Conflict Engagement: A New Model for Nurses

A relational model for nurse managers.

This article is one in a series on conflict. It is part of an ongoing series on leadership coordinated by the American Organization of Nurse Executives (AONE), highlighting topics of interest to nurse managers and emerging nurse leaders. The AONE provides leadership, professional development, advocacy, and research to advance nursing practice and patient care, promote nursing leadership excellence, and shape public policy for health care.

Conflict emerges from human interaction; it's a natural component of any relationship. Conflict is inevitable in complex health care systems such as hospitals, where high levels of interdependence, production pressures, and role ambiguity are common. Failure to address conflict can affect all aspects of an organization, including patient safety, clinical outcomes, cost of services, and the well-being of health professionals.[1]

Providing safe patient care and cultivating healthy work environments require the development of what Runde and Flanagan refer to as "conflict competence."[2] Cultivating conflict competence involves both an understanding of the dynamic nature of conflict within organizations and a deeper understanding of one's own responses to conflict. It's essential for health care leaders to learn how to work with conflict within the context of an organization and to understand their own personal approach and contribution to conflict. Effectively addressing conflict in health care organizations requires the ability to

- understand systemic patterns and group dynamics and how these change over time.
- intentionally engage in conflict by using "relational intelligence"—the ability to notice, reflect on, and shift personal and interpersonal habits and beliefs.

This article, the first in a six-part series on conflict engagement for nurse leaders, will explore these abilities and present a model for addressing conflict based on recognizing the importance of relationships and the patterns they create. This "relational model" blends the skills that enable leaders to observe what's happening within an organization with the skills that focus on intrapersonal (self) and interpersonal (relationship) abilities.[3] We begin our journey at the Happy Hills Medical Center, where two nurse leaders are faced with the difficult task of turning around a troubled nursing unit. (This scenario is a composite based on my experience.)

A PICTURE OF CLINICAL CONFLICT

Happy Hills Medical Center is a 350-bed hospital with over 30 ambulatory clinics and several outpatient facilities. Jonathan Peterson, the nursing director, is responsible for six medical–surgical units and three cardiac intervention laboratories. He has been in his position for nine months and has identified multiple areas that are struggling with poor morale, high turnover, and low scores on patient satisfaction and employee engagement surveys.

One of the medical–surgical units, 5-East, is having the most difficulty. The unit has had five different nurse managers in the past eight years. Its current interim manager, Maria Lopez, is working hard to move the staff forward. She has become aware of frequent absenteeism, bullying behavior by senior staff, criticism from ancillary departments about unprofessional conduct on the unit, and complaints by physicians about the quality of nursing care. Ms. Lopez feels overwhelmed but remains optimistic. Although these patterns of behavior are hard on everyone, she knows the nurses want to provide good patient care and take pride in their work; it's clear they want to be part of a healthier, more supportive workplace.

Despite Ms. Lopez's repeated attempts to meet with staff and address their concerns, there has been little change. The staff feel they haven't had good nurse managers in the past and are not confident the new leader will be any different. They feel they are seldom acknowledged for their work and for their efforts to accommodate several recent major changes on the unit, including a new clinical documentation system, a merger with another unit, an increase in

An Invitation from the Author

Conflict is a daily part of nurses' work. Whether negotiating patient care, managing staffing needs, or responding to upset family members, nurses are at the forefront of navigating layers of conflict in our clinical work environments. Ironically, we are taught very little in nursing school about how to effectively address conflict, particularly conflict with colleagues. We watch what others do and mimic them, or we avoid the pain of engaging in conflict altogether. But these approaches interfere with what matters to us most: safe patient care, good relationships with colleagues, and the opportunity to help others heal.

As a nurse for over 25 years, I know that our work environments are more difficult and complex than ever. The pressure to improve and track quality, treat more patients, reduce costs, and maintain satisfaction scores creates a push–pull workplace that breeds conflict. The shift toward team-based care seems well meaning, but the cultural differences among the professions often work against us. Additionally, the tasks we are given often deviate from the work we signed up for when we became nurses. And yet a way out of this dystopia is within our reach. It resides in our ability to engage with one another with compassion and integrity—two qualities nurses have in abundance.

As a conflict specialist, I have convened many nurses, physicians, and other health care providers to help them engage with one another to communicate their serious concerns and the emotional impact of their work. These conversations are a way to openly address complex issues, including the erosion of trust that can derail even the best efforts to do good work and provide safe care. The conflicts have varied, but in every single case, the quality of the relationships was at the heart of each, and more importantly, was the key to finding a resolution.

This series of articles presents empirical evidence in a true-to-life scenario, so you may consider what a relational approach to conflict might look like. My goal is to provide you with a framework for addressing conflict in ways that align with and optimize our underlying strengths as nurses, and to help you become inspired to improve your ability to address conflict.

I invite you to imagine what it would take to fully engage with your patients, their families, and your colleagues in ways that preserve the meaningful nature of nursing and contribute to your sense of well-being. I invite you to explore what is possible.—*Debra Gerardi*

patient acuity as a result of added telemetry beds, and the arrival of a new medical director who has criticized their skills and publicly humiliated them. "If I could find better nurses to work here, believe me I would," he recently told a patient while a nurse stood in the room. To make things worse, there have been three sentinel events on the unit in the past year—one precipitated a full hospital review by the Centers for Medicare and Medicaid Services. Tensions are high and Mr. Peterson and Ms. Lopez are under pressure to improve working conditions and quality of care.

ANALYZING CONFLICT IN A COMPLEX ADAPTIVE SYSTEM

Health care organizations are dynamic, with many interdependent activities occurring simultaneously. As such, they have been referred to as "complex adaptive systems."[4] Unlike machines, complex adaptive systems evolve as they respond to changes in the environment. Like the human body, they are always in a state of flux. Four qualities characterize complex adaptive systems: they are self-organizing; patterns emerge over time; they are nonlinear (their future is unpredictable); and the patterns result from personal interactions and relationships.[5]

Addressing conflict in complex adaptive systems requires first having the ability to notice how people interact, and then being able to work with the patterns that arise from those interactions. Patterns emerge as a result of the self-organizing behavior of people within complex systems. Over time, these patterns characterize the culture of the unit or group. Conflict is one type of pattern that emerges from ongoing interactions among health professionals. Response to conflict is another.

In complex adaptive systems, the quality of relationships determines the effectiveness of the organization, including the quality of clinical outcomes.[6] Lanham and colleagues found that in high-performing primary care practices, individual traits and interpersonal relationships were characterized by qualities such as trust, mindfulness, heedfulness, respect, social and task relatedness, diversity, and communication.[6] These qualities align with those central to emotional and social intelligence, which include social awareness,

Photo by Simone Van den berg / Thinkstock.

relationship management, self-awareness, and self-management of emotions.[7] There is a positive correlation between social and emotional intelligence and the capacity to engage in conflict collaboratively.[8]

Understanding conflict within the context of complex adaptive systems is a key component of conflict competence.[9] Addressing conflict in these systems requires more than good communication skills, particularly in work environments where tensions are heightened by power dynamics, professional subcultures, productivity pressures, and emotionally taxing work.

A mechanistic view of organizations assumes that fixing the broken parts (or processes) in a system will result in improved overall performance.[10] It's a linear approach that imagines a direct relationship between a specific event and who or what caused that event to occur. It works for problems that require a simple technical fix (for example, if a light bulb burns out, it can be replaced). But this view is inadequate for conflict resolution in complex systems such as health care organizations.[11] The mechanistic approach ignores the dynamic interrelationships between the parts of the system—it simply isn't designed to account for the influence of human interactions.

A mechanistic view of the Happy Hills Medical Center scenario focuses on what has "caused" the situation in order to "fix" it. From this perspective, it would be easy for the nursing staff on 5-East to blame their situation on "management that doesn't support or appreciate us," just as the management team could attribute the situation to "burned-out nurses who resist change." The management and staff might even agree that the troubles were caused by the merger of the units; but this would ignore the many other contributing factors. This fault-finding approach is a common but simplistic response to conflict.

Although it would be easy for the leaders of 5-East to focus on events in which there was disrespectful conduct or abuse of power, responding to these events without considering behavior patterns on the unit ignores the other factors that may contribute to ineffective work patterns. It also scapegoats individuals. Failure to look at behavior patterns also leads to short-term solutions that don't address deeper problems, resulting in recurring patterns of conflict and diminished trust over time.

In health care organizations, there are usually layers of contributing factors that when taken together, create the conditions for conflict patterns to emerge. Just as with most medical errors, there is usually not a single cause of workplace conflict—instead, a number of interrelated variables lead up to an event. Finding a way to identify and assess these contributing factors will provide a framework for better understanding the circumstances generating the conflict, as well as clues for how to intervene. Effectively addressing conflict in complex systems requires an understanding of how systems function, and ultimately a shift in thinking toward a systems view of organizations. Using "systems thinking" changes how conflict is perceived and increases possible responses to conflict.

Systems thinking is described as "a general conceptual orientation concerned with the interrelationships between parts and their relationships to a functioning whole, often understood within the context of an even greater whole."[12] In other words, systems thinking is a means of seeing the interrelatedness of the components of a system and the patterns that emerge from these connections. It provides a method for incorporating the dynamic, interconnected nature of clinical work into the approaches for managing how the work gets done.

To address a conflict in a complex system, a conflict specialist would take the following steps: ask questions about group dynamics and patterns; identify themes embedded in the conflict narratives; and sort these themes into one of four categories in order to design a comprehensive conflict intervention.

Ask questions about group dynamics and patterns. Usually, inquiry into disruptive behaviors or conflict events takes the form of an investigation—for example, who said what, when, and where, and who was harmed. This is fault-finding methodology that looks at the single event and not at the patterns of behavior that allow such events to occur.

In comparison, an inquiry into group dynamics and patterns approaches the problem from a broader perspective and requires a different kind of question. For example, a conflict specialist considering 5-East might ask: Historically, what has been the response by staff and managers to episodes of unprofessional conduct? What was done to proactively address the inevitable tensions associated with the unit merger? What has been the effect on the staff and on patient care of high turnover in the nurse manager position? How well do nurse leaders and physicians work together? What is the process for resolving differences among staff? How easy is it for people to speak up when they have concerns?

These questions uncover some of the tensions that may be contributing to the current situation and triggering defensive behaviors and unproductive work patterns. Crafting these kinds of questions is the first step in conflict assessment.

Identify themes embedded in the conflict narratives. Stories are the way people make sense of their environment; they reveal a great deal about how behaviors emerge and what can be done to interrupt ineffective patterns. Conflict situations generate a good number of narratives—and these conflict narratives have a particular structure and tone. They typically include simple explanations of complex problems, attribution and blame, all-or-nothing thinking, a strong emotional voice, and predetermined and generally inflexible solutions to the problem.[13] It is helpful to listen to the narratives of those involved in a conflict situation to identify the themes and issues reflected in their stories.

Conflict narratives are stories people develop to make sense of a difficult situation. Decoding these stories requires the ability to listen with an open mind and explore the embedded meanings. Listening in this way takes practice and requires presence of mind to know when you are getting "hooked" by the dramatic tensions in the stories. This means that your emotions and experiences become entwined with those in the story, altering the information you hear and how you interpret it. When listening to conflict narratives, it's helpful to identify the themes that characterize each story, such as loss of trust; perceptions of unfairness; or exclusion, shame, or disempowerment.

Sort these themes into categories. Once they have heard the stories and identified their themes, conflict specialists traditionally sort the issues into one of four categories before designing a conflict intervention. These categories include[14]

- substantive issues (the focus of the disputes).
- structural or procedural issues (how decisions are made and how people do their work).
- context (what is happening in the organizational environment).
- relational dynamics (the quality of the interactions among the people involved in the situation and their patterns of response to one another).

Each category contributes to the conflict and can also contribute to its resolution (see Table 1).

ANALYZING THE CONFLICT AT HAPPY HILLS

After listening to the stories of the unit staff, physicians, and ancillary staff, Mr. Peterson and Ms. Lopez meet and make a list of the substantive issues facing the unit. These include poor performance scores, quality of care concerns, staffing issues, staff competency issues, increases in patient acuity, and high turnover in the nurse manager position. They want to address these issues as they work to turn the unit around. They will also consider the ways in which clinical work on the unit is done and services are coordinated.

Questions for Reflection

1. What issues have led to conflict among staff on your unit? What positive or negative patterns have emerged over time to deal with this conflict?
2. How would you describe the quality of relationships among staff and across the professions in your work area? What could strengthen these relationships and create stronger connections?

Table 1. Inquiry and Issues Analysis of Conflict Situations

Category	Content	Issues from the Happy Hills Scenario	Sample Assessment Questions
Substantive issues	The primary issues that are the focus of the conflict.	• Sentinel events • Quality of care concerns • Staff engagement scores • Inadequate staff competency levels • Productivity measures • Patient acuity changes • Low HCAHPS scores	• What are the areas for improvement? • What is the level of staff competency, and what should it be for the acuity of the patients? • What are the trends in staff engagement scores? • How is productivity measured? • What are the trends in the HCAHPS scores? Was there a time when they were better?
Structural or procedural issues	Focuses on process: • Defines how work is done, how decisions are made, and meeting and communication structures • Includes codes of conduct and other policies, practice guidelines, and regulations	Processes for: • Making assignments • Staff schedules • Staff orientation • Communication among charge RNs • Resolution of patient care disputes • Responses to unprofessional conduct • Operational meetings • Patient rounds and safety huddles Policies regarding: • Code of conduct • Practice guidelines • Meeting attendance	• How are staffing and scheduling currently accomplished? • Was there a time when the process was more effective? • How do charge nurses communicate with one another? • How are conflicts among staff addressed? • How are patient care disputes between the nursing and medical staffs resolved? • What has been done to improve communication and decision making between the nursing staff and physicians? • Are interprofessional rounds a part of routine practice?
Context	What has happened historically within the work area or organization? What has happened recently that affects the situation?	Unit history: • Merger of units was difficult • Change in acuity of patients on the unit • Frequent turnover in nurse manager role • New leadership in nursing and medicine • Frequent sentinel events leading to CMS review • Changing payment system focused on quality of care • Little guidance for charge nurse group	• What has been the effect on the unit of the merger? • What has been the effect of high turnover in the nurse manager position? • What was done to respond to the sentinel events, and how has that affected the nursing staff and physicians? • What needs to happen to integrate the physician team to improve quality of care on the unit? • What is the impact of new surveys related to patient satisfaction and employee engagement on staff, managers, and others?
Relational dynamics	The quality of work relationships; the dynamics within groups and between groups or individuals; the relational capacity of leaders and others to engage in solving conflict, boosting morale, and engendering trust and respect among colleagues.	Dynamics on the unit: • Divisions within the charge nurse group • Alliances within the staff • Nurses and physicians not problem solving their differences • Nursing staff alienated from physician leader • Difficult relationship between nurse manager and new medical director • Unaddressed conflict following merger • Fear and shame associated with sentinel events • Loss of trust and feelings of disrespect	• What have relationships been like among the charge nurses? When did they change? • How has retaliation or bullying behavior been addressed? • How has trust been rebuilt and fear addressed following the sentinel events? • What could happen that would improve morale and create a work environment where people feel safe to speak openly? • What could happen to improve the relationship between nurse leaders and physicians?

CMS = Centers for Medicare and Medicaid Services; HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems.

The staff's stories indicate that there are structural and procedural concerns that need attention. These include the way patient care assignments are made (by seniority), the process for putting together the work schedule (favoritism), limited orientation of new staff, inconsistent training and oversight of staff in caring for the higher acuity patients, and poor communication between shifts and between nurses and physicians. They also note that there is little or no staff engagement in improving unit operations, and no process for resolving patient care disputes on the unit—just the filing of incident reports and verbal complaints made to the manager or charge nurses.

The context in which the nurse managers view the current dynamic requires that they look at past and present contributing events. Two years ago, to accommodate the larger organizational strategy, 5-East was merged with a smaller step-down unit, and telemetry beds were added. The merger was especially stressful for the staff and physicians, as they weren't given much notice and the nurse manager at the time was on leave.

One year ago, the organization implemented a new clinical information technology system, changing workflow and adding new nursing tasks. Several nurses struggled to adapt and ultimately were unable to remain in clinical positions. The recent addition of a new unit medical director has heightened tensions. His hard-driving, autocratic style seems to have been a tipping point for the nursing staff, who are refusing to attend staff meetings or participate in committee work until the organization addresses his behavior.

Mr. Peterson and Ms. Lopez also analyze the relational dynamics of the current situation on the unit to more fully understand it. They discover that the nursing staff is predominantly composed of experienced medical–surgical nurses who have been on the unit for more than 25 years. Newer nurses often feel intimidated by this group and report feeling excluded or minimized. Several senior nurses have said they would like to retire but can't afford to do so. They feel they have put in their time on committees and gone the extra mile and now the younger staff can take on those tasks. Not only is the medical director new to the unit, but this is his first time in a physician leadership role and he hasn't had any support with the transition.

The charge nurse group on 5-East is a powerful contingent; it makes most decisions regarding staffing, assignments, scheduling, and patient care management. Since the merger, there has been conflict within this group. The charge nurses still identify with their former units and staff. Everyone on 5-East is aware of the tensions but no one has addressed them. Alliances have formed that perpetuate the charge nurse dynamics. There is a mood of negativity and despair, little trust among colleagues, and many nurses report that they "just want to take care of their patients, get through their shift, and go home."

Mr. Peterson and Ms. Lopez consider all the information they have collected to see where they can begin to make changes that can positively shift the current climate. Looking holistically at the situation, they begin to identify patterns, and a plan to turn the unit around starts to emerge.

In the next installment of this series, Mr. Peterson and Ms. Lopez address the issues on the unit by working with the relational patterns they have identified and designing an intervention aimed at helping the staff to effectively engage with one another. ▼

Debra Gerardi is president and chief creative officer of EHCCO in Half Moon Bay, CA. Contact author: debra@ehcco.com. *The author has disclosed no potential conflicts of interest, financial or otherwise.*

REFERENCES

1. Joint Commission. Behaviors that undermine a culture of safety. *Sentinel Event Alert* 2008(40).
2. Runde CE, Flanagan TA. *Becoming a conflict competent leader: how you and your organization can manage conflict effectively*. San Francisco: Jossey-Bass, Inc.; 2007.
3. Ramsey VJ, Latting JK. A typology of intergroup competencies. *J Appl Behav Sci* 2005;41(3):265-84.
4. Begun JW, et al. Healthcare organizations as complex adaptive systems. In: Mick SS, Wyttenbach ME, eds. *Advances in health care organization theory*. San Francisco: Jossey-Bass, Inc.; 2003. p. 253-88.
5. Anderson RA, McDaniel RR, Jr. Managing health care organizations: where professionalism meets complexity science. *Health Care Manage Rev* 2000;25(1):83-92.
6. Lanham HJ, et al. How improving practice relationships among clinicians and nonclinicians can improve quality in primary care. *Jt Comm J Qual Patient Saf* 2009;35(9):457-66.
7. Goleman D. Rethinking social intelligence. In: *Social intelligence: the new science of human relationships*. New York: Bantam Books; 2007. p. 330-32.
8. Morrison J. The relationship between emotional intelligence competencies and preferred conflict-handling styles. *J Nurs Manag* 2008;16(8):974-83.
9. Sword LD. A complexity science view of conflict. *Emergence: Complexity and Organization* 2008;10(4):10-6.
10. Plsek PE. Appendix B: redesigning health care with insights from the science of complex adaptive systems. In: Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academy Press; 2001. p. 309-22.
11. Jones W, Hughes SH. Complexity, conflict resolution, and how the mind works. *Conflict Resolution Quarterly* 2003; 20(4):485-94.
12. Trochim WM, et al. Practical challenges of systems thinking and modeling in public health. *Am J Public Health* 2006; 96(3):538-46.
13. Winslade J, Monk G. *Narrative mediation: a new approach to conflict resolution*. San Francisco: Jossey-Bass, Inc.; 2001.
14. Scott C, Gerardi D. A strategic approach for managing conflict in hospitals: responding to the Joint Commission leadership standard, Part 1. *Jt Comm J Qual Patient Saf* 2011; 37(2):59-69.

Conflict Engagement: Workplace Dynamics

Part two of a six-part series on conflict engagement in complex systems.

This article is one in a series on conflict. It is part of an ongoing series on leadership coordinated by the American Organization of Nurse Executives (AONE), highlighting topics of interest to nurse managers and emerging nurse leaders. The AONE provides leadership, professional development, advocacy, and research to advance nursing practice and patient care, promote nursing leadership excellence, and shape public policy for health care.

The first installment of this series introduced systems thinking and conflict assessment as a means of understanding and analyzing conflict in complex systems. In this article, we continue with the Happy Hills Medical Center scenario and explore how to use the information gained from a conflict assessment to design an intervention aimed at helping people engage with one another to address their concerns and rebuild trust.

WORKING WITH PATTERNS IN COMPLEX SYSTEMS

Self-organizing behavior is a key characteristic of complex adaptive systems.[1] It occurs when people interact with one another on a regular basis, learn from each other, adopt similar beliefs, and take action in response to those beliefs. Over time, patterns of behavior arise and are established as the norm. These patterns are unpredictable, as they arise from personal interactions and not as a result of centralized or managerial control. When behaviors don't align with what's expected, they can be considered "unreasonable," "resistant," or "inappropriate."[2] In response, managers typically create stricter rules or policies to specify acceptable behavior. This response can stop the flow of information that makes complex systems work effectively. It is better to use approaches that optimize relationships, build trust, and encourage conflict resolution.[3]

When addressing conflict in complex systems such as health care organizations, it's important to look for patterns and not to simply focus on singular events.[2] Working with patterns yields information that can guide interventions in a more systemic way; it can accomplish more than just putting out fires. Working in this way provides an opportunity to interrupt dysfunctional patterns and to strengthen those that are effective. Over time, this approach can shift the overall climate in an organization.

Conflict is one type of pattern that emerges from personal interactions in a dynamic environment. Tensions arise and may cause conflict as health professionals negotiate plans of care, work schedules, daily assignments, patient flow, and clinical operations. Individual responses to conflict can be either constructive or destructive.[4] Destructive patterns negatively affect work relationships and erode trust.

One of the signs that work relationships have become fragile and require attention is when defensive or self-protective behaviors are the norm. Environments marked by ongoing fear and tension produce "disruptive behaviors,"[5] which commonly manifest in bullying, blame and shame, retaliation, silence, and avoidance. Although these behaviors may alleviate tension in the moment, they diminish the quality of the work environment in the long run and perpetuate unhealthy coping strategies.

Dysfunctional patterns can come to define the culture of a unit. Over time, unaddressed tensions can lead to a climate of fear. To manage this fear, some disengage to avoid becoming embroiled in the drama, while others form alliances to create a feeling of safety. These alliances may generate "sides" or "us-versus-them" thinking, which can result in perceptions of favoritism and exclusion.[5]

It takes time to develop cohesion on a unit where relationships are fractured. The process unfolds through a series of conversations focused on improving relationships. These conversations should begin by stating how the staff defines the problems it faces, then working with these descriptions to reframe and expand the individual members' stories. This approach acknowledges the staff's concerns and gives them a voice in considering alternatives—and thus becomes the first step in the formation of new patterns.

Photo © agefotostock.

Interrupting dysfunctional patterns. The goal for nurse leaders is to interrupt dysfunctional patterns in the workplace and promote the adoption of positive patterns that improve cohesion and care coordination. Addressing fear and restoring trust are necessary steps in effecting this shift. Leaders must also look at how they may be contributing to the negative patterns.

Typical responses to conflict on the part of nurse leaders include conflict avoidance, use of power or authority, smoothing and soothing behaviors, and premature adoption of solutions.[6] An ambiguous response to conflict is also common. For example, when faced with a conflict, managers will sometimes overlook it, while at other times they'll take aggressive action.[7] This inconsistency makes it difficult for staff members to know how to respond when faced with their own conflict situations. In circumstances like this, it is the social support and cohesion among work groups that decreases work stress, enhances resilience, and improves the ability of the groups to respond to external stressors that are generally out of their control.[8]

In the Happy Hills Medical Center scenario, Jonathan Peterson, nursing director, and Maria Lopez, interim manager of the 5-East medical–surgical unit, are working to address an ongoing conflict that is negatively affecting clinical care on the unit and the quality of the work environment. Using a systems approach, they have assessed the conflict and have identified a number of issues that are contributing to the challenges on the unit (see the first article in this series, "Conflict Engagement: A New Model for Nurses," March). Below, we see how they work with the patterns they have identified to determine where to begin their intervention.

WORKING WITH PATTERNS AT HAPPY HILLS

Mr. Peterson and Ms. Lopez recognize that the charge nurses have been inconsistent in intervening when problems arise between physicians and nursing staff. They note that these nurses still tend to identify and socialize with the unit staff with whom they worked two years earlier, before the two units merged. No clear direction was ever given to the charge nurses in terms of integrating their expertise and clarifying their roles on the new unit. Before the merger, the fact that the units had differing cultures was never considered. Ignoring the historical context in this case has contributed to the ineffective work patterns and inability of the nurses to engage with the physicians.

Appreciating that the relational dynamics among the charge nurses affects several of the issues that need to be addressed on the unit, Mr. Peterson and

Ms. Lopez decide to begin by interrupting unproductive patterns within the charge nurse group and helping these nurses to better engage with one another. They decide to focus on enhancing levels of trust and openness by helping the charge nurses deal with their differences in a productive and professional manner.

CONFLICT ENGAGEMENT

Conflict engagement is an ongoing process, not a one-time conversation. This fits with the dynamic nature of human relationships. Although not all conflict can be resolved, resolution is rarely possible without some level of engagement. Learning to engage in conflict and stay engaged over a period of time is essential for nurse leaders who seek to promote interprofessional collaboration and effective care coordination across teams, units, and facilities.

Conflict engagement is an ongoing process, not a one-time conversation.

Yet much of the literature in the field of dispute resolution focuses on methods for *resolving* conflict. This places the focus on the outcome and doesn't take into account the importance of conflict engagement as a first step. As Bernard S. Mayer, a leader in this field, has written: "Engaging in conflict means accepting the challenges of a conflict, whatever its type or stage of development may be, with courage and wisdom and without automatically assuming that resolution is an appropriate goal."[9]

Barriers to engagement. Time pressures, fear of retaliation, fear of exclusion, and concern about not having management's support limit the likelihood that staff will step up and engage in a difficult situation with a colleague.[10] In many organizations, the response to conflict is to "outsource" it by filing a union grievance, reporting the problem to a manager, or filing a complaint or incident report with human resources or risk management. While these processes set up the expectation that conflict will be dealt with by someone in authority, often these leaders themselves are not adept at conflict engagement.

Many research studies cite the need for managers and administrators to provide support to staff members who are engaged in conflict, particularly with physicians or others who have greater status or authority.[10,11] Without this support, staff members may not feel safe enough to fully engage in conflict situations. Staff also benefit when managers are able to engage with their own peers and address differences within the management team. In one study, Harris and colleagues found that managers who don't address conflict with other managers can project their personal frustrations onto their staff, who may experience feelings of disengagement, moral distress, and a sense of being diminished.[12] Effective conflict management in health care organizations largely depends on leaders' ability to engage in conflict.

Unmanaged conflict at the senior leadership level filters down through the organization, either directly or indirectly affecting patient care at the bedside. The ability of senior leaders to engage in conflict at the management level is an essential component of safe patient care and is also necessary for cultivating a culture that values and supports direct engagement. Modeling effective engagement approaches and supporting the ability of staff to engage with others underlie the development of conflict competency across an organization. Engaging in a way that does not damage important work relationships or cause harm to others is at the heart of relational engagement.

Engaging relationally. Conflict engagement between individuals provides an opportunity for professional growth that, over time, may also improve the conflict competence of the group. Engaging relationally emphasizes interpersonal dynamics and the contribution each person brings to the conflict. When conflict is approached in this way, the emphasis shifts to improving the capacity of health professionals to relate to one another—even when it feels uncomfortable—in order to coactively resolve issues and restore trust.

Conversations that focus only on substantive issues (such as scheduling or assignment making) without addressing relationship issues can undermine the effort to address conflict, because they don't address the underlying dynamics and emotional tensions. Failure to engage in a way that addresses the relational issues can lead to solutions that are abandoned before they are implemented; this can generate further mistrust, unresolved hurt, and feelings that the process or outcomes are unfair.

A structured process is needed to help most groups engage effectively, particularly when addressing the relational dynamics that interfere with work. Creating a safe space where staff feel secure enough to take risks and be vulnerable is essential for this deeper work to occur. In complex conflicts, a series of processes may need to be created to support engagement across various groups.

USING CONFLICT ENGAGEMENT AT HAPPY HILLS

Mr. Peterson and Ms. Lopez are aware that in the charge nurse group there are high levels of conflict

avoidance, and that the group received little support as it implemented large-scale changes to the unit, including the merger, a new information technology system, and the inclusion of higher acuity patients. They realize that, in the past, management interventions were in response to team incidents or patient care events instead of concerted actions to develop the capacity of the group to engage with physicians and with one another more effectively. The two leaders know that it will take time to unravel the current situation and put structures in place to allow the charge nurses to address issues on an ongoing basis.

Mr. Peterson and Ms. Lopez decide that their first step will be to develop a collaborative process to improve how the charge nurses work with one another. They schedule a series of meetings to clarify expectations of the charge nurse role and develop the group's ability to coordinate care as a team. During the meetings, they invite the charge nurses to be part of the decision-making process. They ask the nurses what prevents them from working more cohesively as a group. The nurses reply that they have trouble addressing complaints about disruptive behavior because they don't feel they have the authority to discipline anyone. Additionally, because they don't meet as a group, the charge nurses haven't established consistent methods to address concerns on the unit; as a result, the staff exploits this inconsistency to use what one charge nurse says against another.

The charge nurses need a clear process for addressing quality of care concerns as they arise. They feel that pointing out examples of poor performance may be offensive, and they don't want to write up a nurse every time such an episode occurs. Mr. Peterson and Ms. Lopez work with the group to put measures in place about how to intervene with staff; they also clarify the scope of authority and set up in-service trainings and routine meeting times for the nurses to problem solve and develop better skills in leading others.

Mr. Peterson and Ms. Lopez also decide to work with the physicians to develop a process for addressing clinical conflict situations as they happen. Focusing on these processes for the charge nurses and the physicians at the beginning of their intervention allows the two leaders to work on shifting the patterns that are most damaging in the current climate. Although hesitant, the charge nurses see this as a sign of support and agree to explore how they can function as a group to improve care and decrease the tensions on the unit.

The next installment in this series will focus on how to design processes that support conflict engagement, how to implement the plan discussed here to enable the charge nurses to engage with one another, and how nurses and physicians can manage patient care disagreements in a professional manner. ▼

Questions for Reflection

1. What constructive patterns do you see on your unit that enable staff to address issues openly? What patterns make things worse, and how can these be shifted?
2. What can be done on your unit to facilitate conflict engagement among staff? Among interprofessional team members? Among organization leaders?

Debra Gerardi is president and chief creative officer of EHCCO in Half Moon Bay, CA. Contact author: debra@ehcco.com. *The author has disclosed no potential conflicts of interest, financial or otherwise.*

REFERENCES

1. Lipsitz LA. Understanding health care as a complex system: the foundation for unintended consequences. *JAMA* 2012; 308(3):243-4.
2. Plsek PE. Appendix B: redesigning health care with insights from the science of complex adaptive systems. In: Committee on Quality of Health Care in America, Institute of Medicine, ed. *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academy Press; 2001. p. 309-22.
3. Anderson RA, et al. Nursing homes as complex adaptive systems: relationship between management practice and resident outcomes. *Nurs Res* 2003;52(1):12-21.
4. Runde CE, Flanagan TA. *Becoming a conflict competent leader: how you and your organization can manage conflict effectively*. San Francisco: Jossey-Bass, Inc.; 2007.
5. Kahn WA. The stress of caregiving work: the strain of relationship. In: *Holding fast: the struggle to create resilient caregiving organizations*. Hove, UK; New York: Brunner-Routledge; 2005. p. 25-9.
6. Mayer BS. *The dynamics of conflict resolution: a practitioner's guide*. San Francisco: Jossey-Bass, Inc.; 2000.
7. Kressel K, et al. Managing conflict in an urban health care setting: what do "experts" know? *J Health Care Law Policy* 2002;5(2):364-446.
8. Gittell JH. *High performance healthcare: using the power of relationships to achieve quality, efficiency, and resilience*. New York: McGraw-Hill; 2009.
9. Mayer BS. *Beyond neutrality: confronting the crisis in conflict resolution*. San Francisco: Jossey-Bass, Inc.; 2004.
10. Maxfield D, et al. *Silence kills: the seven crucial conversations for healthcare*. Provo, UT: VitalSmarts, L.C.; 2005. http://www.aacn.org/WD/practice/docs/publicpolicy/silencekills.pdf.
11. Simpson KR, Lyndon A. Clinical disagreements during labor and birth: how does real life compare to best practice? *MCN Am J Matern Child Nurs* 2009;34(1):31-9.
12. Harris KJ, et al. Abusive supervisory reactions to coworker relationship conflict. *Leadersh Q* 2011;22(5):1010-23.

Conflict Engagement: Collaborative Processes

Part three of a six-part series on conflict engagement in complex systems.

This article is one in a series on conflict. It is part of an ongoing series on leadership coordinated by the American Organization of Nurse Executives (AONE; www.aone.org), highlighting topics of interest to nurse managers and emerging nurse leaders. The AONE provides leadership, professional development, advocacy, and research to advance nursing practice and patient care, promote nursing leadership excellence, and shape public policy for health care.

The second installment of this series described how to work with relational patterns and the importance of conflict engagement. This article explores how to design processes to facilitate engagement across groups. Again, we'll use the Happy Hills Medical Center scenario, where nurse leaders are helping charge nurses to engage with one another in ways that improve morale, facilitate collaborative problem solving, and elevate the quality of patient care.

TRADITIONAL PROCESSES FOR MANAGING CONFLICT

Health care organizations typically lack effective processes that enable worker engagement across professional or departmental boundaries; this makes it difficult to address conflicts in face-to-face meetings. Time limits, meeting costs, and staffing requirements can derail any attempts to bring people together. Weighing these challenges against the costs of ongoing conflict (such as medical errors or deteriorating morale) is the job of the nurse leader.

In health care organizations, conflict is traditionally addressed using either a hierarchical or a rights-based (or legal) approach. When a staff member files an incident report or informs a person with authority about a problem, it's the start of a chain-of-command process based on hierarchy; essentially, it's passing on a conflict for someone else to manage. A rights-based or legal approach may include a more formal process, such as requesting an investigation or filing a grievance or a lawsuit. Again, in such cases a conflict is being passed on for others to address. While such approaches may be appropriate in certain situations, neither will help those involved in a conflict to agree—nor will they help people engage with each other directly to resolve their issues. Designing processes that enable those involved in a conflict to engage directly is an essential role for leaders.[1]

The Joint Commission emphasizes the need for conflict management in order to improve quality of care and protect patient safety.[2] It lists over a dozen accreditation standards and sentinel event alerts that require a process for addressing conflict and improving communication at various levels within health care organizations.[1] These include a specific standard (LD.02.04.01) requiring that senior leaders develop a process for addressing conflict among themselves.[2]

Busy leaders often have limited time to address day-to-day skirmishes. This can mean that conflicts aren't addressed until they have escalated. And when leaders do respond, it's often through a formal rights-based approach such as an investigation or a compliance process—approaches designed to protect individual rights and limit risk to the organization, not to encourage open conversation and collaborative problem solving. A less formal, more relational approach would use informal conversations within a structure that supports difficult dialogue and honest discussion. Options range from informal conflict management to formal dispute resolution; these allow for issues to be addressed earlier and more directly.[1]

What frequently results from existing dispute resolution processes are investigations, formal documentation, reprimands, unclear or superficial solutions, ruptured relationships, and an undertow of worry that fuels the next disagreement or dispute. Formal grievance processes, progressive disciplinary actions, peer review, compliance hotlines, and other legal processes often escalate a situation and convert what was originally a conflict between colleagues into a legal dispute that rarely addresses the real issues at stake: trust, respect, miscommunication, hurt feelings, and

Photo © AJ Photo / Hop Americain / Science Photo Library.

breakdowns in teamwork and care coordination. This prevents many people from speaking up or coming forward to address the issues, as they don't want to make things worse.

PROCESSES THAT SUPPORT CONFLICT ENGAGEMENT

Managing conflict requires processes that encourage the engagement of all those involved in the conflict. Engagement should occur soon after the actual event to promote early and direct resolution of issues. Such processes should be designed to fit the unique needs of the health care culture—recognizing its power dynamics, its time constraints, its inherent interdependencies, and the importance of trusted work relationships. These processes may be facilitated by leaders or conflict specialists, and organized directly by the staff as needed.

Processes that encourage engagement include mediation, coaching, facilitation, dialogue, and collaborative problem solving (see Table 1 for a description of some of these processes). All are very different from formal investigations. They provide a more participatory and informal option for settling disputes that don't involve legal issues. They can also supplement legal investigations when no legal violations are found but team conflict still exists.

The focus in designing engagement processes should be on rebuilding trust, clarifying misinformation, revealing and testing assumptions, reinforcing respectful conversation, and crafting collaborative agreements on moving forward. In some cases, such as conflict coaching, the process may provide an opportunity for professional growth and personal development by cultivating emotional and social intelligence and creating awareness of constructive approaches to conflict.

Not every disagreement requires a structured process, but when relational dynamics undermine effective patient care, there must be a process for addressing the issues in a way that supports learning, addresses behaviors, deescalates fear, and supports ongoing engagement among colleagues. Such a process should include creating a space in which it feels safe to take risks and speak openly. It should also include a means for addressing concerns about potential retaliation as well as an avenue for addressing retaliation if and when it occurs.

Creating a safe space. Many nurse managers bring staff together to discuss issues when conflict erupts on the unit. When there is trust and the desire to listen openly, these sessions can be very productive. But when there is a climate of fear and a history of mistrust, preparation is needed to create a space that supports productive conversation. This is particularly true when there is mistrust between staff and nurse leaders.

The meeting location is important; participants shouldn't worry that others outside the group may overhear the conversation. It's also important to

Table 1. Processes That Support Conflict Engagement

Process	Description
Individual or group coaching	Use of a peer or professional coach to develop a plan for addressing specific goals related to work situations, personal development, and transitions.
Face-to-face conversations	Direct conversations between those involved in a conflict situation is the preferred approach for building conflict competence among coworkers.
Facilitated meetings and collaborative problem-solving sessions	Using a skilled facilitator to define the purpose and agenda for bringing a group together for collaborative problem solving, strategic planning, team building, and other collective activities.
Facilitated dialogue	A process for sharing with others the perspectives, values, and experiences related to difficult issues that may divide the group; the emphasis is on building understanding and clearing the air.
Informal mediation	Use of a third person (such as an organization leader, ombudsman, or conflict specialist) to help parties negotiate to resolve differences and continue to work together.
Story circles	Traditional storytelling used to move from personal experience to broader issues and to negotiate group conflict and tension.
Formal mediation	Use of a professional mediator (external to the organization) to help parties negotiate and find ways to resolve differences and develop workable solutions; may be in the context of a lawsuit or before any legal claims or actions are initiated; results are not binding.

ensure that other staff members can cover the unit, so that those attending can focus on the conversation. Where there are strong emotions, power imbalances, and a history of retaliation or bullying, it's worth considering bringing in a trained facilitator to address these dynamics during initial meetings.

Developing the purpose and agenda for each session in advance helps alleviate fear and creates a scope for the conversations. While there may be a desire to relieve tensions by finding quick solutions, this can result in failing to address a group's real issues. It can be useful to begin with "listening sessions" in which participants openly discuss how the situation affects them. This allows the group to share its fears and frustrations, rebuild trust, and develop empathy and understanding; only then can it move to effective problem solving and to generating ideas about how to change the dynamics in the future. For complex conflicts, going slow and intentionally engaging with the emotional aspects of the situation will help in problem solving and increase the likelihood that agreements made by the group will be respected.

Together, staff can discuss and establish group agreements to support engagement during the sessions. (See *Group Agreements That Support Conflict Engagement* for a useful list.) Get members started by offering one or two suggestions; then ask them to complete the list. This promotes participation and helps them identify what they need for open engagement. It's also important to protect confidentiality. At the end of each meeting, the group should decide what will be shared and how to share it; this promotes trust and models integrity.

PROCESSES THAT SUPPORT CONFLICT ENGAGEMENT AT HAPPY HILLS

Jonathan Peterson, nursing director of the Happy Hills Medical Center, and Maria Lopez, interim manager of the 5-East medical–surgical unit, initiate two new processes for engaging the charge nurses and managing patient care disputes among the nurses and physicians.

Ms. Lopez sets up a series of meetings with the charge nurse group that will take place over a three-month period. The first session, a facilitated half-day retreat, is designed to encourage participants to express their hopes, needs, and concerns. Participants are also given the opportunity to clear the air and address conflicts they have had with one another. The purpose of this first session is to rebuild trust and to create a common purpose for working together. To address emotions, which have run high for many months, Ms. Lopez decides to bring in a facilitator. This will also enable her to participate in conversations instead of just being the convener of the meeting.

At the retreat, the charge nurses discuss how they felt when the two units merged and bring up their desire for recognition, appreciation, and support from the management. They talk about the extraordinary effort it has taken to support the significant changes—such as the new clinical documentation system—that have been thrown at them. They acknowledge that because of the stress brought on by these changes, they remain more comfortable with staff from their original units. They admit that they've played favorites and concede that it's difficult to negotiate with some of the staff, who push back on assignments and schedules and pit the charge nurses against each other. They begin to recognize how their choices have contributed to the current situation and come up with a vision for how they want to work together going forward.

With Ms. Lopez's assistance, the charge nurse group meets several times after the initial retreat. They use the group meeting agreements adopted at the retreat as a structure for engaging effectively. Having established a new vision of what they hope to achieve, they make significant strides. They develop clear expectations for the charge nurse role, and create a strategy for improving scheduling and making assignments in order to meet patients' needs. Finally, the group develops a plan for standardizing the clinical competency of the nursing staff on the unit.

After supporting the efforts of the charge nurse group, Mr. Peterson and Ms. Lopez work with the medical director and the charge nurses to develop a "rapid review" process for addressing patient care issues as they arise. Within 48 hours of an event, a small number of nurses and physicians will gather to review any contentious clinical situations and make recommendations on improving care coordination. This process is designed to deescalate the stressful staff interactions that were occurring in the hallways, to provide a better analysis of clinical decisions and operational needs, and to enforce standards of professional conduct.

The rapid review process is piloted for one month, adjustments are made, and then it's implemented on the unit. Periodic evaluations assess its effectiveness. As cochairs of this process, Ms. Lopez and the medical director agree to model an interprofessional leadership approach, which they do by demonstrating respect for each other's expertise, modeling openness and listening, showing how to disagree and work through issues without blame, and developing and sharing a common vision for working together to provide high-quality care to patients.

Assessing conflict and developing processes to support engagement are just part of becoming conflict competent in complex systems. Conflict engagement also requires relational intelligence. The next installment in this series will describe how relational intelligence supports nurses' ability to engage in conflict and enhances their capacity to form therapeutic relationships with their patients. ▼

Questions for Reflection

1. What processes are used to address ongoing conflict in your organization? What processes allow for informal, direct conversations? What processes are more formal and involve human resources, risk management, or compliance policies?
2. How could you develop a process that encourages collaborative problem solving and direct conversations when conflicts occur in your department or unit? What is needed in your work area to help people feel comfortable with such a process?

Group Agreements That Support Conflict Engagement

- Listen for understanding.
- Let others speak ("share the air").
- Respect confidences.
- Speak from your experience.
- Own your participation.
- Invite diverse viewpoints and perspectives.
- Bring your whole self.
- Silence is not agreement.
- Use humor.
- Have fun!

Look for part four of this series in our July issue.

Debra Gerardi is president and chief creative officer of EHCCO in Half Moon Bay, CA. Contact author: debra@ehcco.com. *The author has disclosed no potential conflicts of interest, financial or otherwise.*

REFERENCES

1. Scott C, Gerardi D. A strategic approach for managing conflict in hospitals: responding to the Joint Commission leadership standard, Part 1. *Jt Comm J Qual Patient Saf* 2011; 37(2):59-69.
2. Joint Commission. *Comprehensive accreditation manual for hospitals*. Oakbrook Terrace, IL: Joint Commission Resources; 2011.

Conflict Engagement: A Relational Approach

Part four of a six-part series on conflict engagement in complex systems.

This article is one in a series on conflict. It is part of an ongoing series on leadership coordinated by the American Organization of Nurse Executives (AONE; www.aone.org), highlighting topics of interest to nurse managers and emerging nurse leaders. The AONE provides leadership, professional development, advocacy, and research to advance nursing practice and patient care, promote nursing leadership excellence, and shape public policy for health care.

> Engagement is more than the mechanistic behavioral processes of communication (e.g., eye contact, active listening); it is a capacity to connect and be with another in an intersubjective, mutual, and authentic way, all while honoring complexity and ambiguity. To do this requires suspension of tools and techniques and opening oneself to "the uncertain waters of human relating." The result is a further opening of a space for the expression of another's fear, uncertainty, and vulnerability.[1]

The initial three columns in this series focused on the first component of developing conflict competence: understanding conflict dynamics in complex systems (the external). Beginning with this installment, the focus shifts to the second component: building the capacity to engage by understanding one's responses to conflict and improving those responses over time (the internal). For a quick summary of the preceding three installments, see *Retracing the Path of Conflict Competence*.[2]

Although they've developed ways to bring staff together to address many of the issues at Happy Hills Medical Center (the hypothetical facility featured in this series), Jonathan Peterson, the nursing director, and Maria Lopez, interim manager of a medical–surgical unit, know that conflict engagement skills on the unit still need improvement—and this applies to their own skills, as well as to those of the staff. In these last three installments, we will see how these two nurse leaders explore their patterns of behavior in the face of conflict and use what they learn to help their colleagues engage in ways that reflect their professional values and shared purpose.

THE RELATIONAL NATURE OF HEALTH CARE

Addressing conflict in health care organizations is inseparable from the core work of health professionals and the relational nature of that work. Providing health care services, particularly nursing care, is fundamentally a relational endeavor. This essence of nursing is reflected in the formation of therapeutic relationships, the adoption of a relational stance in the care of patients, the incorporation of relational ethics into nursing practice, and the relational coordination of health care delivery. Each of these is described in more detail below.

THE THERAPEUTIC RELATIONSHIP

A therapeutic relationship is at the heart of providing care to patients and families. It has been described as "a professional alliance between the nurse and the client or patient, working together for a defined period of time to accomplish specific health-related goals."[3] The primary components of a therapeutic relationship include "(1) demonstrating respect; (2) being genuine; (3) being there/being available; (4) accepting individuality; (5) having self-awareness; (6) maintaining boundaries; (7) demonstrating understanding and empathy; (8) providing support; (9) and promoting equality."[3]

These components reflect the personal and professional qualities the clinician brings to the relationship. Indeed, these qualities form the foundation for engaging with patients in a way that optimizes opportunities for healing. Clinicians who engage in care delivery from a level of awareness that prioritizes "how" to relate instead of "whether" to relate demonstrate an intentional approach to nursing work that is referred to as "relational consciousness."[4] This perspective builds on the clinical foundation of the therapeutic relationship by incorporating the clinician's personal choice to adopt a relational stance in working with patients.

Photo © Jose Luis Pelaez Inc / Blend Images / Newscom.

A RELATIONAL STANCE IN PATIENT CARE

A relational stance is a mindset or way of thinking that honors the value of relationships and the holistic nature of what it means to "stand in relation to" another human being.[5] It means taking into account the whole person, as well as the basic human dynamics that have a part in all human interactions. In nursing work, a relational stance embodies the body/mind/spirit paradigm and integrates it with the moral dimensions of human connection, such as compassion and respect.[1] Adopting a relational stance is an intentional way of engaging with others that focuses on the intra-and interpersonal skills that constitute human relationships; it takes into consideration the interconnected nature of human beings and their environments.

Engaging in conflict using a relational stance. Given that relationships between clinicians or nurses and patients are essential to clinical work, it makes sense to view conflict as an inevitable part of those relationships and to consider the use of a relational stance as a means of engaging in conflict. This approach sees conflict not as a problem to be "fixed" but instead as a natural part of what it means to be in relationship with another human being. The approach is iterative and contextual, which means that there is consideration for the natural give-and-take between individuals (interpersonal) as well as the context in which the relationship occurs (organizational).

The relational approach addresses conflict as it unfolds—just as a relationship evolves and unfolds over time. It incorporates the essential qualities that form the core of human relationships. It's hard to imagine an approach to conflict that excludes a consideration of integrity, respect, identity, compassion, humility, shame, trust, fear, hope, pride, acceptance, love, joy, and other human dynamics. Many of these are at the heart of most conflicts.

RELATIONAL ETHICS IN NURSING PRACTICE

Nursing practice is founded on an ethical framework that is derived from the principle of primum non nocere ("above all, do no harm").[6] But should this principle extend to the conduct of relationships with colleagues? What's the effect of having one set of values for one group and another set for another group? Does it make sense to offer compassion to patients but withhold it from peers? Would this affect the way conflict is addressed? Certainly it would, and establishing the ethical principle of "do no harm"

Retracing the Path of Conflict Competence

The series so far . . .

This monthly column has chronicled the actions of Maria Lopez and Jonathan Peterson, nurse leaders at the hypothetical Happy Hills Medical Center, as they begin to adopt a new approach to addressing and resolving conflict on a medical–surgical unit.

Here's what they've accomplished so far:

In the first column—"Conflict Engagement: A New Model for Nurses," March—they examined the behavior patterns of nursing staff and physicians and took a "systems view" of the conflict, a view that understands the "interrelatedness of the components of a system and the patterns that emerge from these connections."[2] They also analyzed the issues that contributed to the situation and looked for themes within the conflict narratives.

In the second column—"Conflict Engagement: Workplace Dynamics," April—they looked for ways to interrupt dysfunctional patterns and devised an approach to enable the nursing staff, particularly the charge nurses, to effectively engage with one another.

In the third column—"Conflict Engagement: Collaborative Processes," May—they designed processes to bring nursing staff and physicians together to support conflict engagement and collaborative problem solving.

as a foundation for engaging with coworkers supports a relational approach to conflict.

Relational ethics emphasizes the importance of mutually respectful relationships in which people work to improve their awareness of how their choices and actions help to shape their conversations and social interactions.[7] This includes accepting responsibility for how we communicate and for the effect our communication has on others. It requires the ability to engage with others while simultaneously noting how our actions affect both them and us. This is no easy task. And when emotions are heightened (as in a heated conversation) it's even more difficult. Yet this ability is essential, because it offers us an opportunity to better understand our triggers as well as theirs.

Engaging in conflict provides an excellent opportunity to test the connection between core values and professional conduct. The ethical challenge for nurse leaders is to consciously develop a moral compass that aligns with the core values underlying clinical practice. These values serve as a rudder when job pressures make it tempting to default to habitual behaviors like avoidance or blame. Drawing on moral courage to step in and address conflict is a means of meeting the ethical obligations of nursing practice.[8,9]

Consciously aligning values and actions creates congruence and authenticity and builds trust. But creating this alignment requires engaging in reflective practice, in which each person works to connect core values to conscious choices about who she or he wants to be—particularly when faced with stressful situations that can trigger the usual protective responses (such as attacking or blaming others, smoothing and soothing, or withdrawing). Over time, these conscious choices define a person's "way of being" in the world; they reflect character and leadership potential. Thus, intrapersonal work is at the heart of improving how we engage with others.

RELATIONAL COORDINATION OF CARE

The relational nature of clinical work encompasses both therapeutic relationships with patients and interpersonal dynamics among health care professionals. There is substantial evidence that the leading contributors to medical errors and unsafe care result from breakdowns in teamwork,[10] communication,[11] and the overriding culture of health care itself.[12] A 2010 Thomson Reuters report estimates that $75 to $100 billion per year is lost to medical errors with another $25 to $50 billion lost owing to a lack of coordination of care.[13]

Engaging in conflict provides an excellent opportunity to test the connection between core values and professional conduct.

Care coordination is a key component of interprofessional practice and requires both task and relational coordination—the latter defined as the management of interdependencies and the quality of relationships between health care providers.[14] The process of a patient handoff from one clinician to another is an example of relational coordination. It requires the exchange of complex information between multiple providers, coordination of interventions, education of the patient, and management of time constraints—all within the context of interprofessional relationships that, to be

effective, require mutual respect as well as shared goals and mental models.

Relational coordination has been shown to improve clinical outcomes, shorten lengths of stay, and decrease postoperative pain.[15] There is also evidence that healthy relational dynamics within teams are linked to decreased levels of nursing staff turnover.[16, 17] Furthermore, good relationships between ICU nurses and physicians have been linked to lower levels of staff burnout.[18] Effectively engaging in conflict as it occurs in daily interactions is integral to relational coordination.[15]

APPLYING THESE LESSONS AT HAPPY HILLS

Having previously focused on systems issues, Jonathan Peterson and Maria Lopez now turn their attention to the interpersonal aspects of conflict as a way to promote engagement among the staff.

Adopting a relational stance. Maria and Jonathan's objective in working with the charge nurse group, the nursing staff, and the medical–surgical unit's medical director is to restore trust and mend fractured relationships in order to enable them all to work together to improve outcomes. To accomplish this, the two nurse leaders use processes that honor individual contributions, incorporate joint decision making, create connections, build trust, and enforce expectations for professional conduct and respectful problem solving. They place an emphasis on improving the ways in which everyone works together rather than focusing solely on outcomes (such as patient satisfaction surveys, productivity numbers, compliance with practice protocols, and incident reports).

In addition, Maria and Jonathan agree to adopt a relational stance in pursuit of their goals. They begin with transparency—acknowledging to the group that while neither knows exactly how to "fix" the situation, they are committed to remaining engaged and supportive as the group defines what it needs to be more effective. They share their clear expectations about improving patient care and the work environment, and reinforce the idea that improving work relationships will help to achieve these goals. To build trust and mentor others, they acknowledge that they are working to improve how they interact with unit staff and physicians; they share their struggles with this process and describe what they have learned about themselves. Although they feel pretty good about their progress with the nursing staff and charge nurses, Maria still struggles in her interactions with the medical director. She is triggered by his authoritative, "drive-by" style of problem solving. He continues to dump problems in her lap without any conversation or collaboration. She usually responds by becoming angry and defensive. She knows she needs a less reactive approach. She does some self-reflecting to see what may be at the heart of her frustrations.

Applying relational ethics to conflict engagement. Having previously been assessed by the Thomas–Kilmann Conflict Mode Instrument (see www.cpp.com/products/tki/index.aspx for more information), Ms. Lopez knows that her dominant conflict styles are competitive and avoidant. Sometimes she becomes defensive and attacks the medical director's mismanagement of the physician team or his unprofessional conduct with the nursing staff. Sometimes she consciously avoids the medical director when she sees him on the unit. On a few occasions, he has gone to Mr. Peterson to complain about Ms. Lopez's reactions, which further escalates the situation.

Ms. Lopez wants to find a better way to engage with the medical director. She wants him to feel

Questions for Reflection

1. What personal values underlie your professional practice? How do these values affect your choices when you interact with colleagues—with patients and their families? Do your behaviors reflect your values no matter whom you are interacting with?
2. What would it look like for you to adopt a relational stance with colleagues? What do you know about your hot buttons and triggers? How do these affect your ability to stay engaged with colleagues when you are reacting to them?

Recommended Resources

The following is a useful list of organizations for those looking for qualified coaches, facilitators, or ombudsmen—or for those interested in training for these roles:

- International Coach Federation
  www.coachfederation.org
- Institute of Coaching
  www.instituteofcoaching.org
- International Association of Facilitators
  www.iaf-world.org
- International Ombudsman Association
  www.ombudsassociation.org

supported in his role, and she wants to feel like she is an effective advocate for her patients and nursing staff. Mr. Peterson appreciates her desire to improve the situation and provides a coach she can work with to explore her reactions.

In working with the coach, Ms. Lopez comes to better understand her triggers, habits, and conflict-response patterns. She develops a stronger link between her professional values and her leadership behaviors. She realizes that she values being a good patient advocate, and she wants her staff to see her as a strong leader. She notices that when her values are compromised, she feels an impulse to push back and becomes protective of her unit and staff. In exploring her personal values, Ms. Lopez discovers that she has high regard for professionalism, humility, and justice. She wants to develop the ability to respond to conflict in a way that reflects those values, even when she is angry, fearful, or feels hurt and disrespected. Ms. Lopez and her coach design a plan for tracking and recording her reactions; she documents the times she acts in ways that align with her values, as well as the times she is derailed. Ultimately a pattern emerges, which helps her understand that her confrontational style occurs when she reacts to feeling that her values are violated. She decides to use these insights to develop strategies for responding differently when she is triggered.

Ms. Lopez's personal insights help her to better understand the medical director's stress patterns. This enables her to engage with him more easily. She sees how her responses trigger his behavior and contribute to the conflict on the unit. In searching to find common ground, she realizes that they both want to provide good patient care; she considers this to be a good starting point. She begins to appreciate the hard work of developing conflict competence and the need for ongoing practice in order to shift her deeply ingrained response patterns.

The next installment in this series will explore in more detail the intra- and interpersonal work Ms. Lopez undertakes to improve how she engages in conflict. She will work to develop her emotional intelligence, uncover her personal barriers to change, and improve her responses to the medical director and others. Through her insights and changes in behavior, Ms. Lopez will learn to create connection, build trust, and influence the behaviors of her colleagues on the unit. ▼

Debra Gerardi is president and chief creative officer of EHCCO in Half Moon Bay, CA. Contact author: debra@ehcco.com. *The author has disclosed no potential conflicts of interest, financial or otherwise.*

REFERENCES

1. Wright D, Brajtman S. Relational and embodied knowing: nursing ethics within the interprofessional team. *Nurs Ethics* 2011;18(1):20-30.
2. Gerardi D. Conflict engagement: a new model for nurses. *Am J Nurs* 2015;115(3):56-61.
3. Helming MB. Relationships: therapeutic relationships in holistic nursing. In: Dossey BM, et al., eds. *Holistic nursing: a handbook for practice*. 6th ed. Burlington, MA: Jones and Bartlett; 2013. p. 439-62.
4. Hartrick-Doane G. Beyond relational oblivion. *ANS Adv Nurs Sci* 2014;37(2):84-6.
5. Tapp DM. The ethics of relational stance in family nursing: resisting the view of "nurse as expert." *J Fam Nurs* 2000; 6(1):69-91.
6. Grace PJ. Philosophical foundations. In: Grace PJ, ed. *Nursing ethics and professional responsibility in advanced practice*. 2nd ed. Burlington, MA: Jones and Bartlett; 2014. p. 22-3.
7. Haslebro G, Haslebro MJ. *Practicing relational ethics in organizations*. Chagrin Falls, OH: Taos Institute Publications; 2012. Taos Tempo series: collaborative practices for changing times.
8. Kritek PB. Negotiating at an uneven table: developing moral courage in resolving our conflicts. San Francisco: Jossey-Bass; 1994.
9. American Nurses Association. Provision 1:1.5—relationships with colleagues and others. In: *Code of ethics for nurses with interpretive statements*. Silver Spring, MD; 2015. p. 20.
10. Joint Commission. *Behaviors that undermine a culture of safety*. Oakbrook Terrace, IL; 2008 Jul 9. Sentinel event alert #40; http://www.jointcommission.org/assets/1/18/SEA_40.PDF.
11. Institute of Medicine. *Keeping patients safe: transforming the work environment of nurses*. Washington, DC: National Academies Press; 2004. Richard and Hinda Rosenthal lectures 2003. http://books.nap.edu/catalog/11151/the-richard-and-hinda-rosenthal-lectures-2003-keeping-patients-safe.
12. Walshe K, Shortell SM. When things go wrong: how health care organizations deal with major failures. *Health Aff (Millwood)* 2004;23(3):103-11.
13. Kelley B. Reducing waste in healthcare: impact of IT [PowerPoint]. Thomson Reuters 2010.
14. Gittell JH, et al. Impact of relational coordination on quality of care, postoperative pain and functioning, and length of stay: a nine-hospital study of surgical patients. *Med Care* 2000;38(8):807-19.
15. Gittell JH. Resolve conflict proactively. In: Gittell JH, ed. *High performance healthcare: using the power of relationships to achieve quality, efficiency, and resilience*. New York: McGraw-Hill; 2009. p. 91-104.
16. Brunetto Y, et al. The importance of supervisor-nurse relationships, teamwork, wellbeing, affective commitment and retention of North American nurses. *J Nurs Manag* 2013; 21(6):827-37.
17. Galletta M, et al. The roles of unit leadership and nurse-physician collaboration on nursing turnover intention. *J Adv Nurs* 2013;69(8):1771-84.
18. Poncet MC, et al. Burnout syndrome in critical care nursing staff. *Am J Respir Crit Care Med* 2007;175(7):698-704.

Conflict Engagement: Emotional and Social Intelligence

Part five of a six-part series on conflict engagement in complex systems.

This article is one in a series on conflict. It is part of an ongoing series on leadership coordinated by the American Organization of Nurse Executives (AONE; www.aone.org), highlighting topics of interest to nurse managers and emerging nurse leaders. The AONE provides leadership, professional development, advocacy, and research to advance nursing practice and patient care, promote nursing leadership excellence, and shape public policy for health care.

> Between stimulus and response, there is a space. In that space lies our freedom and our power to choose our response. In our response lies our growth and our happiness.[1]

This series chronicles efforts to improve professional relations on a troubled medical–surgical unit at a hypothetical facility, Happy Hills Medical Center. In last month's installment, the two nurse managers in charge—Jonathan Peterson, nursing director, and Maria Lopez, interim unit manager—shifted their focus from workplace dynamics to the intra- and interpersonal (relational) aspects of engaging in conflict. They learned that when we adopt a mindset that considers conflict to be a natural part of human relationships, we place value on interpersonal relationships and honor our human interconnectedness. A relational view of conflict emphasizes the need for ongoing insight into one's own behavior and the development of skills necessary for relating to others. In this article, we focus on the inner work of transforming habits and improving interpersonal skills through the use of emotional and social intelligence.

SHIFTING INTERPERSONAL HABITS

Leaders can change the climate in the workplace and promote better collaboration among workers by interrupting a group's dysfunctional behavior patterns. Leaders can also influence change by shifting their own behavior patterns and the habitual responses that may be contributing to conflict. Those who leverage personal change can have a significant influence on group dynamics because their actions and decisions are highly visible, particularly during a crisis.[2] As group members watch how the leader handles a situation, they can learn and adopt practices that can become the norm across the workplace.[3]

Beginning in childhood, neural pathways form in response to interactions with others and to stressors in the environment. These experiences create hardwired networks in the brain that initiate established response patterns.[4] Over time, these neural tracks become dominant pathways that enable rapid responses to familiar stimuli. When one is faced with a physical threat, these automatic responses form quick actions that can be useful for self-protection. However, they can also kick in when emotions are triggered that mimic the fear associated with a physical threat.[5] And they can lead to behavior patterns that with time become unconscious habits. Further, because these patterns are embedded in neural pathways, they are difficult (though not impossible) to change.

Becoming aware of one's reaction patterns and noticing them in real time is one aspect of what psychiatrist Daniel Siegel refers to as "mindsight."[4] Siegel's research in the area of interpersonal neurobiology highlights mindsight as a key means of rewiring the brain to respond differently to stressors. Enhancing self-awareness and presence in the moment can break the link between environmental stimuli and habitual responses long enough for a choice to be made that can result in a different course of action.[6]

The development of mindfulness and self-awareness, especially when emotions are triggered, is hard work. It requires an intention to grow and the motivation to stick with it and to monitor changes over a period of time. But doing this work can expand a leader's capacity to address progressively more difficult and more complex situations over time.

DEVELOPING SELF-AWARENESS AND PRESENCE: THE HAPPY HILLS SCENARIO

Maria Lopez, interim manager of the 5-East medical–surgical unit, has worked hard to identify her hot buttons and reaction patterns under stress. She wants to get better at noticing her reactions as they happen. She works with a coach who helps her track her defensive responses to stressful situations so she can begin to make different choices in how to react.

As Ms. Lopez documents her professional interactions in a journal, she begins to notice behavior patterns that link her internal feelings to her external behaviors. She realizes that she reacts differently when she is feeling balanced than when she is feeling pressured. She also finds that she is especially collaborative when others are calm and open to ideas but more reactive when she experiences resistance or feels at risk. Her journaling provides her with insights into how she contributes to conflict situations and how she may be making it difficult for colleagues to connect with her.

Ms. Lopez learns that, to be mindful, she has to be present in the moment, slow down, and listen more fully. But the unit's fast pace and competing demands on her attention make this difficult. She develops a practice plan to improve her ability to be present and to notice when she is reactive. Following this plan, she works to

- recognize the physical sensations she experiences when she is triggered by a situation (her face flushes, her heart rate goes up, she finds it hard to hear, and her breathing becomes shallow).
- take a step back and breathe deeply three times.
- notice and delay her initial response in order to stop her habit of "fixing" or "solving" a situation too quickly.
- become curious about what she doesn't know, including discerning what the other person really needs.

Using this strategy, Ms. Lopez is able to slow down her reactions and make better choices in how she responds to stressful situations. For example, in a recent conversation with the medical director, she notices when her physical reactions are triggered and uses her breathing technique to stay present. She is able to remain open while listening to his allegations against the nursing staff. In doing so, she observes for the first time how fearful he seems to be. She asks him to share his real concerns. He tells her that he's frustrated by the continued cost cutting and demands for increased numbers of patients that put additional pressure on physicians and nurses. He's afraid there will be a serious error or sentinel event on his watch. He feels helpless to prevent it and tells her he is relying on her to keep the nursing staff vigilant. Ms. Lopez says she worries about that as well and asks if, in order to benefit everyone, they could find a better way to address their mutual concerns.

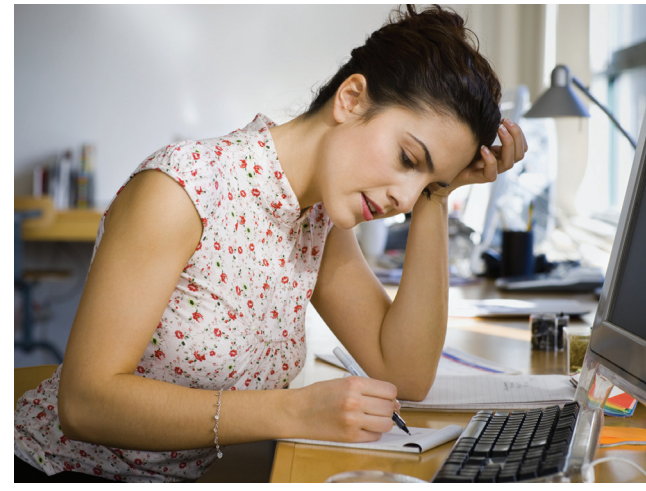


Photo © Rubberball / Getty Images.

Ms. Lopez is proud that she has responded without becoming defensive or withdrawing. Instead, her thoughtful reaction to the medical director established a sense of trust between them; this will enable them to begin to work together more effectively. She knows, however, that she has more work to do to develop her ability to manage her emotions and remain connected to the situation when she feels upset.

EMOTIONAL AND SOCIAL INTELLIGENCE

Emotional and social intelligence are defined as "skills that enable an individual to understand the impact of emotions on behavior and thinking, to regulate emotions and behavior, to understand the importance of emotions in others, and to understand social interactions and engage in adaptive ways with others in social situations."[7] Several theories regarding the development of emotional intelligence have emerged over the years; these define the skills, traits, and abilities necessary to achieve high levels of emotional self-management.[8] Together with emerging research in neuroscience, new insights into how to develop emotional and social competencies have also grown. A primary area for the application of these competencies is in leadership development in organizations.[9]

Self-awareness and the ability to regulate one's emotions are necessary to achieve high levels of emotional intelligence.[5] Emotional intelligence provides the foundation for social intelligence, which includes social awareness and relationship management.[5,10] Without well-developed self-awareness and self-regulation, there is little chance one will develop social intelligence. Research in these areas has led to the creation

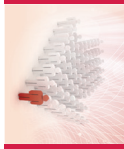


Table 1. Integrating Emotional and Social Intelligence with Conflict Engagement[13]

Emotional Intelligence Competencies	Personal Abilities and Skills	Applying Emotional Intelligence to Conflict Engagement
Self-Awareness		
• Emotional awareness • Accurate self-assessment • Self-confidence	• Aware of emotions and their link to behaviors and beliefs • Aware of values, strengths, and weaknesses • Aware of how emotions affect performance • Self-reflective and open to feedback from others • Maintain a sense of humor and can adopt a bigger perspective	• I'm aware of my emotions and reactions in conflict situations. • I can take responsibility for my feelings in the moment and afterward. • I notice when I'm being triggered; I'm aware of my hot buttons. • I can reflect on my habits and appreciate how they influence my effectiveness. • I seek feedback from others whom I trust to be honest with me. • I'm aware of my strengths and when I may be overusing them. • I don't take myself too seriously!
Self-Regulation		
• Self-control • Trustworthiness • Conscientiousness • Adaptability • Innovativeness	• Manage emotions and impulsive reactions • Act ethically and own up to actions or mistakes • Build trust, be reliable and authentic • Remain present and focused under pressure • Be flexible and seek perspective of others • Generate innovative ideas • Connect to purpose or mission • Persist with hope and optimism in face of obstacles • Separate personal identity from external outcomes • Integrate goals of others with personal goals and values	• I'm able to calm myself down or soothe myself when I'm upset or afraid. • I can openly own my mistakes and be accountable for my actions rather than blame others. • I'm able to own my contribution to a conflict situation and share that with others. • I can create trust with others to enable feedback and open and honest conversations. • I'm open to the ideas of others even when I disagree with their style or approach. • I'm able to adjust my conflict style to match what's needed in each situation. • I'm able to connect to a bigger purpose or organizational mission to maintain a broader perspective when dealing with conflicts in my workplace. • I'm able to connect to my values to ground myself and guide my actions. • I'm able to see setbacks and conflict as part of my work and not as a reflection of my self-worth or my value to others.

Social Intelligence Competencies	Interpersonal Abilities and Skills	Applying Social Intelligence to Conflict Engagement
Social Awareness		
• Empathy • Aware of needs of others • Service orientation • Leveraging diversity • Political awareness	• Accurately recognize others' emotional cues • Aware of others' feelings and emotional needs • Able to be curious and seek to understand others' needs and actions • Aware of others' perspectives • Respectful of diverse viewpoints and backgrounds • Aware of and able to accurately read power dynamics and group dynamics • Aware of own use of power and status	• I'm able to be present and mindful when engaging with others. • I'm able to be curious rather than judge others or work to fix the problem too quickly. • I'm able to empathize with others without feeling obligated to agree with their insights or ideas. • I can appreciate the contribution of others and share my appreciation with them. • I can acknowledge my power and recognize the impact it has on the dynamics within the group. • I'm aware of my biases and judgments of those who are different from me.
Social Skills		
• Influence • Communication • Conflict management • Leadership • Change catalyst • Building bonds • Team capabilities • Collaboration and cooperation	• Able to listen openly and seek clarification on issues, needs, and beliefs • Able to stay engaged in the presence of strong emotions and divergent opinions • Able to identify when there are fractures or difficulties in relationships (mine and others) • Able to encourage open conversation and debate • Responsive to emotional cues of others and attune to the situation • Able to give and receive feedback	• I'm able to listen to what others need with curiosity not judgment. • I'm able to acknowledge and validate what I'm hearing. • I'm able to slow down and ask questions before offering opinions and solutions. • I can reflect back and reframe issues in a way that expands the perspective of the conflict situation. • I'm able to use questions to coach others to directly address their conflicts without feeling the need to jump in and fix it for them. • I'm able to model good skills during conflict situations and mentor others to engage effectively. • I'm able to remain diplomatic even when feeling blamed or attacked. • I'm able to look for a range of solutions rather than advocating for one position or idea. • I'm able to create a space that encourages open dialogue and trust. • I'm able to model social competencies and nurture them in others. • I'm able to set boundaries and respect my needs as well as the needs of others. • I'm able to speak up when necessary to address unpopular issues or to stop harmful behaviors.

Questions for Reflection

1. What do you know about yourself as a leader? What do you know about how you react under stress or when you are in conflict with others? What are your blind spots or hot buttons? What are your strengths?
2. How can you develop "mindsight" and begin to notice and track your thoughts, actions, feelings, and habits in conflict situations? What keeps you from making the personal changes you would like to make? What sabotages your good faith efforts to be better at engaging with others?

of several assessment tools used to measure a person's emotional intelligence or emotional quotient.[11,12]

Emotional and social intelligence can be developed over time.[9] Identifying specific skills or abilities related to emotional and social intelligence and setting goals to develop and measure progress toward achieving them can contribute to a leader's overall effectiveness, including the ability to manage conflict effectively (see Table 1[13]).

Higher levels of emotional intelligence among nurses correlate with the use of a collaborative conflict style.

Improving nurses' emotional intelligence can improve their conflict engagement skills. Higher levels of emotional intelligence among nurses have been shown to correlate with the use of a collaborative conflict style.[8] Given that avoidance, compromise, and accommodation are the dominant conflict styles among nurses and other health care professionals, the development of emotional intelligence could help to expand their capacity for collaborative approaches to conflict in clinical settings.[14,15] Such improvements could extend to the overall organization as nurses and others collaborate to resolve conflict situations and, in the process, practice the skills needed for addressing conflict effectively.

MANAGING SELF AND RELATING TO OTHERS

Through discussion with her coach and the use of an assessment tool, Ms. Lopez discovers more about her emotional intelligence. The results of her assessment teach her that when she is feeling stress she quickly moves to action—before fully considering her thoughts and feelings. She wants to be a good leader and to be responsive to others, but her need to act makes it hard for her to slow down and appreciate what others need. She doesn't take the time to hear the real story. Her impulse to fix a problem quickly or soothe someone's distress keeps her from asking questions, understanding another's perspective, or acknowledging the feelings of others.

She also learns that when she's angry or frustrated she tends to disconnect or withdraw from others. This can be perceived negatively. For example, the medical director has accused her of "ignoring" his concerns and the staff have complained that when they come to her with complaints, she can come across as "not caring." Ms. Lopez realizes that she favors staff who communicate calmly over those who are dramatic; she wonders if this affects whether the staff perceive her as fair.

Ms. Lopez realizes that she feels a strong sense of responsibility to protect the staff and patients. Responsibility is an important value to her, and she experiences shame and doubt when she is unable to attend to her responsibilities. This insight helps her to appreciate how vulnerable she feels at times; it provokes in her more empathy for the medical director and for others who also work hard to do a good job on behalf of patients. She sees that they also frequently feel at risk for causing harm or making mistakes.

Ms. Lopez's assessment says that she has high levels of empathy and compassion, which lead her to take responsibility for others when they seem distressed or when they can't or won't advocate for themselves. But these qualities can cause her to become overwhelmed at times. Although she recognizes that her empathy and sense of advocacy are strengths that make her a good nurse and a strong manager, she also realizes that she needs to limit how much she takes on and find ways to encourage others to do more for themselves.

Ms. Lopez knows that it will take time for her to apply these new insights, and she puts a plan in place to practice new approaches that allow her to stay engaged, create connection, and invite others to work with her to resolve emotionally difficult issues and address the ongoing concerns on the unit.

FROM INSIGHT TO ACTION

Changing interpersonal habits is hard work. First, it requires developing an awareness of one's emotional responses and reaction patterns. Next, the insights gained from this self-reflection can support the development of emotional and social intelligence—both of

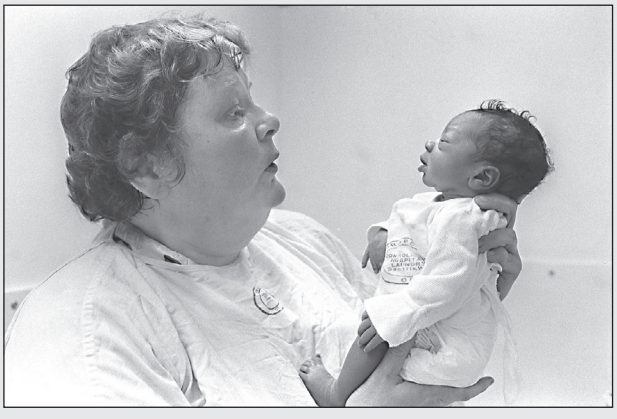
which enhance one's ability to relate to others during conflict. The final installment in this series will outline Ms. Lopez's strategy for putting her insights into action. To do this, she uses an approach that helps her create connection and activates her curiosity so she asks better questions. She will also enlist the support of others to maintain her resilience while practicing her new conflict-engagement skills. ▼

Debra Gerardi is president and chief creative officer of EHCCO in Half Moon Bay, CA. Contact author: debra@ehcco.com. *The author has disclosed no potential conflicts of interest, financial or otherwise.*

REFERENCES

1. Pattakos A, Covey SR. *Prisoners of our thoughts: Viktor Frankl's principles for discovering meaning in life and work*. 2nd ed. San Francisco: Berrett-Koehler Publishers; 2010.
2. Goleman D, et al. Primal leadership: the hidden driver of great performance. *Harv Bus Rev* 2001(Dec):40-51.
3. Ramsey VJ, Latting JK. A typology of intergroup competencies. *J Appl Behav Sci* 2005;41(3):265-84.
4. Siegel DJ. *Mindsight: the new science of personal transformation*. New York: Bantam Books; 2010.
5. Goleman D. *Working with emotional intelligence*. New York: Bantam Dell; 1998.
6. Silsbee D. *Presence-based coaching: cultivating self-generative leaders through mind, body, and heart*. San Francisco: Jossey-Bass; 2008.
7. Siegel DJ. *Pocket guide to interpersonal neurobiology: an integrative handbook of the mind*. New York: W.W. Norton and Company; 2012.
8. Morrison J. The relationship between emotional intelligence competencies and preferred conflict-handling styles. *J Nurs Manag* 2008;16(8):974-83.
9. Boyatzis RE, et al. Developing resonant leaders through emotional intelligence, vision and coaching. *Organ Dyn* 2013;42(1):17-24.
10. Goleman D, et al. *Primal leadership: realizing the power of emotional intelligence*. Boston: Harvard Business School Press; 2002.
11. Bar-On R. *Emotional quotient inventory (EQ-i): a test of emotional intelligence*. Toronto, ON: Multi-Health Systems; 1997.
12. Wolff SB. *Emotional competence inventory (ECI) technical manual*. Consortium for Research on Emotional Intelligence in Organizations; 2005. http://www.eiconsortium.org/pdf/ECI_2_0_Technical_Manual_v2.pdf.
13. Consortium for Research on Emotional Intelligence in Organizations. *Emotional competence framework*. New Brunswick, NJ; 1998. http://www.eiconsortium.org/reports/emotional_competence_framework.html.
14. Valentine PE. A gender perspective on conflict management strategies of nurses. *J Nurs Scholarsh* 2001;33(1):69-74.
15. Sportsman S, Hamilton P. Conflict management styles in the health professions. *J Prof Nurs* 2007;23(3):157-66.

In Memoriam: Kathryn E. Barnard



Kathryn E. Barnard, PhD, RN, FAAN—a pioneering researcher in the field of infant mental health—died on June 27 at her home in Seattle, at the age of 77. Barnard was an influential educator whose finding that parent-child interaction is an important predictor of cognitive development helped shape public policy. Born in Omaha, Nebraska, Barnard began her nursing career at the age of 16 and earned her bachelor of science in nursing in 1960 from the University of Nebraska and her master's degree from Boston University. In 1963, she was recruited by the University of Washington (UW), where in 1972 she earned her PhD in the ecology of early childhood development. She taught and worked at UW for more than 40 years until her retirement in 2006. There she conducted groundbreaking research on the beneficial impact of rocking and heartbeat sounds on infant growth and development. The rocking bed she developed for infants is now a standard in hospital nurseries and neonatal ICUs. Additional pioneering work by Barnard included the creation of parent–child interaction assessment scales and providing the foundation for Nursing Child Assessment Satellite Training (NCAST), an early form of distance learning. NCAST enabled Barnard to disseminate her research globally to infant mental health professionals and caregivers. She served on the board of directors of both the nonprofit ZERO TO THREE: National Center for Infants, Toddlers, and Families and the World Association for Infant Mental Health. In 2012, the center Barnard established at the UW in 2001 was renamed the Barnard Center on Infant Mental Health and Development in her honor. For more on Barnard's legacy, read *AJN*'s 2002 profile at http://journals.lww.com/ajnonline/Fulltext/2002/06000/Rock_On.57.aspx. ▼

Conflict Engagement: Creating Connection and Cultivating Curiosity

Part six of a six-part series on conflict engagement in complex systems.

This article is one in a series on conflict. It is part of an ongoing series on leadership coordinated by the American Organization of Nurse Executives (AONE; www.aone.org), highlighting topics of interest to nurse managers and emerging nurse leaders. The AONE provides leadership, professional development, advocacy, and research to advance nursing practice and patient care, promote nursing leadership excellence, and shape public policy for health care.

Addressing conflict in clinical work environments is an ongoing challenge for nurse leaders who choose to do the hard work of bringing people together to resolve issues and repair professional relationships. Making time to address conflict in the midst of competing demands can be overwhelming. Yet as the previous columns in this series have described, the benefits of removing barriers to care coordination are significant for patients and health professionals alike.

Developing the systems that enable effective conflict engagement takes time and commitment. Designing a reflective practice, experimenting with new behaviors, tracking what works (and what doesn't), and adapting actions in response to feedback is a lifelong learning process. Friends and colleagues who provide ongoing support for personal and professional growth also promote the resilience needed to stay engaged in the process.

The final installment in this series introduces an approach to practicing the skills needed to create connection and cultivate curiosity when addressing conflict on the unit. We conclude the story of the nurse leaders, physicians, and staff members of the 5-East medical–surgical unit at Happy Hills Medical Center and examine how far they have come in creating a healthier work environment where they actively support one another and feel proud of the care they provide.

CREATING CONNECTION

Creating connection helps to build trust, demonstrates respect, and forms a space for the kinds of conversations that can lead to the resolution of issues. In addition, creating connection reinforces the importance of relational values and mutuality by showing colleagues that there is an interest in cocreating a process for working together to discover solutions.[1] This differs from deciding on and advocating a solution without including input from others.

Developing a connection between two people is an iterative process in which one person attends to and responds to the other person. Similar to a dance, connection is built one step at a time. When each person listens fully and responds specifically to what was just said, connection emerges through a series of responses that build on information provided by one person to the other.

Such connection enables a response that is opposite to the "fight or flight" impulse; a response that has been referred to as "tend and befriend."[2] When we feel connected, we lower our defenses, become more humble, and feel safe to share our vulnerabilities and fears. Connection also enhances our ability to take in and process information, feelings, requests, and ideas. Feeling connected is a precursor to generating solutions and collaborative problem solving. But learning how to create connection during difficult conversations takes practice.

It's easy to disconnect or move away from others in uncomfortable situations or when experiencing strong emotions. Changing a pattern of response requires the ability to self-reflect and then self-correct. Self-reflection leads to insight or self-awareness. Reflecting on the following questions can be useful in developing self-awareness of your responses: "What do I usually do when faced with conflict?" "What is my emotional response when others are upset?" "What leads me to respond the way I do?" "How do I want to respond instead?" "What could I do to help change my typical response?"

With new insights and self-awareness, it's easier to identify behaviors or skills to practice during interactions with others. Practicing new skills and reflecting on that practice creates an ongoing learning

Photo by Ed Eckstein.

process. Practicing skills that create connection with others improves one's ability to engage in conflict and leads to mastery.[3] So what are the skills that create connection?

THE PEARLA APPROACH

Practicing the skills that create connection can be achieved by adopting an approach known as PEARLA, a mnemonic that provides a great way to remember responses that forge connection in real time.[4] (It sounds like but differs from PERRLA—"pupils equal, round, reactive to light, accommodation"—often used in neurologic assessment.) PEARLA stands for **P**resence, **E**mpathy, **A**cknowledgment, **R**eflect or reframe, **L**isten openly, **A**sk questions (see Table 1[4]). Taken together, these skills constitute a compassionate approach toward engaging with others. Connecting through compassion provides a therapeutic space that diminishes fear and supports conversations that can lead to conflict resolution.[5]

When someone is agitated, creating connection deescalates the situation and lessens feelings of threat.[6] The goals for creating connection during conflict are to[4]:

- deescalate a situation by noticing and acknowledging the emotional state of others
- elicit insight by revealing others' concerns, wants, and needs
- build trust as a foundation for problem solving
- clarify what's possible and realistically move forward

Creating connection using the PEARLA approach can often be enough to resolve a situation by providing a space in which others are able to clarify their needs or even solve the problem themselves. Connection also creates a foundation for ongoing conversation in the event that multiple interactions are needed to resolve complex issues. The first challenge in creating connection is overcoming the resistance to do so.

ADDRESSING RESISTANCE TO CREATING CONNECTION

It's easy to imagine feeling resistant to the idea of creating connection with someone who is blaming others, not listening, or acting disrespectfully. In such an escalated emotional state, it's hard for people to observe their behavior or appreciate the effect they are having on others. Paradoxically, although these behaviors push others away, it's through connection that people are more likely to be heard and have their issues addressed.[1]

Adopting an empathic stance toward another person helps to maintain connection. Giving others emotional first aid by remaining calm and engaging with presence can be reassuring and help to create an effective space for resolving conflict.[2,5] This approach

Table 1. Creating Connection Using PEARLA[4]

PEARLA	Description
Presence	Use mindfulness and personal presence to be aware of what is happening in the moment.
Empathy	Appreciate what others are feeling or experiencing and have compassion for what they're going through.
Acknowledgement	Notice and name the issues that others indicate are important. Let them know you've heard them and that you understand what matters to them by reflecting back or summarizing what you perceive to be their feelings and concerns.
Reflect or reframe	Reflect back what you hear and reframe the conversation in a way that captures what is important while creating an alternative or expanded way of viewing the situation.
Listen openly	Adopt an open stance and listen at multiple levels to better understand what's being said and what's unsaid.
Ask questions	Use open inquiry and curiosity to ask questions and clarify and expand the conversation.

allows others to tell their story in a way that reveals what is at the heart of their concerns. Being present for someone's lament requires equanimity and the ability to notice when you are "triggered" or emotionally "hooked." To avoid this, it's important to set boundaries if the other person is yelling or speaking in a way that makes the content hard to understand. Asking a speaker to communicate respectfully, for example, so that it's easier to hear her or his concerns is an effective way to ensure that both parties remain engaged in the conversation.

Acknowledging what others are saying reassures them that their concerns are being heard and understood. Acknowledging emotional distress is not the same as accepting or agreeing with the story behind it. It doesn't condone behavior or imply agreement with a position or assertion. It's simply a way of letting people know you are present and understand that the situation is difficult for them. Reflecting back what you hear is one way to clarify their concerns. For example, saying, "It sounds like you are upset because you were hoping to hear back from the doctor by now," acknowledges and also captures the source of their frustration. Reframing what you hear both acknowledges what is said and helps others to perceive the situation from a different point of view. For example, one way of acknowledging frustration with the doctor and reframing the problem might sound like: "Creating a reliable way to receive updates from the team sounds important to you." Reframing and reflecting back are useful skills for moving a conversation forward.[7]

Sometimes resistance comes from believing it will take too much time to engage using PEARLA. In busy work environments conversations are often cut short and there may be a tendency to problem solve before creating connection. However, adopting the PEARLA approach can save time in the long run.

Connection with another person or group helps to clearly define a problem and invites collaborative problem solving. This prevents time wasted by solving the wrong problem. For example, an upset mother becomes distraught after an adverse outcome has led to a prolonged hospital stay for her five-year-old son. Although clinically he will be fine, her tone is accusatory and she threatens to call her lawyer. But when the nurse listens closely and asks questions, she realizes the mother is upset because her son's extended stay means cancelation of a promised trip to the zoo for his sixth birthday. This new information reveals a much different problem to address than what may initially have sounded like an attempt to punish the health care providers or seek monetary compensation.

It takes practice to overcome our desire to be heard, be right, appear strong, or protect ourselves from blame. In difficult situations, there is a strong desire to have our story heard and acknowledged. But responding to people with explanations, rational arguments, or data rarely encourages them to listen to us when they are upset. Instead, it's more effective to reassure them that we are open to hearing what they have to say; this creates the space for our story to also be heard. And it models the behavior we are seeking. Finding a space of empathy from which to respond enables us to temporarily set aside our own needs and invite others to work with us to resolve issues, rather than push them away with our own positions and demands.

With practice, the PEARLA skills become easy to use, even in difficult situations. Returning to our scenario in the 5-East medical–surgical unit, we see how Maria Lopez, the interim nurse manager, implements her practice plan to create connection and model effective conflict engagement skills for her staff.

CREATING CONNECTION: THE HAPPY HILLS SCENARIO

Over the past several months, Ms. Lopez has worked to develop her insights into her emotional intelligence, reaction patterns, and dominant conflict styles. This work has paid off. She has a better understanding of her strengths and has identified the areas in which she

needs to develop her skills in order to be more effective. Determined to transfer her insights into action, she puts together a practice plan to improve her skills and model effective ways of engaging.

After learning the PEARLA skills, Ms. Lopez decides to practice using them during her workday. She knows they will be easier to use with patients and families than with the medical director or her boss, nursing director Jonathan Peterson. After all, resolving conflicts with patients is part of her job and, moreover, she feels less vulnerable with them than she does with her boss. While making rounds on the unit, the charge nurse asks Ms. Lopez to speak with an angry family member who has asked to see the manager owing to "concerns about the quality of care." Ms. Lopez invites the charge nurse to go with her and observe how she addresses the situation. (For Ms. Lopez's conversation with the family member, see *Using PEARLA: A Sample Conversation*.)

At the end of the conversation, Ms. Lopez asks the charge nurse to join her in a nearby conference room to debrief. She asks him what he observed her doing to deescalate the situation. Then she explains how she created connection by being present, listening openly, acknowledging the wife's concerns, and refraining from offering explanations that could sound like excuses. She points out how she invited the wife to problem solve with her and how she created connection by demonstrating empathy and compassion.

Ms. Lopez asks the charge nurse if he feels he could try this approach the next time a conflict situation arises. She agrees to coach him as he practices the skills to support his learning. In this way, she invites the nurse to take on more responsibility for resolving conflicts, and she continues to build the capacity of staff to engage with each other and with patients and physicians by modeling behaviors and debriefing with them whenever the opportunity arises.

Ms. Lopez continues to practice her PEARLA skills with the medical director and with colleagues from other departments. She tracks what she does well and what she would like to improve. She is pleased to discover that she becomes better able to listen to, empathize with, and acknowledge the feelings of others, and notices when she is "hooked" by a situation and adjusts her focus in order to listen better.

Yet she still struggles with being fully present and continues to grab onto a solution before trying to clarify a situation or hear another's perspective. She makes a plan to practice becoming more curious and to ask better questions.

CULTIVATING CURIOSITY

Health care professionals are valued for their judgment and expertise, not necessarily for their curiosity. Indeed, professional training can suppress curiosity by emphasizing haste, confidence, and nonreflective learning, which may limit one's ability to build self-awareness and respectful relationships.[8] A relational approach to conflict relies on one's ability to be curious about a situation, about a person, and sometimes about the relationship itself.

Resolving conflict with others involves asking questions that inspire deeper reflection, invite insight, and expand possibilities. Shifting from an expert stance to a relational stance allows access to a different set of questions. Indeed, questions that come from a place of curiosity invite collaboration and encourage new ways of seeing a situation. They are fundamentally different from questions used to investigate, fact find, or validate solutions. The following example demonstrates the difference questions can make in encouraging collaborative problem solving.

ASKING QUESTIONS OF COLLEAGUES: THE HAPPY HILLS SCENARIO

Mr. Peterson, the nursing director, meets with Ms. Lopez to evaluate the progress they've made since initiating their intervention to help address conflict on the unit over the past few months. He is clearly agitated. He begins by discussing his frustration with the most recent patient satisfaction scores. Although these scores improved early in the intervention, they have dropped again. He is feeling pressure to improve scores on all of his units by the end of the next survey period, which occurs in one month. In addition, he had also anticipated that the annual employee engagement scores would be higher, given the amount of time he and Ms. Lopez had spent with the charge nurses, physicians, and staff. Mr. Peterson has begun to doubt that their efforts were worth the time.

Although Ms. Lopez is also frustrated with the results and has several ideas about what may be contributing to the disappointing data, she decides not to try to justify the situation. Instead, during their meeting,

Questions for Reflection

1. How can you practice creating connection with colleagues and others? What relational skills do you want to improve? Who could support your growth in this area?
2. What aspects of being a nurse are worthy of your best intentions and highest aspirations? When you look back at your career, what will you say gave you joy, meaning, and a sense of contributing to improving the lives of others?

Using PEARLA: A Sample Conversation

Edward Adams, 58, has end-stage liver disease but is not a candidate for a transplant. His two children from his first marriage have not had much contact with him lately. Celia Adams, his second wife, is distraught. She has had an explosive argument with Mr. Adams's son at the bedside. He stormed off the unit exclaiming that he will have Ms. Adams declared incompetent and have security remove her from the hospital. Maria Lopez, the nurse manager, enters Mr. Adams's room to talk with his wife.

Ms. Adams (excitedly): That son of his has no right to show up now expecting to be in charge of what happens to my husband! He hasn't been around for the past nine years, when his father needed him! I do *not* want him here upsetting me and my husband! I will get a restraining order against him if you can't keep him out!

Ms. Lopez (takes a deep breath): I'm sorry you are going through all of this. It's clearly upsetting to have one more thing to deal with. *(PEARLA skills used: presence, empathy, acknowledgement)*

Ms. Adams (more animated): Upsetting? It's more than upsetting! I'm furious! I've been by my husband's side throughout his whole illness. It's not fair that something like this should happen to him. My husband is a good man and he didn't do anything to deserve this. This past year has been horrendous and you would think his children would have offered to help us. They haven't. I've managed everything on my own and I don't need their help now.

And why can't he have any water? His mouth is so dry he's developing sores on his lips. The nurse last night didn't even give him a bath. And I haven't been able to talk to the doctor in four days! Doesn't anyone know what they're doing around here?

Ms. Lopez (calmly): I didn't mean to minimize what you've been through. Anyone in your situation would be angry. It's not fair that good people have bad things happen to them. *(Presence, empathy, acknowledgment, reflecting back, reframing)*

It sounds like you have been a lifeline for him and he has had to rely on you a lot during his illness. You obviously care a great deal about what happens to him. Providing good care is our goal too. *(Presence, empathy, acknowledgement, reflecting back [without getting into explanations])*

What do you need right now that would help? How can we support you? *(Asks clarifying questions)*

Ms. Adams (worried): I need to know that others care about him and that no one is going to harm him. He is so vulnerable and if I'm not watching over him every minute, I'm afraid of what will happen to him.

Ms. Lopez (with compassion): This must be a pretty scary situation for you. What are you afraid will happen? *(Acknowledges emotions, asks clarifying question)*

Ms. Adams (quietly): I'm afraid he will die. I'm afraid I have failed him. (She begins to cry.)

Ms. Lopez (comfortingly): Yes, he is very sick and you are doing a great job of advocating for him. He's lucky to have you helping him! If you like, I can take you to the private family room for a little while; you can return whenever you're ready. Is there someone you would like me to call, or would you like time to talk with the chaplain or social worker? *(Empathy, asks questions)*

Ms. Adams (calmly): Yes. Thank you for understanding. You have been very helpful. This is just incredibly stressful for me.

Ms. Lopez: I can see you're under a lot of stress. Let's work together and take this one step at time.

she practices asking questions as a means of working through the situation together. In preparation for the meeting, Ms. Lopez had spent time considering the survey results and wondered how Mr. Peterson would respond. She was curious about how the scores would affect him and also what he would think could be done going forward. She wondered if he was aware of the complexity of the environment on 5-East and if he knew that achieving a turnaround would take longer than the time between surveys. She also wondered how to enlist his support in slowing down the frequent rollout of change initiatives; the timing of these

initiatives was making it difficult for the staff to adapt to and master one major change before being asked to implement another.

Ms. Lopez came up with some potential questions to ask Mr. Peterson during their meeting. These included: What did you hope the survey scores would be at this point? How do the low scores affect you professionally? What do you think may have contributed to the current scores? What other indicators might we consider that could tell us whether things are getting better on 5-East overall? What do you think has been the effect on the staff of the continued rollout of change initiatives? What would it take to limit these initiatives or pace them differently so the staff could focus on spending more time with patients? How could we work together to do that? What information would help you to justify the survey data to the executive team? Where should we go from here?

During the meeting, Ms. Lopez listens openly to Mr. Peterson's concerns, acknowledges his frustration, and shares her own worries. She asks him several of the questions she drafted before their meeting. She finds that these questions create an atmosphere of collaboration that is quite different from that of her past interactions (which began with explanations and justifications rather than curiosity). She notices that as she asks more questions and uses her connection skills, Mr. Peterson becomes less agitated and more open to hearing her concerns and ideas.

Ms. Lopez shares her ideas for continuing to work with the staff to keep moving forward. She reiterates her need for Mr. Peterson's support in negotiating the pace of change initiatives to give the staff some breathing room. Mr. Peterson appreciates her willingness to work with him and her understanding of how difficult it is to manage his workload as well as the pressures associated with the public survey data and other outcomes indicators. He compliments her on how hard she has worked to move the unit forward and acknowledges that overall things are much better than they were when they began the process several months earlier. He notes that there are fewer sick calls and less overtime, staffing numbers are better, there have not been any sentinel events, and the charge nurse group is working together much more efficiently. He also notes that the medical director has stopped coming to his office to complain about nursing care on the unit.

The two agree to check in again in a few weeks and to develop a strategy for prioritizing and pacing the change initiatives currently scheduled to be implemented. They agree to include the medical director in their planning so together they can develop consensus on the best plan for meeting the unit's goals.

Ms. Lopez and Mr. Peterson both recognize the need to remain resilient in order to stay engaged with ongoing demands. Although they have yet to achieve all of their goals, they have come a long way and the improved morale on the unit is a clear indicator that things are moving in the right direction. In addition, the staff is working more collaboratively with the physicians and almost everyone seems to be more willing to support each other to make the unit a better place to work.

CONCLUSION

This six-part series on conflict engagement outlines a relational approach to conflict that aligns with the relational nature of providing health services in complex systems. Conflict competence in the clinical work environment is a multifaceted endeavor that involves using systems thinking in working with group dynamics and organizational patterns. It also entails developing a better understanding of one's inner landscape and how personal and professional growth becomes the primary means for collaboratively effecting change.

Engaging fully in the work of addressing conflict in health care reflects a conscious desire to create healing spaces for patients and colleagues. It is work that's worthy of the best of what nurses have to offer to their patients and to the profession. ▼

Debra Gerardi is president and chief creative officer, EHCCO, Half Moon Bay, CA. Contact author: debra@ehcco.com. *The author has disclosed no potential conflicts of interest, financial or otherwise.*

REFERENCES

1. McCauley M. Relational-cultural theory: fostering healthy coexistence through a relational lens. In: Burgess G, Burgess H, eds. *Beyond intractability*. Boulder, CO: Conflict Information Consortium, University of Colorado-Boulder; 2013. http://www.beyondintractibility.org/essay/relational-cultural-theory.
2. Jordan JV. *Valuing vulnerability; new definitions of courage*. Wellesley, MA: Jean Baker Miller Training Institute at the Wellesley Centers for Women; 2008. Paper No. 102. Work in progress.
3. Bowling D, Hoffman D, eds. *Bringing peace into the room: how the personal qualities of the mediator impact the process of conflict resolution*. San Francisco: Jossey-Bass; 2003.
4. Gerardi D. Professional conduct toolkit, module 2. Responding to behaviors that undermine safe patient care. 2010.
5. Gold L. Mediation and the culture of healing. In: Bowling D, Hoffman D, eds. *Bringing peace into the room: how the personal qualities of the mediator impact the process of conflict resolution*. San Francisco: Jossey-Bass; 2003. p. 183-214.
6. Richmond JS, et al. Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *West J Emerg Med* 2012;13(1):17-25.
7. Moore CW. *The mediation process: practical strategies for resolving conflict*. 3rd revised ed. San Francisco: Jossey-Bass; 2003.
8. Dyche L, Epstein RM. Curiosity and medical education. *Med Educ* 2011;45(7):663-8.