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Hamline Journal of Public Law and Policy
Spring 2008

Special Feature:

Fall 2007 Symposium on Advanced Issues in Dispute Resolution

What Makes Health Care Conflicts Different?

***243** THE INEVITABILITY AND PERILS OF 'INVISIBLE' HEALTH CARE CONFLICT

David Matz [FN1]

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We know that every organization generates a lot of conflict among the people who work in it. When we say that, we usually refer to any of three kinds of conflict:

a) Those that wind up in formal proceedings (hearings, meetings);

b) Those that collide with our lives (someone won't talk to us; two of our supervisees constantly bicker); or

c) Those we hear about via gossip, often concerning people higher up the bureaucratic ladder.

In addition, if we are professionally or personally prone to think about organizations and conflict, we know that in addition to "a", "b" and "c", there must be much more conflict - conflict that remains out of our experience or vision. We conclude this because so many people working together must exhibit a wide variety of interests, those interests must collide, and many of those collisions must generate the heat that turns them into conflicts. [FN2]

This last category of conflict I am calling "invisible conflict." "Invisible" means that almost no one other than the parties knows that the conflict exists. Kolb calls this "hidden conflict," which seems to emphasize the intent of the parties to keep the process secret. [FN3] I agree that keeping the conflict away ***244** from the awareness of others is often one characteristic of the conflict I am focusing on, and there will be occasions when keeping it hidden is a central feature. But I am hypothesizing that these conflicts are invisible for a number of reasons, intent being only one possibility, and I do not want to label the behavior in such a way as to make intent the inevitable centerpiece. The key point is that the conflict occurs and that it is unknown both to the level of management that might otherwise be able to do something about it, and to those who work with the parties.

This essay will begin to build a hypothesis about invisible organizational conflict, and then it will present some methods for testing the hypothesis. My interest in this question arose from contact with a hospital department in which all patients are high risk, many professional decisions are fraught with life and death meaning, and time is always of the essence. My hypothesis will thus be built about such a culture. As most of us do not work in life-and-death situations, some characteristics of this setting will be atypical, but this still leaves the

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question: are lessons from this setting applicable to others?

The first element of the hypothesis is that there is a lot of invisible conflict. This occurs because there are many interactions among highly trained, highly-strung, ambitious professionals, among whom status and experience levels are not always well correlated, working in tight time constraints on problems with high stakes both personally and professionally.

Second, most of the conflict is “negotiated”, more or less consciously, by the parties, and thus has no continuing impact on professional performance. [FN4] “Negotiation”, in this usage, can take place in a moment, can be non-verbal and depend on an exchange ***245** of behaviors, and can be done by parties without their realizing they are doing it.

Third, much conflict is negotiated, but some of it nonetheless leaves a residue of sensitized feeling which can be aroused by a future event.

Fourth, some conflict, when not negotiated and resolved, instead starts a fall of dominoes. These dominoes can take the following directions:

a) The parties' ability to communicate with each other is impaired or ruptured so that key information is not transmitted with adequate clarity or adequate timeliness.

b) One party gives inadequate weight to the judgment of the other thus distorting the professional action of the first or the professional impact of the second.

c) When the parties are required to work as a team their intuition about the work of the other is impaired.

d) Those who work immediately around the parties are impacted, even though, according to the hypothesis, they don't know of the conflict.

Fifth, because the conflict is visible to no one aside from the parties, the number of people who can take responsibility to contain or resolve it is sharply limited.

Sixth, there are many pressures in the organization that work to keep the conflict invisible: these may tend both to contain and resolve it, or to keep parties from focusing attention on it, allowing it to fester. Some pressures that will do this include:

a) The culture disfavors ‘whining”;

b) The level of authority that influences advancement and preferment disfavors “whining”;

c) The time pressure on professional work does not allow leeway for confronting the conflict;

d) The requirements of teamwork (civility, sharing, and trust) override the impulse to confront the conflict;

***246** e) Allowing a conflict to become public suggests that one can't “handle it” alone, a significant weakness in a culture of competence;

f) There is a widely shared clarity about decision-making authority even when the decision made and the person making it is resented.

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And seventh, and by far the most important, the cascade of dominoes caused by conflict not negotiated or resolved can result in professional error and harm to a patient. It is the possibility of this last that justifies an investigation. There are potentially two kinds of error here. There is the violation of accepted standards (e.g., wrong dosage), and there is the use of judgment that is defensible but not as good as other judgment.

The primary research question raised by my hypothesis is this: does conflict lead to medical error often enough to suggest that there should be intervention to manage such conflict? There are a number of ways to prevent medical error, and the very invisibility of conflict makes intervention to keep it from leading to medical error very difficult. Intervention will be justified, therefore, only if there is evidence that the problem is quantitatively significant. (What constitutes a significant level is of course a key question but outside the scope of this effort.) Again, invisibility will make it difficult to assess quantity with any precision, but that does not mean it is impossible to begin estimating.

How to learn about these hypotheses? How to find the invisible and how to trace its path through organizational functioning? How to do so without disrupting the health care work of the professionals and without inflaming a modest conflict into a major one by inquiring about it? As the core concern and hypothesis is that medical error results from some of these conflicts, how to follow a conflict to see if it produces error, or how to work backward from an error to see if it resulted from a conflict? As a medical error will often be the result of many causes, how to isolate one of them, a preceding conflict?

***247** Four methods are proposed to begin a sketch of this issue. First, identify one area where the culture says there is endemic conflict: in this case, the relationship of residents to nurses. Nurses ordinarily have experience (both as professionals and in that institution) well beyond that of residents, but residents often outrank nurses in decision-making authority. The gender issue, though in some state of transition, is not irrelevant. A survey of nurses and residents can start to tease out the areas of conflict and the methods of coping with them; this can be followed by a discussion with some of the nurses and residents to dig deeper into issues raised in the survey. This may bring out conflict stories; it will be less likely to surface the chain of causation, as few individuals ever get to see the whole chain in action.

Second, one way to skirt the desire not to be a tattle-tale is to prompt employees with hypothetical stories of conflicts, and to ask how they would handle the situation, or how they would expect others around them to handle them.

Third, some players may be willing to tell lengthy stories showing the chain of events from conflict to error. They are more likely to be managerial, or the few individuals with a penchant for seeing the big picture and

Fourth, an organizational anthropologist can study a hospital and create a multitude of access points to watch a conflict evolve via personal interaction, phone, email, eyebrow, and silence. This is expensive and will still leave blind spots, but it is the one method not totally dependent on self-report.

None of these methods is perfect, of course, but in combination they have been used to elucidate patterns, to give support to hypotheses, and to reveal patterns not anticipated. [FN5] At ***248** the bottom, the purpose of all methods is to make findings that show a causal link from conflict to error with sufficient frequency that a manager will feel justified in taking remedial action.

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[FN2]. For purposes of this essay I will say that conflict exists when people experience real or perceived differences with others in their organization, and when those differences engender emotion, and influence the behavior, of any of those people.

[FN3]. Deborah M. Kolb & Linda L. Putnam, Introduction, The Dialectics of Disputing, in Hidden Conflict In Organizations: Uncovering The Behind-The-Scenes Disputes 19 (Deborah M. Kolb & Jean M. Bartunek, eds., Sage Publications, 1992).

[FN4]. See Calvin Morrill, The Private Ordering of Professional Relations, in Hidden Conflict In Organizations: Uncovering The Behind-The-Scenes Disputes 92 (Deborah M. Kolb & Jean M. Bartunek, eds., Sage Publications, 1992).

[FN5]. See generally The Disputing Process-Law in Ten Societies 1-11 (Laura Nader & Harry F. Todd, Jr. eds., Columbia University Press, 1978).

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