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Overcoming Barriers to Change

***261** PREPARING PHYSICIANS TO MANAGE CONFLICT, OR, HOW THE PHYSICIAN LEADERSHIP
COLLEGE TEACHES PHYSICIANS TO USE INTEREST-BASED PROCESSES

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I. Abstract

The nature of physicians' mental models derived in part from their training, makes it harder for them to participate in interest-based approaches to resolving conflict. A study of the Physician Leadership College at the University of St. Thomas, Minneapolis, suggests some of the causes of physicians' aversion to engaging in interest-based problem solving, and a way to correct this weakness. Physician education may be important for physicians if they are to be included in top-level leadership, and may be essential for developing their ability to collaborate and resolve problems based on meeting interests of key stakeholders.

The necessity of managing conflict and working in a collaborative manner in health care organizations has become apparent, as it was demonstrated at the Fall 2007 Biennial Symposium on Conflict Resolution: "An Intentional Conversation About Conflict Resolution in Health Care", at Hamline University. Health care personnel and conflict management experts met to explore the need for and possibilities of improving conflict management in health care organizations. This interest is reflected in the recent literature [\[FN3\]](#) and can be summed up in the following ***262** quotation: "In today's healthcare environment, handling conflict appropriately is a crucial part of developing healthy work environments and fostering productive working relationships." [\[FN4\]](#)

Physicians are obviously key stakeholders in health care. One of the factors in managing conflict in health care is the ability of physicians to participate in interest-based processes. We define interest-based processes as those which aim to satisfy the interests of all involved parties, to the extent this is possible. We do not claim that all conflict has to be resolved in an interest-based manner. However, inability to use interest-based approaches in resolving conflict makes one unable to participate effectively in modern conflict management processes, such as principled negotiation and mediation. Research suggests that physicians might have tendencies that actually make it harder for them to use interest-based conflict resolution processes such as principled negotiation, mediation and collaborative decision-making. [\[FN5\]](#)

We want to be clear that physicians are not the only potential health care leaders who may require education before they are able to use interest-based processes effectively. However, because the focus of our research was on physicians, we will explore their ability to use interest-based processes in health care. There are two major barriers to successful conflict management: individual and organizational. In this article we explore both ***263** individual and organizational barriers for physicians in leadership positions.

Let us note that we are using “interest-based processes” to refer to collaborative work as well as to conflict management. Both draw on the same concepts, and we imagine them as two sides of the same coin. Collaborative decision-making, which entails working to make sure all interests are met, is a proactive and positive approach. When conflict occurs, conflict management uses interest-based approaches for the purpose of resolving disputes. We define conflict management as responding to conflicts in ways that are, at least at first, interest-based in their nature. These interest-based ways of responding include conflict resolution and alternate dispute resolution. In our experience, conflict management and collaborative decision-making have the power to reinforce each other in the workplace. In both, people try to meet the interests of all parties. We write as academics, who teach and research about conflict and organizational change, and also as practitioners, who consult with conflict in organizations, including health care organizations.

II. Individual Barriers

We will use the study [FN6] that was conducted to assess the outcomes of the Physician Leadership College (PLC) at the University of St. Thomas, Minneapolis, Minnesota to shed light on the ability of physician leaders to engage in collaborative decision-making and other interest-based processes. Two of the assumptions of the PLC design were that physicians are not nearly as self-aware as they should be, and nor are they particularly good listeners. The study's findings supported these assumptions. These findings are consistent with other observations that the physicians may not be very self-reflective, and that they may have been trained not to listen well beyond what is required in ***264** diagnosing an illness. [FN7] Poor reflection and listening skills have implications for physicians' ability to work collaboratively and to use interest-based procedures for decision-making or conflict resolution.

A. Self-awareness

It was assumed that a physician whose self-awareness was low was the result of a lengthy and difficult educational formation, in which the physician was mastering the knowledge and skills needed to become a physician. In addition, the medical practice is extremely demanding in terms of time and of mental and emotional energy. Physicians work extremely hard, which leaves little time to develop the ability to be self-reflective. Long working hours and tension in maintaining work-life balance are commonly reported side effects of the time demands on physicians. It takes time and effort to develop a strong sense of one's inner self, and the physicians have not had the time to engage in such work.

In any conflict or negotiation, to reach a “win-win” outcome in other words to meet each party's interests, people have to know their own interests. In our experience, identifying all of one's interests is not a simple task. The more one understands one's self and has the habit of introspection; the more one is able to discern and give voice to one's own interests.

B. Listening

Physicians also tend not to be good listeners. According to interviewed physicians, they were taught to know “what is right” in medical school and residency. They meant that there was one best way to treat patients, and this became the right way. Knowing the right way was important, because of their intense desire to help the patients. Not knowing the right way might lead them to hurt *265 patients. The habit of seeking the objective right way to treat patients seeped into their world-view, and they behaved in non-medical situations as if they knew the right way, and so frequently were not open to listening to others. Research shows that most physicians can come up with two or three possible diagnoses within minutes of meeting a patient. [FN8] Once the physician knows the answer, or the diagnosis, which is the purpose of the physician-patient conversation, a physician ceases to listen, or stops listening. The other reason for the cessation of listening could come from the intense time pressure felt by many physicians, because they have to tend to more and more patients to meet the demands of health care organizations. Physicians have reported to us that this habit of listening often spills over into the rest of their lives.

Time pressure and physicians' belief that they know “what is right” have the potential to stifle interest-based processes. An interest-based process is based on the premise that two or more people working together can be creative in finding ways to meet each other's interests. However, when physicians feel pressured for time, it becomes harder to brainstorm ideas. Also, if a physician has the mindset which is honed in medical training and practice, and believes that she or he knows what is right, then there is little incentive to listen to others. We assume this is not a conscious behavior of physicians; however, their medical training, which has formed their attitude about being right, has in turn shaped the physicians' attitudes towards listening.

It is common knowledge that listening is a key element in interest-based processes. Active listening, in which one makes sure that he or she understands the other and communicates that understanding to the other person, is a frequent tool used in conflict management. Such listening helps to discover the other's interests, as well as to develop a process in which people feel more respected and trusted. While trust is not necessary for negotiation to be effective, it is very helpful for maintaining positive working relationships, which is the exact kind of relationships needed for *266 physicians in leadership roles. Developing better listening skills would help physicians work more collaboratively, and manage conflict in an interest-based manner.

C. Administration skills

Physicians were not trained to be business administrators. They did not receive training in finance, human resource management, law, marketing, or strategic planning. Lack of awareness in these fields makes it harder for physicians to be involved as health care leaders with responsibility for administrative decision-making. Summary education about the mentioned topics may result in physician leaders becoming much more confident and participative in these leadership roles. Understanding business is not required for managing conflict in health care. But when the conflict involves business practice, lack of knowledge of business concepts limits physicians' participation in interest-based conflict management processes. The same can be said for collaborative decision-making.

III. Organizational Barriers

A. Conflict of espoused values and deep beliefs

Having said all of the above, we can expect that many physician leaders are not readily prepared to understand the need for conflict management in the workplace, nor to understand the importance of changing the organizational culture to support interest-based approaches. These claims deserve explanation.

People have a set of espoused values, and a set of deep beliefs. The espoused values are what people profess to believe and generally people are convinced that they do behave in accord with their espoused values. Deep beliefs are often unconscious and usually drive people's actual behavior. These are what *267 Argyris [FN9] called "theories-in-use." It is common for espoused values and deep beliefs to be in conflict, without the person being fully aware of the conflict.

We have observed that physicians often espouse values that are supportive of collaboration and interest-based problem solving. We have also frequently observed that these same physicians did not behave in accord with these espoused values, but rather they behaved in accord with the governing values shaped by their deep beliefs that form theories in use. For example, we worked with one group of physician leaders, training them in conflict management concepts and skills. The training was well received, and the participants professed that they were ready and willing to use the concepts. Later in the year we heard of one business unit in which the conflict level was high, which led to high turnover. Yet these same physician leaders did not use their knowledge of interest-based processes to address the conflict. They ignored the conflict. We assume that these leaders were not even aware that they acted in a manner contradictory to interest-based processes.

Why is it likely that physicians do not live up to the espoused values of constructive conflict resolution? There is an individual and an organizational reason. The individual reason is that under pressure people are much more likely to resort to core beliefs rather than to espoused values. Many physicians are under stress, work long hours and deal with the continuing failure to adequately fund health care. The physicians often have an inadequate understanding of the business and administrative processes in their organizations, and therefore feel left out of decision-making process. This feeling coupled with stress makes it hard for physicians to embrace, promote, and model a new way of thinking.

The organizational reason is that often, when employees are trained in interest-based processes and are eager to use them, the existing culture of the workplace does not allow them to apply *268 new skills. Schein says that training often fails when participants return to their cultures that are not supportive of newly learned concepts, values and assumptions. [FN10] If the culture of an organization is resistant to change, then this resistance may reject innovations. To reach sustainable organizational change, it is necessary not only to change the beliefs of the participants, but also the culture of the organization.

In order to change the culture and make an organization receptive to interest based processes, the leaders have to model these processes and live up to the espoused values of collaboration and conflict management. The leaders have to understand interest-based processes themselves and then promote their use in the organization by educating and training employees. Leaders also have to put in place systems to assist people to resolve conflicts as well as the reinforcements to encourage people to continue to use interest-based processes. Employees should have hope that these systems are safe enough to try and that employees will benefit from interest based problem solving. If top leaders do not model new behaviors and attitudes to constructive conflict resolution, interest-based processes will most likely fail to reach their potential.

Physician leaders may well espouse interest-based approaches to problem resolving, but their espousal may

have little effect until their deep beliefs change, and they begin to model the values that they espouse. Without this modeling, any other attempts at culture change will probably fail.

IV. Preparing Physicians To Use Interest Based Processes

The Physicians Leadership College curriculum was designed to educate physicians to become leaders in health care organizations. The educational content stressed the use of *269 dialogue, adaptive and servant leadership, principled negotiation, and developing reflective skills, as well as an introduction to administrative skills. Successful leaders have to be able to respond effectively to the rapidly changing circumstances that characterize modern health care. If leaders are unable to see that change is needed, and that this change must be created collaboratively, then the leaders will fail. Physicians in PLC learn about leadership through the lens of Heifetz's work, which encourages a shift from authoritarian form of leadership to an adaptive one. The point is that leaders must give up the practice of being the expert who provides solutions, and involve others in the collective development of solutions to business problems. Becoming an adaptive leader is not easy, partly because being the expert who provides solutions is what promoted many physicians to their leadership positions in the first place. As Heifetz says:

The locus of responsibility for problem solving when a company faces an adaptive challenge must shift to its people. Solutions to adaptive challenges reside not in the executive suite but in the collective intelligence of employees at all levels, who need to use one another as resources, often across boundaries, and learn their way to those solutions. [FN11] In other words, to be a successful adaptive leader one has to be able to collaborate.

The core idea of the PLC program is that an effective leader has to be in harmony with one's self as well as others. Therefore, physician leaders must be able to listen well to others and to their own selves. Physicians in the program grew significantly in their ability to listen to others without judging what they heard, and without ceasing to listen before the other party *270 finished talking. Physicians also grew in their ability to be introspective, listening within more profoundly than ever before. This self-reflection increased the physicians' ability to identify their needs and desires, or in conflict management jargon, their interests. Both the skills of self-reflection and good listening are important in using interest-based processes.

However, educating individuals does not often lead to organizational change. Since 2000, graduates of the PLC have been returning to their workplaces with the intention of applying new knowledge and skills. In spite of the fact that organizations are resistant to innovation, there have been positive changes in some organizations. Two health care organizations stand out. One is a major hospital that had a large number of physicians attend the PLC program. As a result the hospital developed a Clinical Council in which physicians and administrators work together, sharing information and collaboratively making decisions. [FN12] The other is a health care system that had over 20 physicians attend PLC. These physicians are now part of a major effort to change the culture of the organization to one that is more collaborative.

V. Conclusion

Two barriers can prevent physicians from being effective in making collaborative decisions, and in managing conflict. The first barrier is the inward barrier, the habits and mind-sets that prevent a person from listening well, or being self-reflective. This barrier can be overcome through education, as in programs like the PLC. The second barrier is organizational. The organization must also change its culture so that the individuals' new

skills can thrive. It is possible for organizational culture to change, but it requires modeling of the new practices by leaders. This brings us full circle. Leaders are individuals, and when leaders model new behaviors then organizational culture changes, which in turn *271 encourages new behaviors on the part of all members. For health care to embrace fully the use of interest-based processes, physicians' beliefs and organizational cultures have to change.

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