Open Journal of Applied Sciences, 2016, 6, 123-130
Published Online February 2016 in SciRes. http://www.scirp.org/journal/ojapps
http://dx.doi.org/10.4236/ojapps.2016.62013

Managing Conflict in a Time Critical Environment—A Neglected Non-Technical Skill Submission for Special Edition—Team Management

Elizabeth M. Norris

Educator for Resuscitation Council UK & European Resuscitation Council, London, UK
Email: lizzynorris@mail2doctor.com

Received 11 January 2016; accepted 26 February 2016; published 29 February 2016

Copyright © 2016 by author and Scientific Research Publishing Inc.
This work is licensed under the Creative Commons Attribution International License (CC BY).
http://creativecommons.org/licenses/by/4.0/
Open Access

Abstract

The aim of this study was to the explore the nature of conflict and increase the understanding of the role of conflict as a non-technical skill, drawing on literature from organizational behaviour, leadership, patient safety and medical simulation. The review highlights the different conflict types in time critical settings, both emotional and constructive. It proposes that it may be possible to use this knowledge to enable team leaders and team members to be aware of "emotional" or "dysfunctional" conflict, and appreciate when it is about to escalate and consider strategies that could be useful in such a setting to defuse it. "Emotional conflict" is often exacerbated by stress and/or previous learned feelings of failure or helplessness. If individuals learn to recognise conflict does not have to be destructive and learn techniques such as reappraising a situation, active listening and good respectful communication with team members, the emotional climate in teams could be improved and useful discussion regarding patient care would ensue. Finally the study hopes to show how teams could make use of "constructive" conflict to improve team function, team member confidence and a flattening of hierarchies within the team.

Keywords

Emotional Conflict, Recognition of Stress, Stress Management, Conflict Management Strategies, Organizational Structure, Constructive Conflict

1. Introduction

Conflict is a state of mind where there is a perceived incompatibility of actions, goals or ideas among involved

How to cite this paper: Norris, E.M. (2016) Managing Conflict in a Time Critical Environment—A Neglected Non-Technical Skill Submission for Special Edition—Team Management. *Open Journal of Applied Sciences*, **6**, 123-130.
http://dx.doi.org/10.4236/ojapps.2016.62013

parties [1]. The origin of the word comes from Middle English "a conflict of arms" and tends to imply a negative connotation [2]. Dysfunctional conflict is often destructive and occurs mainly when emotions run high and will be described as "*emotional conflict*". It is hoped that by highlighting the emotional element within the name, this will help individuals to recognise their own arousal response in the presence of stress or an emergency. Many medical staff react negatively just hearing the word conflict and it frequently conjures immediate thoughts of threat, fear, bullying and helplessness. Conflict management is seen as time consuming resulting in avoidance of discussion of problems in emergencies and yet this is when the "stakes" may be particularly high regarding patient safety.

The literature illustrates conflict can also be useful, functional or constructive in promoting team discussion and acting as a catalyst for change and this may potentially prevent errors in medical diagnosis and treatment. Functional conflict involves logic and critical thinking and is also called "*constructive conflict*" and this is the term which will be used in the paper [3].

The paper attempts to answer three questions:

1) Could/should doctors and nurses be taught to recognise both "emotional" and "constructive" conflict in an emergency setting?

2) What theory and indicators of stress and emotional arousal might be taught to team leaders and team members to understand their response to emotional conflict and defuse it?

3) Could team leaders be taught behaviours and techniques to maximise constructive conflict?

2. Methodology

A number of literature searches were carried out in Google Scholar: "types of conflict" produced 1210 results and "constructive conflict" 258. Relevant abstracts were read from these two searches but few were found to be relevant. Books on leadership, organizational behaviour and medical simulation were individually searched. There is a wealth of literature published in organizational behaviour and for the business world, regarding both negotiation and management of confrontation and the paper is derived mainly from those sources deemed to be particularly relevant.

Little is written in the medical literature or taught to medical students and doctors in training about how to manage conflict despite its recognition as a non technical skill [3]. This is particularly important in terms of Crisis Resource Management, when a challenge to a more senior colleague or team leader might be time critical, for example in managing a cardiac arrest when a team member feels a wrong diagnosis has been made, incorrect treatment given or a drug error may be about to take place. Doctors and nurses are told they ought to speak up in these situations but may not have been taught the language necessary to make a challenge without making the team leader angry or more stressed [4].

3. Results

3.1. Types of Conflict

Emotional/dysfunctional conflict

In a stressful situation the emotional and cognitive responses to stress (**Table 1** and **Table 2**) are such that people are more likely to become angry and or defensive and this may result in unnecessary conflict [3]. In a crisis setting when team leaders and team members are under pressure, a team leader may be struggling to be appear calm when his/her emotions are reacting to stress and he/ she may not appreciate this. Stress can affect people both *emotionally* and *cognitively* and there is a recognised association between stress and safety [3]. In addition, in an emergency there is an increasing need for mental concentration to cope with tasks, their distribution and situational awareness. This escalation of *cognitive load* makes people more likely to fixate on tasks [5].

Larsson [6], looking particularly at anaesthesia, suggests that the stress response depends on whether an anaesthetist encountering a critical situation perceives a problem as a threat or a challenge. If the anaesthetist sees a problem as *a threat* then fear and anxiety may follow, whereas if perceived as *a challenge* the anaesthetist mobilises coping strategies and positive emotions follow which attenuate stress. Appreciating the need to change how a problem is perceived is called *cognitive reappraisal* [7]. An individual must re-evaluate the potentially emotion-eliciting situation in a way that changes its emotional impact. A heightened emotional state prevents people from acting logically because it is distracting and it is difficult for the individual experiencing it to control their impulses. In order to prevent this people need to be made aware of this response to stress and how to

Table 1. Emotional reactions to stress.

Anxiety
Fear
Irritability
Helplessness
Tearfulness
Sweating
Tachycardia
Nausea, vomiting, diarrhoea

Table 2. Cognitive effects of stress.

Tiredness
Hard to concentrate
Hard to remember
Impaired decision-making

manage it. It may be helpful to encourage team leaders to actively pause and reappraise a situation in order to see problems as challenges rather than threats. This distancing from a problem is useful in both stress management and defusing conflict [8].

Communication issues were the chief cause of many errors and frustrations in a Swiss hospital [9]. It can be difficult to express opinions and emotions clearly, particularly in a hierarchical environment such as the emergency department or operating theatre. Conflict amongst team members may arise regarding team processes "you should be doing this, not me…" or for interpersonal reasons [10]. Emotional conflict can escalate rapidly causing team members to "compete" with one another for attention and over tasks, tension then escalates and shouting and unpleasant verbal exchange may result. Cole [11] showed that there was more shouting and general noise in the Emergency department when junior doctors were leading teams than senior doctors. It may be that with experience senior doctors are coping with situations they have previously seen and have greater knowledge and skills enabling them to see the situation simply as a problem to overcome and therefore less stressful. If a team leader shouts or sounds very grumpy team members may take this response very personally. This type of response can damage a team and lower morale and may make a team leader even more defensive or emotionally vulnerable. Some senior doctors are able to adapt their surgical and communication style when operating with junior doctors, making it more facilitative which reduced stress, avoided conflict and helped juniors to cope and avoid error [12].

Unfortunately this emotional conflict, shouting and heated arguments encourages team members to develop *avoidance behaviour* and a reluctance to speak up in a timely manner and individuals who do challenge decisions may become labelled as "difficult". Conflict avoidance means problems do not get solved and risk is enhanced. Team leaders in particular may not realise that any challenge to their authority may be automatically and subconsciously perceived as a threat which causes an *immediate emotional* arousal response in that individual. Therefore it is not surprising that individual team leaders, already in a heightened emotional state in a medical emergency may feel even more vulnerable when a team member tries to speak up and ask a question. The team leader needs to be able to perceive their own "threat level", pause and use distancing or distracting techniques in order to be able to listen and answer questions.

Crew resource management training in the airline industry acknowledges some conflict will be inevitable [13]. Crews are taught how to make challenges, escalating their language if there is no response. This is important because the team leader response may be affected by the language the team member uses when raising an issue. A team member who says "you are wrong" is much more likely to heighten the stress of a team leader than if the same question is offered in a different way—"should we consider this problem could be…?" The former comment will make most individuals become defensive and emotional conflict can quickly escalate, fraying tempers, impairing judgement and making everyone more prone to error.

Careful use of moderate language may need to be rehearsed in round table style discussion in order that people will think about how they word a challenge and avoid escalating the emotional climate in an emergency. It may be important to consider other factors. Steiner [14] suggests the nature of a response is also determined by which ego states a team leader is utilising at the time. Emotional reaction to stress can depend on numerous factors: previous success and failures in similar settings, experience, fatigue, adequate training or the lack of team support. Individuals can develop "learned helplessness" which decreases their performance or confidence from past experiences. Clearly the opposite is also applicable with team leaders and members growing in assurance when situations have gone smoothly.

Transactional analysis considers three ego states [14]

The Parent—this is known as our super ego and this is the behaviour copied from our parents. It is probably the state each individual needs to be most conscious of because in this state people can act instinctively, with repetition of how their parents would have acted or behaved. A person's life experience can add or subtract from this *Parent* repertoire of behaviour depending on other role models and copied behaviour.

Adult ego is the logical computer functioning self, detached from feelings and it is the ideal ego state for managing a team. This state is illustrated by a team leader focusing and listening to team member contributions and potentially changing actions.

The Child ego is the part of oneself that experiences joy and is very important in resilience and recovering from difficult experiences.

Many people have not experienced a happy childhood so the *parent ego* is damaged. An adult who experienced an unhappy childhood may feel more likely to fail, more alone and more vulnerable when a stressor arises. Stressed or depressed team members may struggle to recover the *child ego* within themselves and require time off after serious incidents. Ego states operate one at a time, sometimes an individual acts in one state while another ego state is arguing within. Basic knowledge of the ego states and the knowledge and awareness of the internal dialogue can help a leader. The leader my realise his/her own level of arousal is high, pause and force him/herself to reflect and use the *adult ego.* The *parent* state can be particularly useful too if control needs to be established quickly and a team is procrastinating [14]. However, if a team leader uses power and intimidation to rule the team this may create barriers within the team [4].

Doctors' training could include at least the rudiments of recognising emotional arousal and the emotional and cognitive effects of stress. Stress management may then be taught using the techniques of Meichenbaum [15] who suggests gradual exposure to stress with review of individual emotions, then various strategies to reduce arousal. Storytelling is an important means of vicarious experience helping people develop decision-making skills and lessen arousal when similar events occur in the future [3]. This ties in with De Weerdt's [16] use of reflective practice to help people make sense of previous experience. Adequate preparation, rehearsal, storytelling can all help people develop the capacity to effectively execute coping responses [3] [13]. Breathing exercises, practising "what if" scenarios, learning to shut out distractions such as a sick child at home may all help. People should be encouraged to ask for advice and moral support from friends, senior colleagues or mentors, these are all recognised strategies for learning to cope. Resilience training can also help people "bounce back" from difficult events.

If emotional conflict or the potential for conflict is recognised is it possible to defuse it?

Gerzon [4] describes an eight step approach to conflict mediation, the first four steps are process related and the second four are orientated to outcome. None of these steps are lengthy and could be executed quickly; this approach might help to manage both stress and conflict amongst team leaders and team members.

3.2. 8 Steps to Conflict Mediation

Processes

1) Remind the team of the need to focus on the integral vision of doing one's best for the patient-all team leader and members should be committed to active listening to one another [17].

2) The team leader must identify the key elements creating the conflict: diagnosis, more help needed, different treatment etc.

3) Presence: Leaders must practise being totally focused "*in the moment*" in order to access their full range of mental and emotional resources. Emmerson [17] outlines a communication model with patients, suggesting the doctor should imagine a "*focus of attention*" as a tangible thing between the doctor (team leader) and the patient

(team member). When proper focus is maintained the leader creates a suitable climate for discussion of a problem.

4) Inquiry: A team leader should ask the team questions to stimulate constructive conflict and de-escalate emotion. Active listening amongst the team helps both parties to be understood and to defuse tension.

The above four points constitute the processes and the following make for the resolution.

1) Conscious conversation: everyone in a team needs to think about how they phrase their challenges and comments and to listen carefully to team leader updates, suggestions and any questions.

2) Dialogue: The team needs to communicate to build trust using mutual inquiry.

3) Summary statements "bridge the gap" caused by any difference in opinion and can defuse the tension. This "defusing" may be more appropriate immediately post crisis or at a full later debriefing [3]. The leader asks for further ideas from the team, again this may be more useful afterwards when there is time to review cases.

How could a team leader carry out these steps rapidly?

- Leaders need to practise using an "accepting" response to questions and acknowledge the legitimacy of the team member. This sets a neutral ground and builds trust for the team member to continue. This does not solve the problem but may lower the tension.
- If the challenge is more aggressive in tone or the team member disagrees more strongly then again "acknowledging" the contribution is the first appropriate response "yes, there is clearly another way to look at this problem, let's consider the alternatives…"
- A pause after the reply allows the team member time to reflect on what the leader has said and defuse any emotional tension a bit further.
- If the team member's comments are not clear it may help if the leader paraphrases the challenge.

If a team leader takes an active listening approach then the tension is defused, the team will all feel empowered to speak up and develop bargaining strategies, exploring alternatives, making suggestions. If teams practise together they may be able to identify potential conflict before it arises and find ways to effectively manage it, increasing the chances of turning conflict into a positive outcome. These strategies are known as bargaining strategies and classified into "win-win" rather than "win-lose", illustrated in the Baker model in **Table 3** [18]. In win-lose the team leader forces his team to go along with his thinking and team members back into submission but the team may then not function as well and team members may be frustrated and less likely to be helpful with the same leader in the future, compounding the risk of errors [19].

The results support the hypotheses that doctors and nurses could be taught to recognise the temperature of a situation and could learn to manage and defuse emotional conflict and it should improve teamwork and patient safety.

Topics which could be considered within a training course include:

- Individuals would learn to recognise their emotional state and manage their stress. Simple stress management with breathing exercises, pauses, deliberate distraction or distancing techniques could be offered to different individuals.
- A basic understanding of transactional analysis may help team leaders and members understand their own reaction in certain settings.
- People can learn cognitive flexibility and Oore [8] suggests the training requires "minimal natural ability, a

Table 3. The Baker model.

TL = team leader, TM team member	**Team member TM asks a question**
Functional = constructive response	Dysfunctional = emotional response
Team leader TL pauses-listens	Team leader upset, angry
Team leader acknowledges TM	TL Shouts
TL asks clarification	TM becomes hesitant
TL shares with team	T M says "it doesn't matter" avoidance
Cognitive response	Emotional response both parties angry and resentful
Team solves problem	Misdiagnosis, errors in treatment occur
Team members feel good	Team members less co-operative, less cohesive

couple of minutes and a moderate motivation to successfully enact". The ability to cognitively reappraise problems and to mirror the behaviour of team members who are being cooperative rather than competitive others could also be practised in a group teaching environment.

- Communication skills to phrase both challenges to senior colleagues and responses as team members and team leaders. Improved communication skills could be developed to make people pause before answering, consider their own emotional state and the other person's point of view. Round table practise of challenges should be able to teach these skills. Team leaders could be encouraged to share their emotional feelings and cognitive response to scenarios, similarly the team should share their coping mechanisms.
- Rudiments of conflict resolution.

With relatively short training doctors and nurses could see *constructive conflict* as a positive tool and separate it from *emotional conflict* where stress or poor communication lead to an escalation in the emotional environment and decrease the ability of team members to contribute to patient management and increase the risk of errors.

3.3. Constructive Conflict

A principal assumption in organizational behaviour is that teams have the ability to make better decisions than individuals [8]. Constructive conflict focuses on goals and improving performance [4]. In companies it is valued as it encourages creativity and productivity, team members provide mutual support and concern for one another and when tasks are accomplished successfully then the team feels happy and elated and contented (4). In Crew Resource Management the captain is no longer the "king" who cannot be challenged [13]. People still give orders but everyone is entitled to monitor everyone else to check commands and question decisions. Safety takes priority over deference and use of first names is encouraged and as a result of the training and confidence learned, air accidents are now very uncommon [13].

The benefits of teams developing constructive conflict and challenges include:

- High team motivation as the team members feel more included.
- Underlying issues are raised and become explicit, for example if a team leader is giving instructions so fast they are difficult for team members to carry them out.
- The team care of the patient should become less risky as team members are confident to ask for repetition or clarification of issues.
- The team has a better understanding of the "big picture" of what is happening.
- Team members become more confident and there is less "avoidance" behaviour where individuals do not speak up [4].
- There is less likelihood members will simply "compromise" rather than reaching a true solution.
- Team members reflect and learn more about clinical situations which benefit both personal and team learning [16].

Constructive conflicts are productive, support the care of the patient and improve performance and are encouraged in industry. The ideas of constructive conflict are already accepted in aviation crisis resource management. "Good teams go through a process of development in which a certain amount of tension and conflict simply cannot be avoided, in fact, when well managed and openly discussed they actually contribute to the establishment of ground rules and consolidation of a group identity" [13]. The aviation industry also makes use of strong processes setting clear boundaries of roles and detailing tasks [13].

Team members are generally genuinely interested in solving a problem and are willing to listen to one another. Business models actively encourage stimulating constructive conflict because it is seen as a great way to improve team performance and generate new ideas. A team can be asked to defend or criticise ideas based on relevant facts but there would rarely be enough time for the business models use of devil's advocate or dialectic method in a critical moment. These approaches might be useful for defusing immediately after events or debriefing some time later [1].

Devil's advocacy

A team member assumes the role of a critic and will pose questions and critique any ideas that the team may have, creating a logical, critical thinking debate. It is recommended that this role gets rotated amongst the team to avoid any particular person from developing a negative viewpoint.

Dialectic method

The dialectic method of thesis and antithesis is attributed to Socrates and involves facilitating a structured de-

bate of pros and cons to the decisions that were made during the case. It should encourage participation by the team and build team focus and confidence in shared decision-making. Shared decisions in a strong team flatten hierarchies which make it easier to for team members to speak up and should reduce the burden of team leadership and consequent stress.

Simulation of emergency scenarios which encourage team leader pauses to update the team, open up inquiry and acknowledge responses in an attentive manner could offer an opportunity to embrace this difficult subject. Discussion of conflict has often been avoided in medicine, perhaps seen as too difficult to discuss and it is time to adopt the lessons learned from our aviation and business colleagues

4. Discussion

The literature suggests that there is a need for doctors and nurses to understand the theory of conflict, stress, knowledge of the ego state and stress management in order to become better team leaders and followers. Literature also suggests that appreciating the concept of constructive conflict could help leaders feel less threatened when challenged by team members. The next step from this review concerns developing training courses to utilise the concepts from this paper. This type of training lends itself to high fidelity simulation courses where there is much more time to practise dialogue within simulated scenarios and more time for debriefing.

The results support the hypotheses that doctors and nurses could be taught to recognise the temperature of a situation and could learn to manage and defuse emotional conflict and it should improve teamwork and patient safety.

Suggested curriculum for a training course:

- Understanding of stress.
- Stress management.
- A basic understanding of transactional analysis to enable team leaders and members to reflect on their personal lives and understand their Adult, Parent and Child states.
- Practise cognitive flexibility by discussion of difficult standardised cases which may appear frightening but with reappraisal and discussion become perceived as a challenge.
- Advanced communication skills practising phrases to ask questions of senior colleagues. Similarly team leaders could practise distancing techniques and stimulating inquiry.
- Consideration of Gerzon's 8 steps to conflict mediation [4].
- A possible training course might include a mixture of theory and round table discussion, followed by communication skills practise. Simulation sessions using carefully scripted conflict management simulations could then follow, encouraging recognition and defusing of emotional conflict and encouraging constructive conflict.

With training doctors and nurses, constructive conflict could be seen as a positive tool and separate it from emotional conflict where stress or poor communication lead to an escalation in the emotional environment and decrease the ability of team members to contribute to patient management and increase the risk of errors.

References

[1] Huczynski, A.A. and Buchanan, D.A. (2007) Organizational Behaviour. An Introductory Text. 6th Edition, Prentice Hall, Pearson Education, UK.

[2] (1973) The Shorter Oxford English Dictionary on Historical Principles. Oxford University Press, UK.

[3] Flin, R., O'Connor, P. and Crichton, M. (2008) Safety at the Sharp End. Ashgate, England.

[4] Gerzon, M. (2006) Learning through Conflict. Harvard Business School, USA.

[5] Deckker, S. (2011) Patient Safety—A Human Factors Approach. CRC Press, Boca Raton.

[6] Larsson, J. and Sanner, M. (2010) Doing a Good Job and Getting Something out of It: On Stress and Wellbeing in Anaesthesia. *British Journal of Anaesthesia*, **105**, 34-37.

[7] Lazarus, R.S. (1999) Stress and Emotion—A New Synthesis. Springer Publishing Company, UK.

[8] Oore, D.G., Letter, M.P. and LeBlanc, D.E. (2015) Individual and Organizational Factors Promoting Successful Responses to Workplace Conflicts. *Canadian Psychology*, **56**, 301-310.

[9] Rosenthal, M.M., Mulcahy, L. and Lloyd-Bostock, S. (1999) Medial Mishaps: Pieces of the Puzzle. Open University Press, Philadelphia, USA.

[10] West, M.A. (2004) Effective Teamwork—Practical Lessons from Organizational Teamwork. 2nd Edition, Blackwell,

USA.

[11] Cole, E. and Crichton, N. (2006) The Culture of a Trauma Team in Relation to Human Factors. *Issues in Clinical Nursing*, **15**, 1257-1266.

[12] Reason, J. (2008) The Human Contribution. Ashgate, England.

[13] Gordon, S., Mendehall, P. and O'Connor, B.B. (2013) Beyond the Checklist What Else Health Care Can Learn from Aviation Teamwork and Safety. Cornell University Press, USA.

[14] Stiener, C. (1990) Scripts People Live: Transactional Analysis of life Scripts. 2nd Edition, Grove Press, New York.

[15] Meichenbaum, D. (1985) Stress Inoculation Training. Pergamon Press, UK.

[16] De Weerdt, S., Hovelynck, J. and Dewulf, A. (2009) Part III Using Simulations for Education, Training and Research. Pabst Publishers, Germany.

[17] Emmerson, G. (2006) Advanced Skills and Interventions in Therapeutic Counselling. Crown House Publishing, Wales, UK.

[18] Kurtz, S., Silverman, J. and Draper, J. (2005) Teaching and Learning Communication Skills in Medicine. 2nd Edition. Radcliffe Publishing, Oxon, UK.

[19] Hargie, O. and Dickson, D. (2004) Skilled Interpersonal Communication: Research, Theory and Practice. 4th Edition, Routledge Publishing, London.