INTERPROFESSIONAL CONFLICT MANAGEMENT STUDY
IN A HOSPITAL SETTING

A Project

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MASTER OF SOCIAL WORK

by

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Division of Social Work
Abstract

of

INTERPROFESSIONAL CONFLICT MANAGEMENT STUDY

IN A HOSPITAL SETTING

by

Leslie Merrill

Keri Miller

When professionals work together as a team, conflict is inevitable. This study aims to explore interprofessional conflict in a hospital setting from physician, nursing, and social work viewpoints. The goal of this thesis study is to inform healthcare providers in effective conflict management skills. Currently conflict management training is not a priority in healthcare education. We wish our study to be the first step in developing a curriculum that will be implemented in healthcare professional educational programs.

The original study was conducted by Dr. Michael Wilkes of the University of California, Davis (UCD) to examine the issues of incorporating conflict management into professional education. Participants in the original study (N=225) came from the School of Medicine at UCD, the Betty Irene School of Nursing (UCD), and the Division of Social Work at California State University, Sacramento. Utilizing secondary data, we assessed narrative responses that resulted in seven central themes of conflict and three primary conflict management styles. The seven central themes include: relationships;
interests, values & ethics; systems; role confusion; hierarchy & power; personality & style; and communication. The three conflict management styles were: avoidance, forcing, and problem solving. We found that social workers have a unique perspective and a higher confidence in managing conflict when compared to the other professions.

_______________________, Committee Chair
Francis Yuen, DSW, ACSW

_______________________
Date
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Chapter 1

Introduction

Conflict is inevitable when individuals work together on a team or project. In a hospital setting, there are a large number of separate professions that need to work together to achieve the collective goal of patient health, safety, and well-being. Due to the interprofessional nature of health care teams and the separate education, ethics, and ideologies that come with each profession, these teams are at especially high risk for conflict (McNeil, Mitchell, & Parker, 2013). Lamb (2006) referenced a sports comparison that still rings true in today’s society - how absurd it is to train football players independently and then assume they will perform efficiently when playing together for the first time as a team. Professionals working in a hospital need to be confident and effective in their conflict management styles, or the patients, the organization, and the professionals themselves will suffer.

One of the authors was working as a graduate social work intern at a hospital. The physicians would continuously ask her to assist the patients with completing a Physician Orders for Life Sustaining Treatment (POLST) form. This form indicates what medical interventions a person would and would not want performed, including CPR if their heart stops beating, mechanical ventilation, and feeding tubes. Oftentimes this form is used with patients who do not want heroic life-saving measures, as this would contradict their personal values regarding quality of life. A POLST form is only valid after the patient or their representative and a physician signs it.
Physicians typically want their patients to have a POLST filled out when they are either chronically ill or at an advanced age. When they would ask the social worker to assist a patient with filling out a POLST form, they would often say, “He needs to be a DNR”, meaning ‘Do Not Resuscitate’. This would make the social worker uncomfortable, as her belief in one’s self-determination contradicted the physician’s belief that he knew what was best for his patient. The social worker would then sit down with the patient and carefully explain and discuss each section of the POLST and record their personal choices. Frequently, if the patient chose something the physician did not agree with, the physician would refuse to sign it, rendering the POLST invalid and the patient’s wishes compromised.

Conflicts of interests, values, and ethics such as this one often arise in a medical setting where each health care professional can have a different educational background, code of ethics, value system, and perspective on patient care. The social work profession places a heavy emphasis on self-determination and dignity and worth of all persons.

Seeing how conflict is inevitable in a hospital setting, the overarching goal is to educate healthcare providers in effective conflict management skills. As a result, collaboration would improve, burnout could be reduced, and job retention and satisfaction would increase. This would all translate into higher patient satisfaction, a reduction of clinical error, it may increase patient safety, reduce costs to payers, etc. As social workers, these are all highly valued goals.
Statement of Collaboration

This thesis was completed in collaboration between Leslie Merrill and Keri Miller. Each contributed equally to the data analysis and writing.

Background of the Problem

Hospital and healthcare systems in the United States have greatly evolved over the years. Healthcare’s main concerns in the early years of this country included sanitation and stopping widespread diseases such as yellow fever and rubella (Gehlert & Browne, 2012). Large cities with problems of overcrowding and little to no sanitation codes gave rise to easily contracted diseases. Social welfare concerns go hand in hand with healthcare setting. Vast changes in the way we manage healthcare has created a need to change how we provide health care. We now have so much knowledge that we need specialists and a team of healthcare providers to manage our diseases. Interdisciplinary care has become the norm. And yet we are still teaching our healthcare students separately and expect them to be able to work together smoothly for the sake of better patient care.

The cost of interprofessional conflict aside from patient safety and care is evidenced by the lack of retention of direct patient care employees. The national average of voluntary resignations resulting from unresolved conflict is 65%, a figure which is surely higher in health care (Lyon, 2012). Changing health care provider behavior can be very challenging. Barriers to change include: time availability, overworked schedules, system factors such as integrating policies that support behavior change, and the general cultures of each profession.
Statement of the Research Problem

Collaboration among a health care team is important. In a medical setting health care professionals need to have the skills to be able to continuously collaborate with other professions. Conflict is an inherent outcome of interdisciplinary teams. Unfortunately, conflict has a negative effect on patient care, job satisfaction, and professional productivity (Cox, 2003 & Greer, Saygi, Aaldering & de Dreu, 2012). Conflict management training is not commonly a priority in healthcare education, which leads to inefficient interprofessional conflict management.

Purpose of the Study

This study aims to explore the scope of interprofessional conflict in a hospital setting from varying professional points of view while providing the reader with the authors’ recommendations to alleviate this problem. In order to explore this problem we analyzed responses from a study recently administered to medical, nursing, and social work graduate students (although six respondents stated they were post-graduate professionals, the dates the survey was taken indicate they were still students). The study also aims to inform healthcare professionals in their consideration of including interprofessional conflict management training in their educational curriculum.

Theoretical Framework

Social workers bring the strengths model into whatever professional atmosphere they are working in. With this perspective, values are based on the human potential to grow, heal, and learn. The strengths model values the human ability to identify wants and the right to self-determination. The focus of a strengths perspective is to combine
personal and environmental resources to create situations for goal achievements.

Conversely, within the medical model, values are based on problem resolutions that are dependent on professional expertise and compliance with prescribed treatments. In a medical model the patient is viewed as lacking insight and knowledge about health and the focus is on the professional diagnosis to determine the specific nature of the person’s problem and to prescribe treatment (Robbins, Chattergee & Canda (2012); Pardeck & Yuen, 1999).

Conflict theory enhances our understanding of conflict between persons, ideas, groups, classes, and larger social structures. Main concepts of a conflict perspective include the ideas that all societies perpetuate some form of oppression, injustice, and structural inequality, power is unequally divided with some groups dominating others, social order is based on manipulation and control by dominant groups, and social change is driven by conflict with periods of change followed by periods of stability (Robbins, Chattergee & Canda (2012); Pardeck & Yuen, 1999).

Power and hierarchy are inherent attributes to both conflict theory as well as the medical profession. Hierarchical structures naturally lead to conflict.

The life model (Glitterman, 2009) stems from the biological science of ecology, which examines the way living organisms interact with surrounding social and physical environments in regards to level of fit, adaptation, and stress. This lens is important to consider when discussing conflict within a team. A person’s behavior is shaped by a number of factors external to the individual, including the people around them, the physical setting, and the level of interpersonal comfort amongst team members.
Additionally, interprofessionals working in a healthcare team are often under a great deal of stress. The behaviors we engage in during stressful times can lead to unwanted conflict.

**Definition of Terms**

For the purpose of this study, the authors defined appropriate key terms.

*Teams* are small groups of workers with complementary skills that have one or more common task or goal (Greer, Saygi, Aaldering, & de Dreu 2012, Lamb 2006).

*Conflict* between two parties occurs when real or perceived incompatibilities negatively affect at least one individual’s desires, thoughts, attitudes, feelings, or behaviors. These differences may arise due to a variety of issues, including values, religious or political preferences, resources, or information and opinions (Cox, 2003; Greer, Saygi, Aaldering, & de Dreu, 2012; Kaitelidou et. al., 2012).

**Limitations**

The population of this study is graduate students with limited professional experience. The study is about physicians, nurses, social workers, and other allied health professionals in a Northern California hospital. The study findings would only be applicable to this hospital or the region. The study’s external validity or generalizability is limited.
Chapter 2

Literature Review

Conflict is an inevitable and natural part of our lives, and something that all of us experience, in large ways or in small, every day. We engage in conflict within ourselves, with our loved ones, with our neighbors, with our coworkers, with anyone or anything interacting with and affecting our lives. Karl Marx gave us conflict theory (Robbins, Chattergee & Canda, 2012), explaining that inevitable conflict between classes is the primary driver behind historical social change. At its most basic level, social change is initiated when it becomes clear that the needs of a group of people are not being met, or a fundamental human right is being violated. This change often occurs from the bottom up, with a large number of the unprivileged “masses” banding together to demand change from those who are in power. As social workers, we value social change when it is enacted to improve the general welfare of society. It is within our professional ethical guidelines to promote and engage in ethical responsibilities to the broader society, with the aim of improving all lives. The National Association of Social Workers (NASW, 2014) standard 6.01 states:

Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice. (p. 26)
Conflict in and of itself is very subjective. The lens of the individual explaining the particular conflict may have a victim’s view, whereas, each player may see themselves as the victim. Who is right? Empathy, or the ability to see from another’s point of view, is often lost once we are emotionally engaged in conflict. How we view conflict differs from person to person as well as from profession to profession. Social workers, by the nature of the profession often work with other professions in a variety of settings. We are working wherever there is a marginalized population. The NASW eloquently states that the primary mission of the social work profession is to enhance human well-being and help meet the needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, or living in poverty. A historic feature of the profession is the focus on individual well-being in a social context and the well-being of society. While working for the well-being of our clients we are often working in an interdisciplinary atmosphere. In health care, medical social workers are usually employed in far fewer numbers as compared to central staff such as the physician or nurse. In spite of this, the medical social worker takes a broader view of the “client” in each case than the central medical staff might. Not only is the patient considered her client, but also the patient’s family, and even the other medical professionals who are supporting the patient. In working with all of these participants in a case, the medical social worker is ultimately looking to help advocate for her patient’s well-being and right to self-determination. The medical social worker has a unique educational opportunity to come into the profession with the background and understanding of how to be an agent for change. This unique
professional perspective allows social workers to be excellent at facilitating difficult conversations and mediating conflict.

In a healthcare setting conflict is inevitable. Many interdisciplinary teams work within a healthcare setting making interprofessional conflict an undeniable reality for many professionals. Healthcare workers are often highly motivated individuals who have been trained to evaluate patients’ cases and advocate for the course of treatment that the medical professional believes will be most effective. When teams are formed of several medical professionals who may each come from a different paradigm of addressing patient issues, it should not be surprising that each professional would advocate strongly for her assessment of the case. In these instances, when professionals express varying assessments, it is easy to see how conflicts would arise. McNeil, Mitchell and Parker (2013) said of interprofessional healthcare teams:

On the one hand, the implementation of such healthcare teams is shown to enhance innovation, reduce healthcare costs and waiting times, and lead to clinical improvements in patients and more effective utilisation of resources. On the other hand, interprofessional teams can be dogged by negative emotions, information withholding, conflict, impeded diffusion of innovation and poor team outcomes. (p. 292)

How we as individuals are going to manage the conflict may be as varied as the way each profession manages conflict. Michael Wilkes (2013) defines conflict as a situation involving opposing or incompatible ideas or expectations and a normal part of human interactions. Although interprofessional conflict may be a normal part of the job in
healthcare it is magnified by the complexities of healthcare systems. Wilkes (2013) states:

…what may start as a disagreement or conflict at an individual level can escalate and impact the quality of communication and decision making which results in undesirable patient outcomes, reduced patient satisfaction, increased medical errors, job dissatisfaction, burnout and employee turnover. (p. 6)

Because conflict can have such serious negative effects on patient and caregivers’ outcomes, it should be a high priority to ensure that all members of the healthcare team have conflict management as a core educational component. In training professionals to address these issues, it should also be emphasized that conflict is inherent and natural no matter what the setting and can be a positive force for change and innovation.

**Sources of Conflict**

The current literature explores many reasons for the occurrence of conflict in interprofessional healthcare teams. Greer, Saygi, Aaldering and de Dreu (2012) state differences in functional understanding between the professions as well as differences in individual beliefs and interests contribute to conflict among the medical professions. In a study done by Kaitelidou, et. al. (2012), organizational problems were the main source of conflict creation. Such organizational issues included having more than one superior giving direction, unclear job descriptions, and inequitable resource distribution between the professions. Other sources of conflict were low job satisfaction and educational differences, which lead to communication issues.
Different professions also tend to perceive and tolerate conflict in different ways as well. Physicians seem to have a higher threshold for stress and conflict which causes them to define a situation as being conflictual at a later time than other professions might, leading to a varied sense of urgency for resolving said conflict between teammates (Skjørshammer, 2001). Janss, Rispens, Segers, and Jehn (2012) support these findings in their definition of conflict asymmetry:

Conflict asymmetry refers to the existence of different perceptions among group members regarding the amount of conflict in their work group. For instance, a disagreement about medication may be perceived as a serious conflict by the nurse, whereas the resident may not perceive there to be conflict at all. Recent empirical results suggest that this asymmetry of conflict perceptions within teams is detrimental to group functioning. (p. 840)

This asymmetry may be exacerbated by the perceived or actual hierarchal structure within a team. Physicians also tend to take charge when participating in interprofessional teams while social workers promote collaboration (Gehlert & Browne, 2012). Brown et. al. (2011) described three main sources of team conflict. The first is a general lack of understanding of other professions’ roles on the team. This leads to confusion regarding who is in charge and the specific importance of each member. The second source of conflict is a lack of understanding of one another’s scope of practice. This is especially apparent when a new profession is added to the team. This causes conflict when the existing profession sees the new profession as having a real or perceived potential to overlap with their role on the team. In turn, the new professional on
the team can experience a lack of collaboration and integration with existing team members. Lastly, accountability can be a source of team conflict. Physicians often see themselves as solely responsible for patient care, while other professions view themselves as accountable for their piece of the patient puzzle.

**Values and Theoretical Differences**

There are some basic differences in values between medical professionals and social workers that can also lead to team conflicts. In general, the medical profession values saving life rather than preserving quality of life for patients. The relationship between physician and patient as well as nurse and patient tends to be an authoritarian one in which the patient is expected to comply with the physician’s or nurse’s instructions in order to achieve the desired life-saving results of treatment. This contrasts with the social work value of patient self-determination (Gehlert & Browne, 2012; NASW, 2014; Reese & Sontag, 2001) in which patients are encouraged to be active deciders in the course of their treatment, and that treatment is refined to match the patient’s choices. There may also be theoretical differences in the ways in which physicians and social workers approach patient interventions. Social workers are trained to use tested, effective theoretical interventions based on theories such as an ecological perspective and systems theory. The ecological perspective and systems theory have both been prevailing theories in the social work profession. According to Pardeck and Yuen (2006):

…ecological perspective is based on the metaphor of biological organisms that live and adapt in complex networks of environmental forces. It is grounded in an
evolutionary, adaptive view of human beings in continuous transaction and interaction with their physical and social environment. According to ecological theory, both the person and the environment continuously change and accommodate one another. (p. 6)

Pardeck and Yuen (2006) further explain that systems theory is a theoretical underpinning of the ecological perspective. Social work practitioners utilize systems theory to understand the way the client system interacts with and is influenced by the greater social ecology. With systems theory, the source of the problem (and therefore the solution) is not based solely on the client but rather includes interactions of the larger social system and the client. These and other social work perspectives and theories may be in contrast with other professions on an interdisciplinary team. For example in a medical setting such as hospice, the nurses, physician, and chaplain may not use psychological or sociological theories as basis for their interventions (Reese & Sontag, 2001). The authors also propose that physicians and nurses are oriented to the medical model which may make it more likely that they will seek out the cause and solution within the individual. Healthcare professionals utilizing the medical model are more likely to use objective measures such as laboratory results and body scans to navigate treatment decisions (Gehlert & Browne, 2012). In contrast, the authors note that social workers are more likely to base their decisions involving patient care subjectively, focusing on the patient’s values and personal thoughts. They also tend to be comfortable in their role of providing emotional support for patient needs and values.
A more recent exploratory study done by Dunworth and Kirwan (2012) in Scotland sought the answer of whether nurses and social workers have different values. They looked at two similar care homes for older people, one managed by a nurse and the other by a social worker. They evaluated written responses to vignettes highlighting what would be done in certain ethical situations with clients. The authors sought to delineate between three ethical theories: Consequentialism, Deontology, and Virtue Ethics.

The authors described Consequentialism as choosing the ethically right action which has the best overall consequences for everyone concerned. Deontologists think the ethically right choice is determined by a set of moral rules that are themselves determined independently of consequences. Virtue Ethics choices are assessed by the specific character trait an action expresses.

Responses from one of the vignette pieces resulted in the social work management home indicating a clear commitment to autonomy, while the nurse home indicated a marginally stronger commitment to Consequentialism. Overall, all responses regardless of their professional background interpreted their duty of care to mean that safety and physical care is more important than allowing autonomy. The main difference between groups was that the social work responses had more comments perhaps indicating greater engagement with the issue or better management. The results according to the authors indicated that the data suggest that the staff managed by a social worker worked in a more autonomous and reflective way. However, the results also indicated that the value differences between nursing and social work are far smaller than commonly assumed (Dunworth & Kirwan, 2012).
Interprofessional Roles

Craig and Muskat (2014) qualitatively studied the role of social workers in urban hospital settings. They described the general recent history of the hospital social worker as beginning with one-on-one direct clinical work with patients, running groups, counseling, and providing psychosocial support to help patients adapt to new diagnoses. With an increase in the number of families with low socioeconomic status in the United States, social workers’ role changed from just counseling to also assisting this growing, needy population with navigating medical expense coverage. The authors of this study also explained that a shift into inter-collaborative teams lead to unclear roles. A belief arose that anybody, regardless of background, can lead groups and ancillary professions like physical therapists wanted to learn Cognitive Behavior Therapy (CBT). The authors maintain social workers have always had the need to clarify their roles among hospital staff. The study was expanded to cover seven hospital settings over a 12 year period. The resulting qualitative analysis of these settings found seven categories of roles described among the many collective interviews of the social workers studied.

The roles the social workers described they filled were: bouncer, janitor, glue, broker, firefighter, juggler, and challenger. The bouncer was described as a mediator/arbitrator that forcibly controls a setting. The janitor cleaned up proverbial messes without a “thanks”, although many literal situations were described such as actually cleaning homes to be ready for discharge. In the glue role, socials workers were those who organize family meetings, do discharge planning, and facilitate communication between staff and patients. The glue holds the interdisciplinary team together. The broker
is also described as a discharge planner, acquiring procurement of tangible resources, and is in charge of durable discharges to prevent frequent flyers. Firefighters provide crisis intervention, such as suicide, etc. As of late the reports are of so many “fires” to put out that an entire work schedule can be devoted to this task. The juggler fulfills patients’ and other healthcare workers’ expectation to transition quickly between all of these roles, having all the hats on at the right place and time. And last is the challenger who represents the advocacy piece of social work, challenging the system with macro roles.

It is clear from these preceding examples that an understanding of roles would be of great benefit in a team working environment. Such understanding would help to align the perspectives of interprofessional team members and relieve some of the conflict resulting from individual perceptions of each member’s place within the team. An ethnographic study (Coombs, 2003) explored decision making between doctors and nurses to examine contemporary clinical roles in an intensive care setting. The micro ethnographic study looked at three intensive care unit sites within both general and teaching hospital systems. Nurses in this study reported feeling that there were not enough opportunities for clinical decision making by nursing, which lead them to feel snubbed from the inner circle. Nurses ascribed this feeling to the power held by medicine, leading to conflict between nurses and medicine. Medicine, on the other hand, did not feel that they had anything to do with the perceived notion of nursing’s lack of power. Doctors also did not critically reflect on the role they played in reinforcing the rigid framework in which nurses perceived themselves. The self-perceived roles of each discipline did not match what the opposite discipline understood. In these intensive care
settings it would behoove us to develop a greater understanding of other roles’ perspectives of our working teams in order to lessen possible future conflicts.

In order to evaluate the effects on social workers’ personal abilities to be effective in their careers, Rai (2010) hypothesized that role conflict and role ambiguity would positively relate to emotional exhaustion, depersonalization, and reduced personal accomplishment. Rai took samples from professionals in four nursing homes and five assisted living facilities among southern states. The author found significant evidence in her study to support her assumption that role conflict was associated with emotional exhaustion and depersonalization. Workers experiencing conflicting expectations regarding their work in these settings would experience greater emotional exhaustion and depersonalization. However, role ambiguity was not strongly correlated with these negative outcomes for workers. The author suggested that one possible confounding factor for the lack of significance was a poorly operationalized definition of the role ambiguity variable.

Kelly (2005) espoused the importance of establishing and maintaining strong interprofessional relationships to ensure safety, care, and survival of patients. The author further identified good communication as one factor that is linked with strong relationships. Kelly states that effective teams have the following characteristics: clearly defined roles, respect, clear communication, common goals, and management support and encouragement. Kelly emphasizes that:

Roles must be clear, each member must understand his or her personal boundaries, as well as those of other team members. As an example, the MD
provides the diagnosis and treatments such as medication while the RN keeps the MD apprised of changing assessment parameters, and administers the medication. At the same time the social worker keeps the family apprised of the condition and process for care. (p. 195)

As this is an RN’s perspective of each discipline’s role, it would be an instructive addition to this analysis to describe these roles from the perspectives of the MD and the social worker, and to evaluate the differences between these perspectives. Previous examples have shown that, regardless of the actual roles within a team, the ways in which these roles are perceived by each member can have a significant effect on the way the team operates. A lack of understanding of roles can often lead to expectations that are unmet which in turn leads to conflict among team members. Kelly (2005) reminds us that patients are negatively affected when these conflicts are not effectively dealt with.

**Types of Conflict**

There are a variety of conflict types that can typically emerge among interprofessional teams in a hospital or healthcare setting. Greer, Saygi, Aaldering, & de Dreu (2012) define three of these types and provide an analysis of their effects of team dynamics: task, relationship, and process.

Task conflict is defined as disagreement over the content and the actual outcomes of the task being performed by the members of the team. One example of a task conflict would be a disagreement about which treatment strategy to use with a patient. Task conflicts have a negative influence on team members’ satisfaction and commitment, as individual members may feel that their recommendations for task performance are being
discounted or ignored. Further, team members are less likely to commit to a course of action that is not in line with their own evaluation of the patient’s needs. Because this type of conflict often originates with team members’ personally held opinions about a task, it is important to focus on keeping the conflict from becoming personal to members.

Relationship conflicts are disagreements that center around personal issues unrelated to the task at hand. These issues could be due to a difference in values, beliefs, or opinions between team members. Relationship conflicts have a negative impact on many aspects of the team environment, including personal performance within the team.

Process conflict results from a disagreement over the logistics of completing the task. This might include conflict over the frequency of meetings and who is assigned what responsibilities in the process of completing the task. While relationship conflict can significantly impact the personal performance of a team member, process conflict was found to have the most negative effect on the broader team environment.

Management of Conflict

The literature agrees on some basic ways in which people handle conflict. From his study of interprofessional teams in hospital settings, Skjørshammer (2001) described three ways in which people choose to handle conflict: Avoidance, Forcing, and Negotiations. The participants in this study overwhelmingly used avoidance behavior to deal with interprofessional conflict.

Avoidance came in forms of silent withdrawal, keeping the conflict to oneself, or talking out the conflict with other peers. Physicians engaged in extreme avoidance behavior stating they preferred to leave and get a new job in order to avoid consistent
conflict with another professional. Many young professionals stated that their reason for avoiding conflict was to protect their self-image and future career opportunities. Interestingly, the perspective of nurses in avoiding conflict was focused more on group maintenance than personal benefit. Nurses in leadership roles wanted to avoid the unit being labeled as troublesome. Skjørshammer explained that if avoidance behavior did not take care of the issue, the next most common alternative conflict style used was forcing, which involves the use of formal or informal positional power.

Forcing is often used hastily and outside of the formal organizational structure. Forcing emphasizes disparate “sides” of a problem and creates “winners” and “losers” in its resolution. While this may lead to a quick end to the conflict, the aftermath may perpetuate ongoing resentments and negative relationships between team members. Forcing is accomplished by those who wield either a real or perceived hierarchal power in the organization or within the team unit. Greer et al. (2012) also identified this style of conflict resolution, and noted that it can occur through verbal force, lying, or ignoring other viewpoints. The researchers further described yielding as a method of addressing conflict that involves giving into a forcing resolution.

Skjørshammer (2001) noted that negotiations are usually staged when leadership levels higher up in the organization, such as unions or the personnel department, have been involved in the conflict. He also notes that this form of conflict resolution is often ineffective: “When leaders get involved in conflict management, as they do when negotiations are staged, it seems that they come in too late” (Skjørshammer, 2001, pg. 14). In addition to forcing, yielding, and avoiding, Greer et al. (2012) identified the
technique of problem solving. Problem solving occurs when both parties involved in the conflict proactively participate in effective communication to find a mutually acceptable solution.

One study discussed three sources of organizational conflict that may affect teams. Intrapersonal conflict occurs within an individual as an internal struggle. While the individual team member experiences a conflict, it may or may not exist for or be identifiable by others. This is a situation in which “oppositely directed, simultaneously occurring forces of about equal strength occur in a person” (p. 154) and result in an internal turmoil. Interpersonal or intragroup conflict occurs when there are disagreements among members within one group regarding goals, roles, and activities of the group. Such disagreements may lead to task, personal, or process conflicts. Lastly, intergroup conflict occurs due to disagreements between two or more separate groups regarding authority, territory, and resources (Cox, 2003). These conflicts are reminiscent of those identified by Brown et. al. (2011) among team members who had differing perceptions about the roles of each individual.

Cultural Considerations

It is important to consider cultural implications when examining conflict. Because our study is conducted in hospital settings within the United States it would appear safe to assume that the individuals have an individualistic cultural background. However, within hospital settings there are many professions that contain members who have come from various cultural backgrounds besides the U.S. Billing et. al (2014), studied the role of individualism vs. collectivism in work-family conflict. Individualist cultures tend to
prioritize individual goals and personal accomplishments, whereas collectivist cultures prioritize group goals. The authors looked at conflict within four national contexts: the United States, Australia, South Korea, and Japan. These four particular nations were chosen to represent the following cultural values respectively: vertical individualism, horizontal individualism, and vertical collectivism. The vertical dimension was defined as incorporating hierarchy and command structures in society as being important. The horizontal dimension incorporates the value of equality in the society (Billing et. al, 2014). While concepts such as individualism and collectivism describe broad macro themes, vertical and horizontal dimensions were proposed to measure individual level inclinations. The results of their study showed that cultural variations operationalized at the individual level were important predictors of work–family conflict. Vertical individualism was found to be a strong predictor of work–family conflict regardless of the national contexts. In contrast, the study showed overwhelmingly that there is no relationship between cultural variations of horizontal individualism and the experience of work–family conflict. Horizontal collectivism was negatively related to work–family conflict. Horizontal collectivism emphasizes the interdependence of self, and equality with the members of the in-group (Billing et. al, 2014).

The different values, theories, and professional ethics that social workers bring to the medical field are essential to effectively providing patient centered care. An associate professor of chemistry at Rhodes College in Memphis asserts that a marriage between liberal arts and the sciences yields improved results in any endeavor (Jackson-Hayes, 2015). There is a push from the current presidential administration to graduate more
students in science, technology, engineering, and math, as our nation’s competitiveness depends on it. Conversely, liberal arts, humanities, and the social sciences are dealing with program cuts and being told there are too many graduates in these areas (Jackson-Hayes, 2015). Our culture continues to draw a sharper line between the arts and sciences, creating a false, either/or dichotomy when the reality is that the one enhances the other. All aspects of the natural world highlight the need for balance. The health and healing of a patient does not end with the doctor visit, it continues to occur when they go home and when they interact with the world around them. Healing happens when we are cared for, attended to, and have our mental needs met at the same time. We need compassion, a roof over our heads, and social supports, as well as the medicine.

In reviewing the literature it became apparent that there is a need to explore why interprofessional conflict takes place. As social workers in a medical setting, we understand that we are there to support not only our patients and their families, but also our interprofessional colleagues. Becoming aware of why we engage in conflict is the first step in understanding how to manage it. Burnett, Mattern, Herakova, Kahl Jr., Tobola and Bornsen (2009) describe the nature of a hermeneutic phenomenological inquiry explaining that it explores the lived experiences of people who have participated in a particular phenomenon. The phenomenon we are studying is conflict among healthcare professionals in a hospital setting. We will look at the underlying themes found in the conflictual experiences and determine any patterns or meanings that we can interpret. This process is not exact and interpretations can vary, however we will utilize our educational expertise and an interprofessional team to explore the materials.
Chapter 3

Methodology

Our purpose is to study the nature and impact of conflicts in a hospital setting among social workers, physicians, and nurses. Conflict management styles, particularly those among social workers, is further explored. Secondary data is used for the current study.

Heaton (2008) provides a clear definition using meta-analysis of previous study definitions. She explains that there are some main components in defining secondary analysis such as re-using pre-existing qualitative data from previous studies. Examples of types of qualitative data would include: interviews, open-ended survey questionnaires, field notes, or research diaries. Our secondary data consists of open- and closed-ended survey questions administered with an online survey tool. Heaton also points out that secondary analysis is different from meta-analysis and systematic reviews in that these approaches involve going back over studies rather that reworking or revisiting the data. Heaton states there are two main functions or purposes for using secondary data; to investigate new or additional research questions, and to verify the previous findings. For our study purposes we are investigating new research questions.

The author describes three modes of secondary data. The first mode involves formal data sharing. In this mode researchers are using data collected by others by accessing data sets which are stored in public or institutional archives. While utilizing this kind of mode secondary analysts may contact the primary researchers, but usually the primary researchers are not involved to the extent that they are named as co-authors on
the study. In the second mode, researchers may re-use their own data to explore and formulate new research questions or verify their own findings. An example of this would involve a pair of researchers teaming up and joining their data sets to analyze. While this involves both primary researchers, there would be no additional researchers joining the teams. Another example involves the sole primary researcher or a primary team re-using data they themselves collected but applying new research questions. The final mode of secondary data is called informal data sharing. In this mode the primary researcher may hand over the data to another researcher with no more involvement in the analysis, or the primary researcher shares their data with additional researchers that were not involved in the primary research, but take a lead role or be a part of the new team. This may also involve two or more primary researchers pooling their data sets and working with other independent data researchers to analyze the secondary data set. Our research falls under the mode of informal data sharing in which we as independent researchers have joined the original primary researcher, Dr. Michael Wilkes, who is sharing his data set with us as well as staying involved in the analysis. Our team uniquely consists of professionals from the medical professions of physician, nursing, and social work, which are the same three categories our study focuses on. This allows for interprofessionally exploring the same group in our data set.

**Study Design**

This data were originally collected by Michael Wilkes, MD of UC Davis in 2013. His research, entitled Addressing Conflict Management in Health Sciences Education, is a curriculum development project with an evaluation component. Wilkes and his research
team aimed to identify the nature and impact of conflict in healthcare settings and its effects on providers, institutions and the healthcare industry. In order to develop a well-rounded needs assessment, Wilkes decided that the analysis of the survey data should be interprofessional to reflect the interprofessional emphasis of the study. Literature reviews of previous interprofessional studies have shown that data in these studies were only analyzed by researchers from a single profession. Because of this gap in the literature, we leaped at the chance to bring a cross-discipline perspective to a study of conflict in healthcare settings.

In order to accomplish this objective he planned to collaborate with partner schools to devise a needs assessment, conduct a review of the literature to determine incidence, nature and impact of professional and interprofessional conflict in the healthcare setting, and conduct an organizational conflict assessment to determine common conflicts and how the organizations and individuals deal with the conflicts. This data was collected through an online survey distribution service, surveymonkey.com. The link to the survey was emailed to the participants. The survey (see Appendix) was disseminated to graduate students (although six respondents stated they were post-graduate professionals, the dates the survey was taken indicate they were still students) from the Division of Social Work at California State University, Sacramento, the Betty Irene School of Nursing, and the UC Davis School of Medicine through collaborative efforts of corresponding professors. Two hundred and twenty five responses were collected from March 9, 2014 through January 1, 2015.
Of the 214 respondents who disclosed their gender, 149 (69.6%) were female and 65 (30.4%) were male. Of the 170 respondents who provided their ethnicity, 84 (49.4%) answered White/Caucasian, 40 (23.5%) Asian/Pacific Islander, 23 (13.5%) Hispanic/Latino, 10 (5.9%) Black or African American, 2 (1.2%) American Indian or Alaskan Native, and 22 (12.9%) preferred not to answer.

The current study focuses on social workers in a healthcare setting and compares their conflict management and resolution styles to those of professionals in other disciplines. Our analysis, while informed by the literature, is also informed by collaborative interprofessional meetings in which we discussed interprofessional conflict from our respective disciplines including: social work, nursing, and medicine. It is our goal that the social work perspective from this study will help to inform Wilkes’ ongoing study, and ultimately contribute to helping students learn improved interprofessional conflict management strategies.
Our process will include quantitative statistical analysis comparing and contrasting all social work respondents to the rest of the non-social work respondents. For the qualitative content analysis we will use a stratified sample divided into the main categories of professions: medical, nursing, and social work.

Our research hypotheses include the following:

1. There will be certain types of conflict reflected in this study.

2. Social workers management styles will be different than other disciplines.

3. Social workers will have a unique perspective and confidence in managing conflict, according to this study.

4. Social workers will have different themes for engaging in conflict.

**Sampling Procedures**

We extracted the population of “social work” respondents to get a deeper understanding of conflict from their perspective. The social work participants consisted of 28 females, 3 males, and 5 unidentified who are in the graduate social work classes of 2014 and 2015. All participants had field placements in medical/health settings. This thesis study used both the qualitative and quantitative responses of the social work participants.

Given the large number of respondents, we compiled a stratified sample to include all three professions (physicians, nurses, and social workers) for comparison purposes. We used a random number generator to obtain our stratified sample. After reading through the chosen narrative responses we discarded the ones that did not follow the directions given and replaced them using the random number generator. In total we
collected narratives from 20% of our entire survey population (n=45). Included in the 45 respondents were 20 respondents from the “physician” category, 18 from the “nursing” category, and 7 from the “social work” category.

Data Collection Procedures, Instruments, and Data Analysis

Dr. Michael Wilkes downloaded and provided us the entire de-identified secondary data set, both qualitative and quantitative, in an SPSS and an Excel file. These files were further reorganized and used for the qualitative and quantitative analyses for the current study. The original survey questionnaire is included in the Appendix.

Quantitative results were analyzed using basic descriptive statistics and Chi square analysis. Narrative responses of the stratified samples were recorded and organized in a Word file. Qualitative results were analyzed using a basic content analysis approach with sorting, organizing, coding, and constant comparison to identify, themes, patterns, trends, and alike. Research questions indicated earlier guided the data analysis.

To categorize each narrative with the appropriate theme regarding what the conflict was about, they were first reviewed separately by the two authors. After this the authors met face-to-face to discuss and solidify and define the typology. The narratives were individually analyzed once again, and then the two authors met face-to-face to compare and refine results. When there was a discrepancy, each author explained their reasoning and then, with every instance besides one, came to an agreement. After the two separate discussions, consensus was met with a 99% inter-rater reliability. This was calculated through each instance of agreement divided by the total number of labels given throughout the content analysis. The authors utilized the same procedure when defining
and labeling other findings, such as “victim” and “hero”. All other basic content analysis was met with 100% inter-rater reliability.

**Protection of Human Subjects**

The California State University, Sacramento Research Review Committee approved this as an exempt study. The proposal was approved on October 14, 2014 and expires October 14, 2015. Participant names were replaced by identification numbers prior to the authors acquiring the data set. All participants were informed of the voluntary nature of their participation prior to completing the survey. All de-identified data was electronically stored on the authors’ password protected personal computers, ensuring confidentiality and anonymity.
Chapter 4

Study Findings

The survey is quantitative in nature, but also has a rich set of ethnographic qualitative data that came from two open-ended questions. This first question had several instructional parts. “Please describe a conflict you have encountered in a clinical setting, involving health professionals. Please do not include conflicts involving solely patient-provider interactions. Please provide an overview of the conflict, the players involved, and the major issues contributing to the conflict.” The second open-ended question asked, “Please describe how the conflict was handled.” The narrative responses from these two questions encompass the qualitative data analyzed.

In order to analyze the qualitative data, we utilized a stratified sample. From the total population (n=225) of medical, nursing, and social work students, we pulled 20% of the respondents (n=45). Included in the stratified sample were 20 respondents from the “physician” category, 18 from the “nursing” category, and 7 from the “social work” category, totaling 45 narratives that were analyzed.

The original primary researcher and his team developed themes from their literature review as well as from the narratives responses themselves. These original themes were: relationships, interests, values, systems, hierarchy, personality, style, and ethics. The two authors began the stratified content analysis by evaluating the original themes and the current literature. After the two authors separately read through the stratified samples the two met face-to-face a number of times to compare notes and agree upon appropriate themes for the purpose of this study. We allowed for an organic flow of
themes from the narrative responses to emerge, influencing our final list. In the end, we defined seven different types of conflict. Listed below are these themes. Some of the final themes were taken directly from the primary researcher’s list just as they were and some were combined to make one larger category. Additionally, we introduced two new themes. We have included descriptions and specific examples taken directly from the narrative responses located in Table 4.1.

Table 4.1

Conflict Themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
</table>
| 1. Relationships | Relationship conflicts between colleagues or co-workers occur when two or more individuals have a relationship external to their obligatory job interactions. | A medical student wrote about a conflict involving a friend and fellow medical student. They had written a patient note together and the friend took full credit for the note when an attending complimented the student. The medical student wrote after confronting the friend, “I felt betrayed and also felt like she was a liar. I decided...
2. Interests, Values, & Ethics

Conflicts of interest are described as a disagreement or type of competition where the needs of one are ignored over the needs of the other. This may include tangible or abstract resources.

Conflicts in values and ethics can be seen when professionals have differing opinions over right and wrong due to educational backgrounds, professional code of ethics, or personal opinion. Conflicts arise when one person tries to enforce his own set of values on another. Due to the fact that health professionals follow both employer values and professional code of ethics, they are at especially high risk for experiencing ethical conflicts.

A nurse wrote, “The machine that provides sanitation of the cameras and other devices used during the procedure was not meeting a quality assurance standard of sanitation. The conflict arose when it was implied that the machine may be able to be "tricked" into meeting quality control assurance by increasing the volume of sanitation fluid by diluting it with regular water….and it was implied to use less of preferential methods in order to save costs, yet potentially increase the recovery process for the patient”.

to never trust her”.

A social worker wrote, “Social worker and MD had a disagreement over a patient's right to self-determination. The patient came in with a DNR and MD wasn't adhering to the DNR”.

3. Systems

Systems conflicts are caused by forces external to the people in dispute. These forces are the policies and procedures set out by an organization, such as management, educational requirements, compensation system, and leadership style.

A nurse wrote, “I arrive on my shift to find that a nurse on my team had been replaced by a medical assistant. When I asked the charge nurse about the decision to short us a licensed person with an unlicensed person who would only be able to assist us with a few duties that were in her scope of practice, she stated it was a budgetary decision”.

4. Role Confusion

Roles are often defined by policy, job A social worker wrote, “A
However, roles can be influenced by norms, behaviors, and social structure assigned within each setting. Conflicts regarding role confusion can occur when individual or interprofessional roles, duties, or scopes of practice are unclear or misunderstood.

5. Hierarchy & Power
Conflicts regarding hierarchy and power involve situations where one person or group is placed above other people or groups. This is extremely apparent in a hospital setting, as the rankings of professionals are deeply ingrained in our society. When hierarchal differences exist, people on the lower end of the hierarchy tend to be uncomfortable speaking up about problems or concerns. Intimidating behavior by individuals

A medical student was asking his attending for her reasoning behind giving her patient the instructions she had. The attending stated, “It makes sense to me, you probably disagree, but when you're the physician you can decide what advice to give your patients. Let's move on.”
at the top of a hierarchy can hinder communication and give the impression that the individual is unapproachable (H. McDermott, personal communication, October 16, 2014).

Power is defined as the real or perceived ability of an individual, usually at the top of a hierarchy, to influence or control others (Janss, Rispens, Segers, & Jehn, 2012).

6. Personality & Style

Personality refers to individual differences in characteristic patterns of thinking, feeling and behaving, such as being laid-back or task-oriented (APA, 2014). Style is defined as a person’s preferred manner, technique, or method of doing something. Conflicts of personality and style may be due to an individual's leadership style, time

A social worker wrote, “The nurse was telling the social worker about a patient he worked with over the weekend, whom he described as a ‘drug seeking piece of shit’.”
management, organization, or
creativity. These types of conflicts
can be exacerbated by perception and
emotion.

7. Communication
Communication and conflict are inextricably tied. How a professional communicates in a conflictual situation has profound implications on the outcome of that conflict. If two work associates are involved in a conflict, they may engage in repetitive, damaging behaviors with one another, or they may successfully manage the conflict. Thus, communication can be used to exacerbate the conflict or lead to its productive management (McCorkle, 2014). Lack of communication during a conflict can do just as much harm as negative communication can.

A medical student reported that while on surgery rotation, some of his team members would be hesitant to bring up mistakes. This poor communication led to mistakes that were not caught as early as they could have been.
Conflict Management Styles

Utilizing the resolution strategies described in the literature review established by Skorshammer (2001) and Greer (2012), we identified three styles for the purpose of analyzing how the professions differ in their conflict management techniques. These themes are: avoidance, forcing, and problem solving.

Avoidance can take the form of silent withdrawal, keeping the conflict to oneself, or talking out the conflict with other peers. A great example of avoidance came from a social work respondent, stating, “I wish I could have said something, but as a student talking to a person I don't know, and in front of my supervisor, it was very awkward.”

Forcing involves the use of formal or informal positional power. One response from a nurse who was questioning why a patient was getting a certain medication stated, “Resident MD states ‘Just give it’ and walks away.” The nurse here was emphasizing the power the resident MD had when forcing their medical opinion onto the nurse who was questioning. Problem solving occurs when both parties involved in the conflict proactively participate in effective communication to find a mutually acceptable solution. One nurse reported this effective conflict management style, stating, “Options for improvement discussed and changes implemented.”

While analyzing the stratified sample narratives for conflict management styles, we found that the majority of the respondents did not provide adequate information for us to confidently determine what style was exclusively being utilized by each party involved in the conflict. A large number of respondents reported their conflict from a singular perspective, not allowing for a comprehensive and multidimensional analysis of the
conflict. In some cases, we were unable to determine whether or not the other party involved was even aware that the conflict occurred. Due to the lack of clear evidence, we were unable to quantify our analysis of conflict management styles. However, it appears that the three professions all utilize a variety of conflict management styles, with no obvious trends.

**Roles in Conflicts**

During our analysis of the narrative responses, we also found two emerging roles: the “victim” and the “hero”. The victim describes themselves as the sufferer or martyr of the circumstance, stating no personal fault and placing total blame on the other party. We found that physicians presented in the victim role 75.0% of the time, nurses did 33.3% of the time, and social workers had no presentations in the victim role. The hero describes themselves as the one to come to the rescue; the conflict was resolved due to their specific contribution. This was shown in two narratives, both from nursing respondents.

**Specific Qualitative Findings**

Utilizing our stratified sample and a qualitative content analysis, we found social workers had a higher prevalence of conflict regarding interests, values, and ethics (71.4%) as well as personality and style (71.4%). Nursing and physician responses had a higher rate of conflict due to hierarchy and power issues (55.6% and 50.0%, respectively). Due to the hierarchical nature of the nursing and physician professions, this data is not surprising. On the other hand, social workers tend to view one another as equals, with no specialization or group being above another.
Table 4.2

*Conflict Frequency Categorized by Theme, From Stratified Sample*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Physician Respondents</th>
<th>Nursing Respondents</th>
<th>Social Work Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td>1 (5.0%)</td>
<td>5 (27.8%)</td>
<td>3 (42.9%)</td>
</tr>
<tr>
<td>Interests, Values, &amp; Ethics</td>
<td>5 (25.0%)</td>
<td>3 (16.7%)</td>
<td>5 (71.4%)</td>
</tr>
<tr>
<td>Systems</td>
<td>5 (25.0%)</td>
<td>5 (27.8%)</td>
<td>1 (14.3%)</td>
</tr>
<tr>
<td>Role Confusion</td>
<td>2 (10.0%)</td>
<td>1 (5.6%)</td>
<td>1 (14.3%)</td>
</tr>
<tr>
<td>Hierarchy &amp; Power</td>
<td>10 (50.0%)</td>
<td>10 (55.6%)</td>
<td>4 (57.1%)</td>
</tr>
<tr>
<td>Personality &amp; Style</td>
<td>4 (20.0%)</td>
<td>7 (38.9%)</td>
<td>5 (71.4%)</td>
</tr>
<tr>
<td>Communication</td>
<td>8 (40.0%)</td>
<td>7 (38.9%)</td>
<td>0 (0.0%)</td>
</tr>
</tbody>
</table>

We also classified each stratified qualitative response based on the professions involved in the conflict described in Table 4.4. Nurses reported 2 conflicts not involving nurses, physicians reported 1 conflict not involving physicians. These were not included in Table 4.4. Physicians reported the highest rates of conflict with one or more physicians (70%), nurses reported the highest rates of conflict with one or more nurses (38.9%), and social workers reported the highest rates of conflict equally with one or more physicians and one or more nurses (28.6% each). Social workers discussing a conflict with one or more social workers were only reported at 14.3%. Physicians and nurses did not
acknowledge any conflicts involving a social worker; the only narratives that discussed a conflict involving a social worker were disclosed by social workers themselves.

Table 4.3

*Conflict Frequency Categorized by Profession, From Stratified Sample*

<table>
<thead>
<tr>
<th></th>
<th>One or more physicians</th>
<th>One or more nurses</th>
<th>One or more social workers</th>
<th>undisclosed/other health professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians reporting</td>
<td>14 (70.0%)</td>
<td>4 (20.0%)</td>
<td>0 (0.0%)</td>
<td>1 (5.0%)</td>
</tr>
<tr>
<td>conflict with</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses reporting</td>
<td>5 (27.8%)</td>
<td>7 (38.9%)</td>
<td>0 (0.0%)</td>
<td>4 (22.2%)</td>
</tr>
<tr>
<td>conflict with</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social workers reporting</td>
<td>2 (28.6%)</td>
<td>2 (28.6%)</td>
<td>1 (14.3%)</td>
<td>2 (28.6%)</td>
</tr>
<tr>
<td>conflict with</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

While dissecting the narratives from the stratified sample, we noticed an apparent difference in the way the different professions discussed their conflict story. Social workers almost always described a conflict involving themselves (85.7%), while only half of the nurses did (50.0%) and the minority of physicians did (40.0%). The rest of the...
conflicts described were either involving their entire team (but not naming themselves
being a specific player) or a conflict they had only witnessed or heard about.

Diving deeper into those narratives that involved the respondent, it was found that
none of the social workers took a “victim” role when describing the conflict. Nursing,
however, put themselves in this role 33.3% of the time, and physicians at a whopping
75.0%. This was indicated by phrases such as “the resident doctors always tried to make
me look bad” and by noting a number of things the respondent did right and things the
other person did wrong. Additionally, there was just one response (from a social worker)
who plainly stated “I handled this conflict poorly” and explained how she had negatively
contributed to the outcome. Every other response either explained how the conflict
played out without any negative management style on their part, or in the case of two
nursing responses, how they were the “hero” by being the significant factor in resolving
the conflict. There were also just two responses (both social workers) that expressed
professional growth through the experience of conflict, one represented by recognizing
the mistakes the respondent had made while trying to resolve the conflict and the other
through taking the recommendations given to her by her supervisor and applying them to
her future work in the field.

**Specific Quantitative Findings**

Following up on the narrative questions, the respondents were asked if the
conflict they described was resolved to their satisfaction. As an entire population
(n=225), it was found that the majority of respondents were either highly or moderately
dissatisfied (44.1%), compared to highly or moderately satisfied (28.8%). The remainder,
27.1%, stated they were neither dissatisfied nor satisfied. Social workers also tended to
believe that a compromise was reached at the conclusion of the reported conflict at a rate
higher than the other professions (42.9% and 27.5%, respectively). Social workers were
significantly different from non-social workers ($\chi^2 = 7.152$, df = 2, p = .028) in believing
that the conflict they described would adversely affect patient care, at a rate of 50.0%.
The non-social workers reported that it was not at all likely to affect patient care at almost
the same rate (46.3%). This discrepancy emphasizes that social workers believe a number
of external factors within an environment can affect a person, including conflict between
their healthcare providers.

Table 4.4

\textit{Likelihood That the Conflict Described Adversely Affected Patient Care}

<table>
<thead>
<tr>
<th></th>
<th>Non-Social Workers</th>
<th>Social Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all likely</td>
<td>69 (46.3%)</td>
<td>4 (20.0%)</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>44 (29.5%)</td>
<td>6 (30.0%)</td>
</tr>
<tr>
<td>Highly likely</td>
<td>36 (24.2%)</td>
<td>10 (50.0%)</td>
</tr>
</tbody>
</table>

The quantitative data supports research findings from the narrative responses.

When asked “Please rate HOW OFTEN you personally experience conflicts with the
following health professionals”, respondents chose one of the following options: I have
never worked with this health professional, Never, Rarely (once or twice), Occasionally
(a few times in my career), Often (several times a year), or Very often (more than
monthly). In order to numerically quantify these answers, we assigned a score of “0” to
both I have never worked with this health professional and Never, “1” to Rarely, “2” to Occasionally, “3” to Often, and “4” to Very often. From the original sixteen professional categories listed on the survey, we collapsed them into four broad categories. The “Physician Staff” category includes pre-clinical year medical students, clinical year medical students, residents, and physician faculty. The “Nursing Staff” category includes staff nurses, supervisory nurses, faculty nurses, and physician assistants/nurse practitioners. The “Social Work Staff” includes social work students and social work staff / faculty. Finally, the “Other Staff” includes pharmacists, clerical staff, ancillary health professionals (speech, PT, RT, etc), and hospital/organization administration (risk management, human resources, etc). The total scores using this type of analysis are summarized in the chart below.

Table 4.5

“Please rate HOW OFTEN you personally experience conflicts with the following health professionals”, From Whole Population

<table>
<thead>
<tr>
<th></th>
<th>Physician staff</th>
<th>Nursing staff</th>
<th>Social work staff</th>
<th>Other staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>440</td>
<td>304</td>
<td>35</td>
<td>136</td>
</tr>
<tr>
<td>respondents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>195</td>
<td>261</td>
<td>34</td>
<td>192</td>
</tr>
<tr>
<td>respondents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social work</td>
<td>33</td>
<td>65</td>
<td>37</td>
<td>49</td>
</tr>
<tr>
<td>respondents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
As indicated above, nurses as well as social workers reported highest rates of conflict with the nursing field. Upon further investigation, it was found both professions have the most conflict specifically with staff nurses. Physicians reported highest rates of conflict with the physician field, specifically residents.

Social workers reported a higher rate of confidence on the general topic of conflict when compared to the other two professions. Social workers are statistically significantly more likely ($x^2 = 4.773$, df = 2, $p < .10$) to believe that they could explain the common styles of conflict management to a colleague or friend when compared to non-social workers (74.2% versus 54.1%). They are more confident that they could lead conflict management efforts (48.4% versus 40.7%) and they state they have a comfortable conflict management approach with more confidence (67.7% versus 51.6%).

**Overall Findings**

At the beginning of this study we identified four key hypotheses. We have conducted sufficient analysis to discuss each one.

1. **There will be certain types of conflict reflected in this study.**

   We introduced a typology consisting of seven different themes that arose when analyzing the qualitative data. These seven themes were found throughout the analysis: relationships; interests, values, and ethics; systems; role confusion; hierarchy and power; personality and style; and communication.

2. **Social workers management styles will be different than other disciplines.**

   We could not find specific differences between the professions regarding conflict management styles, as each profession utilized a variety of styles. Due to the fact that all
our respondents were students and power and hierarchy are imbedded into the structure of internship, a common response to describing how the conflict was handled was, “I was a student and so did nothing about it”.

3. Social workers will have a unique perspective and confidence in managing conflict, according to this study.

Social workers seem to be more comfortable with conflict and how to manage it effectively. They were able to describe a conflict they were involved in with more objectivity than other professions, and have found ways to grow professionally from their experiences with conflict.

4. Social workers will have different themes for engaging in conflict.

The professions differed in the most consistent type of conflict, with physicians and nurses speaking about hierarchy and power most often, and social workers discussing conflict revolving around interests, values, and ethics as well as personality and style most often.
Chapter 5

Conclusion

A total of seven conflict themes (relationships; interests, values, and ethics; systems; role confusion; hierarchy and power; personality and style; and communication) and three conflict management styles (avoidance, forcing, and problem solving) were identified and discussed. The seven conflict themes verified our first hypothesis assertion that there would be specific types of conflict in this study. While the three conflict management styles that we expected to see based on the literature were evident, there were no specific differences between the disciplines. Therefore our second hypothesis could not be supported.

Our third hypothesis, that social workers will have a unique perspective and confidence in managing conflict, was supported as social workers reported a higher confidence rate when compared to non-social workers. Social workers also described their narratives using objectivity and showed professional growth. Our fourth hypothesis was supported by the results indicating that social workers had a higher rate of conflict regarding interests, ethics, and values and personality and style while nurses and physicians reported higher rates with hierarchy and power. Physicians tend to experience conflict with other physicians, nurses with other nurses, and social workers with both physicians and nurses. The only profession to report conflict with social workers was social workers themselves.
Discussion

The authors presented their findings to an interprofessional collaborative meeting with the original researchers. A discussion and evaluation of the findings took place to give the authors varying professional perspectives. The discussion below incorporates the interprofessional feedback.

While nurses and especially physicians often took on the “victim” role when explaining their conflict, we would like to point out that this is not to be taken negatively. Due to the rigid hierarchical structure of the internship program for medical students, it is quite possible that these respondents were truly not at fault and did not contribute to the conflict in any way. Ingrained in medical school programs is the belief that medical students are at the absolute bottom of the pyramid and if they are berated or discriminated against from those above them, they are to simply accept it with utmost respect. As a student it is difficult to speak up against a high ranking attending physician who has a lot of clout within the system, knowing that they would never be reprimanded for bad behavior when they bring in so much money for the hospital. As the cycle evolves, the medical student begins as the victim of conflict, then becomes the resident, and ends up the perpetrating physician who berates the new medical students.

These experiences differ from the social work internship programs, in which students are sometimes seen as equals to full-time staff, and are encouraged to discuss questions and feelings that arise during the workday. It is not uncommon and the intern may even be encouraged to take a mental health day. Self-care is a skill that is emphasized in all fields of social work.
During the interprofessional discussion it was agreed upon that conflict is not always bad. Without conflict we would not be able to move forward with new and collaborative ideas. The end goal should never be groupthink, the psychological phenomenon in which people put aside their personal beliefs in order to gain consensus (Cherry, 2015). Conflict can be constructive as it can stimulate creativity and innovation. It encourages self-examination and reflection.

**Recommendations and Implications for Social Work**

Educating healthcare professionals on effective ways to manage interprofessional conflict in medical settings is necessary (Greer, Saygi, Aaldering & de Dreu, 2012; Hanyok, Walton-Moss, Tanner, Stewart & Becker, 2013). We would like our study to influence a curriculum to be used with students going into healthcare professions. Through the use of this curriculum, the students would be able to identify a conflict, distinguish characteristics of the conflict and the players, define various interventions and strategies for mediation, understand how and when to follow up and reassess conflicts, and where to turn for advice. There are already interprofessional medical classes in place at the local universities, and a conflict management lesson could easily be incorporated into the existing curriculum.

The data suggest social workers are clear candidates to lead conflict management efforts and education. The social work professional is trained to use a strengths perspective, giving them the ability to see the strength in patients and individual situations. Social workers seem to have a high sense of empathy in understanding other professions’ point of view when it comes to being in conflict with them, which leads to
more efficient management of the conflict. Social workers were less likely to take the “victim” role when describing their conflicts and more likely to show professional growth from their conflicts which illustrates self-reflection skills and the ability to objectively see all sides of an issue. Most importantly, social workers are significantly more likely to see interprofessional conflict as negatively affecting patient care, which is an important first step in realizing the seriousness of unresolved or poorly handled conflict. Greer, Saygi, Aaldering and de Dreu (2012) advise conflict managers to use active, collaborative, integrative approaches to conflict in order to understand, accept, and embrace individual differences in a constructive manner. Social workers are trained to use such approaches.

As this study was conducted with students in the healthcare field, we recommend replicating the study with seasoned professionals with experience in a hospital setting. Seeing how beneficial the qualitative data was to our study, we also think organizing an interprofessional focus group would bring forth an extremely rich data set for content analysis purposes.

**Limitations**

When answering quantitative questions on the survey, a number of respondents chose “undecided”, “neither/nor”, and “I haven’t had any interaction with this profession”, which may indicate the respondent’s lack of experience in a hospital setting. Students typically have a limited amount of field experience and therefore might not have had adequate interactions with various professionals and departments to give truly representative responses.
While only utilizing students for our study population is a limitation, they are integral to the learning environment to ensure that standards are being met and the next generation of physicians, nurses, and social workers have received the best education.

The study was conducted in a Northern California hospital. The study findings would only be applicable to this hospital or the region. Therefore the study’s external validity or generalizability is limited.

Through this study, we aimed to explore the scope of interprofessional conflict in a hospital setting from varying professional viewpoints. Our dissection of the narrative responses provided us with seven central themes of conflict and three primary conflict management styles. It is clear from our review of the literature and the findings of this survey that positive methods of conflict management are an essential interprofessional skill set, and should be incorporated into healthcare curriculum. As more studies confirm and complement these findings, it is our hope that the entire healthcare community will begin to acknowledge the importance of conflict management education, and that one day such instruction will become a required part of healthcare curriculum.
Appendix

Conflict Assessment

<table>
<thead>
<tr>
<th>Conflict Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. What is your health profession and educational level?</strong></td>
</tr>
<tr>
<td>- Nursing, Graduate Student</td>
</tr>
<tr>
<td>- Nursing, Undergraduate Student</td>
</tr>
<tr>
<td>- Nursing, Postgraduate professional</td>
</tr>
<tr>
<td>- Medical Student, 3rd year</td>
</tr>
<tr>
<td>- Medical Student, 4th year</td>
</tr>
<tr>
<td>- Medical Resident (post graduate)</td>
</tr>
<tr>
<td>- Physician, Postgraduate professional</td>
</tr>
<tr>
<td>- PA or NP, 1st year</td>
</tr>
<tr>
<td>- PA or NP, 2nd year</td>
</tr>
<tr>
<td>- PA or NP, Postgraduate professional</td>
</tr>
<tr>
<td>- Social Work, Undergraduate Student</td>
</tr>
<tr>
<td>- Social Work, Graduate Student</td>
</tr>
<tr>
<td>- Social Work, Postgraduate professional</td>
</tr>
</tbody>
</table>
Conflict Assessment

2. Please enter your year of residency

☐ 1st year resident
☐ 2nd year resident
☐ 3rd year resident
☐ 4th year resident
☐ 5th year resident
☐ 6th year resident or more
# Conflict Assessment

**3.** If you are receiving academic credit for completion of this survey, please enter your first and last name.

*Please note this information will be kept private and will not be disclosed*

**4.** Please enter your clinical specialty (e.g. peds, internal medicine), or if you are not a physician then your primary work area (e.g. ED or ICU), or mark undecided.

**5.** What is your gender?

- [ ] Female
- [ ] Male

**6.** Please rate the following statements in terms of how strongly you agree with each

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am aware of my own conflict management style</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I understand the issues and behaviors that set me off and influence the</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>way I handle conflict</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If asked, I could explain the common causes of conflicts to a colleague</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>or friend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If asked, I could explain the common styles of conflict management to a</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>colleague or friend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If asked, I could lead a work team in a discussion about conflict</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>management approaches or strategies that would be useful for the group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I currently have a conflict management approach or strategy that I</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>would feel confident using when approaching a conflict in the workplace</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Conflict Assessment

Below we have asked you to describe a work-related conflict. Please be honest in your answers. However, we ask that you NOT use any identifying names as we are interested in the situation but not the individual people.

*7. This next question has several parts.

Please describe a conflict you have encountered in a clinical setting (class, clinic, hospital, etc) involving health professionals. Please do not include conflicts involving solely patient-provider interactions.

Please provide an overview of the conflict, the players involved, and the major issues contributing to the conflict (power issues, money, patient care, medical error, promotion, etc.)
Conflict Assessment

*8. Please describe how the conflict was handled.

*9. Please choose the option that is closest to the ultimate outcome of the conflict

- one party prevailed while the other was a clear loser
- both parties reached a compromise
- the conflict was addressed but there was no resolution
- the conflict was avoided and no resolution was reached

*10. Was the conflict resolved to your satisfaction? Please rate your satisfaction below.

- I was highly dissatisfied with the result of the conflict
- I was moderately dissatisfied with the result of the conflict
- I was neither satisfied nor dissatisfied with the result of the conflict
- I was moderately satisfied with the result of the conflict
- I was highly satisfied with the result of the conflict

*11. Given the conflict you've described above, please indicate the likelihood that it:

<table>
<thead>
<tr>
<th>Event</th>
<th>Not at all likely</th>
<th>Somewhat likely</th>
<th>Highly Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adversely affected patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adversely affected workplace morale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adversely affected your personal well being</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Conflict Assessment

**12. Please rate HOW OFTEN you personally experience conflicts with the following health professionals:**

<table>
<thead>
<tr>
<th>Health Professional</th>
<th>Very often (more than monthly)</th>
<th>Often (several times a year)</th>
<th>Occasionally (a few times in my career)</th>
<th>Rarely (once or twice)</th>
<th>Never</th>
<th>I have never worked with this health professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>pre-clinical year medical students</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>clinical year medical students</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>residents</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>physician faculty</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>staff nurses</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>supervisory nurses</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>faculty nurses</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>physician assistants/nurse practitioners</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>social work students</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>social work staff / faculty</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>pharmacists</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>clerical staff</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Ancillary health professionals (speech, PT, RT, etc)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Hospital/organization administration (risk management, human resources, etc)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

**Comment as you wish:**

---

**13. Have you ever participated in any Conflict management or Conflict resolution training?**

- [ ] Yes, I have been enrolled in one or more training courses
- [ ] No, but I have gathered information and/or tips on conflict management on my own.
- [ ] No, I have never been exposed to any training in conflict management or resolution
*14. Do you think that conflict management is something that can be taught effectively?

- Yes
- No
- Not sure

If no, why not?

*15. How important do you feel learning about managing conflicts is to your education and eventual practice?

- Critically important - can't manage without it
- Very important
- Somewhat important
- Not important, but helpful
- Not necessary for my training

Other (please specify)

*16. What is your ethnicity? (Please select all that apply.)

- American Indian or Alaskan Native
- Asian or Pacific Islander
- Black or African American
- Hispanic or Latino
- White / Caucasian
- Prefer not to answer
References


