COGNITIVE CONFLICT

The Cure for Anger in Hospitals

Managing Conflict to Help Create Better American Hospitals

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Internal conflict can be utterly destructive to any hospital.

It can also have a positive effect when hospital leaders learn how to turn diversity of thought into innovative and collaborative decision-making.

Compare and analyze the different types of conflict and their impact upon management decision.

Evaluate how conflict can be turned into a positive factor in the collaboration among physicians, nurses, staff and administrators in a hospital setting.

- Cary D. Gutbezahl, MD
We all want what we want.

Addressing our differences can cure abuse and anger in hospitals.

Conflict arises when the needs of the organization run counter to what we want as individuals. The more complex the organization, the greater the likelihood of such dissonant behavior.

So is it any wonder that there exists a high level of conflict within American hospitals—some of the largest employers and most complex of all organizations outside the government itself?

Too often the result of conflict in our hospitals is disruptive behavior, process design failure, operational breakdown and inefficient utilization of resources. Performance breakdowns have consequences for patients, doctors, staff, and the hospital itself.

Failure to manage conflict is a leading cause of hospital inefficiency that needlessly adds cost to the healthcare system and to hospital operations. It decreases physician and staff satisfaction and has been linked as a cause of staff turnover. Furthermore, unresolved conflict is a cause of distraction that can result in poor care.

In fact, behavioral conflict is so common and has such a significant impact on hospital efficiency and safety that The Joint Commission has issued standards for dealing with professionals who create disorder. Medical centers with leaders who create teams that turn diverse input into an organizational strength will outperform peer hospitals.

The potential rewards are enormous.
When those of us who work in hospitals decide to defend our little squares of authority instead of driving the entire hospital to become better, the organization suffers. The most powerful people in the organization can create the most disruption and damage.

The work of serving patients is too important to allow self-interest to translate into a “you take care of your department and I’ll take care of mine” mentality.

Hospitals are not departments; they are living organisms comprised of many complex integrated systems—all designed to help patients get better as effectively and economically as possible.

Sadly, the three examples below will sound all too common.

Example 1: The surgeon shows up late. Everyone else was ready to operate on the patient 20 minutes earlier. The surgeon gets mad and justifies not arriving on time because the OR is always late and she has more important things to do than to sit around drinking coffee. The next operation is then off-schedule, too. And by the end of the day, the last operation is significantly delayed, overtime is rampant, and no one is happy – including the surgeons and patients.

Example 2: A Chief Nursing Officer is so unwilling to implement needed changes that she should be fired, but the senior management team is unwilling to take this needed action. This lack of leadership flows through the organization causing widespread relationship conflicts, organizational inefficiency, doctor and nurse dissatisfaction and poor quality outcomes.

Example 3: A Quality Director identifies patient care issues at her hospital that must be fixed before the State shows up for an unannounced survey. She knows that these problems must be fixed to avoid a ruling of Immediate Jeopardy, but the COO ignores her concerns, citing a lack of budget resources without moving money from other projects. Making budget changes would be unpopular with certain stakeholders.
Good Conflict

Cognitive Conflict is disagreement on goals, key decisions, and actions resulting from diverse backgrounds that can, when well managed, lead to improved decisions.

Bad Conflict

Relationship Conflict results from negative interpersonal relations and factional group loyalties that then lead to anger and frustration; such conflict can interfere with positive and aligned group decisions.
Conflict and Decision-Making Insight

Conflict originates with a perceived incompatibility between the desires of related but distinct groups.\textsuperscript{1} Cognitive conflict, also called task conflict, occurs when there is disagreement about goals, key decisions, procedures and actions.\textsuperscript{ii} Such conflict helps uncover underlying assumptions that might otherwise lead to incomplete analysis and poor decisions. In this context, cognitive conflict resulting from diversity of thought on the collaborating team is a positive element. It should be encouraged unless it transitions from positive discussion into potential relational disagreements.

Studies of top management teams have shown that those engaging in cognitive conflict while avoiding the drawbacks of relational conflict are more effective.\textsuperscript{iii}

\textit{Misunderstanding and mismanaging the different types of conflict can have disastrous consequences.}

Groupthink occurs when a group avoids cognitive conflict and agrees to a decision without adequate consideration of the full range of issues and any unintended consequences.\textsuperscript{iv} This may occur because members try to avoid relationship conflict that could damage future working relationships.

Affective or relational conflict stems from how individuals categorize others. This impacts the degree to which we like or dislike these individuals. Common social categories include age, gender, race, and tenure (how long a member has been part of a group).

Age and gender have less potential for creating affective conflict, while race and tenure differences accelerate affective conflict. One noted exception to age discrimination is the so-called “nurses eat their young” phenomenon, where more tenured nurses have historically made it rough-going for incoming nurses. Leaders and facilitators should be wary of the role that such social categories can play on the team’s decisions.
Factors related to cognitive conflict that are less likely to slide into affective conflict include job-related differences (education and career experiences) and functional background (medical, nursing, finance, or marketing). It is our experience that bringing such diverse thinking into a decision-making group is positive, unless the members of a job group display more loyalty to their job group than the hospital as a whole.

Conflict and performance are affected when individuals see themselves as representatives of a factional group instead of the larger organization. Factional groups view their particular group differences as important and demanding of respect. This particular form of group loyalty holds the potential for behavioral disintegration that interferes with information exchange, collaboration, and joint decision-making. In the past, research on factional groups has focused on demographic issues in multinational organizations. However, inter-professional differences within hospitals are also likely to adversely affect performance in this setting, given the dynamics of clinical decision-making and the nature of hospital care teams.

**Personal perceptions of issues impact potential for conflict.**

Members of decision-making groups in hospitals are impacted by how individuals interpret issues. If subjects are perceived along political lines that affect subgroups, conflict will increase. If these issues are perceived as benefiting a group, but are not important to the hospital, then conflict goes down. These phenomena seem to support the traditionally observed wisdom that “politics trumps strategy, always.”

Even while individuals engage in useful decision interactions, cognitive conflict can transition into affective conflict, particularly when individuals are unable to resolve differences. Social judgment theory suggests that when discussion participants are unable to justify the positions to which they are adhering, then other group members become more suspicious of motives and distrust increases. Because task-related conflict may be based on subjective observation and personal preferences, task conflict can expand into relationship conflict.

Thus, a disagreement that starts as cognitive conflict can degrade into affective conflict because group members are unable to persuade others or are unable to arrive at an acceptable group decision. In the absence of factual evidence, emotional disagreements can take hold, causing the group to split along emotional boundaries.
Conflict Can Strike Anywhere in The Hospital

Unfortunately, hospitals are not immune to any of the types of personal and group conflict revealed in the growing body of research. It can strike during strategic planning meetings, on care unit floors, or in critical care sectors like the emergency department, operating room, or intensive care department.

Resolving Interpersonal Conflict Within A Medical Center

Patient care involves multiple types of clinicians—nurses, physicians, respiratory therapists, etc.—with specialists for almost any conceivable patient service. Clinical work, including physician decision-making, is not always guided by expert medical decision-support systems. This allows errors to occur and causes experts to disagree with one another.

Cognitive conflict may prevent mental errors from affecting the patient. Ideally, all caregivers should feel comfortable raising concerns about decisions that they feel are not safe for the patient. When cognitive conflict is expressed, the decision and situation should be reassessed.
However, the collaborative relationship that can accompany cognitive conflict rarely exists in clinical situations. Instead, defensiveness is the more likely response. An exception to this generalization is in clinical settings, such as intensive care units, emergency rooms, or so-called “focused factories,” where the relationships are different because the hospital is the sole location of the physician’s work and the unit’s success is important to all participants.

Relationship conflict can be especially destructive in a clinical setting. When questions are interpreted as personal attacks, communication breaks down. This increases the risk of poorly coordinated patient care.

**Examples of Cognitive Conflict**

**Example 1:** A nurse might question a physician’s decision to order a particular dose of medication that might lower the blood pressure in a patient that is hemorrhaging. By introducing cognitive conflict, the nurse causes the physician to reassess the situation and determine whether the drug is necessary and whether a lower dose might be safer. Although the physician may decide to proceed with the original treatment plan, the act of reassessment improves the decision. The physician may decide to proceed with the original treatment plan, the act of reassessment improves the decision.

**Example 2:** A physician may express concern about nursing care, citing an incident in which insulin was given to a patient whose care plan forbids taking food by mouth (an NPO patient). This type of cognitive conflict should result in managerial reassessment of nurse competencies and training, assuring that caregivers are given the education needed to provide optimal care for the patient.
Task conflict often degenerates into relationship conflict. For example, a physician may become dissatisfied with nursing care due to errors in following physician orders or complaints from patients or their families. When this happens, the physician ceases to trust the nursing staff.

When trust wanes, the physician might begin to speak disrespectfully to the nurses. This behavior can be disruptive if it causes the nurses to focus on the physician rather than on their patient care tasks.

Management meetings are one setting in which groups are often utilized to evaluate clinical performance, set priorities, manage processes, and allocate resources. Although these gatherings are intended to be collaborative, they can frequently be the site of additional conflict.

The functional diversity that is intrinsic to management teams and other hospital workgroups should stimulate cognitive resolution strategies. However, the multi-professional composition of a workgroup may generate relationship conflict when members view themselves as representing their professions, rather than working as part of a larger team.

This type of subgroup loyalty creates factional fault lines, which can interfere with constructive conflict resolution. Fear of the relationship conflict that often arises from this factional thinking can inhibit the expression of cognitive conflict and limit the discovery of important issues. Alternatively, escalated relational conflict can shut off debate altogether, preventing teams from uncovering important clinical issues. The real danger of escalated conflict is that it reduces the quality of the group’s decision-making and may create a culture where problems are allowed to persist. Many hospitals that ride this slippery slope will eventually face serious compliance issues that are publicly embarrassing and difficult to fix.
The Physician’s Role in Conflict Management

Although nurses spend more time with patients, physicians are critical players in the patient care process within any hospital setting. They are deeply involved in the hospital’s work and can impact the success or failure for the hospital. But unless they are employed by the hospital, physicians usually do not consider themselves to be a part of the organization. Four factors create this unique relationship and contribute to the physician’s unusual role in decision-making.

Physicians often work at more than one hospital. This reduces their commitment to the well-being of any one medical center. Working at multiple hospitals allows doctors to minimize their dependence upon one facility, its administration, and its financial condition. This arrangement also enables physicians to care for patients at the patient’s preferred hospital when there are competing care providers in the same locality. If a patient complains about nursing care at one hospital, the physician can maintain the doctor-patient relationship by working at another facility. Patients also tend to view physicians and hospitals as separate entities; they can direct displeasure at the hospital without impacting the relationship with their doctor.
Physicians are not directly accountable to hospital management. In accordance with The Joint Commission’s standards (2009), physicians are accountable to their peers through an organized Medical Staff.

The Medical Staff has its own by-laws, rules, and regulations that define the obligations of the physicians, as well as how infractions are investigated and resolved. Although the Medical Staff is accountable to the Board of Trustees, the Board members are limited in their ability to intervene when the Medical Staff has decided not to act. Peers evaluate and judge each other according to how they would expect to be evaluated. Although there are exceptions, most Medical Staffs take action for only the most obvious and egregious problems.

Physicians believe hospitals need them more than they need hospitals. Physicians are economically independent of hospitals. Most private practice physicians are paid on a fee-for-service basis, which means that the more services they provide, the more revenue they will generate. Work on hospital committees is not financially rewarded. With their primary attention directed towards personal productivity, physicians are not generally focused on the needs of the hospital staff and must be enticed to participate on hospital workgroups.

Physicians tend to be autocratic. They are trained to make independent decisions and expect non-physicians to follow their direction. Physician education emphasizes that answers are right or wrong. Consequently, some physicians bristle when their decisions are questioned, especially when questions are asked by non-physicians. At the same time they tend to be hypercritical of errors made by hospital staff.

As a result of these four factors, private practice physicians present challenges to working collaboratively with the hospital and its staff. While they may represent reality, these factors need to be better managed by everyone in the system.
Disruptive behavior by any clinician is a dangerous threat to patient safety. Such behavior is characterized by clinicians who interfere with the team’s ability to provide effective and safe patient care. Outbursts of anger, throwing objects, intimidation, and criticism in front of patients that undermines patient confidence in the team or the hospital are unacceptable, but often ignored. Lack of emotional intelligence is a significant factor underlying such disruptive behavior.

In a survey of 1,627 physician executives, 95.7% reported regularly encountering disruptive physician behavior, and 70.3% said disruptive behaviors nearly always involved the same physicians. A majority (56.5%) reported that disruptive physician behaviors involved conflict with nurses or other allied healthcare staff. Nearly 80% said disruptive behaviors are under-reported because of victim fear of reprisal.

Disruptive behavior not only interferes with patient care, but also can result in increased turnover among nurses, which further degrades care and increases hospital costs. This behavior was, in one study, reported by 96 percent of nurses. Problem clinicians are often tolerated—clinical teams just find a way to work around such people. This tolerance of unacceptable behavior occurs frequently, despite a Joint Commission requirement that hospital leaders must create and implement a process for managing disruptive and inappropriate behaviors.

Hospital leaders should create a system-wide understanding that disruptive clinician behavior is a violation of safe and effective care. Furthermore, such behavior should be managed with a comprehensive approach that includes clear expectations, progressive discipline and training to change learned attitudes and behaviors.
Teams consist of a small number of people with complementary skills, who are committed to a common purpose, common goals, and an approach for which they hold themselves mutually accountable. Decreasing the likelihood that task conflict will degrade into emotional conflict is a key role of team management.

Three factors can help keep group discussions moving toward positive decisions:

1. **Intra-group Relational Ties**
   
The willingness to place collective goals over individual goals improves the ability of a group to make good decisions. Trust is an antecedent to collective action, but it is also built by effective collective action. Trust can be resilient if based on norms and experience, or fragile if based on explicit rules or mandates. Where there is resilient trust, groups can withstand stress without increasing relationship conflict. Physicians and hospitals as separate entities; they can direct displeasure at the hospital without impacting the relationship with their doctor.

2. **Emotional Intelligence of the Group Members**
   
Members of strong teams have an understanding of how their emotions influence their behavior and affect those around them. An emotionally intelligent person will be able to adjust their responses to conflict through social skills such as self-awareness, self-regulation, motivation and empathy. In negotiations, individuals with high emotional intelligence created higher levels of objective value and a more positive experience. Teaching emotional intelligence should diminish the likelihood that task conflict will cross over to affective or emotional conflict.
To prevent the mere avoidance of emotional conflict and accelerate positive collaboration, leaders can reinforce the value of constructive conflict. For example, managers can remind their teams that the organization can learn from conflict by documenting and reviewing episodes of intra-organizational conflict. Reporting makes the conflict and its resolution transparent. Transparency enables the organization to understand the basis for the final decision, which may help prevent future emotional disruptions. Transparency also ensures that the basis for resolving differences is broadly understood. This reduces the potential for second-guessing the process, or worse yet, key team members leaving the meeting with apparent agreement only to subvert the decision later.

Recurrent conflict generally has its roots in members feeling like their perspectives and concerns are unheard. This may arise due to systemic issues that generate tension for the entire organization. When managers identify recurrent conflicts, they can fix these problems before they snowball, getting bigger and bigger until finally addressed.

**Norms for Reducing or Preventing Negative Emotionality**

Group norms and values influence conflict. When members share similar values, both cognitive and affective conflicts are reduced. Group norms that tolerate disagreements, however, increase both types of conflict. If mutual relationships are established before cognitive conflict is encouraged, affective conflict is less likely to disrupt the process. This suggests that facilitators should encourage trust, open discussion norms, and high levels of respect among the members and promote a supportive environment.

**Transparency of issues accelerates positive collaboration.**
Recommendations for Managing Conflict

Conflict is best managed before there are adverse consequences.

To achieve this, healthcare leaders should use three related approaches:

1. **Managing Culture**
   Cultural attitudes that embrace and encourage cognitive conflict need to be developed. Leaders should emphasize the positive aspects of conflict and the value of the rich professional diversity of the organization. This enables groups to identify and address issues before they become problems. Managers, including physician leaders, can develop model methodologies for resolving conflict when it arises. These methodologies focus the group on the issues, rather than on emotions associated with conflict. Norms around conflict need to be defined and discussed. In particular, tolerance of disagreement, openness, mutuality, and concern for others should be encouraged.

2. **Implementing Training and Development**
   Hospital staff can participate in classroom activities and supervisory coaching to develop better communication skills and learn to focus on task problems, instead of people problems. Healthcare providers should have a clear understanding that performance failures are often system errors, not people errors. Teach problem-solving skills and methods for resolving conflict. In addition, hospital staff should be trained to identify the signs of relationship conflict and be able to intervene when these signs first appear. Training should encourage viewing interventions as constructive time-outs, not as taking sides. Finally, training that enhances emotional intelligence can improve the group effectiveness by diminishing the likelihood that task and process conflict would be associated with relationship conflict. Enhancing emotional intelligence involves classroom training on the underlying concepts, but the organization must make efforts to develop skills that require ongoing supervision and coaching. Skills development can be included in personal development plans for executives, managers, and supervisors.
Provide Facilitators for Group Meetings

Facilitators should be trained to guide group meetings, reminding participants of the group norms. In addition, facilitators should monitor the development of conflict. Their goal is to encourage group members to focus on task conflict and restrain tendencies to develop interpersonal conflict. They can monitor the pattern of conflict emergence and intervene if less effective patterns develop (such as too little task conflict in the mid-point of a project). They can help the group implement constructive conflict resolution strategies, emphasizing process-controlling and problem-solving behaviors. Facilitators can assist the group in using and developing conflict resolution methodologies. These methodologies may be useful in other settings within the hospital.

Although hospital staff can be trained in organized classes and human resources development programs, physicians are not likely to participate in these activities. Instead, physicians are more likely to learn if brief training is provided during a workgroup meeting. Physicians may also be willing to participate in one-on-one counseling with a trusted physician leader. Emotional intelligence training could be offered as part of a continuing medical education program, since this skill is relevant to communicating with patients. Similarly, conflict resolution training could also be provided in these programs, although coaching provided by a respected physician leader would increase acceptance. Conflict resolution training could emphasize the importance of developing concern for others, viewing conflict in terms other than right and wrong, accepting criticism as an opportunity to reexamine the situation, and resolving cognitive differences without reacting emotionally.
Cognitive conflict has a beneficial effect upon decision-making. It can be useful, if not necessary, to safeguard patients in clinical settings and improve the quality of clinical decisions. Since conflict is a source of tension, it will be avoided unless the hospital staff and physicians develop an understanding of the differences between task and affective conflict. To enable their organizations to benefit from conflict, hospital leaders must promote the development of emotional intelligence and conflict resolution skills.

Managing good and bad conflict is a hallmark of how Compass Clinical Consulting approaches each assignment. We have learned that people are the key to successful projects and processes. We address people conflicts as process issues to avoid reactive posturing by those involved. When relationship conflicts are seen transparently as process issues, it is easier to resolve them and move forward. We integrate our understanding of personal interrelationships, factional groups, organizational history, and hospital culture into our planning. When conflict is turned into a discovery tool instead of a standoff, progress can be smooth and long-lasting.
End Notes

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