Organizational Change and Learning

A Strategic Approach for Managing Conflict in Hospitals: Responding to the Joint Commission Leadership Standard, Part 2

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This article is the second in a two-part series discussing The Joint Commission's leadership accreditation standard, LD.02.04.01, which states, "The hospital manages conflict between leadership groups to protect the safety and quality of care."[1] (Sidebar 1, page 71). The phrase *leadership groups* refers to the governing board, senior management, and leaders of the organized medical staff. In Part 1, we discussed the importance of aligning a hospital's organizational mission with its conflict management practices, the types of conflict that typically can occur among leadership groups, and how to conduct a conflict assessment as a first step in creating an effective conflict management process.[2] We now focus on designing a process for managing conflict among hospital leaders and for developing their competencies to engage constructively with conflicts among members of their leadership groups.*

Designing Conflict Management Systems for Hospital Leaders

In its introduction to Standard LD.02.04.01 (Sidebar 1), The Joint Commission acknowledges that conflict can be successfully managed without being resolved: "The goal of this standard is not to resolve conflict, but rather to create the expectation that hospitals will develop and implement a conflict management process so that conflict does not adversely affect patient safety or quality of care."[1] The Joint Commission also realizes that conflict "commonly occurs even in well-functioning hospitals and can be a productive means for positive change."[1] A well-designed process for hospital leaders should both retain the positive benefits of constructive conflict engagement and minimize the adverse consequences that unmanaged conflict can have on patient care.

This two-part article builds on well-established principles from the field of dispute system design (DSD) in offering

Article-at-a-Glance

Background: A well-designed conflict management process for hospital leaders should both retain the positive benefits of constructive conflict engagement and minimize the adverse consequences that unmanaged conflict can have on patient care. Dispute system design (DSD) experts recommend processes that emphasize the identification of the disputing parties' interests and that avoid reliance on exertions of power or resort to rights. In an emerging trend in designing conflict management systems, focus is placed on the relational dynamics among those involved in the conflict, in recognition of the reciprocal impact that each participant in a conflict has on the other. The aim is then to restore trust and heal damaged relationships as a component of resolution.

Components of the Conflict Management Process: The intent of Standard LD.02.04.01 is to prevent escalation to formal legal disputes and encourage leaders to overcome their conflict-avoidance tendencies through the use of well-designed approaches that support engagement with conflict. The sequence of collaborative options consists of individual coaching and counseling; informal face-to-face meetings; informal, internally facilitated meetings; informal, externally facilitated meetings; formal mediation; and postdispute analysis and feedback.

Conclusions: Every hospital has unique needs, and every conflict management process must be tailored to individual circumstances. The recommendations in this two-part article can be adapted and incorporated in other, more comprehensive conflict management processes throughout the hospital. Expanding the conflict competence of leaders to enable them to effectively engage in and model constructive conflict-handling behaviors will further support the strategic goal of providing safe and effective patient care.

* The publication of this article does not constitute an endorsement by The Joint Commission or Joint Commission Resources of any services that may be offered to health care organizations by the authors or other entities cited in this article.

Sidebar 1. Hospital Leadership Standard LD.02.04.01

The hospital manages conflict between leadership groups to protect the quality and safety of care.

Elements of Performance for LD.02.04.01

1. Senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups.

2. The governing body approves the process for managing conflict among leadership groups.

4. The conflict management process includes the following:
   - Meeting with the involved parties as early as possible to identify the conflict
   - Gathering information regarding the conflict
   - Working with the parties to manage and, when possible, resolve the conflict
   - Protecting the safety and quality of care

5. The hospital implements the process when a conflict arises that, if not managed, could adversely affect patient safety or quality of care.

This accreditation standard became effective as of January 1, 2009.

Source: The Joint Commission: *2011 Comprehensive Hospital Accreditation Manual: The Official Handbook.* Oak Brook, IL: Joint Commission Resources, 2010. Element of Performance 3 ("Individuals who help the hospital implement the process are skilled in conflict management. Note: These individuals may be from either inside or outside the hospital.") was deleted from the standard.

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approaches and recommendations for designing a process for managing conflict among hospital leaders. DSD experts overwhelmingly recommend processes that emphasize the identification of the disputing parties' *interests* and that avoid reliance on exertions of *power* or resort to *rights*[3-5] (Figure 1, page 72). Disputes resolved by attempted unilateral exercises of power—for example, strikes, facility closures, and firings—can be costly in terms of money, time, goodwill, and morale and can result in all the parties suffering significant losses. In rights-based methods for addressing disputes, such as litigation and binding arbitration, a neutral third-party uses rules, laws, contracts, policies, or other objective criteria to determine the winner and loser in a conflict.

By contrast, an interest-based approach to managing conflicts focuses on the negotiation of underlying interests of the participants and, as much as possible, relies on the participants themselves to resolve their problems collaboratively and to craft "win-win" solutions that meet their interests. Any conflict management process for a hospital setting should encourage interest-based, collaborative strategies rather than power-based

or rights-based approaches for resolving most conflicts, particularly among leaders who must continue to work with and rely on each other within complex, high-stress environments. Consistent attempts should be made for collaborative conflict management in light of the *common* interests shared by the three hospital leadership groups to provide safe, high-quality patient care.

An emerging trend in designing conflict management systems goes beyond identifying interests and focuses on the relational dynamics among those involved in the conflict in recognition of the importance of emotional intelligence and collaborative capacity as keys to conflict engagement.[6-9] The newly developing field of collaborative law reflects this trend. Originally developed in family law settings, collaborative law encourages consensual, nonadversarial resolution of disputes and has been proposed for use in health care settings.[10,11] This emerging trend recognizes the reciprocal impact that each participant in a conflict has on the other and aims to restore trust and heal damaged relationships as a component of resolution (Figure 1).

In the context of rapidly changing health care environments, conflict management processes should be both dynamic and adaptive.[4] These processes should also be relevant and customized to the organizational environment and the needs of the professionals who will be using them.
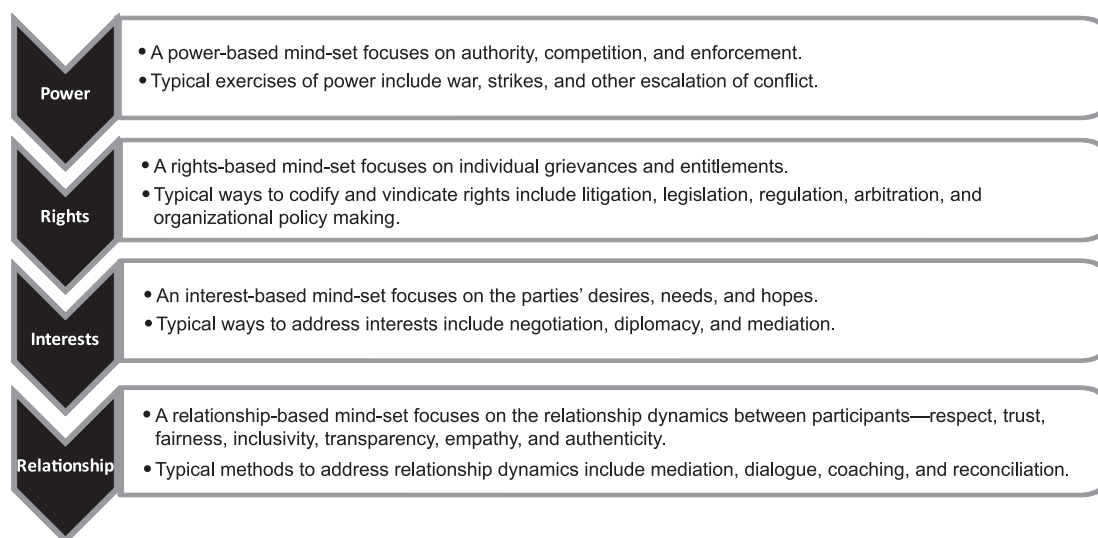
DSD experts recommend designing systems that provide participants the option to start with low-cost, informal collaborative methods for addressing their conflicts and that progressively offer more formal, rights-based methods as needed.[3,5] They also recommend providing "loop-backs" that allow the participants at any stage in the process to return to more informal methods (Figure 2, page 73).[3,5]

These core characteristics of well-designed systems are applied throughout this article to the design of effective conflict management processes for hospital leadership. Table 1 (page 74) lists recommended best practices in conflict management system design.

Developing a Shared Approach to Conflict

Team research supports the need for shared mental models and common language to accomplish group objectives effectively.[12] Without a shared model and common language for speaking about conflict, leadership groups are unable to work together to develop successful approaches for managing conflict. Core representatives of all three leadership groups might benefit from a collective, facilitated retreat as a first step in designing a conflict management process. A collective retreat focused on develop-

Typical Approaches for Resolving Conflicts

Power
- A power-based mind-set focuses on authority, competition, and enforcement.
- Typical exercises of power include war, strikes, and other escalation of conflict.

Rights
- A rights-based mind-set focuses on individual grievances and entitlements.
- Typical ways to codify and vindicate rights include litigation, legislation, regulation, arbitration, and organizational policy making.

Interests
- An interest-based mind-set focuses on the parties' desires, needs, and hopes.
- Typical ways to address interests include negotiation, diplomacy, and mediation.

Relationship
- A relationship-based mind-set focuses on the relationship dynamics between participants—respect, trust, fairness, inclusivity, transparency, empathy, and authenticity.
- Typical methods to address relationship dynamics include mediation, dialogue, coaching, and reconciliation.

Figure 1. *The mind-set of the participants determines the methods used to address the conflict and affects the way in which decisions are made and outcomes achieved. Conflicts can be resolved by exercising power, vindicating the rights of disputing parties, addressing each party's underlying interests, and fostering functional relationships between the parties in conflict. Adapted from a model developed by Dr. Phyllis Beck Kritek (used with permission) and from Costantino C., Merchant C.:* Designing Conflict Management Systems: A Guide to Creating Productive and Healthy Organizations. *San Francisco: Jossey-Bass, 1996, p. 45 (reference 3); Ury W.L., Brett J.M., Goldberg S.B.:* Getting Disputes Resolved: Designing Systems to Cut the Costs of Conflict. *San Francisco: Jossey-Bass, 1988, pp. 8–19 (reference 5); and Morris C.:* Definitions in the Field of Conflict Transformation. *2002. http://www.peacemakers.ca/publications/ADRdefinitions.html (last accessed Dec. 9, 2010).*

ment of a shared framework and a common language for collaborative problem solving and interest-based negotiation can form the basis for effective conflict management. A well-organized retreat could be a very positive first step, especially if hospital leaders have had little or no experience with or exposure to collaborative approaches to conflict or to alternative dispute resolution (ADR) tools.[13] The retreat could also serve as a time to review the conflict assessment (described in Part 1[2]) prepared before the beginning of process design, and leaders can use the time to designate a design team to develop a draft of their conflict management process. A critical goal of the retreat is to help the leaders build trust and confidence among themselves, as well as to learn new approaches. It is also very important that the conflict management system that leaders adopt reflects the mission and values of the institution as a whole, as discussed earlier.[2]

The Design Team: Identifying Conflict-Competent Individuals and Conflict Specialists

After a conflict assessment is complete and the leadership groups have accepted the findings, a few key representatives from senior administration, medical staff, and the governing body should work together to design the conflict management process. Having an inclusive and representative working group ("design team") is important to ensure that the respective interests are represented and that the process will ultimately work well for the individual institution. Depending on its members' skill sets, the quality of relationships at the institution, and the institution's needs and resources, this design team may wish to work with an outside consultant with expertise in conflict management in hospital settings. To the extent possible, the design team should build on existing strengths within the institution and develop an "incremental, experimental, reflective process consistent with the organization's goals and needs."[4(p. 156)]

The design team should begin by taking stock of individuals inside or outside the institution who have conflict management skills to assist in designing and implementing the process once it is adopted. In its Introduction to Standard LD.02.04.01, The Joint Commission states, "It is important that hospitals identify an individual with conflict management skills who can help the hospital implement its conflict management process."[1] The design team will want to consider how to identify and/or develop these conflict-competent individuals. Conflict competence

Progression of Collaborative Options in a Conflict Management Process
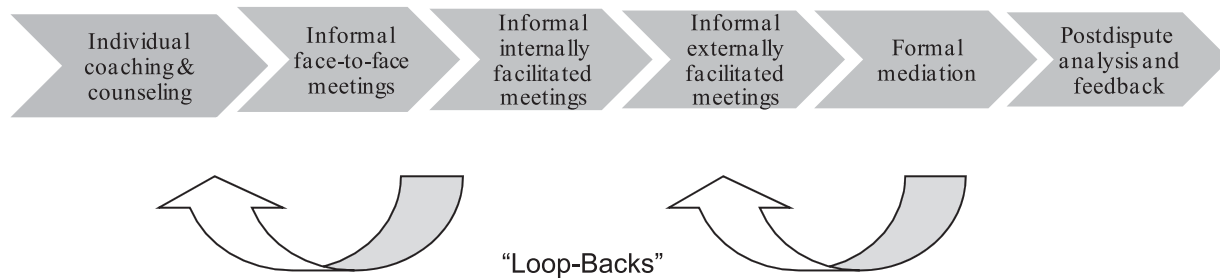
Figure 2. *These multiple options for managing conflict rely on interest-based, collaborative problem-solving methods and progress from more direct, more informal, and lower-cost processes to more formal structures. Conflict assessment (discussed in Part 1 of this series of articles) provides a foundation for effective integration of these approaches. At every stage, participants should be allowed to "loop back" to more direct, collaborative strategies. More formal (and costly) rights-based methods of dispute resolution are available through arbitration and litigation if the participants cannot resolve their conflict through these collaborative process options. Adapted from Costantino C.A., Merchant C.S.:* Designing Conflict Management Systems: A Guide to Creating Productive and Healthy Organizations. *San Francisco: Jossey-Bass, 1996, pp. 59–61 (reference 3); Ury W.L., Brett J.M., Goldberg S.B.:* Getting Disputes Resolved: Designing Systems to Cut the Costs of Conflict. *San Francisco: Jossey-Bass, 1988, pp. 52–56 (reference 5).*

ranges from novice to expert. Conflict-competent individuals may be naturally adept at conflict engagement, or, more likely, they may have honed their skills through experience and training. Individuals who have highly developed conflict-engagement skills or expertise—"conflict specialists"[14]—can be especially helpful at key points in the design and implementation of the process. Conflict-engagement specialists are professional practitioners with expertise in conflict theory and practice who work as mediators, facilitators, ombudsmen, conflict trainers, and coaches. Table 2 (page 74) lists core conflict competencies for health care professionals.

Individuals skilled in conflict management can come from the leadership groups or from other administrative areas, or they can be outside experts who are brought in to help with design and implementation. Although it is prudent to encourage all leaders to become conflict competent, it is advisable to have one or more clearly identified conflict specialists who can serve as a resource at any stage in the process and support leaders when conflicts arise. These specialists should have particularly good conflict management expertise and should undergo intensive training in communication skills, coaching, facilitation, and mediation. Some experts recommend developing at least one conflict specialist within the institution—sometimes called an "internal neutral"—who can be a champion for the process as well as ensure its successful implementation.[4] These professionals should also have the flexibility to be able to serve as internal counselors, coaches, facilitators, and mediators on

request. The typical characteristics of qualified conflict specialists are listed in Table 3 (page 76).

Components of the Conflict Management Process

Any new conflict management process for leadership should incorporate the minimum components required by Element of Performance (EP) 4 for Standard LD.02.04.01 (Sidebar 1). Although these components sound quite basic, they are contrary to how many conflicts are currently managed. The human tendency toward conflict avoidance often preempts early engagement in the issues, as we discussed in Part 1.[2] Many times, conflicts may be referred to a third party for adjudication or investigation rather than providing for a direct conversation between the conflicted parties. Attempts to smooth over, minimize, deflect, and work around the conflict are typical responses. By contrast, the approaches discussed in this article are intended to enable constructive engagement with, and, where possible, resolution of, conflicts among leadership groups.

The following tiered options, which reflect an expanded discussion of the identified minimum components for Standard LD.02.04.01, offer multiple options. These options rely on interest-based and collaborative problem-solving methods and range from more direct and less formal processes to more formal structures. At any step in a newly designed conflict management process, participants should be allowed to "loop back"

Table 1. Best Practices for Conflict Management Systems*
■ Inclusiveness and stakeholder involvement in system design
■ Multiple process options for participants to pursue, including ability to "loop back"
■ Focus on the interests and needs of the participants
■ Open communication and collaborative problem-solving approaches
■ Development of internal conflict specialist(s) to champion/ monitor/review system (e.g., "internal neutral," peer coach, ombudsman, mediator)
■ Assurance of voluntariness and confidentiality
■ Transparency, accountability, and continual refinement of the system
■ Education and training of stakeholders on using process options
■ Provision of adequate resources to support the system
■ Prohibition of retaliation and adverse consequences for using the system
* Adapted from Robinson P., Pearlstein A., Mayer B.: DyADS: Encouraging "Dynamic Adaptive Dispute Systems" in the organized workplace. *Harvard Negotiation Law Review* 10:339–382, Spring 2005 (reference 4) and Smith S., Martinez J.: An analytical framework for dispute system design. *Harvard Negotiation Law Review* 14:123–169, Winter 2009 (reference 16).

Table 2. Core Conflict Competencies for Health Care Leaders*
Competency in conflict engagement involves a range of abilities, which include but are not limited to the following:
■ Conflict analysis
■ Reflective practice
■ Negotiation
■ Communication skills (listening/acknowledging/reframing)
■ Giving and receiving feedback
■ Shared decision making
■ Debriefing and process evaluation
■ Group facilitation
■ Conflict dynamics
■ Mediation (or mediative techniques)
■ Conflict assessment
■ Conflict coaching
■ Agreement management
* Compiled from Mayer B.: *The Dynamics of Conflict Resolution: A Practitioner's Guide.* San Francisco: Jossey-Bass, 2000; Moore C.W.: Toward an excellent practice of mediation. In Moore C.W.: *The Mediation Process*, 3rd ed. San Francisco: Jossey-Bass, 2003, pp. 442–465; *Conflict Resolution for Managers and Leaders: The CDR Associates Training Package.* San Francisco: Jossey-Bass, 2007; Kestner P.B., Ray L.: *The Conflict Resolution Training Program: Leader's Manual.* San Francisco: Jossey-Bass, 2002; and Runde C.E., Flanagan T.A.: *Becoming a Conflict Competent Leader: How You and Your Organization Can Manage Conflict Effectively.* Hoboken, NJ: John Wiley & Sons, 2007.

to lower-cost, more informal, and more collaborative strategies. Figure 2 illustrates a progression of these steps and the opportunities for loop-backs. Sidebar 2 (page 77) provides an in-depth case study of conflict engagement for a large-scale system change and illustrates the variety of tools and processes, which we now discuss, that leaders can employ to manage conflict.

AVAILABILITY OF INDIVIDUAL COACHING AND FEEDBACK

Whenever a leader is experiencing a conflict with one or more other leaders, he or she should be able to approach a "peer coach" within the institution with whom to bounce off concerns and ideas and to gain some individual coaching or feedback. Peer coaching, a "developmental relationship with the clear purpose of supporting individuals within it to achieve their job objectives,"[15(p. 490)] is a voluntary, nonevaluative partnership between two professionals with similar levels of experience.[15] The expectation should be of complete confidentiality for coaching sessions. The peer coach should have an "open door" policy for these informal conversations, and all peer coaches should have foundational training in coaching techniques and best practices. Coaching is different from mentoring, and delineation of the role is important, particularly in the

context of conflict coaching.[15] Whereas a mentor serves in an advisory role, coaching is a collaborative process that relies on a coaching plan, distinct goals, and a non-hierarchical relationship.

There are various models for having "conflict coaches" available for individual coaching. Organizations may choose to identify a peer coach from each leadership group as a point person from whom members of each leadership group might seek support. One benefit of having three peer coaches representing the three leadership groups is to encourage conflict management skills and expertise across these leadership groups. Another benefit is that, at least in some cases, a leader who is seeking coaching may be more comfortable addressing his or her concerns with a colleague who shares a common background. Alternatively, a leader of one group may prefer to discuss concerns with a peer coach from another leadership group, providing that there are assurances of complete confidentiality. Criteria for developing a cadre of internal coaches should be explicitly outlined as part of any process design.

Access to an internal conflict specialist, such as an ombuds-

man, whom any leader might access, is another option. An organizational ombudsman is a "third party within an organization who deals with conflicts on a confidential basis and gives disputants information on how to resolve the problem at issue. The ombuds may also serve as a mediator."[16(p. 169)] An ombudsman may also help in systems thinking and design, developing procedures, and providing training.[17]

Alternatively, access to an external professional conflict specialist with coaching expertise can be made available to leaders. Conflict coaches provide assistance in developing conflict skills and in crafting effective approaches to conflict. Conflict coaching is an integral component of executive coaching. Professional conflict coaches are becoming more common as conflict specialists add this expertise to their professional service offerings.[18] The International Federation of Coaching provides guidelines for certified coaches.[19] Such specialists can in turn serve as mentor coaches for internal peer coaches.

INFORMAL FACE-TO-FACE MEETINGS

The underlying premise of a conflict management process should be that good-faith, genuine efforts should always be made to first discuss the conflict directly (face-to-face) by the involved individuals. To the extent that conflict training is undertaken broadly at the institution (Sidebar 2), leaders will have increased the individuals' collaborative problem-solving, communication, and conflict management skills to make this a productive and successful first step. The old-fashioned "cup-of-coffee" or "let's-have-lunch" conversations are good settings for these informal discussions and negotiations. In line with the recommendation of DSD experts to build in preventive methods for managing conflict,[3] focusing on this kind of informal discussion as an early step may be the best way to forestall conflicts and prevent escalations as hospital leaders gain increased skills and comfort levels with interpersonal conversations. Each face-to-face conversation serves as not only a learning opportunity but also an opportunity to strengthen relationships and build trust.

INFORMAL INTERNALLY FACILITATED MEETINGS

Obtaining the assistance of an internal third-party facilitator could be the next step if leaders find that their conflict is difficult to resolve directly with each other. Ideally, the facilitator should be mutually agreed on by all participants and should have skills in facilitating difficult conversations. Peer mediators or coaches may serve this function, as could an ombudsman. The facilitator should be able to draw from a range of different collaborative processes when convening an informal meeting

among leaders who are in conflict. These collaborative processes include dialogue, facilitation, mediation, appreciative inquiry, and coaching.

The facilitator should create an appropriate space for the meeting and establish group agreements, gather needed information, help set an agenda, enhance communication, and assist with scheduling. Although there is no single way to convene every meeting, some experts have outlined a step-by-step process that such an internal "intervener" might use to informally resolve the conflict.[20] Engaging leaders to address their conflict using any one of a range of informal methods is consistent with the DSD experts who recommend processes that "allow disputants to retain maximum control over choice of ADR method and selection of neutral wherever possible."[3(p. 132)] In the event that participants are unable to agree on an appropriate facilitator, the conflict management process can include a default provision designating someone from the governing body to select an appropriate meeting facilitator.

Consideration must also be given to the practicalities of employees facilitating conflict conversations among senior leaders, which could be awkward and have an inherent impact secondary to the reporting relationship. Hiring external consultants who are conflict specialists is increasingly common in health care organizations.

INFORMAL EXTERNALLY FACILITATED PROCESS

Depending on how high the stakes are, how complex the issues are, or how many members of each of the leadership groups are involved in the conflict, the next option would be for the leaders to consider whether it would be helpful to solicit the assistance of an outside conflict specialist who is experienced in facilitation and mediation in health care settings (Table 3).

Many consultants offer services to address complex conflicts among hospital leaders.* These professionals work with leaders within the hospital setting and may use assessment, coaching, facilitation, mediation, and dialogue processes as part of the overall intervention. The number of participants and extent of issues determine the type and duration of this option.

RIGHTS- AND POWER-BASED APPROACHES

The intent and scope of Standard LD.02.04.01 are aimed at

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* In addition to ADR training, the American Health Lawyers Association (http://www.healthlawyers.org) offers mediation, arbitration, and other ADR services, as do JAMS (http://www.jamsadr.com) and the American Arbitration Association (http://www.adr.org). A variety of consultants also offer conflict management services and training in health care.

Table 3. Characteristics of Health Care Conflict Specialists*		
Qualifications	**Qualities**	**Experience**
■ Training/education in conflict resolution and conflict management, group dynamics, conflict theory, facilitation, mediation, and coaching ■ Background in health care or other complex organizational environments ■ Ability to apply theories and social technologies to fast-paced, real-world situations ■ Ability to communicate, coordinate, plan, and strategize ■ Advanced conflict assessment skills with emphasis on appreciation of power imbalances, understanding of the impact of identity and culture on the conflict, existing conflict resolution practices, and awareness of how one's own response to conflict affects the process	■ An ability to model the constructive conflict skills, "to walk the talk" ■ A sense of perspective ■ Reflective capacity ■ Compassion ■ Ability to generate trust and create safe environments ■ Integrity in maintaining confidences ■ Improvisational capacity to adapt to frequent changes ■ An ability to move from the abstract to the concrete and back again ■ Knowledge of the current state of the mediation field ■ A desire and skill to coach others ■ A willingness to share control, to be flexible, and to collaborate ■ An understanding of and commitment to ethical practices ■ A sense of humor to lighten the challenge of facing difficult and uncomfortable situations	■ Working with complex factual situations and complex systems ■ Working with health professionals from frontline staff to senior leadership ■ Mediating and facilitating small and large groups ■ Working with co-mediators or other consultants ■ Performing conflict assessments ■ Working with diverse cultures ■ Integrating collaborative approaches with requisite legal requirements ■ Coaching individuals or groups using accepted coaching techniques practiced by certified coaches

* Conflict specialists may be internal or external to the organization. The characteristics in this table are derived from Hoffman D., Bowling D.: Bringing peace into the room: The personal qualities of the mediator and their impact on the mediation. *Negotiation Journal* 16(1):5–12, 2000; Mayer B.: *Beyond Neutrality: Confronting the Crisis in Conflict Resolution.* San Francisco: Jossey-Bass, 2004 (reference 14); Schön D.A.: *Educating the Reflective Practitioner: Toward a New Design for Teaching and Learning in the Professions.* San Francisco: Jossey-Bass, 1987; Lieberman E., Foux-Levy Y., Segal P.: Beyond basic training: A model for developing mediator competence. *Conflict Resolution Quarterly* 23:237–257, Winter 2005; Harges B.M.: Mediator qualifications: The trend toward professionalization. *Brigham Young University Law Review* 78:687–714, 1997; and Moore C.W.: Toward an excellent practice of mediation. In Moore C.W.: *The Mediation Process*, 3rd ed. San Francisco: Jossey-Bass, 2003, pp. 442–456.

informal and direct methods for managing conflict. The standard strives to prevent escalation to formal legal disputes and encourages leaders to overcome their conflict-avoidance tendencies through the use of well-designed approaches that support engagement with conflicts. Of course, there will be disputes in which legal rights are the primary focus. For such disputes, well-established processes such as evaluative mediation, arbitration, and litigation remain as options.

The governing body has the authority and the responsibility to decide the ultimate resolution of any conflict that threatens the quality and safety of patient care. If resolution cannot be reached after genuine, good-faith attempts under interest-based, collaborative problem-solving approaches, which is the model encouraged here, the governing body has the power to impose a resolution, or the parties can resort to an adjudicated determination of their rights.

POSTDISPUTE ANALYSIS, FEEDBACK, AND REFINEMENT

To encourage follow-through, identify lessons learned, and prevent future conflicts, DSD experts recommend evaluation and feedback after a conflict has been resolved[3,5] (Figure 2). All conflict management processes—whether they be coaching, face-to-face negotiation, facilitation, or mediation—should incorporate a method for evaluating both the process and the progress made by participants after the process is completed. There should be regular opportunities at leadership meetings to identify and discuss conflicts that have been addressed using the system. A "Conflict M & M [mortality and morbidity conference]" to debrief significant conflicts is an effective means of learning from the conflict, as well as evaluating the effectiveness of the process used and the individual skills of the participants. Health professionals should take advantage of the opportunity to debrief conflict situations as a beneficial tool for learning and

Sidebar 2. Case Study: Managing Conflict Associated with a Clinical Information Technology Implementation Project

Background: The board of directors at Halcyon Hills Medical Center is eager to position its organization to obtain funding and to avoid potential penalties under the ARRA HITECH Act[1,2] by demonstrating to CMS "meaningful use" of the organization's clinical information technology (IT) system. (The HITECH Act established a set of incentives and penalties for adoption and use of certified electronic health record systems.) A vendor selection process has been completed, physician champions have been designated in the various specialties, an operational steering committee has been created to oversee design and implementation, and the IT department leadership has lined up an expert team of clinicians and implementation specialists, programmers, and designers.

Potential for Conflict: The board recognizes the immense cost to the organization if the implementation is not successful or if clinician use of the system does not achieve the benchmarks designating eligibility for the incentive payments. To address the risks, the board anticipates the high probability of conflict associated with the culture change, work-flow redesign, and clinical practice changes required for successful adoption of the new technology.

Conflict Management Plan: Working with a conflict specialist, the board and the project leaders adopt the following conflict management plan as a component of their overall project plan:

Assessment and Postdispute Evaluation:
■ Embed a conflict assessment as a component of the readiness assessment before project kickoff, including the following:
  –Evaluation of current relationship dynamics among leadership groups that could affect the project
  –Evaluation of conflict competence within the project governance teams
  –Evaluation of current processes for addressing conflicts across departments and among the various physician groups
  –Evaluation of existing or residual conflicts that could derail the project
■ Integrate a process for postdispute analysis with feedback to relevant stakeholders to improve communication and decision making across the involved service areas.

Coaching and Training:
■ Incorporate a conflict coach to work with project leaders, governing team members, and board members as needed during the implementation and adoption phases.
■ Incorporate conflict training as a part of the project plan for key participants (e.g., project leaders, super-users, clinical implementation team, physician champions).

Informal Face-to-Face Meetings, Facilitation, and Mediation:
■ Develop and get agreement on a clear conflict management process as a key component of the governance plan to address internal conflicts as they arise.
■ Address existing conflicts among key stakeholders that may derail the implementation.
■ Designate skilled facilitators who will work with clinicians and other end users to develop consensus around practice protocols, workflow design, consistent adoption of best practices, discussion of practice variation, integration of community physicians, and compliance with regulatory standards.

Formal Mediation:
■ Include mediation clauses in vendor/partner contracts.
  (Note: conflict management techniques have been used by the construction industry to provide a means of addressing conflicts in real time in order to avoid litigation, project delays, expensive buy-outs, and project overruns.)[3]

References
1. American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, Feb. 17, 2009. http://www.recovery.gov/About/Pages/The_Act.aspx (last accessed Dec. 8, 2010).
2. Centers for Medicare & Medicaid Services (CMS): *EHR Incentive Program.* http://www.cms.gov/EHRIncentivePrograms (last accessed Dec. 8, 2010).
3. Heley M.J.: Mediation of construction cases using "blind negotiations": Can providing less information generate better results? *William Mitchell Law Review* 34(1):273—301, 2007.

This conflict management plan illustrates how leaders can use the range of approaches outlined in Figure 2 to prevent conflict from escalating and to support real-time conflict engagement during large-scale change initiatives. The plan also incorporates conflict assessment at the outset, which is a process described in more detail in Part 1 of this series of articles. ARRA, American Recovery and Reinvestment Act; HITECH, Health Information Technology for Economic and Clinical Health; CMS, Centers for Medicare & Medicaid Services.

developing conflict competency.[21] There also should be ongoing periodic evaluations of the efficacy of the processes, coaches, and facilitators. Such ongoing feedback and evaluation are necessary to create and maintain trust in the conflict management process, as well as to ensure its effectiveness. Using the lessons learned from actual experience with the process allows leaders to continually refine and improve it.[4]

An effective conflict management process depends on robust communication and the creation of an environment that encourages full discussion of differing viewpoints. To support this environment of open communication and collaborative problem solving, DSD experts strongly recommend that organizations prohibit retaliation for participating in or initiating any process.[4] For individuals to trust the process and one

another, actions should be taken to address instances of retaliation or adverse repercussions associated with use of the conflict management process.

Finally, Standard LD.02.04.01, EP 5, requires that the newly designed conflict management process actually be implemented when it is needed. It is not enough merely to write the policy. It is essential that leaders find the courage to overcome conflict-avoidance tendencies and use the process to address their conflicts when necessary.

Training and Education to Become Conflict Competent

The Joint Commission acknowledges that conflict management skills can be obtained through various means, including experience, education, and training. The leadership chapter states, "If the hospital chooses to train its leaders, it may offer training sessions to key individuals or bring in experts to teach conflict management skills."[1] For long-term successful implementation of a credible enterprisewide conflict management process, leaders themselves must have and model constructive conflict skills, particularly during high-profile conflicts[22] (Table 2).

Training should be encouraged or required for representatives of all leadership groups. Leadership's failure to adopt and demonstrate good communication and conflict management skills undermines the success of the organization to manage conflict at all levels. Moreover, without a conflict-competent leadership, others receiving training to promote these skills are unlikely to find a supportive environment in which leaders back up their attempts to engage. Creating a foundation of motivation, skills, and resources is the role of leaders and an essential component of effective conflict management.[3,5]

ONGOING EDUCATION

The senior administration, medical staff, and governing board should be encouraged or required, as finances permit, to attend programs addressing conflict styles, conflict-engagement techniques (including collaborative problem solving and interest-based negotiation), relational dynamics, and communication skills. Such training should do the following, as stated elsewhere[22]:

■ Incorporate established theories and practices from the field of dispute resolution

■ Be customized to be relevant and meet the needs of health professionals

■ Use established training techniques that are effective for developing conflict competency

■ Make use of qualified and effective conflict trainers and coaches

Whether the leadership groups should attend separate training sessions tailored to their respective needs and responsibilities or whether they should attend educational programs together depends on the wishes and finances of each institution. Facilitating conflicts between others, as well as managing one's own conflicts, are core competencies for hospital leaders and senior health professionals. Individuals will vary from novice to expert in their levels of conflict-engagement skills, and training should be appropriately targeted to their different levels of expertise and experience with conflict engagement. Follow-up coaching can help with the transfer of newly learned skills from training to the workplace. Advanced training programs—including coaching and mediation training—will probably be reserved for those serving as internal "conflict specialists" or peer coaches, who are most likely to employ such skills on an ongoing basis.

PHYSICIAN TRAINING

Physicians' historical lack of interest in, and their lack of self-perceived need for, communications skills and conflict management training is well documented.[23,24] A cardiac surgeon reportedly said, "I would rather be up all night for seven days in a row than to be trapped in a room with my peers talking about how we can do a better job communicating."[25(p. 8)] Yet, conflicts involving the medical staff are likely to directly and adversely impact patient care and patient safety. Fortunately, increased emphasis on communication and collaboration skills by The Joint Commission and leading medical education organizations has led to increased focus on and physicians' requests for conflict training.[26,27] There are also recent signs of acceptance within the academic medical communities of the need for communication skills training among physicians, which may have reached a "tipping point" that signals a more widespread acceptance among physicians in the near future.[28]

Providing training first to those medical staff members who are most likely, by virtue of their reputation and stature at the hospital, to be influential with other physicians encourages collaboration and proactive conflict management through the creation of physician champions and supports participation by other physicians.[29] Using this kind of influential peer behavior—often called "social proof" in the social sciences—can improve the chances for successful implementation of the conflict management process among the hospital's medical staff leaders.

Because physicians are trained largely through role modeling

and mentoring during their formative years, some experts recommend taking a train-the-trainer approach, so that senior physician leaders can effectively model constructive conflict management behaviors for other physicians in the institution.[30] Pairing training with peer coaching is highly effective. The training should be relevant and customized to meet the needs of busy clinicians, be congruent with their learning styles, and build on skills they already have developed.[21] Given the educational and professional backgrounds of the medical staff leaders and senior management, training and coaching should be done by those who are familiar with the dynamics of contemporary hospitals, and often it is beneficial if the trainers are health professionals themselves.

Educating Leaders About the Conflict Management Process

Everyone in the three leadership groups should be made aware of the hospital's new written conflict management process (and policy) after it is it is approved. Efforts to ensure awareness should be comprehensive and efficient. It might be helpful to have a one-page statement documenting the hospital's commitment to its mission and values through a successful conflict management process among hospital leaders and outlining the steps in the process. This simple statement could be given to the leaders and posted in the main boardroom and administration conference rooms as a strategic reminder of the institution's alignment of its mission with its conflict management process.

How the hospital's leadership manages conflict will have ripple effects throughout the institution. Creating a process that models the type of conflict engagement that is supportive of safe patient care is a powerful means of improving conflict management at all levels of the organization. The breadth and generality of Standard LD.02.04.01 and its EPs are beneficial because they allow organizations to develop approaches that best fit their resources and culture. This is not a one-size-fits-all process. As organizations develop effective approaches, it will be useful for them to share their insights with other organizations. Conflict management is a difficult aspect of governance. To the extent that leadership groups are able to find effective processes that restore trust and protect professional reputations, patients and health professionals alike will benefit.

Conclusion

This two-part article has proposed a strategic framework for hospitals to comply with Standard LD.02.04.01, which requires hospitals to manage "conflict between leadership groups to protect the quality and safety of care." Every hospital has unique needs, and every conflict management process must be tailored to individual circumstances. Our recommendations are intended to provide an appropriate starting point for designing an approach tailored to each hospital which meets the stated requirements for the new accreditation leadership standard. The recommendations can be adapted and incorporated in other, more comprehensive conflict management processes throughout the hospital. Expanding the conflict competence of leaders to enable them to effectively engage in and model constructive conflict-handling behaviors will further support the strategic goal of providing safe and effective patient care. **J**

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