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EXPLORATION OF CONFLICT MANAGEMENT
STYLES USED BY MEDICAL-SURGICAL NURSES

A Major Paper Presented

by

Michelle Gianfrancesco Leveillee

Approved:

Committee Chairperson _____ (Date)

Committee Members _____ (Date)

_____ (Date)

Director of Master's Program _____ (Date)

Dean, School of Nursing _____ (Date)

EXPLORATION OF CONFLICT MANAGEMENT
STYLES USED BY MEDICAL-SURGICAL NURSES

by

Michelle Gianfrancesco Leveillee

A Major Paper Submitted in Partial Fulfillment

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Abstract

Conflict has been pervasive to societies throughout time, has caused power struggles, problems, and competition amongst and between people and groups. Conflict is especially problematic in healthcare. Communication issues may trigger conflict troubles between nurses and physicians. The literature review supported that there is an increased need for collaboration between physicians and nurses, which has been shown to have multiple benefits in regard to patient care, but is also very underutilized in the healthcare setting. The purpose of this study was to explore the conflict management styles of medical-surgical nurses. The Thomas-Kilmann Model of Conflict Management was used to guide this research project. This descriptive survey was disseminated to a medical-surgical unit at a local, non-profit hospital, and Level 1 trauma center. Twenty-three nurses completed the survey, a 48.9% response rate. The styles of conflict management that were most utilized by nurses were compromising and accommodation, followed by avoidance. Competition was not utilized at all, and one participant used collaboration and compromising. Collaboration may be the ideal conflict management style, where optimal patient outcomes are the utmost priority and an interdisciplinary approach to teamwork is used. The collaborative style upholds that open, effective communication between the individuals, or parties, leads to everyone expressing their viewpoints, but that the individuals, or parties, come to an agreement on a solution that ultimately benefits the patient. Advanced practice registered nurses play a valuable role in the future of healthcare, research, and micro and macro level policy changes, especially in regard to this subject.

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Exploration of Conflict Management Styles Used by Medical-Surgical Nurses

Background/Statement of the Problem

Conflict has been pervasive to societies on a continuous basis and throughout time has caused power struggles, problems and competition amongst and between people and groups (McEwen & Wills, 2011). Conflict has also been described as unavoidable, dynamic, constant and an innate human attribute (Almost et al., 2016; McKibben, 2017). Almost et al. (2016) further defined conflict as interpersonal discord from disagreement about ideas, values, or beliefs of two or more people or groups. Furthermore, it is characterized by involvement and cognizance of at least two individuals/groups or more, strong negative emotions, thoughts, objectives and behaviors that are directed toward defeating or suppressing the adversary to achieve power or a specific outcome over another, or other, individual(s) or group(s) (Almost et al., 2016; Jerng et al., 2017; McKibben, 2017). McEwen and Wills (2011) add that it is equally exclusive of values and beliefs.

Psychologist Kenneth Thomas (1992) explained that no two individuals have exactly the same expectations and desires, so conflict is a natural part of our interactions with others. Conflict begins when one party identifies that another party is becoming, or is, unsatisfied with a matter of the first party (Thomas). Conflict situations therefore arise in which the concerns of two people appear to be incompatible and lack the inability to work collectively (Jerng et al., 2017; Thomas, 1992). In interpersonal conflict situations, an individual's behavior can be described along two dimensions: (1) assertiveness, the extent to which the person attempts to satisfy his own concerns; and (2) cooperativeness,

the extent to which the person attempts to satisfy the other person's concerns (McEwen and Wills, 2011). Furthermore, conflict behavior in the workplace is a result of both personal predispositions and the requirements of the particular situation (Johnson, Thompson, & Anderson, 2014; Thomas, 1992). Although many other theorists including, Karl Marx, Max Weber, George Simmel, and Lewis Coser have constructed theories revolving around conflict and conflict management in relation to societies, due to the focus of this paper being on conflict management in healthcare, Ralph Kilmann and Kenneth Thomas' theory will be explored.

Conflict in healthcare is a significant issue with undesirable consequences (Almost et al., 2016; Jerng et al., 2017). Workplace conflict is commonly reported, especially in high-stress areas such as operating rooms, emergency departments and intensive care units. More than 50% of healthcare workers, and specifically 53% of nurses, have endorsed conflict in the work environment, including disorderly physician behavior (Jerng et al.). Workplace conflict may be due to poor or lack of communication between the healthcare team members, primarily nurses and doctors, intense work stress and misinterpretation of prioritization of job tasks (Jerng et al.). Johnson and Kring (2012) further noted that complicated healthcare issues, disorderly physician behavior and more intensive clinical specialties may all lead to unruly communication.

Although communication issues may set off conflict troubles between nurses and physicians, research has shown that there are a multitude of other reasons, including lack of explanation about roles and scopes of practice, ineffective management and/or lack of leadership (or strong leadership) (Hendel, Fish, & Berger, 2007; Leever et al., 2010). Nurses reported that they do not feel supported by their administrative leaders when it

comes to conflicts between themselves and physicians (Rosenstein, 2002). Nursing executives and leaders, in conjunction with physician leaders, need to guarantee that systems in an organization have policies in place for disruptive physicians, but also do not promote a culture of conflict between both professions (LeTourneau, 2004). Instead, a culture of change and safety should be encouraged (Almost et al., 2016). To accomplish this, LeTourneau (2004) suggested that committees consisting of both nurses and physicians hold educational session in and out of the hospital setting; both professions should be committed to patient care.

Nurses are also concerned that they may be disciplined if they do not agree with physicians (Leever et al., 2010). Physician advising procedures regarding unruly behavior may not be effective, underutilized and healthcare professionals might not know they exist (Hendel et al., 2007; Jerng et al., 2017; Leever et al., 2010). Joel (2013) acknowledged similar barriers to communication which include educational segregation (in terms of educational programs and their structure), organizational hierarchy, unrecognized diversity (differences in culture, education, and experience), professional superiority, inefficient and unsuitable communication patterns and professional discord. Traditionally, the relationship between physician-nurse has been unbalanced, with nurses having the subordinate status (Johnson & Kring, 2012).

Dissimilar theories and models of education between nurses and doctors have also been known to cause conflict between nurses and physicians (Hendel et al., 2007; Leever et al., 2010). Differing documentation features and methods, differences in professional training, knowledge, skills, values and approaches to coordination and continuity of care can also be included as motives for conflict (Hendel et al., 2007; Leever et al., 2010).

Negative images of the interdependence of work units, lack of knowledge of responsibilities and tasks, ongoing and rapid advances in medical technology, increase in patients' acuity and need for time spent on care, increase in healthcare costs and hospitals' need to set financial goals are imperative to mention. Nurses and physicians' lack of self-reflection and mindfulness and nurses' perception that they lack the independence to make prudent decisions are also cited as contributing factors (Hendel et al., 2007; Leever et al., 2010). Interruptions in the flow of patient affairs, nursing shortages, staffing issues, multiple patient handoffs and an increased in patient acuity may lead to the breakdown of communication between nurses and physicians (Flicek, 2012).

The Affordable Care Act (ACA), or Obamacare, current healthcare reform by the Trump administration, the emergence of the electronic medical record, and complicated paging and ordering system, have also impacted communication between nurses and physicians (Flicek, 2012; Hendel et al., 2007; Leever et al., 2010). In a survey conducted by Rosenstein (2002), the author found that physicians actually valued the level of respect for nurses' input and collaboration in patient decisions significantly higher than the nurses themselves. This discord in perceptions may also be what leads to poor communication, lack of trust and creation of a defensive, non-collaborative environment, which in turn leads to the increase in medical errors, decrease in patient safety and decrease in positive patient outcomes (Rosenstein). Understanding the reasons behind what causes conflicts helps to guide research to emphasize collaboration between nurses and physicians. Almost et al. (2016) declared that if conflict is effectively dealt with, positive outcomes will ensue. Having knowledge of the style(s) that nurses and

physicians use to manage conflict may deescalate conflict as may utilization of accommodation and collaboration (Almost et al.).

Johnson and Kring (2012) defined interprofessional collaboration as more than two professional individuals working collectively towards common goals with joint responsibility, which improves patient care and increases patient satisfaction. Joel (2013) defined collaboration as a dynamic, transmuting process to create an environment of shared decision making and fair, flexible distribution of status and power. It consists of both parties detecting individual values, knowledge and understanding to work toward a specific resolution, intention or outcome. Then, using the element of shared power, both or all parties come to a consensus even if all individuals involved do not agree with all points (Joel). Streeton et al. (2016) defined collaboration as shared decision making in advocating for patients, which leads to less nurse burnout and turnover. The authors cited that in 2012 The Joint Commission (TJC) reported that 70% of adverse events were due to communication errors, and that 60% of sentinel events were due to communication errors. These statistics lead TJC to add a Patient Safety Goal focused on improving communication (Streeton et al.).

Research evidence demonstrates that collaboration and open, effective communication between nurses and physicians is not only necessary, but also decreases medical errors, decreases patient deaths, decreases supply waste, decreases care expenses, increase quality of care, increases patient outcomes, increases patient satisfaction, increases professional satisfaction, improves continuity of care, creates less “burnout” and increases retention time for nurses (Jerng et al., 2017; Nelson, King, & Brodine, 2008). Johnson and Kring (2012) emphasized that interprofessional collaboration may

also decrease costs, decrease patient mortality and morbidity, decrease patient length of stay, and improve efficiency and understanding of the nursing role.

O'Brien, Martin, Heyworth, and Meyer (2009) helped to identify four vital factors to achieve effective collaboration: approachability, interpersonal skills, listening and verbal message skills. These tie into the four factors and purpose of collaboration which include distinct and unique practice scopes, common objectives, joint power control, and shared concerns. Unit-based care teams, that include both physicians and nurses, use of the SBAR (Situation, Background, Assessment, Recommendation) or SBAR-P (P for patient) handoff format, obligatory interdisciplinary rounds, proper orientation to the unit, and collaborative educational undertakings may all lead to better and improved interprofessional communication (Flicek, 2012). D'Amour, Ferrada-Videla, Rodriguez and Beaulieu (2005) completed a literature review that focused on how interprofessional collaboration could increase the effectiveness of health services currently offered to the public. The concept of collaboration can be defined by five ideas: sharing; partnership; power; interdependency; and process. The authors emphasized the importance of patients being involved in their own care and were dissatisfied at the limited research done on how patients and the health care team could work together, while respecting patients' decisions on their own health (D'Amour et al.). Effective collaboration defines effective communication as when physicians and nurses participate in a two-way conversation and discuss information and concerns, specifically related to patient care (Joel, 2013). When not done, this leads to a break in the system of written and verbal communications. Ineffective communication pathways effect working collaborations and can result in

separate, professional decision-making and can lead to increased misunderstandings and patient safety concerns (Joel).

Even though medicine has changed over time and interdisciplinary care is encouraged, nurses continue to recognize problems with conflict between themselves and medical providers, such as physicians, physician assistants and nurse practitioners (Joel, 2013). A culture of change in practice is needed to support collaboration and nurses can be empowered to influence this change process no matter what area of nursing they practice in (Tschannen et al., 2011). With an increase in knowledge and training, nurses may be better prepared to facilitate open and effective communication with providers for the best possible patient care. Conversely, if no culture change occurs and conflict persists, it can lead to detrimental effects; hence, the importance of nursing administrators providing leadership in conflict management and collaboration (Tschannen et al.). Almost et al. (2016) stressed that if inadequate patient care quality is provided, it could jeopardize the integrity of the nursing profession, and nurses. Given the evidence for the benefits of collaboration, it is imperative that all nurses learn how to effectively manage conflict (Tschannen et al., 2011). Nurses must learn to adapt to challenging and difficult situations in a professional manner to impede and/or settle conflicts, and work through differences between colleagues (McKibben, 2017). Studying the conflict styles nurses utilize is vital to finding ways to mitigate conflict (Almost et al., 2016).

Much of the research on nurses' conflict management styles, however, has been conducted on critical care nurses. Studies of medical-surgical nurses is limited and there is a need for more information about the conflict management styles of these nurses.

Most comprehensive models of collaboration were based on a solid theoretical

background. Additionally, the literature on this topic was very diverse, and at times the frameworks did not produce clear links between factors in frameworks and where they were implemented. Flicek (2012) advocated that more research needs to be carried out to generate solid, successful solutions and opportunities for nurse-physician collaboration. Previous research has shown that communication and collaboration may be perceived differently in critical care or intensive care units than general medical-surgical units (Joel, 2013). Physicians alleged that critical care nurses had more knowledge than general medical-surgical nurses; therefore they were more willing to communicate and collaborate effectively with the ICU nurses (Joel).

The purpose of this project is to explore the styles of conflict management used by medical-surgical nurses to deal with conflicts with medical doctors, physician assistants and nurse practitioners working in a tertiary care hospital.

Next, the review of the literature will be presented.

Literature Review

The literature review for this project was conducted through the Rhode Island College Adams Library and at times with the aid of the resource librarians. The databases used were Academic Search Complete, CINAHL PLUS with Full Text, EBSCO, Google Scholar, MEDLINE, MEDLINE (Ovid), MedlinePlus, PubMed, and PubMed Health. Dates of the articles ranged from 1977-2017, with no limits on dates. The articles collected covered all levels of the Research Evidence Pyramid, with the least amount of articles being editorial or expert opinion papers. Literature was searched using the following individual and combined terms ranging from broad to specific and included: conflict; conflict management; conflict resolution; collaboration; Thomas-Kilmann MODE; conflict management+collaboration; conflict resolution+collaboration; conflict management+healthcare professionals; conflict resolution+healthcare professionals; conflict management+physicians+nurses; conflict resolution+physicians+nurses; conflict management+nurses; conflict resolution+nurses; conflict management+inpatient nurses; conflict resolution+inpatient nurses; conflict management+medical-surgical nurses; conflict resolution+medical-surgical nurses; conflict management+Thomas-Kilmann; conflict resolution+Thoman-Kilmann; conflict management styles+nurses; conflict resolution+collaboration+interprofessionalism; and lastly Thomas-Kilmann+nurses.

Communication, Collaboration and the Importance in Healthcare

Thomson (2007) studied nurse-physician collaboration, primarily on medical-surgical units. A descriptive, prospective study was conducted using the Jefferson Scale

of Attitude toward Physician-Nurse Collaboration to collect data, which focused on four areas of collaboration: shared education and teamwork; caring versus curing; nurses' autonomy; and physicians' dominance. In total there were 104 participants: 65 nurses; 37 physicians and two were unknown. The participants were recruited from the Office of Research at Wake Forest University School of Medicine. Results showed that there were discrepancies in the attitudes toward nurse-physician collaboration, specifically in this setting. Nurses demonstrated more positive attitudes toward nurse-physician collaboration than did physicians: 52.7 vs. 47.6 (range = 15-65). Nurses had a more optimistic viewpoint toward nurse-physician collaboration than physicians. The findings also revealed positive trends by nurses and physicians in the areas of shared education and teamwork (26.1 vs. 22.8; range = 7-28), caring versus curing (10.2 vs. 9.8; range = 3-12), and nurses' autonomy (11.3 vs. 10.4; n = ranging from 3-12). Regarding physician dominance, the view that physicians have all of the authority, nurses and physicians' scores tended to be more impartial (5.1 vs. 4.6; range = 2-8), therefore affirming an encouraging trend towards collaboration (Thomson).

Schmalenberg and Kramer (2009) analyzed the stories of over 20,000 critical care nurses, extracting data from six previous studies and synthesizing their findings to elaborate on five styles of nurse-physician relationships: collegial relationships; collaborative relationships; student-teacher relationships; friendly stranger relationships; and hostile-adversarial relationships. They also compared the conflict management styles and differences in nurse-physician relationships found in Magnet hospitals with those found in non-Magnet hospitals, particularly in intensive and specialty care units. According to the authors, physicians are becoming aware of the difference and

uniqueness of the nurses' scope of practice and how it overlaps with theirs', and because of this the importance of collaboration and acting as a team. Some of the key factors that were reported by the physicians and nurses to increase collaboration included: creating an environment centered around the patient; implementing a policy highlighting conflict resolution and methods to aid in resolving problems executing interdisciplinary rounds; and taking into account that the R in SBAR stands for recommendations. Because of nurses' close contact with patients, they developed the confidence and competence to make knowledgeable recommendations in regard to patient care (Schmalenberg & Kramer).

Tschannen, Keenan, Aebersold, Kocan, Lundy, & Averhart (2011) conducted a study in a large Midwest university hospital on two units. In this prospective study, using a pre and post-intervention design, two groups comprised of nurses and doctors were asked to complete questionnaires about their perceptions regarding openness, accuracy and timeliness of communication, conflict resolution and difficulties in the work environment. The groups were then asked to consent to be recorded in groups during a span of four sessions four message types were noted throughout the conversation in each group: give opinion; give information; ask information; and support/agree. Cultural norms were also addressed, since norms need to be changed to improve openness in communication and to increase collaboration. The authors found that the most utilized message type in the groups was to provide opinion; this was for both nurses and physicians, although mostly used by physicians. The second most utilized message types were to give information and to ask information, followed by support/agreement. In terms of support/agreement, nurses used this message type more often than physicians.

Results also revealed that 60-70% of medical errors were caused by faults in communication. Collaboration between nurses and physicians was shown to decrease errors, improve patient outcomes, decrease patients' deaths, and improve continuity of care, increase patient and professional satisfaction and decrease supply waste (Tschannen et al.).

Johnson and Kring (2012) conducted a study to discover the differences in nurse-physician collaboration between intensive care unit (ICU) nurses and medical-surgical unit nurses (MSU). Intensive care unit nurses usually have a limited patient assignment due to the higher acuity of the patients they care for, whereas MSU nurses usually have more patients, more interactions with various physicians and shorter interactions with both their patients and other healthcare professionals. This quasi-experimental study took place at a 975-bed urban hospital in Southeastern United States. A 25-item survey, the Lippincott Williams and Wilkins Nurse-Physician Relationships Survey Tool, was distributed to eight MSUs and three ICUs.

Of the 170 nurses that replied, 54% (n=89) were medical-surgical nurses and 46% (n=77) were intensive care nurses. Half held Bachelors of Science in Nursing degrees (n=83); more ICU nurses had a BSN and had five years or less experience (n=80). More ICU nurses, 75% (n=74) as opposed to 65% (n=84) of MSU nurses, conveyed satisfaction with nurse-physician relations. An average of 77%, in both groups of nurses (n=87 of MSU nurses and n=75 of ICU nurses), expressed that physicians valued their decisions. Fifty-seven percent (n=94) of nurses had witnessed disruptive physician behavior, but only 26% (n=43) reported it, with ICU nurses reporting a higher percentage of this behavior. More ICU nurses, 75% (n=71) as opposed to 33% (n=80) of

MSU nurses, acknowledged that they attended interdisciplinary rounds. Half of the nurses in both groups reported that physicians did not understand what their role responsibilities are, but that they had better relationships with younger doctors. Both groups of nurses did not know how to report or were unaware of policies related to this concern; more ICU nurses reported disruptive physician behavior and stated that physicians treated them like maids. Johnson and Kring noted that medical-surgical nurses may be less invested in forming relationships with physicians, or interdisciplinary rounding, because of the higher nurse to patient ratio leading to more interruptions. They concluded that there is a need for improved nurse-physician relationships, educational activities, interdisciplinary rounding, and for outside activities, whether educational or not (Johnson and Kring).

Research performed by Moore, Leahy, Sublett, and Lanig (2013) focused on understanding nurse-to-nurse relationships and their impact on work environments. Although not specifically addressing the relationships between nurses and physicians, this article emphasized the importance of knowing nurses' environmental stressors that influence their relationships with other team members. These stressors may lead to conflicts not only with their nursing colleagues, but also with other healthcare professionals, especially physicians (Moore et al.). More importantly, knowledge of these stressors and how to cope with them may improve patient care. A mixed method research design was used by the researchers to collect both qualitative and quantitative data, but for the purpose of this article, the data gathered was from the Nurse-to-Nurse Relationship questionnaire. The nurses were recruited from five chapters of Sigma Theta Tau. Eighty two nurses responded out of 400 nurses that were contacted (21% response

rate), most working in critical care units (n =17; 21%), followed by emergency departments (n=12; 14.6%), then medical-surgical units (n=10; 12%), and the least who worked on adult mental health units (n=6; 7%).

The 82 nurses that responded to the survey perceived that stable environmental characteristics were necessary to form positive relationships. They recognized that four aspects of a stable environment included supportive interpersonal behaviors (helping one another and decreasing lateral violence; n=36), constructive leadership actions (managers acting in a supportive manner towards staff; n=28), teamwork (inter-professional collaboration; n=17), and effective communication (n=15). The researchers stressed the vital role that nurse managers played in helping to form these positive relationships, citing that the nurses reported the desire for more respect, assistance and adequate staffing from the managers. Positive relationships and healthy work environments were said to increase positive outcomes not only for the nursing profession as a whole, but also for patients. Maintaining retention rates and recognizing the downfalls as to why nurses leave a specific unit or the profession, seeing as the nursing shortage will reach 260,000 by 2025, was viewed as a point of concern which needs more attention overall. The authors stressed the significance of upholding positive work environments (Moore et al.).

An integrated literature review comprised of 17 articles was conducted to examine the perspectives of nurses and physicians on physician-nurse collaboration, the factors affecting this relationship and strategies to improve physician-nurse collaboration (Tang, Chan, Zhou, & Liaw, 2013). Researchers searched for articles by means of the CINAHL, PubMed, Wiley Online Library, and Scopus databases between the years 2002-2012. Overall, both doctors and nurses respected collaboration and reported that it

helped to improve the quality of patient care and safety, improved patient satisfaction and lead to quicker recovery and lower mortality rates. Conversely, doctors perceived physician-nurse collaboration as less important than the nurses did. Those nurses that respected the use of collaboration were more likely to apply it compared to the physicians, as cited by four of the research studies examined. The authors discussed that differences doctors and nurses have in their perceptions of a collaborative relationship may be due to the fact that their training is very different: physicians focus on finding a cure for the disease or illness, while nurses focus on the rapport with patients and take on more of a holistic view. Physicians and nurses may have different perceptions of what collaboration is about. Physicians may view inputting orders and having the nurses competently and cooperatively carry out their orders as collaboration, hence the lower percentage of dissatisfaction regarding collaboration from nurses. In addition, factors that affected physician-nurse collaboration were thought to be communication, respect and trust, unequal power, understanding or lack of professional roles, and task prioritization. Lastly, the researchers sought to compile improvement methods for physician-nurse collaboration, including inter-professional education within the hospital setting that focuses on effective communication skills, body language and crucial factors for effective collaborative practice. Other possible improvement strategies were interdisciplinary unit rounds, where doctors and nurses discuss pertinent information about patients. Initially, this tactic was seen as a positive implementation; however due to time constraints from both physicians and nurses, the participation rates in the unit rounds declined (Tang et al.).

Fewster-Thuente (2015) theorized that nurse-physician collaboration was a fundamental social process in which groups of individuals formed and could transform together. The author conducted a study at a large academic medical center in the Midwest, in which participants were recruited via email from the chief nursing officer and chief hospitalist. Recorded and transcribed interviews were then carried out with each participant, in which open-ended questions were asked regarding their viewpoints on nurse-physician collaboration. Twenty-two participants, 12 nurses, three advanced practice nurses and seven resident physicians, were recruited by the chief nursing officer and chief hospitalist. Attending physicians were not recruited because nurses worked mainly with the residents. Participants believed collaboration is comprised of two or more parties from various professions to discuss a patient issue, together determining that course of treatment and care and finally providing that care. Additionally, in regard to providing care, nurses and physicians needed to form a group and work in harmony to deliver optimal patient care to attain a mutual goal. There was a process used, consisting of seven stages: acknowledgment of something needing attention; knowledge of who to talk to; seeking out the right person to talk to; working together; exchanging thoughts; executing the plan; and monitoring improvement and outcomes. Ultimately doctors and nurses who participated in the study gained an appreciation for collaboration and working together with the patient in the center. The author theorized that collaboration and working together could be used as tools for education and practice to ultimately improve patient outcomes, save resources, and of course, to save lives (Fewster-Thuente).

Streeton et al. (2016) analyzed ways to improve nurse-physician relationships. The researchers conducted a continuous quality improvement project on a 22-bed

gynecology surgical unit in which nurses from the Continuous Improvement Committee (CI) presented data at a physicians' meeting that focused on obtaining thoughts to improve teamwork and communication on the unit. Physicians willing to participate and nurses from the CI then formed the Multidisciplinary Collaboration Committee (MCC); a pharmacist was later invited to participate, as well. The MCC created multidisciplinary action plans and nurtured an environment of open communication and teamwork. Joint events and projects were also put into place, including fun events. The involved nurses, the nurse manager, the unit's Clinical Nurse Specialist, physicians and residents dispersed the information presented at the monthly MCC meetings (Streeton et al.).

Results, as evidenced by pre and post intervention (range = 3.6 to 9.1 on a scale from 0= very poor to 10= couldn't be better) scores lead to increased comfort in providing positive feedback to doctors (range = 7-8.4), increased comfort in providing constructive feedback to doctors (range = 3.6-7), increased sense of teamwork on the unit (range = 8.6-9.1), and an increased sense of teamwork between nurses and physicians on the unit (range = 6.7-8.6). A question related to the nurse-physician collaboration was later added to the original patient satisfaction survey. Results showed increased patient satisfaction, an increase in safer environment for patients, an increase in a better work environment and beneficial, and daily nurse-physician interactions. Out of 434 patients surveyed between August 2012 - March 2013, 373 (86%) rated the newly added question to the patient satisfaction survey regarding perceived nurse-physician collaboration as excellent (Streeton et al.).

Initially nurses were asked, through a survey, about physicians' reactions to calling the Rapid Response Team (RRT), which most of the time the physicians did not

see the need for. After the formation of the MCC, there was a 50% reduction in apparent resistance to call the RRT. Ten months after the development of the MCC, another survey was distributed to the unit nurses. Nurses were more comfortable paging physicians with inquiries or for clarifications, expressed increased confidence in both professional skill sets, reported an increase in physicians helping to cross-cover and answer lights, noted an increase in the use of their first names by physicians as well as an increase in trust. There was also an increase in positive feedback about the monthly MCC meetings, participation in joint research activities, charge RN conducting fall huddles and planned rounding (Streeton et al.).

Conflict Management in Health Professions

Valentine (2001) investigated the role of gender in nurse-physician conflict management. The author synthesized research outcomes from eight previous research studies that utilized the Thomas-Kilmann Mode Instrument (TKI) to measure conflict-handling approaches. Three gender viewpoints were employed in this study. The first viewpoint, the 'gender-centered approach', stated that gender impacts behaviors, attitudes and traits of women and men, due to biological and socialization differences. The second viewpoint noted that beliefs, theories, perceptions, and behaviors of men and women differ due to situational and organizational aspects. The last viewpoint, the 'gender-organization system', incorporated both of the aforementioned viewpoints. In addition, this perspective stated that individuals and organizations could not be understood unless from the same society or culture. A modification in individuals, organizations, and systems triggers a change in aspects such as sex-role labels, expectations, beliefs, culture and values. The author's investigation revealed that both avoidance and compromising

were utilized by all groups of nurses, including staff nurses and managers.

Compromising, although second, was still considered weak because all parties were regarded as equally disadvantaged. Accommodation was third, but a mode identified as not being helpful. Collaborating was underused and competing was utilized mostly by men, and not women, possibly due to its power-struggle nature. The author also discussed that gender possibly has some influence in what conflict management mode nurses choose. Nursing is primarily a female dominated discipline. This may explain why nurses, as mostly women, choose collaboration and support the notion that females tend to seek harmony and universally are more concerned with interpersonal aspects of relationships as compared to men. The general public and other healthcare professionals tend to view nurses' role in the traditional manner that has existed for decades even though there have changes in the role itself and in the role of women in the work force in general (Valentine).

According to Hendel et al. (2007), conflicts between nurses and physicians ensue on a daily basis. Collaboration may be the factor that separates Magnet hospitals, which excel in positive patient outcomes and other aspects of patient care, from non-Magnet hospitals. The researchers sought to investigate conflict mode choices between physicians and head nurses in acute care hospitals to determine the factor or factors that influence collaborative practice. The study was a cross-sectional correlational design that followed up on a previous study conducted in five different, acute care hospitals in the center of Israel. The 30-item Thomas-Kilmann Conflict Mode Instrument (MODE) was presented to 125 physicians and 60 head nurses, in which participants were asked to choose one of two statements that most identified their beliefs; of the aforementioned

sample, 75 physicians and 54 head nurses responded. The maximum score for any of the scales was 12, which correlated to very high use of a particular mode. The results showed that the compromising mode was the mode most significantly used by physicians, with a mean of 7.3, followed by avoidance at 6.9; scores for physicians ranged from 4.86 to 7.3. The compromising mode was also used by nurses most, with a mean of 7.3; however, accommodating was the second most used by the nurses, with a mean of 4 (range = 4-7.3). Head nurses utilized collaboration (mean = 6; range = 2-9) more than physicians and avoidance and accommodation were used least frequently by nurses (mean = 6; range = 2 - 10 and mean of approximately 4). Most participants had characterized themselves as using mixed modes, while 40% claimed to use only one mode. In essence, the compromising mode was the mode most frequently used by the doctors and head nurses (Hendel et al.).

Research by Sportsman & Hamilton (2007) sought to determine prevalent conflict management styles used by nursing, radiology and respiratory care students. The study recruited a convenience sample of 126 participants; university students enrolled in Associate, Bachelor's, and Master's degree programs in the above health sciences. Students were asked to complete the 30-item Thomas-Kilman MODE Instrument (TKI) and a demographic data tool developed by the researchers. Responses ranged from 4.0-7.5 out of a possible range of 4.0 to 7.5. Similar to the Hendel et al. study, students were asked to choose between one of two statements that most described their beliefs, which may reflect which of the five modes the individual prefers of conflict resolution the TKI is known for. Investigators found that nursing students used the compromise mode the most followed by avoidance, with means of 7.3 and 6.3, respectively; scores ranged from

4.4 to 7.3 for nursing students in terms of all five modes. The allied profession students used the avoidance mode most often, followed by compromise, with means of 7.3 (for both radiology and respiratory care students), and 6.7 (radiology students) and 6.8 (respiratory care students), respectively. Scores for the radiology students' scores ranged from 4.8 to 7.3, and for the respiratory care students' ranged from 5.2 to 7.3. Competition was the least likely mode used by the participants, with a mean of approximately 4.7. More than half of the sample had two styles of conflict management they used, mostly avoidance and accommodation with both at 51% at or above the 75 percentile.

In the nursing group there were 0 Associate's degree students, 54 Bachelor's degree students, and 11 Master's degree; 60 of the students were females and 5 were males. In the radiology group there were 18 Associate's degree students, 2 Bachelor's degree students, and 32 Master's degree students; there were 41 females and 11 males. Lastly, in the respiratory care group there were 0 Associate's degree students, 9 Bachelor's degree students, and 0 Master's degree students; 6 students were female and 3 were male. Only 9.8% of the students used collaboration, which increased as educational level increased. Compromise decreased as educational level increased. Competition was mostly used by graduate level students, with a mean of 5.3. Avoidance was mostly utilized by associate degree students (mean of 7.2), followed by graduate students (mean of 6.8) and lastly by bachelor's degree students (mean of 6.5). Women used the compromise mode most often and men used avoidance more frequently, with mean of 7.0 and 7.3, respectively. Overall results showed no significance ($P \leq .05$) between

the style of conflict resolution used in relation to educational level, health care discipline, and gender (Sportsman & Hamilton,).

Compromise was the mode most utilized in this study, but the authors pointed out that this may not be the best mode to aid in resolving conflicts as it only somewhat placates both parties and collaboration. In contrast, utilizing collaboration seeks to explore solutions that completely obliges both parties, despite being more resource heavy. This study has implications for the future of healthcare, as teaching communication techniques and methods to nursing and allied health schools will prove beneficial. It may be possible to incorporate these techniques in conjunction with each other during training within the respective programs. The researchers acknowledge that more research is needed (Sportsman & Hamilton).

Tabak and Koprak (2007) conducted a study that focused on the outcomes of Israeli nurses' modes of conflict management, as defined by Thomas and Kilmann (1974). Researchers argued that the causes of conflict were interprofessional disagreements, gender differences, gaps in education and socioeconomic status and lack of understanding and sympathy when nurses attempt to act more independently and take on more professional responsibilities. The authors highlighted that nurses tend to develop a rapport with their patients more so than physicians whereas doctors tended to be more technical in carrying out their professional duties. The researchers asked a non-randomized, convenience sample of nurses, comprised of 117 nurses (112 women and 5 men) at one of the largest hospitals in Israel, to fill out four different questionnaires consisting each of 5 questions with answers based on a scale from 1= never to 5= very likely. The questionnaires' items were related to aspects of Thomas-Kilmann's mode of

conflict resolution, job stress and job satisfaction. Results showed that some nurses reported a combined style approach to conflict resolution: integrating + dominance was mostly reported (mean= 4.07); obliging + avoidance was the other style combination used. Nurses who favored the obliging (smoothing) tactic (mean= 2.31) were more likely to have increased stress levels because they were more concerned with the other party and submitted to that party's wishes. Those nurses who adopted the avoidance tactic (mean = 2.30) had no resolution, were unable to handle stress and had less concern for the other party. Integration (Thomas and Kilmann's equivalent to collaboration) was shown to be most utilized (mean = 4.21). Avoidance was least utilized (mean = 2.30). Nurses who obliged more were shown to have decreased job satisfaction; moreover, increased stress also attributed to decreased job satisfaction. This authors referenced the importance of nurse managers providing nurses with opportunities to study and reflect on conflict resolution and collaboration methods, especially newer and younger nurses who may have not yet developed the skills to communicate effectively and confidently with physicians as their more seasoned counterparts have done throughout their career (Tabak & Koprak).

A study that used the Thomas-Kilmann instrument explored the topics of collaboration and conflict resolution in relation to nurse and physician job satisfaction, recruitment and retention (Nelson et al., 2008). A non-randomized, convenience sample of 95 nurses and 49 physicians from multiple medical-surgical units in a Californian hospital were asked to fill out a questionnaire called the Collaboration Practice Scale (CPS) geared towards both disciplines; the nurses' questionnaire had nine items and the

physicians' questionnaire had 10 items. Answers ranged on a scale from 1 to 6, with 1 = never and 6 = always).

Results showed that collaboration occurred at a lower rate on medical-surgical units than on other units, supporting previous evidence that medical-surgical nurses and physicians do not work as closely and collaboratively as those on critical care units. Physicians asserted that they felt confident and comfortable collaborating and communication with nurses in regard to patient outcomes, as shown by the higher mean scores on their CPS (mean = 4.31; range = 3.2 to 5.1) but this viewpoint was not shared by the nurses. Nurses' CPS scores (mean = 3.52; range = 2.4 to 4.6) indicated that they lacked the assertiveness to communicate with physicians, even when it came to patient care and outcomes. Long-standing hierarchal relationships, male dominance in the medical field, and nursing being seen as a subservient profession were cited as barriers to quality patient care. The authors noted that power in a collaborative relationship should be equivalent and evenly distributed. Collaboration was viewed as a vital factor in decreasing health costs, decreasing length of patient stays, reducing "burnout" and increasing retention of nurses. The authors concluded that there was a need to increase nurse-doctor collaboration, initiate team building programs at schools, both nursing and medical as well as work settings, design training programs to help nurses increase assertiveness and confidence, and last but not least, to break through the current culture to help reach the goal of quality patient care (Nelson et al.).

In a qualitative study of nurses, investigators found that collaboration between nurses and physicians was vital in providing quality care (Leever et al., 2010). These researchers focused on the factors that determined the style of conflict management that

nurses decide to use. This study took place at a Dutch University Medical Center, where two surgical specialties were located including gynecological and oral/maxillofacial surgery. In total, 12 participants, six nurses (all females) and six physicians (three males and three females), contributed. Participants were interviewed using a semi-structured tool with open-ended questions that focused on collaboration between nurses and physicians, definition of what a conflict is and other aspects of conflict and conflict management and preferences as to what style(s) the participant preferred.

Results showed that the participants were generally pleased with the amount of collaboration; nonetheless, they reported that there were times where the use of collaboration was not favorable in a particular conflict. Participants' responses exposed there were two ways in which they dealt with conflict: ignoring the conflict or engaging in the conflict, either by force or discussion. If a discussion took place, the participants noted that they did take into account the other side's perceptions and beliefs. Five factors influenced the nurses' choice of conflict management: impact of one's self; impact of the other party; nature of the conflict; situation of conflict; and personal motivations. One of the most important conclusions to note from this study was that the better the collaboration between nurses and physicians, the better the patient outcomes (Leever et al.).

Although the literature on conflict management is extensive, physician and nurse modes of conflict management vary widely due to individual characteristic and the nature of their work environments. In general, however, avoidance and competing are the modes that seem to be least utilized; the three other modes, including collaboration, compromising and accommodating are all used to a greater degree (Kilman & Thomas,

1977). A common theme found in most of the articles is that there is a need for more collaboration between nurses and physicians. Constructive and positive work environments, understanding of a profession's tasks and responsibilities, focusing on the client and their needs, the presence of strong leadership (especially nursing leadership), education and the need for increased education on conflict management are all factors that influence what style(s) of conflict management are utilized by physicians, nurses and other health professionals (Joel, 2013). For the purpose of this study, despite there being many other manners and styles of conflict management, the Thomas-Kilmann Model and their instrument will be primarily addressed.

Next, the theoretical framework guiding this study will be presented.

Theoretical Framework

The Thomas-Kilmann Model of Conflict Management was used to guide this research. The Thomas-Kilmann theory proposes that collaboration meets everyone's needs, occurring between individuals or groups to come to an agreement on a solution that benefits the greater good of the person, patient and/or people involved (McKibben, 2017). The Thomas-Kilmann Instrument (TKI), developed by Kenneth W. Thomas and Ralph H. Kilmann, is based on a conceptual framework proposed by Robert Blake and Jane Mouton (1964). Blake and Mouton suggested five basic attitudes and styles of control for managers that could be placed on a managerial grid (Blake & Mouton, 1964).

Organizational conflict can occur between individuals, small work teams and groups (Kilmann & Thomas, 1977; Thomas, 1974; 1992). Conflict situations are those in which the concerns of two people appear to be incompatible. In such situations, individual behavior can be described along two dimensions: (1) assertiveness, the extent to which persons attempt to satisfy their own concerns; and (2) cooperativeness, the extent to which persons attempt to satisfy other person's concerns (Kilmann & Thomas, 1977). These two basic dimensions of behavior define five different modes for responding to conflict situation.

1. Competing is assertive and uncooperative: individuals pursue their own concerns at the other person's expense. This is a power-oriented mode in which people use whatever power seems appropriate to win their own position - their ability to argue, their rank, or economic sanctions.

Competing means "standing up for one's rights," defending a position which you believe is correct, or simply trying to win (Kilmann & Thomas, 1977; McEwen & Wills, 2011; McKibben, 2017).

2. Accommodating is unassertive and cooperative: the complete opposite of competing. When accommodating, individuals neglect their own concerns to satisfy the concerns of the other person; there is an element of self-sacrifice in this mode. Accommodating might take the form of selfless generosity or charity, obeying another person's order when you would prefer not to, or yielding to another's point of view (Kilmann & Thomas, 1977; McEwen & Wills, 2011; McKibben, 2017).

3. Avoiding is unassertive and uncooperative: persons neither pursue their own concerns nor those of the other individuals. Thus they do not deal with the conflict. Avoiding might take the form of diplomatically sidestepping an issue, postponing an issue until a better time, or simply withdrawing from a threatening situation (Kilmann & Thomas, 1977; McEwen & Wills, 2011; McKibben, 2017).

4. Collaborating is both assertive and cooperative: the complete opposite of avoiding. Collaborating involves an attempt to work with others to find some solution that fully satisfies their concerns. It means digging into an issue to pinpoint the underlying needs and wants of the two individuals. Collaborating between two persons might take the form of exploring a disagreement to learn from each other's insights or trying to find a creative

solution to an interpersonal problem (Kilmann & Thomas, 1977; McEwen & Wills, 2011; McKibben).

5. Compromising is moderate in both assertiveness and cooperativeness. The objective is to find some expedient, mutually acceptable solution that partially satisfies both parties. It falls intermediate between competing and accommodating. Compromising gives up more than competing but less than accommodating. Likewise, it addresses an issue more directly than avoiding, but does not explore it in as much depth as collaborating. In some situations, compromising might mean splitting the difference between the two positions, exchanging concessions, or seeking a quick middle-ground solution (Kilmann & Thomas, 1977; McEwen & Wills, 2011).

People are capable of using all five conflict-handling modes and no one can be characterized as having a single style of dealing with conflict. Certain people, however, use some modes better than others and therefore tend to rely on those modes more heavily than others, whether because of temperament or practice. Conflict behavior in the workplace is a result of both personal predisposition and the requirements of the situation in which one finds oneself (Kilmann & Thomas, 1977; Thomas, 1974, 1992).

Taking Thomas and Kilmann's theory, and information from the literature, this researcher will explore the style(s) of conflict management used by medical-surgical nurses in dealing with medical doctors, physician assistants and nurse practitioners.

Next, the study methods will be presented.

Methods

Purpose

The purpose of this research was to explore the styles of conflict management used by medical-surgical nurses to deal with conflicts with medical doctors, physician assistants, and nurse practitioners working in a tertiary care hospital.

Design

The design for this project was a descriptive survey using the Thomas-Kilmann MODE Instrument (TKI) (Kilmann & Thomas, 1977; Thomas, 1974; 1992)

Site and Sample

This descriptive, survey study was conducted in a 700+ bed, teaching, not-for-profit hospital, with a Level-1 trauma center, located in the Northeastern United States. A target group of approximately 47 nurses on the selected medical-surgical unit were eligible to be recruited. There were no exclusion criteria for nurses to participate in the project.

Measurement

The 30-question Thomas-Kilmann MODE Instrument (TKI) was disseminated to nurses who worked on the selected medical-surgical unit and wished to participate. This questionnaire has been utilized in many previous studies and is an appropriate tool for this particular project as it focuses directly on the variables of interest.

The TKI (Appendix A) is a self-scoring assessment that takes approximately 15 to 20 minutes to complete. The tool is a 30-item forced-choice measure, where the respondent selects one of two alternatives, making the social desirability of response options an important consideration, as well as the statement that is most characteristic of the individual's behavior. Thomas and Kilmann designed the TKI to account for social desirable responding by having participants rate the response alternatives of the TKI instrument on a 9-point scale, ranging from "Extremely Undesirable" to "Extremely Desirable." They chose and tested each item pair to ensure that neither response was more socially desirable. A study examining the ability of the instrument to control social desirability found that the TKI significantly reduced the social desirability response bias when compared to similar tools assessing conflict behavior, a strategy adapted from A.L. Edwards (Kilman & Thomas, 1977).

Originally, the TKI had 50 items, but after analyzing data from samples of graduate students, who consented to participate in the testing of the TKI, it was shortened to its current version. Extensive and numerous correlation studies were run on the TKI against itself and each question (to test the consistency, reliability, and validity of each question), and against other comparable instruments. In turn, the instrument corrects itself for any bias or having one of the two choice in each item being more desirable than the other. For this reason, each conflict mode is paired with the remaining conflict modes three times. Raw scores are calculated by counting the number of times each mode is chosen, with scores ranging from 0 to 12. The raw scores are converted to percentile scores. Percentile scores indicate the percentage of people in a norm group who scored at or below a given raw score. In addition, percentile scores are partitioned into three

interpretive ranges—high (the top 25%), medium (the middle 50%), and low (the bottom 25%) (Johnson, Thompson, & Anderson, 2014).

Procedures

During the winter of 2018, the project proposal was submitted to Lifespan Institutional Review Boards (IRB), followed by the RIC IRB; the IRBs determined the project to be exempt. Permissions were sought from the hospital's Chief Nursing Officer (CNO) and the medical-surgical unit's Clinical Manager (CM) and Assistant Clinical Manager (ACM). Student researcher familiarity with the unit and the CNO may have proven helpful, as did the CNO, CM, and ACM's ongoing support of nursing research.

The unit manager, and/or ACM, were asked to aid in distributing reminders regarding the study via email, due to their easy access to the staff's email addresses. Two reminders via email were sent to the nurses (one reminder the beginning of the first week of data collection and another reminder the beginning of the second week of data collection). A paper version of a reminder was also posted throughout the unit (i.e. nurses' stations, staff break room, and staff locker room); both versions had the date the survey will close.

The questionnaire was disseminated via paper. Copies of the questionnaire along with the IRB approved informational letter were placed in a manila envelope. The informational letter outlined the purpose and of the project, study procedures, that responses were confidential and anonymous and how data will be utilized, kept, and analyzed. Subjects were provided the principal investigator's and student researcher's contact information in case of questions or concerns.

Nurses were instructed to put the completed survey in a locked drop box. Within the two weeks nurses had to complete the survey, the student researcher checked on the manila envelope, making sure there were enough blank copies, and that completed copies, located in the lockbox, were removed and filed appropriately. Pens, placed in a pocket glued to the front of the envelope, were also supplied to complete the survey.

Data Analysis

The data collected were scored based on Thomas and Kilmann's scoring methods, corresponding to the questionnaire. Microsoft Excel was used to analyze the data and produce descriptive statistics.

Next, the results will be discussed.

Results

Out of 47 potential participants, 23 (48.9%) nurses completed the questionnaire.

Figure 1 below displays the number of surveys that were collected reflecting each conflict management style.

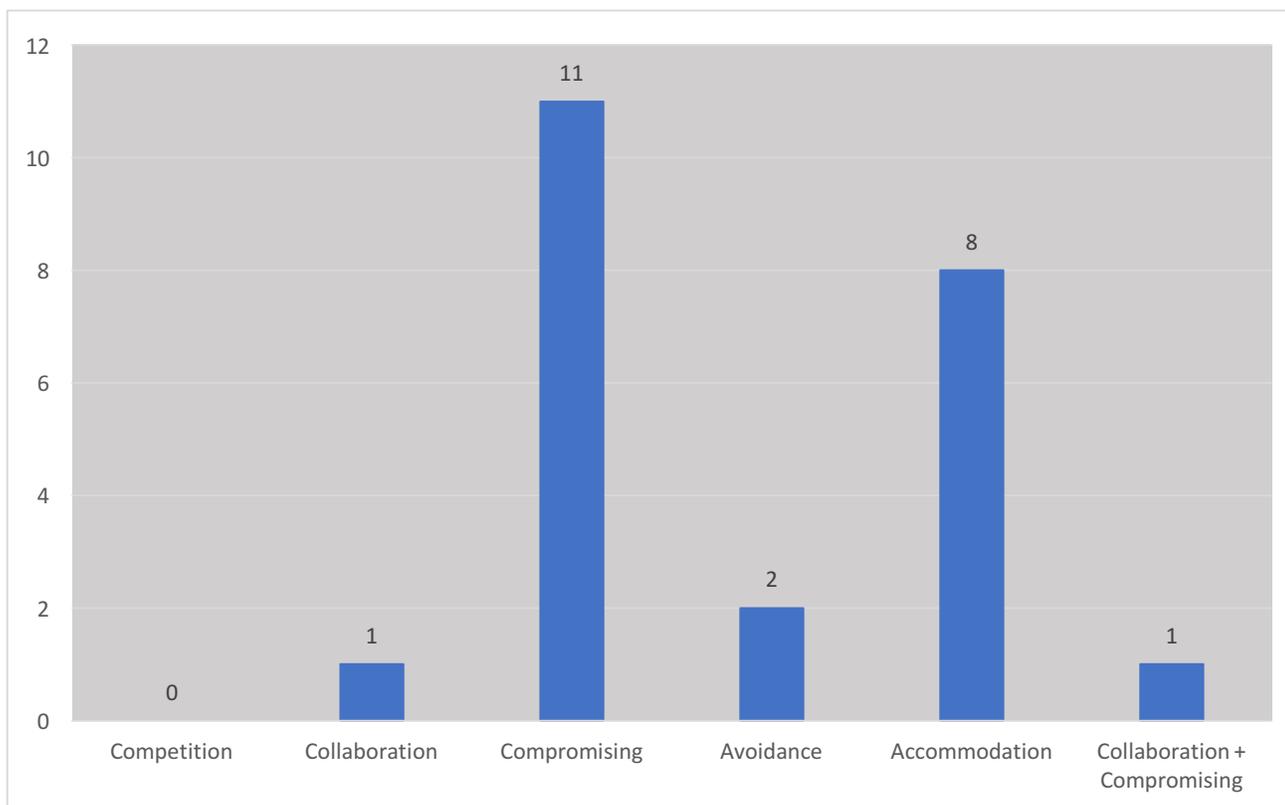


Figure 1. Number of completed surveys that reflect each conflict management style

The two most utilized styles of conflict management were compromising, followed by accommodation. The third utilized style was avoidance and collaboration mode was the fourth. The competition mode was not utilized at all. One respondent used collaboration and compromising equally.

Figure 2, below, represents the percentages of completed surveys that reflect each conflict management style

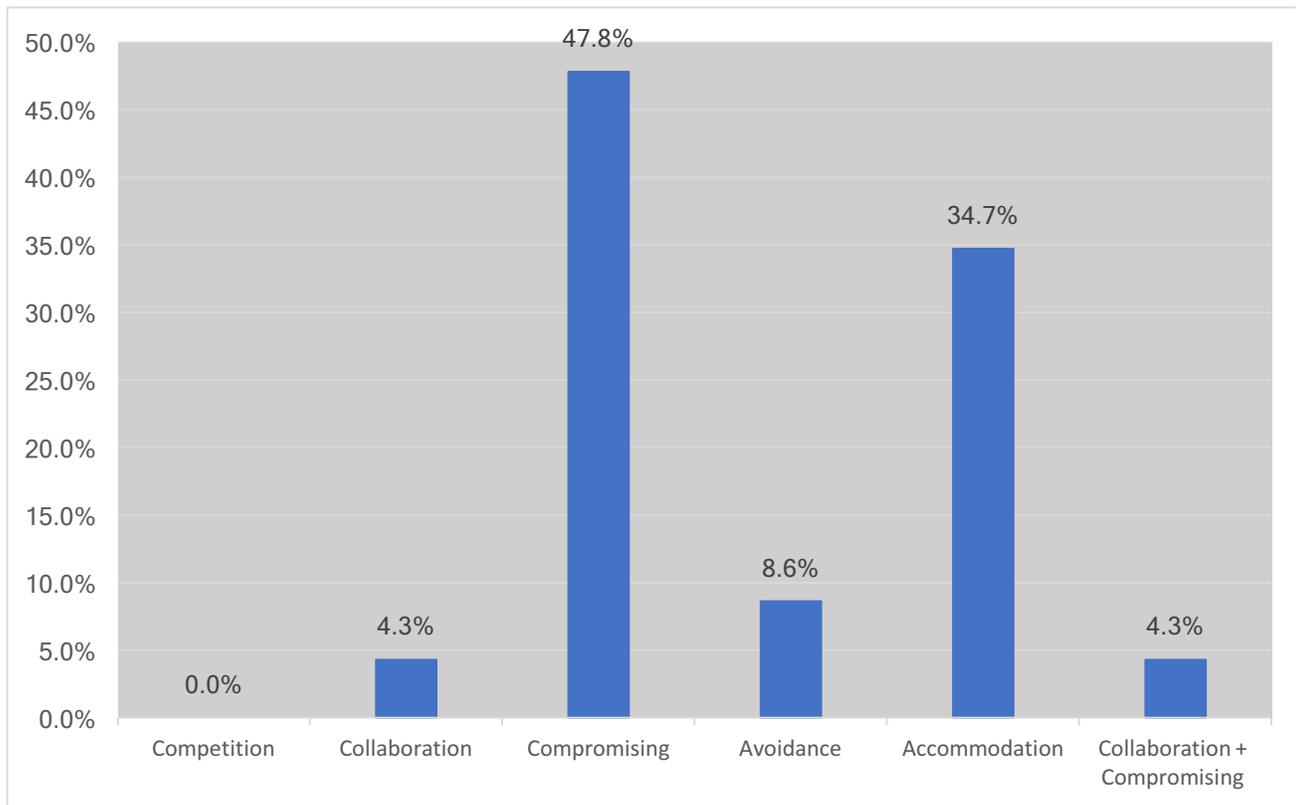


Figure 2. Percentages of completed surveys that reflect each conflict management style

Eleven out of the 23 surveys (47.8%) resulted in the compromising mode, while eight (34.7%) respondents employed the accommodation mode. Two respondents, (8.6%) used avoidance, one used the collaboration style (4.3%), and one scored equally between collaboration and compromising (4.3%).

Next, summary and conclusions will be presented.

Summary and Conclusions

Past research has shown that collaboration with physicians and other providers results in numerous positive outcomes. Conflict has also been described as unavoidable, dynamic, constant, and an innate human attribute (Almost et al., 2016; McKibben, 2017). Nurses continue to recognize problems with conflict between themselves and medical providers, such as physicians, physician assistants and nurse practitioners, therefore noting the significance of interdisciplinary care (Joel, 2013). Multiple articles in this study discussed the importance of interdisciplinary care, as well as, ways on how to develop it between nurses and physicians. One key point is that conflict can occur on any type of unit, as hospitals take on the burden and stressors of the persistent changes in healthcare.

This study sought to explore the conflict management style utilized by nurses in a medical-surgical setting in a local tertiary care, and Level 1 Trauma and Comprehensive Stroke Center. Participants, who willingly chose to participate, were asked to complete The Thomas-Kilmann Instrument, a questionnaire created by Kenneth Thomas and Ralph Kilmann themselves. In their theory, Thomas and Kilmann (McEwen & Wills, 2011; Thomas, 1992) proposed that use of collaboration may be the ideal conflict management style, specifically in the healthcare setting, where optimal patient outcomes are the utmost priority and an interdisciplinary approach to teamwork is encouraged. The collaborative style upholds that open, effective communication between the individuals, or parties, leads to everyone expressing their viewpoints, but that the individuals, or parties, come to an agreement on a solution that ultimately benefits the patient (Kilmann & Thomas, 1977; McEwen & Wills, 2011; McKibben, 2017).

The styles of conflict management most utilized by the nurses that participated in this study were compromising followed by accommodation. Compromising, known as “The Fox” mode, is equal and moderate in terms of obligation to personal and relationship goals, respectively; these individuals are willing to relinquish something if the other party also relinquishes something. Accommodation, known as the “The Teddy Bear” mode, is different than compromising in that obligation to personal goals is very low, while obligation to the relationship goals is very high. These individuals may “brush away” doctors or appease them when they give orders and may go against what they truly believe is true or right for the patient. Avoidance, known as the “The Turtle” mode, was the third most utilized, and is characterized by low commitment and relationship goals, respectively. These individuals refuse to reach out to either talk or listen, so the conflict continues with no resolution. Collaboration, known as “The Owl” mode, was the fourth least utilized mode in conflict management. This mode is characterized by open and fair communication, in addition to, optimism and satisfaction towards reaching their own goals and the goals of others. Competition, known as the “The Shark” mode, was not utilized at all, and is regarded as a forced win-lose situation, with high commitment to one’s beliefs and low commitment towards others. While compromising and accommodation were the styles of conflict management most frequently identified, there is no one mode that is “right”; individuals may use more than one style of conflict management (Kilman & Thomas, 1977; McEwen & Wills, 2011). There is also the possibility of utilizing all five modes, even though Thomas and Kilman believed that individuals usually use one or two modes the most (Thomas & Kilman, 2009). Conflict management and handling depends on the conflict itself, and what is

necessary to deal with it. Nonetheless, personality and an individual's character traits have to also be taken into account.

One of the challenges of this project was the literature review on this topic, as majority of previous research has been done in ICU settings. Another limitation was the sample size ($n = 47$). Other limitations potentially include the lack of compensation and time to complete the survey, the length of the questionnaire, and survey burnout, especially with the recent influx of surveys distributed throughout the organization. Furthermore, there were a number of novice nurses that had recently begun their nursing training or have less than one year of experience, however all of the new nurses added to the staff are new to this facility; therefore, they may not be familiar with the process and value of research.

In summary, this study showed that on a medical-surgical unit, nurses most utilized conflict management style of compromising, followed by the use of use of accommodation. The results of this study coincide with the literature regarding this topic, in that comprising and accommodation are the two most utilized modes in conflict management in healthcare settings. A medical-surgical environment differs from that of an intensive care unit, where doctors and other providers may not be readily accessible, as they may have numerous other patients on other units throughout the facility; particularly at a site as large as this where there are several other medical-surgical units. In ICUs, collaboration was perceived as the ideal conflict management style, even though severely underutilized; compromising, accommodation, and avoidance were mostly utilized in this order. Competition was the style used by many physicians. In general, the literature demonstrated that when collaboration is used to unravel a patient-related issue,

both parties bring forth diverse, but nonetheless, valuable skills and knowledge to generate a resolution.

Next, recommendations and implications for practice will be presented and discussed.

Recommendations and Implications for Advanced Practice

Advanced practice registered nurses (APRNs) hold the key to the future of healthcare and the changes that will ensue (McEwen & Wills, 2011). The nature of their work and experiences will prove vital to those changes and will spurn ideas, concepts, and plans to initiate changes that some others might not think about.

One major implication from this research study is the need for interprofessional collaboration, and interdisciplinary care, to be an aim for all direct care providers to strive for. This could assist in preventing the various negative patient outcomes that can ensue when conflict exists within the team. D'Amour et al. (2005) completed a literature review that focused on how interprofessional collaboration could increase the effectiveness of health services offered to the public. According to D'Amour et al., the concept of collaboration can be defined by five ideas: sharing; partnership; power; interdependency; and process. The authors emphasized the importance of patients being involved in their own care and lamented the limited research conducted on how patients and the health care team could work together, while respecting patients' decisions related to their own health. The ultimate goals are to prevent patient errors, improve patient outcomes, increased patient satisfaction, and increase provider and patient collaboration.

Organizations, principally ones as large as the site used for this research, need to consider programs or curricula to engage interdisciplinary direct healthcare providers in finding constructive strategies to recognize, effectively manage, and ultimately reduce conflict. Organizational leaders at all levels need to be on board and open to the idea of change and actively facilitate positive change in the area of conflict management.

Advanced practice registered nurses can initiate these vital conversations with nursing leaders, as they can serve as mediators between the nursing and medical disciplines. Examples of these initiatives that could be used to target effective conflict management could include research projects, focus groups, curricula-based courses, and quality improvement projects. Advanced practice nurses can be instrumental in the creation, planning, implementation, and evaluation of these initiatives. Ultimately, these could potentially not only increase the quality and quantity collaboration between healthcare providers but could facilitate the common goal of safe and quality patient care and optimal patient outcomes.

On-going and relevant education and training is essential for all healthcare providers in order to be able to manage the on-going changes in healthcare. The APRN can serve as a leader, educator, and role model in developing, implementing, and evaluating educational opportunities related to conflict management. Currently, within local medical and nursing programs, simulations occur between medical, social, and pharmacy students that aim in increasing collaboration, in an educational and ideal learning environment. Further local and national funding support for this type of creative program is needed. Simulation provides a real-life opportunity for health care professionals to practice conflict management skills in a safe, non-threatening environment

Further research is needed to further examine strategies to increase collaboration between providers. A research design using pre- intervention measurement an educational intervention on the topic of conflict management and strategies to increase collaboration and effective communication and followed by a post-test would be useful

Further research is needed on medical-surgical nurses and other sub-specialty areas within nursing. Research is also needed to explore gender and cultural issues that impact conflict management style and strategies.

Advanced practice RNs can advocate for and lead change within their organization and beyond. The APRN needs to advocate for local and national policy to improve interdisciplinary collaboration and effective conflict management. One vehicle through which this can occur is via active participation in professional organizations. . On a local and national level, there has been a push for the increased performance of interdisciplinary rounds as a means of incorporating all disciplines to discuss patients' overall disposition, specifically utilizing the SBAR-P method of presenting the patient's information. These interdisciplinary rounds can help bring forth ideas from all areas of healthcare to optimize discharge plans and continuum of care.

Advanced practice nurses are crucial, in the roles of researcher and educator, to solidify best practices to improve collaboration, communication, and conflict resolution in healthcare. Whether it be with physicians, pharmacists, other RNs, case managers, or numerous other providers, the basis for APRN practice, to in provide holistic and quality patient care, needs to be at the forefront.

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Appendix A

THOMAS-KILMANN CONFLICT MODE QUESTIONNAIRE

Consider situations in which you find your wishes differing from those of another person.
How do you usually respond to such situations?

On the following pages are several pairs of statements describing possible behavioral responses. For each pair, please circle the "A" or "B" statement which is most characteristic of your own behavior.

In many cases, neither the "A" nor the "B" statement may be very typical of your behavior, but please select the response which you would be more likely to use.

1. A. There are times when I let others take responsibility for solving the problem.
B. Rather than negotiate the things on which we disagree, I try to stress those things upon which we both agree.

2. A. I try to find a compromise solution.
B. I attempt to deal with all of another's and my concerns.

3. A. I am usually firm in pursuing my goals.
B. I might try to soothe the other's feelings and preserve our relationship.

4. A. I try to find a compromise solution.
B. I sometimes sacrifice my own wishes for the wishes of the other person.

5. A. I consistently seek the other's help in working out a solution.
B. I try to do what is necessary to avoid useless tensions.

6. A. I try to avoid creating unpleasantness for myself.

B. I try to win my position.

7. A. I try to postpone the issue until I have had some time to think about it.

B. I give up some points in exchange for others.

8. A. I am usually firm in pursuing my goals.

B. I attempt to get all concerns and issues immediately out in the open.

9. A. I feel that differences are not always worrying about.

B. I make some effort to get my way.

10. A. I am firm in pursuing my goals.

B. I try to find a compromise solution.

11. A. I attempt to get all concerns and issues immediately out in the open.

B. I might try to soothe the other's feelings and preserve our relationship.

12. A. I sometimes avoid taking positions which would create controversy.

B. I will let another have some of their positions if they lets me have some of mine.

13. A. I propose middle ground.

B. I press to get my points made.

14. A. I tell another my ideas and ask them for theirs.

B. I try to show him the logic and benefits of my position.

15. A. I might try to soothe the other's feelings and preserve our relationship.

B. I try to do what is necessary to avoid tension.

16. A. I try not to hurt the other's feelings.

B. I try to convince the other person of the merits of my position.

17. A. I am usually firm in pursuing my goals.

B. I try to do what is necessary to avoid useless tensions.

18. A. If it makes the other person happy, I might let them maintain their views.

B. I will let the other person have some of their positions if they let me have some of mine.

19. A. I try to get all concerns and issues immediately out in the open.

B. I try to postpone the issue until I have had some time to think it over.

20. A. I attempt to immediately work through our differences.

B. I try to find a fair combination of gains and losses for both of us.

21. A. In approaching negotiations, I try to be considerate of the other person's feelings.

B. I always lean toward a direct discussion of the problem.

22. A. I try to find a position that is intermediate between mine and another person's.

B. I assert my wishes.

23. A. I am often concerned with satisfying all my wishes.

B. There are times when I let others take responsibility for solving problems.

24. A. If the other's position seems important to them, I would try to meet their wishes.

B. I try to get the other person to settle for a compromise.

25. A. I try to show the other person the logic and benefits of my position.

B. In approaching negotiations, I try to be considerate of the other person's wishes.

26. A. I propose a middle ground.

B. I am nearly always concerned with satisfying all my wishes.

27. A. I sometimes avoid taking positions that would create controversy.

B. If it makes the other person happy, I might let them maintain their views.

28. A. I am usually firm in pursuing my goals.

B. I feel that differences are not always worth worrying about.

29. A. I propose middle ground.

B. I feel that differences are not always worth worrying about.

30. A. I try not to hurt the other person's feelings.

B. I always share the problem with the other person so that we can work it out.