

WHY CONFLICT?

WHEN YOUR work is health care, your daily routine requires constant negotiation and involves some measure of conflict. Decisions affecting a number of people have to be made. Competing priorities have to be balanced. There is the pressure of time and the need for constant vigilance that the job is done correctly.

Health care work is accomplished via an intricately structured and constantly evolving set of relationships. Formal and informal rules determine who speaks to whom, who makes what decisions, who has and who does not have what information. People are organized and decisions are aligned in a cautiously defined order. The most important or momentous information, person, or decision gets the uppermost attention, and the rest trails behind. This sequence is intended to yield systematic and value-based decision making.

Most important, the work is done by people and for people. There is perhaps no endeavor more intimately tied to who you are, your identity, than the duties you perform or the care you receive through the health system. Health care is on the cusp of life and death and the quality of life. Whether you are in the role of patient, provider, or manager, your values, beliefs, and personality are exposed and interlocked with the values, beliefs, and personalities of others amid the interpersonal proximity of health care decision making, negotiation, and conflict. And if your role is in the realm of health policy, service regulation, or finance—far removed from the immediate point of care or population served—values, beliefs, and personality remain just as important even though the impact may appear far more abstract. What you do affects how—and sometimes even whether—others live.

What if this complex puzzle does not smoothly fit together? What if there are differences about what or who is more important? What if a mistake occurs? What if there is a clash of personalities among people who must closely interrelate? What if there is dissonance between the policies and procedures and the people

who inhabit these relationships? What if various professionals are working under different incentives? How will this affect what you do and how you do it?

Consider the following scenario.

It is another hectic night in the emergency department of Oppidania Medical Center. A frenzy of activity centers at the desk, where nurses, residents, attending physicians, and emergency medical technicians gather to exchange information, tell stories, and take a rare break.

Nearby, Artie Ashwood, a twenty-four-year-old graduate student, moans in one of the beds. The monitors and machines surrounding him are beeping, flashing, and filling him with life-saving fluids. He has an enlarged heart, arrhythmia, and shortness of breath. It has been three hours since he came in, and it is time to decide where he should go next. In the visitor's room, his mother, Anna Ashwood, and girlfriend, Cindy Carrington, nervously await news of his condition.

The attending physician, Dr. Beatrice Benson, oversees the work of the medical residents. On crazy busy nights, she sometimes has to remind herself, "The emergency department is for triage—not treatment." She has to remember that their job is to assess the patient and decide the next step. If the problem is life threatening, they admit to intensive care. If the patient doesn't need to be in the hospital, they discharge with a treatment plan and instructions. If the problem is someplace in between, then they admit for observation and treatment. So, if it's an admission, the question is to which service?

A small cluster of staff have gathered to discuss Ashwood's condition. It defies a conclusive diagnosis: his young age is a concern. His symptoms could signal a dangerous situation. Hoping for more information, they hold him in the emergency department, waiting for stabilization. Nurses and residents are constantly monitoring his condition, but nothing changes.

Suddenly, Charlotte Chung, the triage nurse at the desk, announces the impending arrival of a patient with multiple gunshot wounds. The door to the specially equipped trauma room opens, and the staff move to their places around the gurney that will hold the seriously injured man.

Benson talks by telephone with the paramedics in the ambulance to assess the incoming patient's condition and prepare for briefing the staff. As she turns toward the trauma room, Chung suggests that the young man with the enlarged heart be admitted to one of the floors in the hospital, because it is looking like a busy night.

Preoccupied, Benson says, "Good idea," and walks off with no further instruction. Chung snaps a pencil in two as she watches Benson head toward the incoming patient.

There are, so far, three people in our story. Artie Ashwood's fate is in the hands of the people who surround him. He is in great pain. He is frightened. He does not know what is happening to him and what it might mean for the rest of his life. People are asking him questions, many of them repetitive. Some of those who speak to him seem genuinely concerned about how he is doing. Others seem to be asking rote questions from a prescribed list. He is afraid of being lost in this loud mass of people. He overhears that a gunshot victim is on the way. Might the hospital explode in shots if the attackers come here to finish the job? Even more frightening, might the nurses and doctors who have been at his side forget him once someone sicker arrives? He has been waiting for a long time. Can't they just fix him up and move him along already? He is intimately dependent on people who now seem otherwise occupied.

As the attending physician in the emergency department (ED), Dr. Benson oversees and has responsibility for the work of the ED medical residents and physicians. She simultaneously tends to many constituencies and concerns and is interdependent with many parts of the system. She is vigilant on behalf of the patients, watchful over the residents, and in touch with others in distant departments. When she asks, "Is intensive care backed up?" she hears a variety of answers: "Yes, we can accept a patient severely cut in an accident at work." "No, we are not taking a nine-months-pregnant, cocaine-addicted woman being dumped by a suburban hospital." By its very nature, her work is in the short term: her responsibility is to keep the flow of patients moving. She sees patients for a matter of hours before they disappear into the labyrinth of the hospital or out to discharge. She rarely sees them again. The long term is an abstraction. She has some power and influence, though others in the hospital understate the authority she believes is hers. There is, however, no underestimating when it comes to responsibility. For a miscalculation, the attorneys will chase Dr. Benson with their lawsuits, the administrators will challenge her wastefulness, and the patients will complain about their delayed or inadequate care. She is constantly negotiating and continually trying to keep the many parts of the system in balance.

Ostensibly, as the triage nurse in the ED, Charlotte Chung has the role of screening patients and determining the severity and urgency of their conditions. In fact her function is to create order among the unpredictable and sometimes chaotic flow of patients arriving at the ED. That order must align with the contingent of nurses, physicians, and other personnel staffing the shift. It is a matter of creating a fluid balance. Patients arrive at the hospital in pain or discomfort and are all anxious to be seen at once. Family or friends who accompany them advocate, question, and worry. It is up to her to decide who will be seen when, by whom, and where: she holds the criteria and judges each case

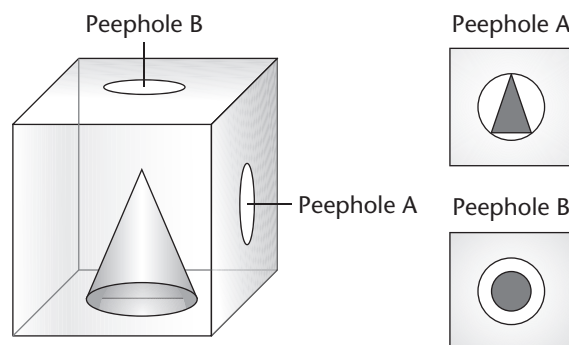
accordingly. Physicians, nurses, technicians, and housekeeping personnel scurry to keep up the pace, caring for one patient and preparing for the next. They depend on Chung to make the right calls, to hold off patients who cannot yet be seen, and when the staff are overloaded, to focus on only the most severely ill. Her desk is like a lightning rod for conflict. She mediates among the needs of patients, the capacity of the staff, and the personalities who may explode under the pressure and stress of the decisions she is required to make. Her greatest sources of irritation are the obstacles erected by those, especially physicians, who hold greater authority but who carry far less perspective and understanding than she does.

Each of these people is part of the same reality, yet their perspectives are very different. The question is whether their distinct responsibilities, concerns, and decisions can combine in a congruent manner, allowing each to satisfactorily achieve his or her reason for being in the ED this night. If they can, the interaction will be productive and mutually beneficial. If they cannot, friction is inevitable. Conflict often has its roots in common experiences seen from different perspectives and with expectations that are seemingly at odds.

Different Purposes

The complexity of health care interaction and decision making can be illustrated by the simple analogy of the cone in the cube (Figure 1.1). Two people peer into different holes in an otherwise opaque cube. Their task is to determine what is inside. The person peering into peephole A, on the side of the cube, sees a circle. The person peering into peephole B, on the top of the cube, sees a triangle. They are both viewing the same shape but from very different perspectives.

FIGURE 1.1 Look in the Cube



The person peering into peephole A points to his extensive education and expertise, declaring, “Do you realize how smart I am? If I say it’s a triangle, then it’s a triangle!” The person peering into peephole B counters, “I don’t care how smart you think you are. I control the budget in this institution. If I say it’s a circle, it’s a circle!” Although this analogy is simple, it is emblematic of the failure to account for the multiple dimensions of a problem. Whether those involved are physician and nurse, patient and clinician, or administrator and payer, there are myriad ways for people to get mired in different perspectives and positions on the same problem. Achieving an integrated perspective is at the heart of the health care negotiation and conflict resolution process.

We often begin our health care negotiation and conflict resolution course with a classic game theory simulation exercise called *Prisoners’ Dilemma*. (For a discussion of Prisoner’s Dilemma and game theory, see Luce & Raiffa, 1957; Goldberg, Green, & Sander, 1987; Rahim, 1992.) This exercise demonstrates the difficulty of negotiating when people have little opportunity for direct or prolonged interaction, like prisoners in different cells trying to communicate. Each participant in the exercise is part of a foursome divided into two pairs. The two pairs sit with their backs to each other—which intentionally limits any direct interaction between the pairs—and an instructor moves messages on paper between them. In a series of transactions, they exchange *X*’s and *I*’s, which when combined could translate into either gains or losses for each of the two sides.

To simulate conditions in real organizations, the directions for the exercise are purposefully ambiguous. One line in the directions encourages the participants to “do the best you can to achieve a high level of benefit from the transactions.” The unspoken quandary is that the *high level of benefit* is intentionally left open to interpretation. Because they must begin negotiating immediately, the players often do not have a common definition for what they are trying to achieve. As a result, one of the four players may assume that *winning* means his pair receives more points than the other pair. Another player may conclude that winning requires collecting more points while also reducing the other side’s points. A third may assume that winning means each team receives an equal score. And finally, the fourth may surmise that winning means both teams get a score close to zero.

The problem is readily apparent. If each player assumes a different interpretation of high level of benefit, there is certain to be conflict. In essence, one person is playing one game, *defeat the opponent*, while his or her partner is playing another game, *let’s all win together*.

Even among the most subdued of players, the interchange becomes eagerly animated. At face value they are only exchanging *X*’s and *I*’s—symbols with no inherent value. The heated exchanges emerge from the underlying belief systems, perspectives, and objectives that influence the players’ actions during the game.

Each person is playing, in part, to advance and validate his or her own belief system. It is common for someone to say during the after-exercise debriefing, “It wasn’t that I was going for points. I was trying to show that we can play to win together.” It is also common to hear, “I love to win, no matter what I am doing.” Each party strives to justify the principles that frame his or her behavior.

The cone in the cube problem and Prisoner’s Dilemma parallel the situation in the ED: different perspectives on the same problem combined with differing objectives, a recipe for a high level of consequences and emotional conflict.

Artie Ashwood stares up at the tiles of the hospital ceiling. He is in a great deal of pain. He is frightened. He wants his computer. Then he could go online and get answers for himself about what is happening to his body. They won’t even let him use his smart phone, which would let him turn to his online social networks for help. He hopes that the people around him will care for him well. His confidence in the system is flagging.

Ashwood’s condition continues to defy a conclusive diagnosis. Hoping for more information, Dr. Dave Donley, the resident who has been following Ashwood, holds him in the emergency department, waiting for the stabilization. Nothing changes.

Her earlier suggestion to move Ashwood still unheeded, Charlotte Chung signals Dr. Benson over to the triage desk and asks if anyone might be ready to move along. The waiting room is full, and the gunshot wound is stretching everyone thin. Perhaps if Benson decides on her own, things will start happening. This is a nursing maneuver Chung learned a long time ago. Turn your problem into someone else’s and then hand her your solution. When she chooses it, congratulate her wise decision. She dislikes having to play this game but smiles to herself every time it works.

Benson nods and shifts into command mode. She calls over to Dr. Donley, “We’re too busy to hold this fellow any longer. Call cardiac intensive care and tell them we’ve got an admission. Tell them he needs to go up there right away.”

It has been a busy shift on the cardiac intensive care unit (CICU) as well. Seven of the CICU’s eight beds are filled. Six of these patients require heavy-duty care. The seventh patient had been sent up by the ED three hours ago, and once the CICU nurses and physicians completed the workup and admission, it was clear that the ED had misjudged that patient: it was not a case requiring intensive care. The CICU had had enough of the ED for one night. With three hours left in the shift, the CICU staff were hoping the night would calm down.

The chief resident of the CICU, Dr. Eli Ewing, knows that he is running an expensive unit. That misjudged patient not only consumed a great deal of unnecessary time and work, it also cost the hospital and some insurer a lot of money. Ewing believes he has a responsibility to screen out patients who do not

require this most technical level of care. Ewing also has a responsibility to the staff. In the parlance of the teaching hospital, a *wall* is a resident who succeeds in keeping out admissions to the unit. A *sieve* is someone who doesn't know how to say no. Walls are heroic, sieves are not—and Ewing is clear about which he prefers to be.

Ewing takes the call from Donley. Still smarting from the last case, Ewing listens sardonically to the report on Ashwood's enlarged heart. Donley admits he is not certain that the patient is in a medical crisis. Ewing's reaction is terse: the patient doesn't need to be admitted to the CICU and the unit is not going to take him. He suggests calling one of the general medical floors, which can do a far better and far less expensive job of babysitting. Ending the call abruptly, Ewing turns to the CICU staff and smiles, "Another victory!"

Donley is perplexed. Is there something he is missing? He walks into the bustling trauma room, where Benson is now intently overseeing work on the patient with the gunshot wound. He explains the situation. Benson barks back, "Tell Ewing he is taking the patient. End of story."

The ensuing back-and-forth goes nowhere. Forty-five minutes later, Benson emerges from the trauma room to find Ashwood still in the bed. "They just won't take him," the frustrated resident explains in defeat.

Enraged, Benson grabs the phone and demands that the CICU chief resident get on the line. "I want you down here right now." It is now a battle of rank versus wall.

"Look," Ewing replies sharply, "this guy doesn't need to be admitted to the CICU. If you want him in for observation, send him to one of the medical floors. We've already had to sweat out one misread from you guys tonight."

"Fine, then let's see what Fisher thinks about this case." Dr. Fred Fisher is medical director for the medical center. This is now a power contest. Benson has no doubt that she will win.

The CICU resident pauses. "Fisher? You're going to run to Fisher over this?" Ewing decides that Benson wouldn't risk escalation unless she were sure of how Fisher will react. "All right, don't get too worked up. I'll be down."

The parties in this emergency department admission scenario are in a situation similar to Prisoner's Dilemma. They have little opportunity to meet. Yet they must engage in a series of transactions and reach a set of common decisions that are utterly interdependent. As with the cone in the cube, they are looking at the same patient but seeing very different images.

Although the parties share many common objectives, their definition of *high level of benefit* is heavily influenced by their immediate context, be it a crowded emergency department or an overworked CICU staff. The ED weighs the care required by each patient against that needed by other patients flowing into the

hospital. Therefore, decisions are relative to ED conditions at the moment, as well as the patient's immediate medical needs. The CICU's decisions are based on far more standard criteria. An insurer will not reimburse the hospital for this expensive level of care if a patient's condition does not warrant it. Thus the emergency room staff have one set of criteria for admitting a patient to the CICU, and the CICU staff have a very different set.

When the ED attending physician ordered the CICU admission, the problem with the patient still wasn't clear. The possibilities ranged from minor to life threatening. So the admission decision was made with limited information and a great deal of ambiguity. However, once parties adopt a line of thinking, they can become allegiant to it. Each believes there is much at stake, be it the patient's life, the work of the staff, money, time, or professional prestige. The interchange then becomes passionate as the parties defend principles. "The emergency department decides who is admitted and to which department they are going," maintains Benson. "Without that authority, I can't make this place work."

Ewing counters, "Only the CICU can determine who needs its care. Without that authority, this hospital would turn into expensive chaos. With the threat of lawsuits hanging over us, no physician wants to take the risk of undertreating a patient. Before you know it, every patient will be sent through the CICU as a precaution."

Each of the parties, from his or her own perspective, was trying to wield the control necessary to satisfy his or her considerations. Nonetheless, given the different criteria that the parties brought to the task, it was likely that they would experience a great deal of conflict in the process. The CICU resident was trying to insulate the system as well as his staff from the issues he foresaw. The attending physician was trying to maintain a reasonable balance in the ED while doing what she felt was best for the patient. The ED resident was mediating between the two. And the patient was hoping that the people who would determine his fate could assure him the best possible level of care.

Bottom line, what binds the people, institutions, and activities that we call *health care* is the patient. Although the patient focus is a constant, there are so many different meanings and interpretations of what good patient care is that, ironically, it often becomes a fulcrum for passionate conflict.

The Complexity of Conflict

The first step in negotiating and resolving conflict is beginning to understand it. Even the effort to begin reflecting can mark a turning point, because polarized disputants are often more interested in winning than they are in understanding.

Many times it is difficult, even in retrospect, to fully comprehend the origins and manifestations of a conflict. (For a discussion of conflict analysis, see Likert & Likert, 1976; Potapchuk & Carlson, 1987; Kolb & Bartunek, 1992; Losa & Belton, 2006.)

We want to understand the causes of conflict so we can modify the ingredients that vary its presence and impact. Conflict itself is inevitable. Nevertheless, it does present us with choices. There is good conflict and bad conflict. Good conflict effectively exposes problems, it generates creativity, and it opens possibilities that would otherwise not be found. It is conducted in a respectful manner, it is focused on the problem and not the people, and it follows a mutually accepted process. Bad conflict is a bitter distraction, is costly, and can be destructive, especially when negotiating high-stakes decisions regarding health care. Bad conflict is conducted in an adversarial manner in which defeating or even destroying the other side becomes more important than solving the presenting problem. As we begin to observe and understand conflict, we can make choices about both substance and process. We can learn from conflict. It is a vehicle to help us better perceive ourselves, the people we work with, and what we are trying to achieve together. If we truly comprehend it and intentionally choose how to work with it, conflict can uncover opportunities for institutional as well as personal improvement.

What are the ingredients of conflict? If you wanted to create it, what factors would you blend together?

To start with, formulate ambiguity. Take information that could be interpreted in different ways by different people, depending on their knowledge, values, and life experiences. Exclude some important elements of that information, and distribute what remains among different stakeholders. Introduce events that could be viewed and interpreted in disparate and contradictory ways. Create uncertainty about options and outcomes. Sprinkle a dash of vagueness over the mix.

By itself, ambiguity is inconsequential; that changes when it is baked in the heat of requisite decisions and actions. Artie Ashwood presented to the emergency department without a medical chart. The ED staff have no information about his baseline medical condition. In addition he is unclear about his medical history. It is impossible to unequivocally predict what is going to happen next. And who knows how his insurer will assess the appropriateness and necessity of care when his case is reviewed in retrospect? If the wrong decision is made, it could be unnecessarily fatal for Ashwood or unnecessarily expensive for the hospital. Yet a series of decisions must be made by a widely dispersed cast of characters.

Next, add complexity. The more people who are involved in or affected by a decision, the greater the potential for conflict. Some people are physically present in the scenario: physicians, nurses, and patients. Others are not actually on the scene but their presence is felt nonetheless. They are the people who devise

health care policy, who construct the rules of reimbursement, who determine appropriate professional conduct, or who write hospital policy. Even though one person holds the responsibility for making a health care decision on the spot, that decision is colored by hundreds of people who allow or who constrain what can or cannot be done.

This complexity would not be so problematic if it weren't attached to stakes. Although there may be only one decision on the table, such as whether or not to admit, the stakes differ considerably for the many people involved. Those stakes may be measured in terms of professional responsibility, legal or financial liability, personal pride, or a tough night on the job. They may also be measured in terms of quality of life, time, pain, and stress.

Now, add to this mix competition and evaluation. There are competing departments, professions, and institutions at play. Each wields different amounts of power, prestige, and status. In the intricately hierarchical structure of health care, professionals ascend and descend based on both their own successes and failures and those of others. The CICU resident hopes to boast to his subordinates and his superiors that he has protected the unit from another unnecessary admission, and expects to rise another rung on the ladder of respect and admiration in the process. His conquest becomes someone else's conundrum. However, if his superior is later admonished for wrongful refusal of a patient, the penalty is a precipitous slide down that ladder. Likewise, the attending physician in the emergency department wonders what influence she has on the floors and departments above her. Can she keep patients flowing smoothly through the ED to appropriate destinations? She is dependent on the efficiency of the lab, the timeliness of medical record retrieval by the records department (a process that may or may not be electronic), and the cooperation of the medical services throughout the institution. What if her work and decisions are not respected? It could spell disaster for her, for her department, and for the patients dependent on her work. That conundrum is amplified for the triage nurse in the ED. She views and experiences the logjam first and most immediately, yet she has limited authority to dislodge it and often must fall back on her ability to wield persuasive influence over those in charge.

Like ambiguity, this competition and these hierarchical predicaments would not matter if they occurred in isolation, but here they are boiling up in a context of obligatory cooperation. Information must be exchanged. Care for ill patients must be uninterrupted as they move from one department to another. A heavy workload in one area of the hospital requires assistance from other areas. And the whole operation must be in conformity with the differing rules of reimbursement set by the many health care payers, the evolving standards for quality of care, and the unique needs and desires of patients and their families.

Combine all of the above with stress and pressure. Time is not an abstraction in health care. It is measured in moments when a life can be saved. It is measured in colossal dollar amounts when there is a delay in discharge for a patient who need not be in the hospital. There is little room for error or delay. With time so critical, it is imperative to synchronize actions and decisions. Given the extraordinary interdependence of health care services, procrastination on the part of one individual, department, or institution strains the entire system.

Stress and pressure are amplified by consequences. Whether measured in terms of the patient's quality of life or the institution's financial balance sheet, the implications of even routine decisions can be overwhelming when multiplied by hundreds of patients. Artie Ashwood prays that he will be able to return to a normal life after this horrible night. He hopes the people caring for him have the competence and compassion to make sure that happens. Charlotte Chung and Beatrice Benson both know they are juggling an acute set of choices: a misjudgment could cost them loss of professional prestige, a liability suit, or even their license to practice. Dave Donley knows that he is building the foundation for the rest of his medical career, and he hopes it to be a beginning that will serve him well for years to come. And Eli Ewing wants to show that he can handle the tough decisions required of physicians. That reputation could help win him a prestigious position once his residency is over.

When the most incendiary ingredients are flung into this mix, conflict can become ugly and frightening. Mistrust, lies, trickery, and malicious behaviors breed suspicion and aggression. Manipulation, fear, hostility, and counterstrategies insert a dynamic that can be near impossible to break. As emotions fuel thinking and behavior, each side assumes a battle position. The outrageous acts of one side justify and goad those of the other. Eventually, people lose sight of what the original issues were all about. The conflict assumes a life of its own.

Finally, incorporate all these ingredients into the near constant and evolving process of change. Health care "reform" initiatives cycle through the system regularly. With each wave, reimbursement formulas and incentives are recalculated and realigned, organizations are restructured, professional responsibilities shift, and social expectations adapt. In addition, at the heart of the health system are rapid changes in knowledge, research, and technology that enlarge what health professionals must know and do. Some people welcome these changes and eagerly pursue the opportunities they present. Others recoil from them because these shifts threaten their status, comfort, or influence. This clash between comfortable security and precarious, unknown opportunity magnifies every conflict. The health care system is akin to a colossal jigsaw puzzle in which the parts—money, organization, service, training, and people—are aligning themselves into a new order and a new fit all the time.

Choices About Conflict: Good or Bad?

Thomas Schelling (1960) distinguishes two fundamental approaches to the study and understanding of conflict. One approach views it as a problem, the other as an opportunity.

Those who view conflict as pathological believe it is best silenced or eliminated. Seen through this lens, conflict reflects negatively upon an organization or leader. Conflict is an annoyance in and of itself, as are those people who raise it. People who instigate conflict are labeled *troublemakers*, and the problems they raise are associated with them personally. When this perspective pervades a group, discussion usually descends to blaming, polarization, and nasty personalization of the issues.

This perspective shuns the disruptive implications of conflict and change. This is a conservative view that regards conflict as a challenge to the existing power arrangements. For example, the members of a long-standing management team would likely be intimidated by calls for change within their organization. The concerns and dissatisfactions of those who ignited the conflict are delegitimized, as they endanger the authority and influence of those in charge. The actual problem is lost in the struggle to determine who has the legitimate authority to raise concerns and make decisions. You might hear some version of “there is nothing wrong with what we are doing or how we go about doing it; the problem is with the people who are raising the problem.”

From this point of view, conflict and contest are intertwined in their meaning. The only response to conflict is to end it with a quick and decisive victory. Conflict is viewed as a threat and a source of vulnerability by both sides. Going for a win is akin to fighting for survival. It is an instinctual, self-protective response that allows only an inherently limited set of options.

When conflict is regarded as intrinsically bad and the people who raise it are treated as troublemakers, then little can be learned or gained from the everyday problems an organization or group of people naturally encounters. Rather than considering what may be wrong or what might be fixed, attention is directed to silencing the dissenters and invalidating their concerns. The paradoxical outcome is that the original problem is then exacerbated. Not only does the source of the original dissatisfaction remain. The conflict itself becomes an annoying distraction, gobbling time, resources, and a wealth of missed opportunities. For those who raised the issues, the walls and silence imposed upon their concerns form yet another layer of frustration to endure.

The second approach to conflict views it as a naturally occurring social phenomenon. It is to be expected that people and organizations vacillate in their

interests, priorities, concerns, and relationships. When seen from this perspective, conflict is acknowledged and handled as one measure of the problems or concerns that merit appropriate attention. To silence differing points of view by erecting concrete barriers between them and the established views is also to oppose the values of an open, resourceful, and intellectually entrepreneurial enterprise.

Those who view constructively framed conflict as a positive contribution encourage constructive expression of differences so they can be acknowledged, addressed, and, one hopes, remedied. Rather than discounting expression of dissatisfaction, these leaders solicit it as a way to move toward resolution. This perspective recognizes that the most successful organizations are those that can efficiently and accurately respond to internal as well as external contingencies. Effective solutions are devised by tapping into wide-ranging sources of credible information and then working to invent mutually acceptable solutions.

This approach does not imply that all expressions of conflict are inherently valid. Absolutely not. Not every issue and concern has merit. People may raise matters that are irrelevant to the purposes of an organization, are beyond reasonable expectations, or are without validity. Even so, such issues may still deserve some attention. You might question why the misinformed expectations arose in the first place, and you might want to improve information and communication as a result. That is to say, even when an issue is without merit, it may reveal something important about the conditions, people, or circumstances that spawned it.

Those who approach conflict in this way encourage its expression, endeavor to find its roots, learn from it, and when appropriate, modify conditions. Expressing, learning, engaging, exchanging, and changing form a recurring cycle of robust organizational practice. Often, finding the resolution is a matter of negotiation. The responsibility for enhancing the process by framing the issues constructively lies with all parties to the disagreement. If conflict is to be an opportunity to add value, the initial framing, the response, and the subsequent bargaining must be conducted in a manner that respects the legitimate concerns of all sides.

The approach of this book is to view constructively expressed conflict as an opportunity. It regards conflict as part and parcel of human endeavor and thus part and parcel of health care. It is to be expected. If we accept that differences of opinion, and sometimes even heated differences, are predictable occurrences in health care, then we can prepare for them. We then reframe conflict as opportunity. Conflict is a plus when used as one test for determining what is and what is not working about health care. It can serve as a gauge that points to what needs to be improved. This positively constructed method for attending to conflict can be one part of a continuous quality improvement strategy.

Charlotte Chung wonders aloud what can be done to change this nightly standoff between the emergency department and other units of the hospital. Sure, part of it goes with the territory. There will always be some creative tension between the unpredictability of what happens here and the orderliness of the routines in the rest of the hospital. Nonetheless, there has to be a better way to play out these decisions so that people, herself included, don't get caught in the cross fire.

Artie Ashwood's mother, Anna, and girlfriend, Cindy, have never been on the best of terms. Now, pacing impatiently in the ED waiting room with no information and no treatment decision, each has convinced herself that Artie is going to die. Their old animosities rise to the fore, as each is certain that Artie's death will be a greater tragedy for her than for the other. Anna mutters over and over, "My baby, my baby." Cindy grits her teeth and thinks to herself, "My lover, my lover. You screwed up Artie and now all you care about is 'my' baby." Together they approach the triage desk, pleading to be allowed to see Ashwood.

Chung explains that he is allowed only one visitor at a time. Anna and Cindy both explode, each arguing that she is the one Artie really wants to see. Chung stares them down and then patiently asks them to take a seat while she goes back to see what's happening.

Enough is enough. Chung darts up and heads right for Dr. Benson.

We prepare ourselves for conflict by better understanding it and better negotiating our differences. We prepare our organizations for it by anticipating it and by building mechanisms to resolve it in its early stages. And we incorporate a concern for it when we craft public policies that regulate work and interactions in health care settings in a manner that appreciates the very human and very intimate complexities found in these settings.

It is prudent to expect any nation to periodically readjust its health system, a process shouted out from the headlines as "health reform." New policies, procedures, expectations, and pressures will put their mark on the everyday negotiations and interactions of all parts of the system. These new policies will reframe professional, fiduciary, and organizational relationships between doctors and patients, patients and insurers, nurses and patients, doctors and businesses, and among the many others who are part of the health care system. If those relationships are reframed correctly, then the system will work to keep people healthy and, when they need care, to appropriately provide the service they need. However, if the relationships are not carefully designed, and if appropriate incentives, restrictions, and protections are not in place, people will face great disappointment when they need care for themselves or for a member of their family. The work of health professionals and the fates of those who

depend upon these professionals' work and counsel will form a story of bitter disappointment (Thorne, 1993).

This book is a map to help you better understand conflict, negotiate choices, and build systems to improve the processes of decision making. The book is not intended as a blueprint for a better health care system, a more satisfying health care career, or improved health care experiences. Rather, it is a guide to the process for getting there.

