



A New Focus in Healthcare Conflict Research

Sara Kim*

Department of Surgery, School of Medicine, University of Washington, Seattle, USA

*Corresponding author: Sara Kim, Ph.D., Research Professor, Department of Surgery, School of Medicine, University of Washington, Seattle, WA 98195, USA, E-mail: sarakim@uw.edu

Received date: September 05, 2017; Accepted date: September 18, 2017; Published date: September 25, 2017

Copyright: © 2017 Kim S. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution and reproduction in any medium, provided the original author and source are credited.

Introduction

A scoping review of published articles that reported causes and consequences of healthcare conflicts was conducted to advance the knowledge base in this domain— a field that remains surprisingly underexplored given the evidence associating conflicts with patient care outcomes [1,2]. The purpose of the review was to identify and synthesize key triggers and impact of healthcare conflicts arise during patient care. A meta-analysis of empirical studies on intra-group conflicts in business organizations guided the conceptual framework of our scoping review, which targeted conflicts along the individual, interpersonal and organizational spectrum [3].

Grounded in the key findings from our review, the purpose of this commentary serves to highlight areas of opportunity in healthcare conflict research. First, understanding the sources of conflict among healthcare professionals requires a multifaceted inquiry into individual, interpersonal and organizational dynamics. A likely example from the patient care front can illustrate this point. An intensive care nurse and a hematology-oncology fellow may disagree over how best to care for a patient. Stabilizing the patient may be the nurse's goal; the fellow pursues another aggressive treatment. Both may want the best for the patient. Recognizing this shared goal would ideally enhance their mutual understanding. In reality, the fellow dismisses the nurse's concern during a team round, the nurse feels dismissed in front of the team and subsequently, avoids talking to the fellow and as a result, a communication breakdown between them may lead to less than optimal patient care.

This exemplifies how a disagreement incompatible expectations and wishes [4] can trigger a self-focus at the individual level (i.e. the nurse feeling devalued), power differentials at the interpersonal level (i.e. physician over nurse) and inefficient patient care workflows at the organizational level (i.e. circumnavigating direct communications). In the studies we reviewed, only 28 out of 99 addressed aspects of the multi-dimensional nature of healthcare conflict, raising the question as to whether the current approaches to examining healthcare conflicts closely reflect the complex individual, interpersonal and organizational dynamics healthcare professionals experience on a day-to-day basis.

Second, resource depletion, such as healthcare professionals' exhaustion, stress and burnout, has largely been examined as consequences of conflicts and not as potential antecedents of conflicts. Studies we reviewed predominantly used validated instruments of healthcare professionals' self-reported emotional (e.g. anxiety, depression) and physical (e.g. sleep deprivation, weight loss) health that is associated with workplace conflict. Resource depletion as a conflict trigger and not merely a consequence of conflict, was informed by a large-scale qualitative study that examined 156 conflict narratives collected from healthcare professionals [5]. This study pointed to challenges that healthcare professionals face in managing their

resource depleted selves. As a result, a routine disagreement may escalate into an emotionally charged issue, decisions are carried out in a unilateral over a collaborative manner and the relationships among them remain precarious, which can be a stepping stone for the subsequent conflict. Similarly, psychological capital, such as hope or resilience in individuals, may play a significant role in understanding healthcare conflicts [6]. Those with low psychological capital may form a different perception of a conflict situation than those with a high degree of psychological capital. The latter may less likely personalize a conflict or even approach the conflict as an opportunity to clarify goals and strengthen teamwork. Therefore, an effective or poor emotional management in face of resource depletion or low psychological capital is a promising area of future inquiry.

Third, power differentials in health care settings are ubiquitous whether it be within the same profession (e.g. attendings versus residents), across professions (e.g. nurse vs. medical assistants), or between services (e.g. surgical versus emergency medicine teams). Safety in patient care depends on the ability of the person in a lower status to speak up concerns; similarly, concerns need to be treated with respect and curiosity by the listener. In our scoping review, only seven out of 99 studies examined the role of power hierarchy a similar finding echoed in a review of interprofessional education studies, which reported a superficial treatment of power differentials in published works [7]. Few studies in our scoping review explored psychological safety [8] as an essential factor that mitigates the fear of retributions as a result of speaking up. Leaders' responsibility in establishing psychological safety among team members, especially in the presence of conflicts along the power gradient, deserves a particular attention.

This commentary highlighted three areas of gaps in the existing research: (1) lack of holistic approaches to understanding the multilayered factors involving healthcare conflicts, (2) few studies associating resource depletion and low psychological capital with conflict triggers and (3) the need to understand the role of psychological safety in healthcare power hierarchy. Paradoxically, patient care safety depends on conflicts that may help clarify protocols and standards, thereby minimizing patient harm and developing trust among team members. The current research in healthcare conflict needs a greater degree of evidence associated with the positive impact of conflicts as well as factors that degenerate routine conflicts into entrenched and chronic problems in patient care settings.

References

1. Kim S, Bochatay N, Relyea-Chew A, Buttrick E, Amdahl C (2017) Individual, interpersonal and organizational factors of healthcare conflict: A scoping review. *J Interprof Care* 31: 282-290.
2. Joint Commission (2014) Sentinel event data—Root causes by event type.

-
3. de Wit FR, Greer LL, Jehn KA (2012) The paradox of intragroup conflict: A meta-analysis. *J Appl Psychol* 97: 360-390.
 4. Boulding K (1962) *Conflict and defense. A General Theory*. New York: Harper and Row.
 5. Kim S, Buttrick E, Bohannon I, Fehr R, Frans E, et al. (2016) When focusing on the patient is complicated: Conflict narratives from the healthcare frontline. *Conflict Resolution Quarterly* 33: 255-277.
 6. Laschinger, Heather K. Spence, and Roberta Fida (2014) New nurses burnout and workplace wellbeing: The influence of authentic leadership and psychological capital. *Burnout Research* 1: 19-28.
 7. Paradis E, Whitehead CR (2015) Louder than words: Power and conflict in interprofessional education articles, 1954-2013. *Med Educ* 49: 399-407.
 8. Appelbaum NP, Dow A, Mazmanian PE, Jundt DK, Appelbaum EN (2016) The effects of power, leadership and psychological safety on resident event reporting. *Med Educ* 50: 343-350.