Untangling Conflict in Healthcare

Background

During a recent vacation in Greece a well-respected senior healthcare leader decided to make a side trip to Delphi to seek advice about a problem that had been vexing her for some years. She was hopeful that the oracle at Delphi could provide some guidance. The problem went something like this:

" In spite of the fact that our healthcare facilities and system as a whole are blessed with intelligent, dedicated, hardworking clinicians, caregivers, and managers, we still cannot seem to reach a point where collaborative activity comes naturally - the many silos and mini-kingdoms seem to operate quasi-independently, often to the detriment of safe quality care that responds to the needs of the patients, families and the community. Why does this continue? What is to be done?"

After arriving at Delphi and submitting her vexatious problem the leader was prepared to wait, thinking that this problem might overwhelm the abilities of the oracle. She decided to visit the surrounding countryside, which is truly quite stunning. When she returned later the same afternoon she found the oracle had already produced some advice:

1. **It is well known that complex adaptive systems (CAS) generate not only significant uncertainty and unpredictability but also frequently conflict.**

2. Healthcare is a good example of a CAS, whether this is examined at the level of individual teams, departments, facilities or the system as a whole. Conflict will be manifested differently at various levels of the system.

3. Efforts to address conflict in a given CAS should ideally adopt approaches and techniques that are consonant with the characteristics of that system.

The leader was both satisfied and somewhat perplexed. Satisfied because the oracle had provided clear direction. Perplexed about how the advice could be applied in the context of her specific system. This chapter will de-construct the advice in order to determine the most effective and appropriate way to untangle conflict in healthcare.

CAS and Conflict

What are the important characteristics of a CAS and how do these contribute to conflict? These questions have been examined many times in classic texts and reviewed again in Volume 2 of Resilient Health Care (see Robson 2015). A recent White Paper from the AIHI (Braithwaite 2017) provides a broad overview of this field. These resources are accessible and should be examined in more detail to understand the evolution of the academic and practical understanding of CAS and, in particular, the way in which conflict emerges as an inherent element of these systems.

A very brief summary indicates that CAS are typically **open systems** with **flexible and semi-permeable boundaries**. This means that the CAS is susceptible to influences from outside the usual limits of the system. Ultimately a CAS will develop (through a process known as **self-organization**) as a result of **dynamical, often unpredictable interactions** (often occurring simultaneously at multiple levels) between the **components and agents** that comprise the system at any given moment. These dynamical interactions (the agents are often described as being **semi-autonomous** - while they primarily interact at local levels within a system they are influenced by and respond to factors both within and outside the system) help us to understand the many changing properties of the system, by producing **patterns of activity** through a process known as **emergence**. Said another way, CAS are fundamentally **relational** (the relations between components and semi-autonomous agents defines the nature of a given CAS).

It is not surprising, given the dynamical nature noted above, that a CAS can never be fully controlled. This understanding can be challenging, even shocking, for most of us educated in a

traditional linear, binary and deterministic world view. Once our bruised and fragile egos have recovered from the loss of absolute control with respect to a CAS, we can begin to learn how we are nevertheless able to influence self-organization and emergence with a view to encouraging patterns that are more consistent with the values and goals of society. This is where the question of using appropriate means of addressing conflict within a CAS becomes so important. If we use approaches or techniques that do not reflect the underlying "operating system" of the CAS we are unlikely to be able to influence the self-organization process.

Where does conflict in a CAS originate? With multiple (and multi-level) factors interacting in a dynamical manner it is inevitable that resources will often be inadequate for the functional operations of some components or sub-systems (in healthcare this translates most easily into the needs of various domains/units/departments/programs that can never be fully satisfied). It is therefore not a mystery as to why silos develop in healthcare, competing for insufficient resources while responding to the activities of diverse internal and external agents. It now becomes clear why the frustrated senior healthcare leader who visited Delphi asked about the "silos and mini-kingdoms [that] seem to operate quasi-independently". She was describing (perhaps without fully realizing it) an important manifestation of conflict that develops in CAS.

Addressing Conflict and Disputes

Much has been written about conflict, its origins, and the variety of approaches to address and resolve it through the active engagement of the main players. Foundational texts (Fisher, Ury and Patton, 1983; Bush and Folger, 1994; Marcus et al, 1995; Moore, 1996; Kritek, 2002; Stone et al, 1999; Ury, 1999; Mayer, 2000; Bowling, 2003) include both the historical understanding of conflict as well as an analysis of the main approaches to dealing with disputes. For a long time the approaches to conflict were considered to fall into three categories, relying on the application of **power**, **rules**, or an appeal to the **interests of the disputing parties** as preferred methods to resolve issues.

Power-based approaches are exemplified in 2017 by a number of contemporaneous international situations. The approach is relatively common in organizations and systems that are typically rigid hierarchies where management by "command-and-control" is the order of the

day. Relying on power is also the foundational component of bullying. The resolution of any dispute through a power-based approach is rarely satisfactory and even more rarely permanent. Ury (1999) has written persuasively about this. Of interest, the power-based approach is often softened or gentrified in CAS when combined with rules, written procedures, and codes of conduct.

Rules-based approaches are common in large social organizations whether or not they are CAS (Olson and Eoyang 2000). They are also a common feature in systems with a command and control hierarchical structure and appear as both implicit and explicit rules, extensive procedure manuals (intended to describe in detail how tasks are to be accomplished - often described as “work-as-designed” - Hollnagel 2015), as well as in Codes of Conduct. These are the stock in trade of many Human Resources (HR) professionals in large organizations. HR professionals are frequently called on to intervene in situations where there is a perceived conflict, alleged inappropriate behaviour or an unanticipated outcome of a work process based on an assumption of “human error”.

In such circumstances established rules, procedures or codes of conduct provide a convenient way of apparently “adjudicating” situations that are felt to be negative or undesirable. Given the way in which CAS evolve and develop, this kind of resolution of conflict rarely facilitates more productive interactions between agents and components in the system. A rules-based approach does, it must be said, provide satisfactory “ accountability outcomes” (in other words clearly identifying who is at fault) from the point of view of senior leadership of the organization.

Interest-based approaches have become the methods most commonly adopted by conflict resolution practitioners and mediators over the last several decades. Most organizations also maintain a rule-based approach which may be combined with an interest-based approach. Most mediators and conflict resolution practitioners associate this approach with the work of Roger Fisher and the Harvard Law School Program on Negotiation (Fisher. Ury, and Patton, 1983). Other prominent organizations such as CDR Associates in Boulder Colorado have contributed to and broadened the theoretical basis of this approach (Moore, 1996; Mayer, 2000). The underlying assumption of an interest-based approach is that lying behind formal or public positions adopted by the parties to a conflict there may be more fundamental interests that can

be shared and explored. This leads to a search for mutual common interests (or at least overlapping interests) leading to a potential resolution (the widely hoped for “win-win” solution).

The role of the mediator in such disputes is to adopt a “neutral” or disinterested position, assisting the parties to listen and then hear and acknowledge what each is saying as a way of helping them find mutual interests as a pathway to resolution. The concept of the mediator as a neutral party is central to this “problem-solving” process and the underlying assumption is that once the various individual interests have been identified a solution can be constructed by the parties to “unblock” the conflict. This is a fundamentally linear way of viewing the conflict and the “problem to be solved” is thought to reside in the positions adopted by the parties. These assumptions made sense in simpler situations and have been successful to a certain extent.

A New View

As the complexity of social organizations has increased, challenges have arisen leading to a “post-modernist” or social constructionist analysis of conflict. Some of the philosophical assumptions underlying interest-based approaches have been examined in depth and have been found to be less applicable to a CAS. The application of a social constructionist viewpoint has led to a **relational or narrative approach** to addressing conflict in complex situations. An expanding body of writing and reflection (Winslade and Monk, 2000, and 2008; Mayer, 2004) has identified a number of factors which suggest that a relational or narrative approach to conflict is better suited to the particular nature of complex situations and CAS. As will be seen, this approach is also better suited to addressing conflict in healthcare.

A post-modernist perspective identifies a number of problematic issues concerning the use of interested-based approaches in CAS. The first of these is the **linear problem-solving framework** that is applied with this approach. It can be useful for those processes within a CAS that are also linear and especially if they are tightly coupled (see Perrow 1984) - otherwise, the situations resulting in conflict and disputes in a CAS are the result of the dynamical interactions described above and are much less amenable to influence using a linear approach. The problem-solving approach that is implicit in interest-based mediation leads to a mindset that sees conflict as something to be “fixed” (once this is accomplished, the system will once again run smoothly) very much like the Newtonian or mechanistic view of the world which encourages

us to think that we need only find the “broken parts” in order to heal a broken process (Capra and Luisi, 2014).

A second important issue concerns the implicit assumption that most **conflict originates from within the individuals** involved in a dispute - a result of unsatisfied needs that lead to positions that tend to be binary - rather than emerging from the contextual influences in the system itself. Of course, this ignores the fact that the conflicts or disputes reflect a pattern of behaviour that has emerged from the dynamical interactions of multiple factors and components floating (sometimes swimming and sometimes almost drowning!) in a sea of mysterious contextual influences.

A third central issue that has long been debated within the conflict resolution practitioner community is the **assumption of neutrality** on the part of the mediator or person who is facilitating resolution of a dispute. The romantic notion that mediators can somehow magically rise above their own history and values and remain stalwartly disinterested and neutral with respect to the participants and issues in dispute has been elevated to the legendary status of creed. It does not reflect reality and this becomes apparent when adopting a narrative approach. The “story” that makes sense of a particular conflict grows out of the weaving together of many influences, factors and conditions all drawn from the broader systemic context. Strangely enough the same can be said of the mediator’s “story” which, in spite of truly Herculean efforts to maintain neutrality”, is brought to the table and enters into the efforts to move beyond the conflict. The idea that mediators can magically separate the process issues from the substantive issues is not supported by reality. In some way this dilemma can be seen to be the mediator’s dilemma - a real life application of Heisenberg’s uncertainty principle in quantum mechanics (the inability to know with precision both the position and the momentum of a subatomic particle). A mediator cannot focus on process questions uniquely without also influencing and potentially modifying substantive issues that are central to a given dispute.

The issues raised above are only three of the many philosophic challenges to an interest-based approach, when examined from a post-modern perspective. It is beyond the scope of this chapter to explore the many others. Suffice to say that incorporating a relational or narrative approach to addressing conflict in a CAS corresponds more closely to the ways in which such

systems develop and evolve. This approach is an even better match in healthcare CAS, as will be seen below.

Untangling Conflict in Healthcare

We have arrived at the point where our senior healthcare leader is getting a bit impatient, yearning for concrete advice to help her apply the general principles provided by the oracle at Delphi to the dysfunctional “silos and mini-kingdoms” in her healthcare system. Fortunately, help is at hand in the form of a series of six articles published in the American Journal of Nursing (Gerardi, 2015). These outline in detail how to apply a **relational or narrative approach** to conflict in a CAS. Gerardi raises two fundamental points with respect to applying such an approach in healthcare disputes.

First, providing care is a relational activity (Letiche, 2008), depending on the ability of all providers to work collaboratively by building strong relationships within and between teams and departments in order to connect with the needs of the patient, client, family and community of which they are a part. This applies equally to providing care, developing and expressing empathy, organizing appropriate support and sharing both hope and uncertainty. The central relational nature of caring is true whether this is provided in a simple therapeutic dyad or a more complicated structure - in other words, healthcare is fundamentally a relational enterprise even when it is not provided in a CAS setting. Thus it makes sense that a perspective that sees conflict as something to be broken down into parts that can be fixed or problems to be solved is unlikely to be successful in situations that depend on the development and strengthening of relationships at all levels.

Secondly, Gerardi (2015) and others (Mayer, 2004) argue persuasively that focusing on the **resolution** of conflict misses entirely the need for individuals, teams and systems to be actively engaged in addressing the patterns of behaviour that reinforce and sustain conflict in a CAS. This leads to the important concept of **conflict engagement** which allows participants to be better prepared to address conflict and disputes arising in the workplace. Engagement will entail understanding and reflecting on patterns of behaviour that influence individuals (shocking as it may seem the mediators can also benefit from this self-reflective “engagement” process),

teams, and systems in the way in which they respond to conflict - all of this with a view to becoming more aware of their contributions as they interact dynamically with other agents and components in the system, at multiple levels. Conflict engagement methods and approaches will inevitably lead to different interactions and ultimately to the emergence of new patterns of behaviour.

Unfortunately many organizations have not yet understood the essential nature of conflict engagement and have not created the possibility for this to develop and be sustained at the individual and systemic level. This undoubtedly reflects the overwhelming tendency to think and react in a linear manner, to see conflict as a "problem to be solved", and to imagine that the solutions will come from "fixing the components" whose internal needs and interests have produced the situation in the first place. This perspective is radically different from one that understands conflict as originating in the very nature of the system itself.

The series of six articles by Gerardi (2015) stand alone in providing useful concrete advice about approaching conflict within healthcare CAS. I encourage readers to review the articles in detail (and sequentially!). While these have been written to promote understanding and skills within the nursing community, they are immediately relevant not only to the full spectrum of caregivers in a healthcare setting but also to managers and leaders.

Conclusion

De-constructing the Oracle's advice might look like this:

1. Conflict is a natural characteristic of complex adaptive systems.
2. Healthcare is a typical albeit somewhat more complex (!) example of a CAS.
3. There are several distinct ways to approach conflict, some of which are better adapted to CAS and especially healthcare.
4. Whether seeking seeking specialized guidance in a particular dispute or developing internal plans to improve an organization's conflict "preparedness", select an approach that is suited to your system.

5. For most CAS, this will likely involve adopting a relational/narrative approach to addressing conflict.
6. It will always be appropriate to promote conflict engagement at all levels within your system.

References

Cilliers, P. (1998). *Complexity and Postmodernism*, London and New York: Rutledge

Robson, R. (2015). in Wears, R., Hollnagel, E. and Braithwaite, J. (eds.), *Resilient Health Care*, Volume 2, Farnham, UK: Ashgate Publishing (177-188)

Perrow, C. (1999). *Normal Accidents*, Princeton, Princeton University Press

Braithwaite, J. et al (2017), Complexity Science in Healthcare: A white Paper. Australian Institute of Health Innovation, Macquarie University: Sydney, Australia

Mayer, B. (2004). *Beyond Neutrality*, San Francisco: John Wiley and Sons

Mayer, B. (2000). *The Dynamics of Conflict Resolution*, San Francisco: Jossey-Bass

Moore, C. (1996). *The Mediation Process*, 2nd Edition, San Francisco: Jossey-Bass

Winslade, J., and Monk, G. (2000). *Narrative Mediation*, San Francisco: John Wiley and Sons

Winslade, J. and Monk, G. (2008).*Practicing Narrative Mediation*, San Francisco: John Wiley and Sons

Fisher, R., Ury, W. and Patton, B. (1983). *Getting to Yes*, (2nd Ed'n), New York: Penguin Books

Bush, R. and Folger, J. (1994). *The Promise of Mediation*, San Francisco: Jossey-Bass

Kritek, P. (2002). *Negotiating at an Uneven Table*, San Francisco: John Wiley and Sons

Marcus, L.J., et al (1995). *Renegotiating Health Care*, San Francisco: Jossey-Bass

Stone, D., Patton, B. and Heen S. (1999). *Difficult Conversations*, New York: Penguin Putnam

Bowling, D. and Hoffman, D. (eds.), (2003). *Bringing Peace Into the Room*, San Francisco: John Wiley and Sons

Hollnagel, E. (2015). in Wears, R., Hollnagel, E. and Braithwaite, J. (eds.), *Resilient Health Care*, Volume 2, Farnham, UK: Ashgate Publishing (249-264)

Olson, E.E. and Eoyang, G.H. (2001). *Facilitating Organization Change*, San Francisco, Jossey-Bass/Pfeiffer

Capra, F. and Luisi, P.L. (2014). *The Systems View of Life*, Cambridge (UK): Cambridge University Press

Gerardi, D. (2015). A Six-Part Series on Conflict Engagement in Complex Systems, *American Journal of Nursing*. Volume 115: Conflict Engagement: A New Model for Nurses, March 2015, No.3 (56-61); Conflict Engagement: Workplace Dynamics, April 2015, No.4 (62-65); Conflict Engagement: Collaborative Processes, May 2015, No. 5 (66-69); Conflict Engagement: A Relational Approach, July 2015, No.7 (56-60); Conflict Engagement: Emotional and Social Intelligence, August 2015, No. 8 (60-65); Conflict Engagement: Creating Connection and Cultivating Curiosity, September 2015, No. 9 (60-65)

Letiche, H. (2008). *Making Healthcare Care*, Charlotte, NC: Information Age Publishing