

**Conflict Management Education in Medicine: Considerations for Curriculum Designers**

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**Conflict Management Education in Medicine: Considerations for Curriculum Designers****Abstract:**

It is important to address conflict in the medical field for a variety of reasons ranging from reducing turnover to increasing the quality of care received by patients. One way to assist with the management of medical conflict is by teaching resolution techniques to medical personnel. There is an opportunity for conflict management curriculum to address many of the issues facing physicians, administrators, staff and patients, however, it is also necessary for those developing that curriculum to understand the nature of the environment and appropriate conflict management tools to be used in that environment as part of the design process. This article outlines sources of medical conflict, conflict resolution tools appropriate for medical settings, a possible curriculum model approach for curriculum development, and some considerations for creating curriculum for the unique medical environment.

**Keywords:**

Medical conflict, conflict curriculum, conflict education, medical education, medical curriculum

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Conflict is pervasive in many work environments and medical settings face many of the same challenges from conflict. However, if medical teams fail to work well together it can have devastating consequences for patients such as increased length of hospital stays and increased patient mortality (Lee, Berger, Awad, Brandt, Martinez, & Brunnicardi, 2008). The connection between adverse patient outcomes and medical conflict suggests a need for curriculum on appropriate conflict resolution tools for medical personnel as one way to create a collaborative working environment. Curriculum designers need to understand the unique

nature of the medical setting and various sources of conflict to best create training programs for medical staff, physicians, and administration. This article outlines sources of medical conflict, conflict resolution tools appropriate for medical settings, a possible curriculum model approach for curriculum development, and some considerations for creating curriculum for the unique medical environment.

### **Sources of Medical Conflict**

When people interact in decision-making situations there is a potential for conflict and the more people involved in the process the greater the chance that conflict may arise. Considering the many individuals that are involved in the innumerable decisions that have to be made each day in medical settings, the severe time constraints common to that environment, the power inequities between various medical personnel, and the magnitude of the decisions being made, medical conflict on some level becomes inevitable. In some cases it is the nature of the stress associated with a department that can create challenges to effective communication and lead to conflict (Marco & Smith, 2002). Medical environments provide only limited options for managing disputes as they arise, potentially leaving conflicts unresolved and productive relationships in jeopardy. Curriculum designers and educators do not need to look far for opportunities to provide interventions that address conflict in medicine. Likewise the need is evident considering interprofessional conflict is part of the equation that leads to significant medical errors and adverse patient outcomes among medical residents (Baldwin & Daugherty, 2008).

Prior to developing curriculum it is important to understand the culture and potential sources of conflict of the medical field. Beginning the investigation requires a working definition of conflict, which can be somewhat problematic since the perceptions of conflict can be positive or negative. At one end of the spectrum are those who believe that conflict is

not only inevitable but beneficial (Thomas, Jamieson, & Moore, 1978, p. 91) while others take the perspective that conflict is inherently bad and in need of continual resolution. This study will use a broad definition provided by Skjorshammer (2001) who stated, “conflict occurs when an individual or group feels negatively affected by another individual or group” (pg. 10). Jehn (1994) suggested that conflict can be categorized under the headings of either task or relationship. Where task related conflicts arise from differences of how to perform a particular job or function, relationship conflicts are more focused on personality differences and/or conflict usually accompanied by anger towards other group members (Jehn, 1994).

Deutsch (1994) offered an example of group conflict which he refers to as in-group ethnocentrism. In this phenomenon members of one group view themselves as superior based on that group membership. In the case of physicians, medical specialists and nurses this can lead to unwillingness to consider opinions from other groups due to their perceived inferiority. As mentioned in the introduction, lack of collaboration has increased the length of hospital stay and patient mortality in the Intensive Care Unit (ICU) (Lee, et al., 2008). Since patient care is expected to be the primary focus in this setting, dismissing potentially vital information is not only an element of conflict, but potentially reduces the chance of optimal patient outcomes.

Evidence of in-group ethnocentrism is not difficult to find. It is remarkably overt in the comment by one anesthesiologist who stated, “this is going to sound strange, but you could teach a chimpanzee how to give anesthesia as long as there was somebody supervising him” (Jameson, 2003, p. 571). This comment came as part of Jameson’s study of the relationship between anesthesiologists and nurse anesthesiologists and suggests a negative perception held by anesthesiologists about the value that the nurse anesthetists brings to an operating room. In this case group separation was clear. One nurse noted, “I have chosen not to socialize with them so much. Some of the anesthesiologists want more socializing. When

we have our Christmas parties and things like that it's all very friendly, but it's still separate" (Jameson, 2003, p.572). The relational gap between anesthesiologists and nurse anesthesiologists provides an example of relational conflict.

Jehn (1994) defined relational conflict as, "characterized by friction, frustration, and personality clashes within a group" (p.224). Comparing a colleague's contribution to a task as equal to that of a chimpanzee suggests, at the very least, a hasty generalization and, perhaps more appropriately, a relational conflict present in the situation. Additionally, the medical environment, which is conducive to high stress, time constraints and a host of other hindrances to effective communication (Marco and Smith, 2002) can exacerbate relational conflicts. This is true even of medical training.

According to Baldwin and Daugherty (2008):

The finding that many other variables were significantly associated with both serious interprofessional conflict and significant medical errors clearly identifies a large number of residents who in the course of their training report feeling generally stressed, abused, dissatisfied, overworked, sleep deprived, and inadequately supervised. Such findings are suggestive of a work environment that is not only highly demanding and stressful, but, at times, fragmented, disorganized, chaotic, and abusive. We suspect that both interprofessional conflict and medical errors are likely to occur more frequently under such conditions and, indeed, may be potentiated by a common set of undesirable working conditions. (p. 582)

Fatigue is an everpresent element of the medical environment. Marco and Smith (2002) refer to fatigue as "ubiquitous" and, as an example, point to the demands placed on the emergency room staff who are expected to provide quality patient care "24 hours a day, 7 days a week, including holidays" (p. 347). Baldwin and Daugherty (2008) stated that, "in an

early report involving 254 residents in internal medicine, 45% admitted making medical mistakes, with 41% of these claiming that fatigue had caused them to make their most significant medical mistake” (p. 574). In this regard, fatigue certainly seems to be an inherent component of the role of a medical professional that affects the environment, professional relationships and patient outcomes.

Some of the issues of fatigue are related to the ambiguous nature of time in the medical environment. While time has a very concrete and finite definition when looking at hours, minutes and seconds, the perception and expression of time is much more relative. Words such as “soon” and “hurry” can mean very different things to different people for example. Thus expressing, using, and defining time can lead to medical conflict as well. Skjorshammer (2001) noted that nurses and doctors have vastly different definitions of time. Nurses see time linearly to be controlled and managed while doctors relate time to tasks and prioritization. Since nurses tend to be the front line of patient care they can feel much different time pressures due to their immediate and consistent interactions with patients. Pressure from patients and patients’ families coupled with physicians’ deliberate or prolonged responses may place nurses at odds with physicians regarding the timeliness of diagnosis and treatment prescription. However, it is not only the nurses who can feel as though the system may be moving at a snail’s pace. Doctors also face conflicting definitions of time and how it should be utilized in their interactions with hospital administration. Where physicians are trained to make quick diagnoses to begin treatment, the same does not hold true for hospital administrators who may consider a “quick” decision to be one that is arrived at in only three months (Cohn, 2009). In both cases, where either the physician or nurse encountered conflicting definitions of time, power played a role in determining who ultimately got to create and control the timeframe for action, and to a degree this power led to the dispute.

Conflict can arise through situations of power inequity or ambiguity. The general belief that doctors give orders and nurses carry them out is not always accurate since nurses have sources of power available to them as well. This power may be exerted in refusing to provide care to a patient in instances when they feel their personal safety is in jeopardy or when they are morally opposed to the treatment prescribed (Frederich & Strong, 2002). This creates a potential area of dispute between nurses, doctors and even the patient or the patient's family should the nurse actually choose not to accept an assignment based on some moral conflict or fear of personal safety. Additionally it can be perceived as going counter to the system and highlights a sense of interdependence on behalf of all the parties and the power structure that is inherent in this setting (Skjorshammer, 2001). Power is also an essential element in the "forcing" style of conflict resolution. Forcing is based on the use of informal or formal power to attain one's goal (Skjorshammer, 2001). When a member of the medical team uses power as a way of forcing resolution to a conflict, it may lead to resolution, but also to additional relational conflicts in the future.

One way power manifests itself is in the ability to make decisions regarding how tasks are completed. "Task conflict is that which is characterized by disagreement that pertains to different ideas about a task and how it might be completed" (Rogers & Lingard, 2006, p. 569). The near infinite number of tasks to be completed on a daily basis within a hospital coupled with the wide range of options for completing those tasks, and situations of forced teamwork all increase the chances of task related conflicts (Lee, et al., 2008). As a member of the medical team there are also opportunities for differing perceptions of the acceptable way for the team to interact. "Physicians view themselves as members of an expert culture, so they think of teams in terms of individual contributions, much like members of a golf team compete in their own matches" (Cohn, 2009, p. 6). Discrepant views of team participation and the manner in which tasks should be completed along with concerns arising from the role

of power in decision-making will be important factors in how curriculum designers create and implement their programs.

Conflict is not isolated to arising only between medical personnel, patients themselves add an additional level of potential conflict. Kendall and Arnold (2008) suggest that physician/patient conflict may arise due to misunderstandings or the family's desire to be heard. Whether patient conflict is a result of differences in opinion from diagnoses or treatments the potential for conflict is real. As Curlin, Roach, Gorawara-Bhat, Lantos, and Chin (2005) pointed out, even patient religion is a source of conflict as it can lead to vastly divergent beliefs on the type of treatments that can be considered and how those treatments can be administered. Regardless of the reason, the nature of the potential conflict outlined above highlights the need for appropriate conflict curriculum either as part of formal medical education or medical professional development.

### **Conflict Resolution Tools and Training Impact**

There are a variety of conflict management tools that can be used to address conflict, however, the two that appear to be most appropriate to mitigate conflict informally in a medical setting would be mediation and negotiation. "Negotiation is defined as a strategy to resolve divergence of interests, real or perceived, where common interests also exist" (Anastakis, 2003, p. 74). Whether most people realize it or not, negotiation is a common occurrence in daily life. It can be as simple as negotiating with a family member as to where to eat dinner or what route to take on a trip. Because negotiations can take the form of informal discussions, it has the ability to fit within the tight time constraints of a medical environment. Mediation is a step more advanced than negotiation as it is a negotiation between two parties in dispute that is facilitated by a neutral third person. The neutral third person does not have decision making power in the negotiation and serves to facilitate the



process helping keep the parties on track, provide reality checking, and insure that the sides understand the points that are being discussed. Since this requires including an additional person as part of the process it can be more involved, but it can also help to keep emotions from becoming too explosive or problematic while creating an environment where each party has the opportunity to present their interests. In many cases neutral third parties to serve as mediators may need to come from outside the specific environment where the conflict has occurred, but the use of peer mediators in other settings suggests the potential for a similar model in medical settings.

Using negotiations to resolve conflict in the medical field is nothing new, but the literature suggests a formal approach in which the parties set a time and place to convene, prepare their positions, and then engages in the process at the appointed time. Negotiations are mentioned as a tool for career advancement or bargaining (Sarfaty, Kolb, Barnett, Szalacha, Caswell, Inui, & Carr, 2007, p. 236), however, Marco and Smith (2002) also suggest that looking at the broader application of negotiations can lead to opportunities to reduce conflict and frustration and increase the chance for creative problem solving. Considering the time constraints mentioned as a source of conflict earlier in this article, it is likely that an informal negotiation style may be better suited among medical personnel.

Conflict management education has been shown to have a positive impact in medical work settings. Haraway and Haraway (2005) studied supervisors and managers in a healthcare setting by providing two 3-hour sessions on practical conflict management and administering pre- and posttests to look for statistically significant differences in employee stress. Their study found that the intervention had a positive influence on participant attitudes on several different areas such as psychological strain and interpersonal strain (Haraway & Haraway, 2005). The participants in this study were managers and supervisors, who are expected to manage conflict as part of their professional duties, reported feeling better

equipped to perform their jobs. Physicians, nurses and other members of a medical team, however, may neither be expected nor trained to use these types of communication and resolution skills. In this way the curriculum design model of Mager and Beach (1967) may be fitting in that it directs the designer to identify the job description and task list as part of the process. This seems appropriate since the first challenge to effective training for medical personnel may be to show the relevance and value in possessing these skills as it applies to their work.

Zweibel, Goldstein, Manwaring, & Marks (2008) studied the retention of content and impact of training and found that even over time participants were found to have retained positive attitudes towards conflict and a willingness to engage in conflict management activities. Using two day workshops and confidential pre and post workshop surveys they found changes in the tone in participant responses on the surveys wherein they indicated positive aspects of conflict. Keenan, Cooke, and Hillis (1998) also found that nurses who perceive physicians as collaborative are more likely to take a collaborative approach to their role on the medical team.

The studies of Haraway (2005), Zweibal (2008), and Keenan (1998) suggest that there are benefits to offering training on conflict management related topics. These studies show a change in perception or attitude toward conflict that lead to the next natural step, which is behavioral change and this should now be the direction of future curriculum development in this field. Knowing that there is hope for attitudinal change, curriculum developers, trainers, and educators can move towards skills trainings modified specifically for application by medical personnel in a medical context.

## Curriculum Models

There are opportunities to apply curriculum models to addressing the challenge of developing either specific training or a broad based program related to conflict management. For example, developing peer mediation training for a hospital could be done using Mager's (1967) curriculum development model. One of the strengths of Mager's model is that it is instructionally focused and works for narrower applications. It also fit very well with the instructional perspective in that it begins with a job description, task analysis and identification of the audience that then feeds into developing the objectives. These would be especially critical in a medical environment as power structures could be problematic. One assumption of the model is that a job description exists for the training so a curriculum designer may be better served to suggest a DACUM (Designing A Curriculum) approach to determining specific skills and tasks that would need to be addressed.

Tyler (1949) takes a high level approach for developing curriculum and looks more at the program level rather than an instructional level. Tyler's model may be appropriate for developing a conflict education program for a hospital staff. The models high level perspective is its strength and while it does address some specifics in the sub-steps it allows the designer to stay focused on the overall objectives. In situations where a broad curriculum is needed, such as when covering the many elements of a topic like conflict this model is very fitting.

Where the model needs adjustment is in its focus on a K-12 environment. There are assumptions in the process regarding the audience and core competencies possessed by the participants. In a traditional K-12 setting these may be fair assumptions, however, in a hospital setting they are not. Using this model would require the curriculum developer to spend sufficient time in insuring that no aspects of the context of a medical setting are

overlooked. Still, the way the model helps the developer keep a broad perspective is its strength.

### **Considerations for Curriculum Design**

For those intending to provide conflict management skills education for medical personnel, some aspects of the field must be considered. While the characteristics of medical settings such as time constraints and teamwork are present in a wide array of other settings, medicine combines these characteristics in a unique blend where the ultimate product is patient health. Due to the legality surrounding such a product it is important for educators to keep these considerations in mind while designing conflict management curriculum for medical staff.

1. **Time Constraints** – Time constraints are abundant in medical settings and woven deeply into the tapestry of the field. There is a need for medical personnel to make decisions quickly to address patient needs, long hours and fatigue are a standard characteristic of the profession, and time can also be a tool to exercise one group's power over another. Keeping the issue of time in mind may result in designing a more concise training and covering specific points rather than broad topics. Developers may also want to address the issue of time itself within the curriculum. Knowing the time constraints could lead developers to design multiple, shorter interventions offered at convenient times that cover specific skills and provide a discussion of how a shortage of time affects participants on a daily basis. Tyler (1949) discussed the importance of determining learning objectives from the standpoint of a specialist. He suggested curriculum designers consider how their subject can benefit those who will not become experts in that field. As an expert the temptation may be to cover conflict management too broadly or focus too much on the theoretical

perspective. In this case determining the learning objectives as an early step will be extremely important.

2. **Behavioral Change** – As part of the conflict management, education process it is important to change perceptions of conflict, however, it is equally important to work towards changing behaviors. Building a sustainable environment of collaboration requires more than the belief that collaboration exists; it also requires evidence and modeling of skills being utilized that create and perpetuate that environment. Educators may seek to develop curriculum that leads to skills development that will support and cultivate a perception of collaboration.
3. **Power Structures** – As with most organizations, medical settings have hierarchies that need to be considered as educators suggest various techniques and tools for addressing conflict. These power structures can also be the source of the conflict that the training aims to manage. In this case it may be beneficial to begin training with participants at the upper levels of the hierarchy and work down. In the event that members of various levels are participating in the same training, power structures, and how they may affect participation, will need to be taken into account. In this way both Tyler (1949) and Mager's (1967) notions of sequencing the learning activities may be applied both to the curriculum itself and also to the order in which participants are selected to participate in the process. The preparation stage should direct the developer to identify the most appropriate approach for each specific context.
4. **Assumed Skills** – Training on mediation as a conflict resolution tool where the participants have never been taught effective communication skills may fail to have the desired effect not due to the training itself, but rather due to assumptions of skills already possessed. Due to the time constraints mentioned in point one, it may be tempting to assume some skills, such as communication, empathy or leadership, are

already possessed by participants in trainings and to therefore not address them in the curriculum. This, however, can be a mistake. Depending on the participants' specific education, the development of communication, management, and leadership skills may not have taken place. Curriculum developers may address this concern through a pre-test assessment to determine a baseline and whether or not some attention should be paid to those skills within the intervention.

5. **Legal Considerations** – As with many professional development education programs, legal concerns have to be considered. Due to the high risk of litigation in the medical field, this may be even more important to keep in mind for medical curriculum developers. Where corporate training on customer service may include coverage of effective apologies, malpractice insurers and hospital legal counsel may not approve of their medical staff being trained on how to apologize since this may be misconstrued as an admission of guilt by a patient. Understanding the specific culture of the organization and the legal implications of the content to be delivered will be a critical step in the preparation stage of the process.

## **Conclusion**

Judging from the vast array of potential catalysts to conflict within the medical field, there is certainly a need for curriculum designed specifically to prepare medical professionals not only to “deal with” conflict, but to manage it in such a way that patients are receiving the highest quality care with the fewest possible distractions. The results of research on the impact of conflict education has shown positive changes in participants perceptions of conflict and self efficacy, which suggests an opportunity for further curriculum directed at behavioral changes related to managing conflict. The unique environment of medicine provides some challenges to curriculum developers to achieve these goals, but using the preparation phase to properly investigate the medical environment in general and specifically

the organization for which the curriculum is being designed can address many of these challenges.

## References

- Anastakis, D. J. (2003). Negotiation skills for physicians. *American Journal of Surgery*, 185(1), 74-78.
- Baldwin, D., & Daugherty, S. (2008). Interprofessional conflict and medical errors: Results of a national multi-specialty survey of hospital residents in the US. *Journal of Interprofessional Care*, 22(6), 573-586. doi:10.1080/13561820802364740.
- Cohn, K. (2009, January). A Practicing Surgeon Dissects Issues in Physician-Hospital Relations. *Journal of Healthcare Management*, pp. 5-10.
- Curlin, F., Roach, C., Gorawara-Bhat, R., Lantos, J., & Chin, M. (2005). When Patients Choose Faith Over Medicine: Physician Perspectives on Religiously Related Conflict in the Medical Encounter. *Archives of Internal Medicine*, 165(1), 88-91.
- Deutsch, M. (1994). Constructive Conflict Resolution: Principles, Training, and Research. *Journal of Social Issues*, 50(1), 13-32.
- Frederich, M. E., & Strong, R. (2002). Physician-nurse conflict: can nurses refuse to carry out doctor's orders? *Journal of Palliative Medicine*, 5(1), 155-158.
- Haraway, D., & Haraway III, W. (2005). Analysis of the Effect of Conflict-Management and Resolution Training on Employee Stress at a Healthcare Organization. *Hospital Topics*, 83(4), 11-17.
- Jameson, J. (2003). Transcending Intractable Conflict in Health Care: An Exploratory Study of Communication and Conflict Management Among Anesthesia Providers. *Journal of Health Communication*, 8(6), 563-581. doi:10.1080/716100415.
- Jehn, K. (1994). Enhancing effectiveness: An investigation of advantages and disadvantages of value-based intragroup conflict. *International Journal of Conflict Management*, 5(3), 223-238. doi:10.1108/eb022744.
- Keenan, G., Cooke, R., & Hillis, S. (1998). Norms and nurse management of conflicts: Keys to understanding nurse-physician collaboration. *Research in Nursing & Health*, 21(1), 59-72. doi:10.1002/(SICI)1098-240X(199802)21:1<59::AID-NUR7>3.0.CO;2-S.
- Kendall, A. & Arnold, R. (2008). Conflict Resolution I: Careful Communication #183. *Journal of Palliative Medicine*, 11(6), 925-926.
- Lee, L., Berger, D., Awad, S., Brandt, M., Martinez, G., & Brunicardi, F. (2008). Conflict Resolution: Practical Principles for Surgeons. *World Journal of Surgery*, 32(11), 2331-2335. doi:10.1007/s00268-008-9702-x.
- Marco, C., & Smith, C. (2002). Conflict resolution in emergency medicine. *Annals Of Emergency Medicine*, 40(3), 347-349.
- Mager, R. & Beach, K. (1967). *Developing vocational instruction*. Belmont, CA: Pitman Learning Inc.



- Rogers, D., & Lingard, L. (2006). Surgeons managing conflict: a framework for understanding the challenge. *Journal Of The American College Of Surgeons*, 203(4), 568-574.
- Sarfaty, S., Kolb, D., Barnett, R., Szalacha, L., Caswell, C., Inui, T., & Carr, P. (2007). Negotiation in academic medicine: a necessary career skill. *Journal Of Women's Health (2002)*, 16(2), 235-244.
- Skjørshammer, M. (2001). Co-operation and conflict in a hospital: Interprofessional differences in perception and management of conflicts. *Journal of Interprofessional Care*, 15(1), 7-18. doi:10.1080/13561820020022837.
- Thomas, K., Jamieson, D., & Moore, R. (1978). Conflict and Collaboration: Some Concluding Observations. *California Management Review*, 21(2), 91-95.
- Tyler, R. (1949). *Basic principles of curriculum and instruction*. Chicago, IL: University of Chicago Press.
- Zweibel, E., Goldstein, R., Manwaring, J., & Marks, M. (2008). What sticks: How medical residents and academic health care faculty transfer conflict resolution training from the workshop to the workplace. *Conflict Resolution Quarterly*, 25(3), 321-350.