unsafe cultures and a serious threat to patient safety. We will illustrate how training and education in conflict resolution can provide healthcare professionals with skills to help them deal with the workplace conflicts that they face and in turn allow them to provide a safer environment for patients.

A CULTURE OF FEAR IS A CULTURE OF CONFLICT

As healthcare conflict specialists, the authors have experienced firsthand the reluctance of healthcare professionals, administrators and clients to acknowledge and admit that unresolved conflict is pervasive in today's healthcare system. Healthcare professionals are not alone in avoiding conflict; most people fear conflict and do their best to keep out of and away from it, despite the fact that conflict is an inevitable factor in our daily personal and professional lives.

Conflict is a normal result of interacting with our fellow humans. And yet most of us have never learned how to prevent it, keep it from escalating when it starts, or manage it when it develops. Most of us are loath to admit we are in the middle

of conflict. We suggest that we are having a “discussion” or a “disagreement” or a “difficult situation.” Many of our clients in healthcare facilities are quite prepared to hire us to facilitate meetings, or assist with teambuilding or work on organizational strategic planning. Few are willing to admit that they need help in managing the conflict within their organizations.

As Mayer (2000) suggests, “to say that we are in conflict is to admit a failure and to acknowledge the existence of a situation we consider hopeless.” This attitude towards conflict is remarkably similar to the attitude towards the need to improve patient safety. If we accept the findings of the IOM reports and those of the Canadian Adverse Events study, the situation can seem hopeless and unsolvable. Healthcare professionals feel they are being judged as failures and may respond by questioning the accuracy of the findings (Leape 2004). However, conflict and patient safety issues do not improve through avoidance and denial; in fact they escalate and get worse.

ments lead to an increase in errors, and we also know that positive working relationships within healthcare teams has a significant effect on the safety and efficacy of the care given to patients (Dekker 2001; IOM 2001; Kritek 2002; Spears 2005).

We have ample and longstanding evidence of the importance of communication, collaboration and respect among healthcare team members as a vital component contributing to providing safe quality care to patients (Baggs 1992). Yet healthcare professionals have little or no training in or understanding of the factors that can help to prevent and manage conflict. Healthcare facilities do not routinely include conflict management as a required competency when hiring staff. An understanding of the uniqueness of healthcare organizations may assist in bringing this issue to a state of greater attention and awareness.

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FEAR AND CONFLICT: SAFETY ENEMIES

In this climate of fear, doctors and nurses are loath to report their errors or even their close calls. And patient care suffers not only because of error, but because of what healthcare professionals do or do not do as a result of fear. In a recent study, 51% of physicians believe that as a result of medical malpractice fears their ability to care for patients has gotten worse (Common Good 2002). Nearly half (43%) of all nurses also feel prohibited or discouraged from doing what they think is right for the patient because of rules or protocols set up for legal liability protection. Only one-fourth or fewer of physicians, nurses and hospital administrators think that their colleagues are very comfortable discussing adverse events or uncertainty about proper treatment with them (Common Good 2002).

Other research has shown that organizational and individual barriers to communication creates under reporting and self-blame as a response to error rather than system improvement (Arndt 1994; Spears 2005). Fear creates shame, which leads to silence and missed opportunities for learning, change and improvement.

All of this unspoken fear and anxiety creates an environment of disarray and dysfunction. This dysfunctional state leads to conflict within disciplines, between teams and between clients and care providers. We know that poor-quality work environ-

HEALTHCARE: A UNIQUE AND COMPLEX SYSTEM

Patients and providers alike have no trouble understanding that healthcare service delivery is a complex multilevel system. There are a number of characteristics in the healthcare system that help to generate misunderstandings and disputes:

- Healthcare is a classic example of a complex adaptive system (CAS). Such systems are prone to generate errors on a regular basis; they are also capable of achieving innovation if the correct conditions are created.
- Within healthcare, misunderstandings and conflict usually involve several distinct parties and occur at multiple levels at the same time.
- The healthcare system involves the wide disparity of knowledge, power and control experienced by the various players. While most conflicts involve some disparity between parties, it is unusual for this to be as markedly institutionalized, as is the case in healthcare.
- The ethnic diversity of both consumers and providers of healthcare services in many communities is striking and can generate potential barriers to helping parties create solutions.
- Strong gender inequities remain in healthcare in terms of the services offered to patients, the research done, opportunities for staff and the diversity (or lack thereof) within provider groups.

- Healthcare involves people interacting with other people to repair and preserve the health and personal integrity of patients. Often this involves issues about which people may have strongly held personal or religious values that may seem to be, and often are, irreconcilable.

All of these factors combine to make healthcare environments particularly prone to conflict. It is therefore important for healthcare professionals and administrators to understand the origins of conflict and to develop strategies to manage the conflicts that they will experience.

WHAT WILL HELP?

The rapid development of the patient safety field in the last 15 years has yielded several useful insights that are gradually being translated into practical guidance for clinical providers and healthcare systems designers. One of these insights concerns the use of rapid cycle improvement techniques (PDSA cycle) and the application of various techniques that have been shown to assist clinicians in making it easy to do the right thing and hard to do the wrong thing. These include interventions such as forcing functions, direct and indirect constraints, process standardization and simplification, building in redundancy factors, effective communication training (SBAR being one of the examples often cited), and team resource management training, to name only some of the most tried and true (Leonard, Frankel et al. 2004).

While it is useful to have validated techniques that will concretely reduce unnecessary patient deaths and injuries, it is also useful to appreciate the extent to which unresolved conflict contributes to the many factors which create traps and hazards for healthcare providers and lead to undesired patient outcomes. It is our thesis that having a better understanding of conflict in healthcare and the ways in which it can be successfully prevented, managed and when necessary resolved, will lead to significant further improvement in the safer delivery of healthcare services.

Case Example

A 57-year-old school teacher had a longstanding complex nevus on her shoulder. Changes in the nevus led to concerns that it might be undergoing melanomatous transformation. She elected to have the resection done under regional scalene block due to previous difficulties with general anaesthetic. She was very anxious to have it dealt with, as her favourite niece was being married in two months.

She was on no medications and had no known allergies. She was taken to the OR for a scalene block and was fully conscious. Anaesthetist A was an expert with regional blocks. Nurse B was his direct assistant and had worked with him for many years. They had a comfortable bantering relationship. Other nurses found him difficult to deal with. This was the experience of Nurse C, who was circulating in the OR. Nurse C had found Anaesthetist

A to be very brittle and unwelcoming of questions or suggestions.

B had already begun the initial prep of the left shoulder when A entered the OR. They had been discussing the recent PGA tour results. C was concerned that the block was being done on the contra-lateral side to the lesion. When he (C) tried to raise this concern, first with B (“Are you sure you want to start the prep on the left side?”) and then with A (“I didn’t realize that a scalene block would work when started....”), he was abruptly interrupted by A (“I’ll explain this to you after the surgery – interruptions are not helpful when we are working.”).

The scalene block was successfully completed on the wrong side. The patient was very upset to learn that the procedure would have to be postponed for several weeks, as the OR was descheduling procedures for the summer break.

This example points out how unresolved conflict can lead to an adverse patient outcome. It illustrates the need for positive communication between colleagues and effective collaboration amongst team members. A patient safety review of the incident might conclude that it reflects a “loss of situational awareness” that needs to be addressed. In addition, such a review might also recommend structured communication training for all parties or team resource management workshops for staff in the OR as well as making “time-outs” or safety huddles mandatory in the OR prior to procedures.

On the other hand, a conflict management review of the example might ask the simple question. “Were all the necessary parties present and involved in the process?” The case is a vivid example of how noncollaborative teams with poor communication skills create the conditions for adverse events to occur. It also clearly demonstrates how vitally important it is to connect with the patient and include her in the process; if she had only been consulted, they could have averted a negative outcome. We will discuss these elements of conflict prevention and management below. We will also outline the steps that organizations need to take in order to design and implement conflict management processes.

CONFLICT-RESOLUTION SKILLS AS PATIENT SAFETY TOOLS

Simple conflict-resolution skills such as structured communication and collaboration as well as more formal processes such as mediation are being used to resolve conflict in a wide range of formal and informal manners. These conflict-resolution skills and processes have been used in many domains, including business, legal affairs, neighbourhood disputes, international conflict, national policy discussions, and aboriginal claims, to name just a few. In fact, court-based processes such as litigation and binding arbitration are more the exception than the rule when it comes to problem-solving. It is finally becoming evident that the best way to resolve difficulties is for the parties involved to get together and talk through their issues.

The use of alternative processes in the healthcare field is relatively new. Many healthcare organizations are still using hierarchical, legalistic and punitive-based approaches at the same time that their vision statements declare their commitment to open communication, collaboration and patient involvement.

Lack of awareness may partly explain healthcare's slow acceptance of alternative conflict-resolution processes. As well, it may also be the case that traditional legalistic and adversarial approaches are seen as more appropriate in this area due to a widespread fear of and desire to avoid litigation. While people fear retaliation and legal action if they are open about errors, in our experience this fear is exaggerated and misplaced. Many professionals in healthcare are realizing that open and honest dialogue is preferable to secrecy and that positive communication produces favourable results for both patients and caregivers.

EFFECTIVE COMMUNICATION AND COLLABORATION

As Mayer (2000) has noted, "Communication is at the heart of conflict and resolution." Conflict often arises from ineffective communication; effective or assisted communication and positive collaboration promotes successful resolution of differences. Numerous studies have highlighted the connection between poor communication and failures to collaborate as contributors to adverse outcomes as well as affecting staff morale and staff retention.

In a study of communication among ICU clinicians, Baggs (1992) and colleagues examined the association between nurse-physician collaboration and patient outcomes. Negative outcomes were defined as death or ICU readmission. Three hospital ICUs were compared. At the time of patient discharge from one of these units, questionnaires were completed to assess the extent to which decision-making had been a shared or collaborative process. The risk of negative outcome decreased from 16% of cases when the decision-making was felt to be noncollaborative to 5% when the nurses reported a collaborative process. Working collaboratively seemed to have a major impact (more than threefold decrease in risk) on patient outcomes.

In another study (Sutcliffe et al. 1999), a sample of 26 residents stratified by medical specialty, year of residency and gender was randomly selected from a population of 85 residents at a 600-bed U.S. teaching hospital. The study design involved face-to-face interviews with the residents about their routine work environments and activities, the medical mishaps in which they recently had been involved and a description of both the individual and organizational contributory factors.

Residents reported a total of 70 mishap incidents. Aspects of "communication" and "patient management" were the two most commonly cited contributing factors. Residents described themselves as embedded in a complex network of relationships,

playing a pivotal role in patient management vis-à-vis other medical staff and healthcare providers from within the hospital and from the community. Recurring patterns of communication difficulties occur within these relationships and were associated with the occurrence of medical mishaps.

The study concluded that the occurrence of everyday medical mishaps is associated with faulty communication; but poor communication is not simply the result of poor transmission or exchange of information. Communication failures are far more complex and relate to hierarchical differences, concerns with upward influence, conflicting roles and role ambiguity, and interpersonal power and conflict.

A review undertaken by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reported that the root cause of more than 65% of reported sentinel events ("unanticipated events that result in death, injury, or permanent loss of function") in the period 1995–2004 (more than 2,900 cases reported) was directly attributable to a problem of communication (JCAHO website).

Finally, Thomas (2003) surveyed 320 nurses and physicians in eight nonsurgical ICUs in Texas. The outcome showed considerable discrepancies in the two groups' perceptions of the quality of "interprofessional communication." While 73% of physicians reported that the quality of collaboration was high or very high, only 33% of nurses responded in kind. Compared with physicians, nurses were more likely to report that disagreements weren't resolved appropriately, that their input was poorly received, and that they found it difficult to assert themselves.

These studies highlight the fact that effective communication and collaboration are not merely about addressing techniques, or being a better listener, or a good team player, but rather that these skills and attitudes are a crucial part of the larger issue of culture. If the culture is one in which hierarchy is maintained, power gradients are not dealt with and conflict is not acknowledged and managed, no amount of communication skills training or teamwork workshops will be helpful.

CONNECTION: ENSURING THE RIGHT PARTIES ARE AT THE TABLE

One of the fundamental tenets of conflict resolution is ensuring that the right people are involved in any attempt at problem-solving (Fisher and Ury 1981; Moore 1996). This is reflected in the questions, "Who should be at the table? Who is affected by and involved in this problem? And how do we get them to buy into the process?" Usually it is readily apparent who the parties to the dispute are. However, there are also situations in which there are powerful players behind the scenes who are integral to a resolution, yet are not officially at the table. In addition, there is the problem of the so-called "weak or invisible players" who are being excluded from participating at the table. Patients are still not routinely included in healthcare decision-making,

patient safety initiatives and conflict-management processes.

The importance of getting the right parties to the table is crucial in complex multiparty situations. In our experience, most healthcare disputes are multiparty conflicts. Rare are the situations where there is one physician and one nurse in dispute. More often there are numerous physicians and nurses as well as member of administration and support staff. In disputes involving patients, there are also multiple parties such as the patient, family members, nurses, physicians, allied health workers as well as administration. Any effort to resolve conflicts in which all the appropriate parties are not present is doomed to failure.

The recommendations of IOM (1999) clearly identified the extent of patient safety challenges in the healthcare system. IOM (2001) laid out a roadmap to get us from the present situation to one in which patient safety is a core value. Among the 10 simple rules for the design of the 21st-century healthcare system are the following, which reflect patient-centred approaches.

PRESENT	FUTURE
Professional autonomy drives variability	Care is customized according to patients' needs and values
Professionals control care	The patient is the course of control
Secrecy is necessary	Transparency is necessary
Preference is given to professional roles over the system	Cooperation among clinicians is a priority
Information is a record	Knowledge and information flows freely

It almost seems as if a healthcare mediator was involved in devising these simple rules. The patient has been placed squarely at the centre of the patient safety challenge. The future design has incorporated many of the conflict-resolution principles that have been outlined above. Open, transparent communication, cooperation and patient involvement are all identified as crucial components in transforming the current system to a safer one.

HOW TO INCORPORATE CONFLICT-RESOLUTION SKILLS IN HEALTHCARE WORKPLACES

Clearly the ideas and skills discussed above can be useful in improving healthcare environments and culture. Yet organizations may still experience difficulty in putting these ideas into practice. We suggest a multifaceted approach that would include the following steps to building conflict management strength (for a detailed discussion, see Slaikeu 1992 and Slaikeu and Hasson 1998).

1. Conduct an organizational conflict assessment

- Determine how your organization deals with conflict currently. Most organizations deal with conflict through avoidance, power plays, resorting to higher authorities or less commonly by collaboration. An organization needs to determine which method or option is encouraged and rewarded. High-reliability organizations are more likely to use collaboration as the preferred problem-solving method. Organizations need to determine where they are now and where they want to be. They must also identify the current resources available to assist with culture change and decide what extra resources will be required to move towards a culture of conflict management and positive collaboration.

2. Design a conflict management system that incorporates prevention and early intervention as key components

- Staff and patients should have multiple entry points within the conflict-resolution process; that is, there should be various ways in which a problem could be handled, including direct contact between individuals, access to senior management or human resources assistance as well as identified internal conflict-resolution mentors.
- The process should be designed to have loop-backs throughout. For example, if a patient has an issue with a physician, she may wish to first discuss it with the nurse manager. The nurse manager would encourage the patient to loop-back and discuss the matter directly with the physician. If this was unsuccessful, the patient could then access an internal mediator who could bring the parties together to discuss the situation.

3. Provide training in conflict prevention and management

- To ensure that staff, management and physicians are adept at managing conflict, organizations must commit resources to train everyone in basic conflict-resolution and communication skills. This training must include opportunities for role playing and group exercises that give individuals practice in dealing with difficult situations. In addition, yearly "touch-ups" should be held so that everyone can renew their skills.
- Identify talented internal individuals who can receive additional training to act as internal conflict coaches and mediators. Maintain a roster of these individuals and ensure that their availability is widely known by staff and patients.

4. Provide ombuds services

- Identify internal individuals who can act as fair reviewers of issues that arise.
- Provide external ombuds services that can be easily accessed for those situations that can not be resolved internally.

Again this process should provide for a loop-back to the internal ombuds or conflict coaches to complete the process if the external ombuds is able to resolve some of the outstanding issues. From a purely practical point of view, smaller facilities may find an external ombuds an economically more viable solution than trying to provide this service in-house.

5. Provide external mediation services as necessary
 - A well-developed internal conflict management process should be able to handle most of the conflicts that arise. However, there will still be situations that require the assistance of trained, experienced healthcare mediators. The goal should always be that disputes will be handled internally, but people should also know that there is expert assistance available if required.

CONCLUSION

Conflict resolvers are experts at listening to parties, exploring needs, reframing problems and helping the parties to devise solutions to the issues that face them. Conflict-resolution specialists are adept at helping to resolve a myriad of disputes such as family matters, business issues, neighbourhood disputes, landlord-tenant issues and even criminal matters. Conflict-resolution skills are perfectly suited to the healthcare field, and are easily understood and adopted by healthcare professionals once they have been explained, demonstrated and practiced.

The authors are often challenged by healthcare professionals, administrators and academics who doubt that such simple measures as effective communication, positive collaboration and the involvement of the affected parties can have any measurable effect on patient safety. Healthcare organizations resist the need to design and implement conflict-management processes and argue that there are already well-defined processes within union agreements, individual contracts or in HR policies. Conflict-management processes are not used in place of already existing contracts and policies, but as complementary additions. In many instances, conflict-resolution processes allow for early resolution of issues so that other, more adversarial options are not required.

While we are clearly strong proponents of conflict-management processes, we are not suggesting that these ideas are the sole answer to the patient safety conundrum; patient safety is a complex problem that requires a multifaceted and nuanced approach. At the same time, we reject the notion that our suggestions are self-evident and easily implemented. While the conflict-resolution skills, processes and approaches that we have discussed in this article may appear simple and obvious to many, they are skills that require ongoing education, training and practice. Most people do not communicate effectively, especially when they are under stress. Collaboration is often

ignored in favour of individual decisiveness, even though such decisions may not create optimum results. And getting all the parties to the table is avoided for fear of emotional reactions and time-consuming discussions.

Most organizations do not have well-developed conflict-management systems in place, even though addressing the issue of conflict management is inherent in improving the culture of healthcare organizations. Moving away from hierarchical, secretive, blame-focused structures to create cultures of learning and openness requires all of the skills that we have discussed. High-reliability organizations have generally incorporated effective conflict-management processes and principles into their fabric and culture. Healthcare cultures that manage conflict positively and place a priority on continuing education and training in conflict resolution are equipping themselves with vital pieces to solve the patient safety puzzle.

We have not talked at all in this article about how conflict-resolution skills can be used to great advantage in difficult disclosure discussions and ethical decision-making (Dubler and Liebman 2004). Nor have we discussed the need to begin to use these skills in beginning the process of directly involving patients in devising initiatives and programs. This is a discussion for another article. Here we have clearly identified conflict management as an essential element for successful culture change within healthcare. And while these tools and processes are useful in many avenues and for many situations inside and outside of healthcare, we believe this roadmap to transformation in healthcare delivery systems is particularly useful for patient safety advocates.

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