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CHAPTER 14 Conflict Management and Negotiation Skills

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LEARNING OUTCOMES

After completing this chapter, the student should understand:

- ☛ The definition of conflict.
- ☛ The four basic types of conflict.
- ☛ The five levels of conflict.
- ☛ The five conflict-handling modes.
- ☛ The three major negotiation models.

OVERVIEW

Conflict is inevitable and unavoidable because it is a natural part of human relationships. It is a part of our everyday professional and personal lives, and therefore, it is inherent in any type of work setting (Thomas, 1976). Although there are numerous definitions of conflict, Thomas (1992) suggests that there are three common components to most definitions: (1) perceived incompatibility of interests, (2) some interdependence of the parties, and (3) some form of interaction. For example, Rahim (1985) defined conflict as an "interactive state" manifested in disagreement or differences, or incompatibility, within or between individuals and groups. For our discussions, we will define conflict as occurring when an individual or group feels negatively affected by another individual or group.

No organization is exempt from conflict; however, the healthcare setting has been referred to as one of the highest conflictual environments because of factors such as high stress, high emotions, scarce resources, competition, downsizing, mergers, excessive regulations, diversity and cultural issues, and multiple stakeholders' demands. These factors increase conflict in organizations (Gardner, 1992; Johnson, 1994). For example, research has shown that managers, both healthcare and nonhealthcare, spend an average of 30 percent of their time dealing with conflict, and this is frequently cited as one of the least enjoyable aspects of their leadership roles (McElhaney, 1996; Robbins, 1990; Shelton & Darling, 2004; Thomas & Schmidt, 1976).

It is important to note that conflict does not necessarily lead to ineffectiveness. Conflict, like stress, can either be positive or negative. Positive conflict can act as a stimulus for positive change. Positive or constructive conflict can lead to creative problem solving and alternatives, increased motivation and commitment, high-quality work, and personal satisfaction (i.e., functional outcomes) (Cosier & Dalton, 1990). However, negative or unconstructive conflict can be counterproductive for an organization by diverting efforts from goal attainment (i.e., dysfunctional outcomes). Negative conflict may also affect the psychological well-being of employees. If severe, unconstructive conflicts may result in employee resentment, tension, and anxiety, which may lead to low-quality work, personal stress, and possible sabotage. For example, it is estimated that over 65 percent of performance problems result from strained relationships and that conflict accounts for up to 50 percent of involuntary employee departures (Dana, 2000; Watson & Hoffman, 1996). Negative conflict may create an organizational culture of competition versus cooperation, thereby eliminating the sustainability of supportive and trusting relationships, which are necessary for successful organizations (Baron & Richardson, 1990). For example, Forte (1997) points out that in clinical environments,

conflict among healthcare professionals can be counterproductive with respect to patients, which can result in increased mortality and morbidity rates due to medical errors.

Lewicki, Weiss, and Lewin (1992) identify six major areas in conflict research: the microlevel (psychological) approach, the macrolevel (sociological) approach, the economic-analysis approach, the labor-relations approach, the bargaining and negotiation approach, and the third-party dispute approach. The microlevel approach includes research on factors that affect intrapersonal and interpersonal conflict (i.e., within and among individuals), whereas the macrolevel approach focuses on factors affecting conflict among and within groups, departments, and organizations (i.e., intragroup, intergroup, and interorganization). Economic analysis refers to economic rationality and how it applies to individual decision making. The research areas of labor relations, bargaining and negotiation, and third-party resolution relate to studies that deal with the effects of workplace and conflict resolutions and/or conflict management.

Using this framework, we will first discuss the various types and levels of conflict. Second, we will examine the various methods to deal with conflict effectively, referred to as conflict resolution or conflict management. This discussion includes individual decision making and the negotiation skills necessary for effective conflict management.

TYPES OF CONFLICT

There are four basic types of conflict: goal, cognitive, affective, and procedural (Kolb & Bartunek, 1992). Goal conflict occurs when two or more desired or expected outcomes are incompatible. It may involve inconsistencies between the individual's or group's values and norms (e.g., standards of behavior). Cognitive conflict occurs when the ideas and thoughts within an individual or between individuals are incompatible. Affective conflict emerges when the feelings and emotions within an individual or between individuals are incompatible. Procedural conflict occurs when people differ over the process to use for resolving a particular matter. As illustrated in Case Study 14–1, the different types of conflict are not mutually exclusive.

Case Study 14–1 Who's the Boss?

"Dr. Jordan on line three for you, Mary." When Mary Jones pressed the blinking button, she knew Dr. Jordan was not calling to set up their next tee time. As Chief of Surgery, Dr. Jordan had full access to the Board of Directors and Mary, the Chairperson of the Board, noticed he took full advantage of it. Lately, Dr. Jordan's calls were mostly about Harriet Briggs, the hospital's administrator. Today was no different.

"Mary, as Chief of Surgery, I have authority over all issues that affect the quality of patient care. When something or someone is compromising that quality, it is my prerogative, not the prerogative of some layman [Dr. Jordan's word for anyone not holding an MD] to do what I deem necessary to correct the situation. Don't you agree?"

Mary mentally ran through job descriptions and the hospital's charter and she could remember no clause that explicitly gave the Chief of Surgery this authority. Implicitly though, his stance was probably correct. "I'll reserve comment on that, Alex, until you tell me the specific situation that has you this upset."

The problem that concerned Dr. Jordan involved the nursing supervisor, Judith Brady, RN. Ms. Brady scheduled the hospital's surgical nurses according to her interpretation of established hospital policy. Surgeons were frustrated with her attitude that maximum utilization must be made of the hospital's operating time for training purposes. She therefore scheduled in such a way that nurses were often assigned to procedures they had not seen before. Surgeons complained that this scheduling method often added to the time it took to perform an operation. This caused problems because the Operating Room was run at full capacity. Surgeons already felt they must hurry to complete a procedure because another procedure was scheduled directly following theirs. Having to wait because a nurse did not

automatically know what instrument is needed next only exacerbated this problem and did not permit them sufficient time to complete a surgical procedure in the proper manner.

The surgical staff was concerned that this scheduling system was impacting quality of care. Furthermore, some of the surgeons had complained that Ms. Brady clearly favored some physicians over others and tended to assign more experienced nurses to their procedures.

The situation came to crisis earlier in the morning when Dr. Jordan, following a confrontation with Ms. Brady, told her she was fired. Ms. Brady then made an appeal to Harriet Briggs, the hospital administrator. Harriet overturned Ms. Brady's dismissal and then instructed Dr. Jordan that discharge of nurses was the purview of the hospital administrator and only she had the authority to do so. Dr. Jordan vehemently disagreed. The conversation ended with Dr. Jordan yelling, "This is clearly a medical problem and I am sure the Board of Directors will agree with me." Dr. Jordan then called Mary.

After listening to Dr. Jordan, Mary decided to call Harriet Briggs to get her side of the story. Harriet told Mary, "I cannot be responsible for improving patient care if the board will not support me. I must be able to make decisions and develop policies and procedures without worrying whether or not the board will always side with the physicians. As you already know, Mary, I am legally responsible for the care that patients receive here at the hospital. And another thing, the next time Dr. Jordan tells me that I should restrict my activities to fund raising, maintenance, and housekeeping, I will not be responsible for my actions!"

The severity of the problem was obvious, but the answers were not. All Mary knew was she needed to fix the situation quickly.

Discuss the goal, cognitive, affective, and procedural conflicts illustrated in this case.

Source: "Musical operating rooms: Mini-cases of health care disputes," by R. Friedman, 2002. *International Journal of Conflict Management, 13*(4), pp. 419–420. Reprinted with permission.

LEVELS OF CONFLICT

There are five levels of conflict: intrapersonal conflict (within a person), interpersonal conflict (between or among individuals), intragroup conflict (within a group), or intergroup conflict (between or among groups), and interorganizational conflict (between or among organizations).

Intrapersonal Conflict

Intrapersonal conflict occurs within the individual and may involve some form of goal, or cognitive or affective conflict. Intrapersonal goal conflict happens when several alternative courses of action are available and when the outcome is important to the individual, whether positive or negative (Locke, Smith, Erez, Chah, & Schaffer, 1994). Brehm and Cohen (1962) identified three types of intrapersonal conflict, which may develop involving alternative courses of action:

- • *Approach/Approach:* The approach/approach type occurs when an individual must choose among two or more alternatives, each of which is expected to have a positive outcome. For example, Judy Lewis, a recent graduate of a local university's Master of Health Services Administration (MHSA) program, has been offered job positions in two different health-care organizations. The first is a managed care coordinator position with a national, publicly held laboratory company. The second is a network analyst position with a fast-growing third-party administrator. The salary levels of both positions are comparable.

- • *Avoidance/Avoidance:* The avoidance/avoidance type occurs when an individual must choose among two or more alternatives, each of which is expected to be or result in a negative outcome. For example, after Judy Lewis accepted the position as the managed care coordinator with the laboratory company, management announced that because of a recent merger, the company is in the process of rightsizing. Two options were presented to Judy: to retain her position by relocating to the organization's headquarters, which is 1,000 miles away from her hometown, or be laid off.
- • *Approach/Avoidance:* The approach/avoidance type occurs when an individual must choose an alternative that is expected to have both positive and negative outcomes. Judy Lewis chooses the relocation option. Although Judy realizes she will gain valuable experience working in the organization's corporate headquarters with opportunities for advancement, she is saddened by the fact that she must leave her family, friends, and familiar surroundings.

Intrapersonal conflict may also be a consequence of cognitive dissonance, which occurs when individuals recognize inconsistencies in their thoughts and behavior. As discussed in Chapter 3, individuals seek consistency among their beliefs and/or opinions (i.e., cognitions), and when an inconsistency arises between an individual's attitude or behavior (i.e., dissonance), something must change to eliminate or lessen the conflict. When there is a discrepancy between an individual's attitude and behavior, it is more likely that the individual's attitude will change to accommodate his or her behavior, thereby reducing or eliminating the intrapersonal conflict (Brehm & Cohen, 1962).

In the workplace, dissonance occurs most often within the context of role conflict. The three types of role conflict are: (1) the person and the role, (2) intrarole, and (3) interrole. Person-role conflict occurs when the expectations associated with a work role are incompatible with the individual's needs, values, or ethics—for example, a pharmaceutical representative who believes that making untested claims about a new drug is unethical, but whose work role requires him or her to do so. Intrarole conflict occurs when an individual experiences different expectations from his or her role. For example, a hospital's purchasing manager reporting administratively to the vice president of operations and functionally to the medical director may face conflicting expectations, as the former may, because of decreasing reimbursements, stress cost efficiency by restricting choices of prosthesis devices in the surgery department, whereas the latter may emphasize having available whatever prostheses the surgeons prefer to use without regard to cost. Interrole conflict occurs when there is a clash between work and nonwork role demands. For example, if an individual must travel extensively or work excessive hours, it may conflict with family needs or demands to spend time together.

Interpersonal Conflict

Interpersonal conflict is a natural outcome of human interaction. Interpersonal conflict involves two or more individuals who believe that their attitudes, behaviors, or preferred goals are in opposition. Kottler (1996) relates that there are three major sources of interpersonal conflict: (1) personal characteristics and issues, (2) interactional difficulties, and (3) differences around perspectives and perceptions of the issues. Porter-O'Grady and Epstein (2003, p. 36) summarize these components as follows:

- *Personal Characteristics and Issues:* As a result of the diversity of today's workplace, an extensive range of differences exists between persons and cultures. These differences are embedded with a kind of emotional content related to variations in beliefs, behaviors, roles, and relationships. Individuals function in the context of these diverse characteristics, further validating differences others see in us.
- *Interactional Difficulties:* As we mature and socialize, we learn effective communication and relational skills. A lack of communication skills, combined with our personal and cultural differences, creates powerful deficits in our ability to relate to one another. Because of this broad-based inadequacy, relational conflicts regularly emerge.
- *Perspective and Perceptive Differences:* When combined with personal differences and communication inadequacies, dissimilarity in the way people view issues and interactions is a common source of interpersonal

conflict. This source of interpersonal conflict may include erroneous perceptions based on incomplete information, disparate interpretations of meaning, or personal bias.

Many interpersonal conflicts involve goal conflict or role ambiguity. Role ambiguity involves a lack of clarity or understanding regarding expectations about an individual's work performance. Often, the misunderstanding is the result of perceptual differences regarding an issue or process. Unclear performance expectations may easily intensify interpersonal conflicts and undermine sustainability of healthy relationships. Role ambiguity may cause stress reactions, such as aggression, hostility, and withdrawal behavior (Jackson & Schuler, 1985).

Intragroup Conflict

Intragroup conflict involves clashes among some or all of a group's members, which often affect the group's processes and effectiveness (Chapters 15 and 16 provide a detailed discussion of group dynamics and the various interactions between group members). Jehn and Mannix (2001) suggest that there are three types of intragroup conflict: (1) relationship, (2) task, and (3) process.

- • Relationship conflict is an awareness of interpersonal incompatibilities. It includes affective components such as feeling tension and friction. Relationship conflict involves personal issues such as dislike among group members and feelings such as annoyance, frustration, and irritation.
- • Task conflict is an awareness of differences in viewpoints and opinions pertaining to a group task. Similar to cognitive conflict, it pertains to conflict about ideas and differences of opinion about the task. Task conflicts may coincide with animated discussions and personal excitement but, by definition, are void of the intense interpersonal negative emotions that are more commonly associated with relationship conflict.
- • Process conflict is an awareness of controversies about aspects of how task accomplishment will proceed. More specifically, process conflict pertains to issues of duty and resource delegation, such as who should do what and how much responsibility different people should be assigned. For example, when group members disagree about whose responsibility it is to complete a specific duty, they are experiencing process conflict.

Intergroup Conflict

Intergroup conflict involves opposition and clashes between groups. Under extreme conditions of competition and conflict, the groups develop attitudes toward one another that are characterized by a failure to communicate, distrust, and a self-interest focus (see Case Study 14–2). Nulty (1993) relates that there are four categories of intergroup conflict: (1) vertical conflict, (2) horizontal conflict, (3) line-staff conflict, and (4) diversity-based conflict.

- • Vertical conflict occurs between employees at different levels in an organization. For example, when supervisors attempt to control subordinates, subordinates may resist because they believe that the controls infringe too much on their autonomy to perform their jobs. Vertical conflict may also arise because of poor communication, goal or value incompatibility, or role ambiguity (Pondy, 1967).
- • Horizontal conflict occurs between groups of employees at the same hierarchical level in an organization. It occurs when each department or team strives only for its own goals, disregarding the goals of other departments and teams, especially if those goals are incompatible (see Case Study 14–3; also, Pondy, 1967).
- • Line-staff conflict occurs over authority relationships. Most managers are responsible for the processes that create the organization's services or products. Staff managers often serve an advisory or control function that requires specialized technical knowledge. Line managers may feel that staff managers are imposing on their areas of legitimate authority. Staff personnel may specify the methods and partially control the resources used by line managers. Line managers often believe that staff managers reduce their authority over employees, although their responsibility for the outcomes remains unchanged (March & Simon, 1993).
- • Diversity-based conflict relates to issues of race, gender, ethnicity, and religion. These conflicts may

encompass all five levels of conflict—intrapersonal, interpersonal, intragroup, intergroup, and interorganizational.

Case Study 14–2 Turf Battles

Andrea Bevans, chief operating officer of Holy Name Hospital, knew it was a matter of when, not if. The memo she had just read was the first salvo in what promised to be another turf battle within the medical staff organization. In the memo, the hospital's vascular surgeons demanded that radiologists not be allowed to perform balloon angioplasty. Bevans knew that this treatment used a balloon at the end of a catheter and that after the catheter had been threaded into an artery in the peripheral vascular system, the balloon was inflated to break up deposits that narrowed the arteries.

The memo stated that vascular surgeons had the background, training, expertise, and proven outcomes using surgical skills and that they could best learn and apply the new techniques, if those techniques were appropriate at all. To allow radiologists to work inside the peripheral vascular system would violate previously tried and tested relationships and would cause other, unspecified, disruptions. The memo ended with a chilling, thinly veiled threat: "Should the hospital allow radiologists to perform balloon angioplasty, it may not be possible for members of the surgical staff to be available to treat untoward events, should they occur as the result of a procedure done by radiologists."

Bevans reread the memo and mused about the path of modern medicine. It was reaching the point where many conditions were treated without a scalpel. She thought fleetingly about "Bones," the Star Trek physician, who had only to pass a device over a patient's body to make a diagnosis. "Is this where we're headed?" she thought. "But, enough of science fiction," she said to herself. "How do I solve yet another turf battle without too many casualties, not the least of whom could be me?"

Discuss the intergroup conflicts reflected in the Turf Battle case study.

Source: "The developing crisis in medical staff organization," by K. Darr, 1996. *Hospital Topics, 74*(4), pp. 4–6. Reprinted with permission.

Case Study 14–3 The Managed Care Factor

Cedars-Sinai is a 400-bed community hospital located in a major East Coast metropolitan area. The hospital has a reputation as a high-quality, low-cost provider. The medical staff at Cedars-Sinai comprises board-certified physicians who are predominantly solo practitioners or are part of two- or three-physician practices. No single- or multispecialty group practices are affiliated with Cedars-Sinai. Medical staff matters are handled cautiously and conservatively by the hospital administration.

Nine years ago a large West Coast health maintenance organization (HMO) established a presence on the East Coast and grew rapidly. Because of its fine reputation, Cedars-Sinai has become a major provider of services for the HMO, and many of the HMO's physician–employees have admitting privileges. Almost 20 percent of Cedars-Sinai's inpatient days come from the HMO.

Following a review of the HMO's utilization patterns, a West Coast consultant noted the large difference in hospital inpatient days per 1,000 enrollees between East and West Coast branches of the HMO. The HMO's clinical director was asked to assess how many days of care and, consequently, how many premium dollars could be saved with various levels of progress toward the West Coast utilization patterns.

Word of this study came to the attention of Cedars-Sinai's chief executive officer (CEO), who was immediately alarmed by the implications. He knew that if the HMO's physicians reduced the lengths of stay for their patients by moving utilization patterns toward the West Coast experience, shockwaves would run through the majority of the members of his medical staff—the voluntary, fee-for-service physicians. The consequences of such a disparity in patient-day utilization patterns could be a decision by the medical staff leadership not to reappoint the HMO's physician–employees to the medical staff because the voluntary medical staff would judge that the lengths of stay were inappropriately short and risked patient morbidity and mortality.

Discuss the horizontal conflict reflected in the Managed Care Factor case study.

Source: "The developing crisis in medical staff organization," by K. Darr, 1996. *Hospital Topics, 74*(4), pp. 4–6. Reprinted with permission.

Interorganizational Conflict

Interorganizational conflict occurs between organizations as a result of interdependence on membership and divisional or system-wide success. For example, as Longest and Brooks (1998) point out, healthcare organizations participate in a variety of forms of organizational integration. The most extensively integrated organizations are integrated delivery systems (IDS). As integration levels increase, senior managers increasingly become involved in interorganizational conflict. Integration that involves extensive linking of providers at different points in the patient care continuum—and even more so when IDSs are linked with insurers or health plans and perhaps with suppliers in very highly integrated situations—brings into close interactive proximity what are often quite disparate organizations. Conflicts are unavoidable; knowledge and skills useful in managing them effectively are imperative. Interpersonal/collaborative competence is, of course, required of senior managers in all settings, but in an IDS, such competence becomes more complex overall, especially given the new dimension of managing interorganizational conflict (Longest & Brooks, 1998).

CONFLICT MANAGEMENT

Winder (2003, p. 20) points out that:

- Disagreements between people are an inherent and normal part of life. These disagreements can stem from differences in perceptions, lifestyles, values, facts, motivations or procedures. Differing goals, expectations or methods can turn disagreements into conflict, which can be damaging to both parties. Conflict may also be positive and beneficial in that it can force clarification of policy or procedures, relieve tensions, open communications and resolve problems. In its negative form, conflict can direct energy from real tasks, decrease productivity, reduce morale, prevent cooperation, produce irresponsible behavior, break down communication, and increase tension and stress, all resulting in loss of valuable human resources.

Understanding how conflict arises in the workplace is helpful for anticipating situations that may become conflictual. However, individuals also need to understand how they cope with or handle these conflictual situations. Thomas and Kilmann (1974), building on Blake and Mouton's (1964) work in the area of leadership, identified five conflict-handling modes (see Chapter 9 for discussion of Blake and Mouton's Managerial Grid). Thomas and Kilmann describe the five conflict-handling modes within two dimensions: (1) assertiveness (i.e., attempt to satisfy one's own concern) and (2) cooperativeness (i.e., attempt to satisfy others' concerns). The five conflict-handling modes are: (1) competition, (2) avoidance, (3) compromise, (4) accommodation, and (5) collaboration (see Figure 14–1).

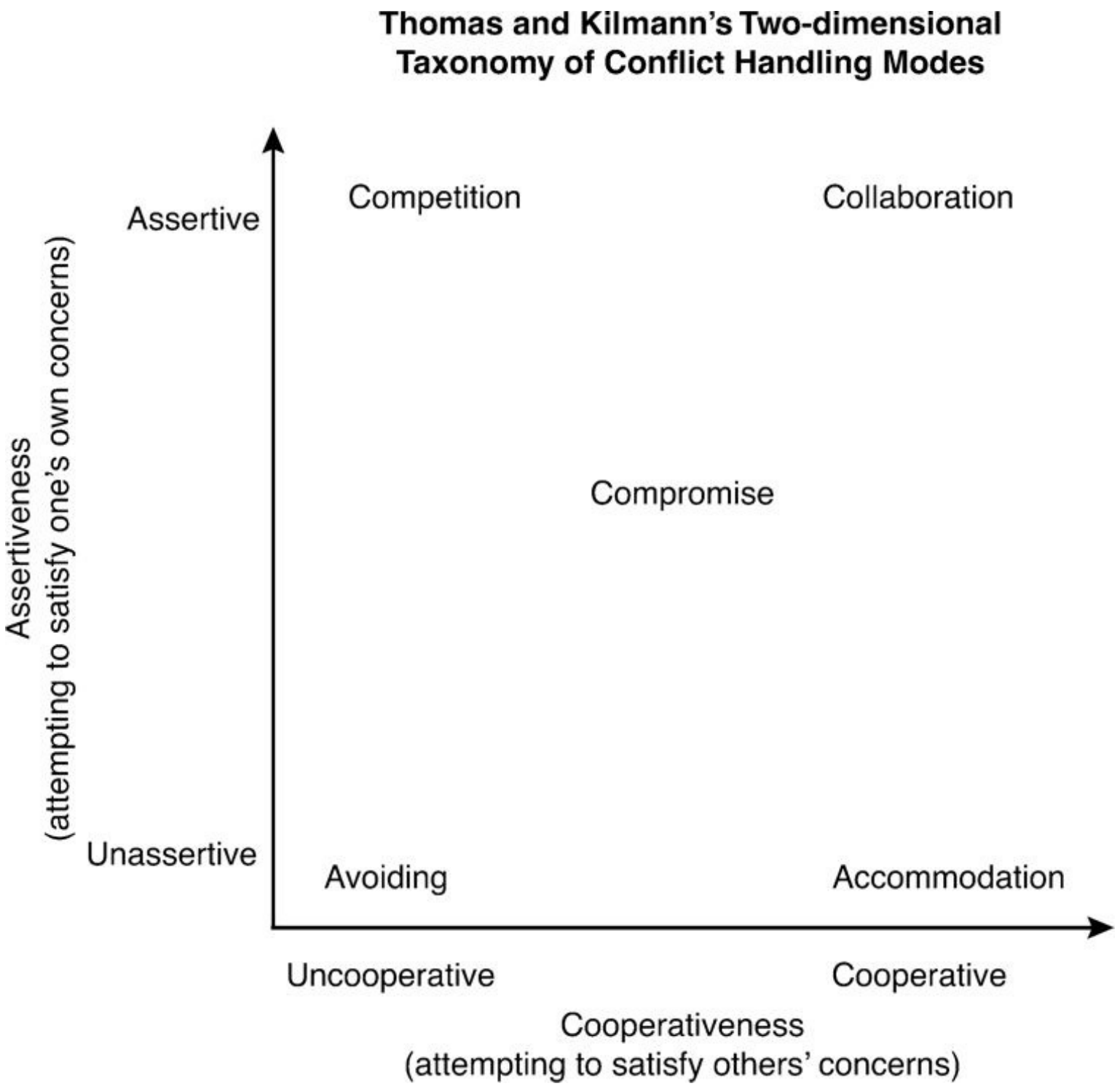
Competition involves assertive and uncooperative behaviors and reflects a win–lose approach to conflict. A dominating or competing person goes all out to win his or her objective and, as a result, often ignores the needs,

concerns, and expectations of the other party (Rahim, Garrett, & Buntzman, 1992). When dealing with conflict between subordinates or departments, competition-style managers use coercive powers such as demotion, dismissal, negative performance evaluations, or other punishments to gain compliance (Winder, 2003). When conflict occurs between peers, a competition-style manager will try to get his or her own way by appealing to his or her supervisor in the attempt to use the supervisor to force the decision on his or her peer (Blake & Mouton, 1984b).

However, in some situations competition-style management is appropriate. For example, when the issues involved in a conflict are trivial or when emergencies require quick action, this style may be appropriate. It is also appropriate when unpopular courses of action must be implemented for long-term organizational effectiveness and survival (e.g., cost cutting, and dismissal of employees for poor performance). This style is also appropriate for implementing the strategies and policies formulated by higher-level management (Dewine, Nicotera, & Perry, 1991; Rahim et al., 1992).

Collaboration involves highly assertive and cooperative behaviors and reflects a win–win approach to conflict. A collaborating-style manager attempts to find a solution that maximizes the outcomes of all parties involved. Managers who use the collaborating style see conflict as a means to a more creative solution, which would be fully acceptable to everyone involved (Winder, 2003). This involves openness, exchange of information, and examination of differences to reach an effective solution acceptable to all parties. Rahim et al. (1992) suggest that when issues are complex, the collaboration conflict-handling mode emphasizes the use of skills and information possessed by different employees to arrive at creative alternatives and solutions. This style may be appropriate for dealing with the strategic issues relating to objectives and policies, long-range planning, and so forth. However, as Winder (2003) points out, this style requires sufficient interdependence and parity in power among individuals so that they feel free to interact candidly, regardless of their formal superior/subordinate status. In addition, this style requires expending extra time and energy; therefore, sufficient organizational support must be available to resolve disputes through collaboration (Winder, 2003).

Figure 14–1 Thomas and Kilmann’s Two-Dimensional Taxonomy of Conflict-Handling Modes



Compromising is the "middle ground," with managers displaying both assertive and cooperative behaviors. It involves give-and-take, whereby both parties give up something to reach a mutually acceptable agreement. According to Rahim et al. (1992), it may mean splitting the difference, exchanging concessions, or seeking a middle-ground position. Compromising may be appropriate when the goals of the conflicting parties are mutually exclusive or when both parties, who are equally powerful (e.g., labor and management), have reached a deadlock in their negotiation.

According to Winder (2003), heavy reliance on this style may be dysfunctional because the compromising style may create several problems if used too early in trying to resolve conflict. First, the people involved may be encouraged to

compromise on the stated issues rather than on the real issues. The first issues raised in a conflict often are not the real ones, so premature compromise may prevent full diagnosis or exploration of the real issues. Second, accepting an initial position presented is easier than searching for alternatives that are more acceptable to everyone involved. Third, compromise may be inappropriate to all or part of the situation, because it may not be the best decision available.

Compared to the collaborating style, the compromising style does not maximize optimal outcomes for all involved parties. Compromise achieves only partial satisfaction for each person. Kabanoff (1991) points out that this style is likely to be appropriate when agreement enables each person to be better off or at least not worse off than if no agreement were reached, achieving a total win–win agreement is not possible, and conflicting goals or opposing interests block agreement on one person's proposal.

Accommodating involves cooperative and unassertive behaviors and is the opposite of competing. Accommodations may represent an unselfish act, a long-term strategy to encourage cooperation by others, or a submission to the wishes of others (Winder, 2003). This style is associated with attempting to play down the differences and emphasizing commonalities to satisfy the concern of the other party. An obliging person neglects his or her own concern to satisfy the concern of the other party; as such, accommodating-style managers may be perceived as weak and submissive because these individuals try to reduce tensions and stress by reassurance and support (Rahim et al., 1992; Winder, 2003).

According to Lee (1990), accommodating is generally ineffective if used as a dominant style, but it may be effective on a short-term basis when individuals are in a potentially explosive emotional conflict situation, and smoothing is used to defuse it; when keeping harmony and avoiding disruption are especially important in the short run; and when the conflicts are based primarily on the personalities of the individuals and cannot be easily resolved. In addition, this style is useful when an individual believes that he or she may be wrong or the other party is right and the issue is much more important to him or her. It can be used as a strategy when a party is willing to give up something with the hope of getting something in exchange from the other party when needed (Rahim et al., 1992).

Avoiding involves unassertive and uncooperative behaviors and is the opposite of collaborating. It is associated with withdrawal, buck-passing, or sidestepping situations (Rahim et al., 1992). This approach often reflects a decision to let the conflict work itself out, or it may reflect an aversion to tension and frustration. Because ignoring important issues often frustrates others, consistent use of the avoidance conflict-handling mode usually results in frustration by others. When unresolved conflicts affect goal accomplishment, the avoiding style will lead to negative results for the organization (Winder, 2003).

Conflict Negotiation Models

Rubin and Brown (1975) define negotiation as the process by which two or more parties decide what each will give and take in an exchange. Since the 1960s, there has been extensive research in the field of conflict resolution or conflict management. From this research, three major negotiation models have been developed: (1) distributive, (2) integrative, and (3) interactive. Each of these models is associated with different goals and indicators of success, and each may be most appropriately applied in different contexts (Winder, 2003).

Distributive Model

The distributive model originated within the field of labor negotiations (Lewicki et al., 1992; Stevens, 1963; Walton & McKersie, 1965) and can be described as a set of behaviors for dividing scarce resources. Distributive negotiation is often referred to as "hard-bargaining" or a win–lose, zero-sum approach. The negotiators are viewed as adversaries who reach agreement through a series of concessions with the goal of obtaining the greater "piece of the pie." Tactics

used in the distributive negotiation model are withholding information, guarded communications, power positioning, limited expressions of trust, use of threats, and distorted statements and demands (Walton & McKersie, 1965). Brett and Shapiro (1998) referred to distributive negotiations as a tug-of-war game with each party trying to tug the other to its own side. The winner wins when the opponent's strength gives out and the opponent is pulled across the midline. The result is a one-sided agreement, where resolved issues favor one side more than the other.

Winder (2003) outlines the four win–lose strategies practiced by negotiators using the distributive approach. The first negotiating strategy is the "I want it all" tactic. This tactic involves making extreme offers and then granting concessions grudgingly, if at all. One party hopes to wear down the resolve of the other by pressuring the other to make significant concessions and forcing the other party into a position of nonreciprocation. The second negotiating strategy is "time warp." The time-warp tactic communicates an arbitrary deadline for acceptance of the offer. For example, the negotiators will relate to the other party that an offer is only good until a certain date and time. If not accepted by the arbitrarily set deadline, the offer will be withdrawn. The third negotiating strategy is the "good cop, bad cop" scenario. In this scenario, one party attempts to sway the negotiator by alternating sympathetic with threatening behavior. The fourth negotiating strategy is the "ultimatum" tactic, which is designed to try to force one party to submit to the will of the other. In this negotiation approach "take it or leave it" offers are presented, and one party overtly tries to force acceptance of demands—one party is unwilling to make any concessions, and the other party is expected to make all of the concessions (Fisher, Ury, & Patton, 1991).

Integrative Model

The integrative negotiation model, similar to the distributive model, evolved primarily within the field of labor negotiations (Follett, 1940, 1942; Lewicki et al., 1992; Walton & McKersie, 1965). It is currently one of the most frequently used models of conflict resolution because of its collaborative versus confrontational approach.

Integrative negotiation is a cooperative, interest-based, agreement-oriented approach to dealing with conflict that is viewed as a "win–win" or mutual-gain dispute. Integrative negotiation is a process by which parties attempt to explore options to achieve mutual gains versus unilateral gains. Parties recognize and define a problem, search for possible solutions to it, evaluate the solutions, and select one that maximizes joint gains (Lewicki et al., 1992).

Filley (1975), building on the work of Walton and McKersie (1965), developed an integrative decision-making model. Filley's six-step approach is as follows:

- 1. Create an environment that promotes equality, cooperation, communication, and information sharing
- 2. Review and adjust perceptions
- 3. Review and adjust attitudes (i.e., create processes that maximize information-sharing and "clear the air" of past hostilities and negative attitudes)
- 4. Define the problem
- 5. Search for alternatives
- 6. Achieve consensus

The concept of integrative negotiation is based on a value system that stresses interpersonal trust, cooperation, a willingness to share information combined with open communication, and a search for mutually acceptable outcomes (Lewicki et al., 1992). This model looks beyond the existing resources and aims to expand the alternatives and increase the available payoffs to both parties through joint problem solving (Winder, 2003).

Fisher and Ury (1981) and Fisher et al. (1991) define integrative negotiation as "principled negotiation." The researchers suggest that negotiations should be grounded in substantive concerns when the participants:

- • Separate the people from the problem. In other words, separate the issues in conflict from the personal

relationships. Negotiators should be hard on the issues, but do so in a cooperative relationship with the other party.

- • Focus on interest or need rather than position. In other words, do not allow individual egos to negate the negotiation process. This requires trust, respect, and open communication by both parties.
- • Identify best alternative to a negotiated agreement (BATNA) for both parties. By identifying BATNAs, the parties' goal will be to achieve better outcomes than their BATNA through negotiations.
- • Invent options or alternatives that provide mutual gain. Brainstorming, prior to and during meetings, will assist in developing creative alternatives.
- • Insist on using only objective criteria to judge solutions. When negotiations are based on objective versus subjective criteria, discussions focus on equitable solutions, not false assumptions.

The integrative-conflict model encourages equitable solutions to problems. Negotiators are viewed as partners who cooperate in searching for a fair agreement that meets the interest of both sides and seeks to maximize the gain for all the parties involved (Winder, 2003) (see "Creating a Win–Win Situation" in Case Study 14–4).

Case Study 14–4 Creating a Win–Win Situation

A hospital anesthesiology department is deeply financially troubled. Department leaders approach senior hospital administrators seeking additional funds. Department leaders say without funding they will lose staff and be forced to close operating rooms. The administrators take the position that if they provide funding to the anesthesiology department, every department will demand it. Furthermore, the anesthesiology department has enjoyed the privilege of having an exclusive contract. If rooms are closed, the hospital may entertain looking at other anesthesiology practices. The senior vice president for medical affairs (i.e., VPMA) is called in to mediate. A meeting is set up to negotiate a solution.

Applying Fisher's principled negotiations, how should the VPMA proceed?

The first component of principled negotiation is to attack the problem over which the parties are negotiating. The further apart the positions, the more likely emotions will obscure the objective merits of the problem. Most negotiations are as much about emotion as they are money. The negotiation process will deteriorate rapidly if both sides firmly settle into their respective positions. If the anesthesiology group and hospital administration settle into their respective positions of closing rooms and denying the anesthesia group their exclusive contract, the negotiation soon will become a series of personal attacks.

The first step is for the VPMA to acknowledge that negotiation is an emotional undertaking. As mediator, he or she should encourage both parties to consider what they would be thinking if they were on the other side of the table. The point is to get both parties to address the problem and not to react immediately to emotional outbursts.

Relationship building and the "spirit of the deal" are important factors to keep in mind. The way to accomplish this relationship building is simple. Lay down the ground rules so that each party agrees to show the same degree of honesty, respect, and fairness that it would demand from others.

The ultimate objective of any negotiation is to satisfy the underlying interests of each side in the best way possible. As mediator, the VPMA must get each party to recognize the importance of each other's interests.

What are the interests of each group in this example? For the anesthesiologists, it may be increasing salaries to retain current staff and recruit new staff, while not having to work unreasonable or unsafe amounts of time to achieve this goal. For the hospital, it may be maintaining or even increasing operating room time to retain and attract high-volume surgeons.

The point is that each side has multiple interests. Positions such as "We will close down an operating room" obscure the underlying interests. Both parties must be cautioned to recognize and avoid any preconceived perceptions they may have about the other party.

For example, not all anesthesiology groups seeking stipends are greedy. Not all hospital administrators are clueless to clinical issues. No attempt should be made to discard any solutions until there has been a discussion of the problem and interests at hand.

With the interests articulated and understood, the VPMA should begin to look at options, looking first for shared or common interests. In this example, it is a common interest for both the anesthesiology group and hospital to keep the operating rooms open and running, since both derive revenue from the cases (i.e., common ground).

Unfortunately, it may be difficult or impossible to find common ground in many situations. As a result, capitalizing on differences may hold the key to developing options for achieving agreement. For example, the hospital may state that in order to provide a stipend, the anesthesiology group must be willing to expand operating room coverage in the evenings. The anesthesiology group may claim it does not have the staff to expand coverage and there is no need for expansion.

Could there be a solution in the disagreement? If both sides agree to look at both decreasing room turnover time and more accurate posting of procedure times by surgeons on the basis of historical data, the interest of the hospital in providing time for high-volume surgeons, and the anesthesiologists' interest in not expanding evening coverage, might be achieved. Remember that agreement often can be based on disagreement.

Once the parties begin looking at options, the problem can be discussed on the basis of objective criteria. The VPMA must have both parties prepare objective data to present prior to negotiating a solution. The anesthesiology group should be prepared to have benchmarks as to current salaries, workload, and operating room staffing models. The hospital should know how other institutions handle stipends, the legal implications, and objective criteria used to judge performance.

Source: "The role of the physician executive in negotiation," by D. P. Tarantino, 2004. *Physician Executive, 30*(5), pp. 71–73. Reprinted with permission.

Interactive Model

When negotiations become locked into a win–lose situation, a third party may be invited to assist in resolving the issues (Schwarz, 1994). Interactive problem solving is a form of third-party consultation or informal mediation. Third-party facilitators can be mediators, arbitrators, or consultants. Depending on the situation, a third-party facilitator may have high or low control of either the conflict-resolution process and/or the outcomes. For example, the third party in intraorganizational conflicts is most often the person in the hierarchy to whom the contesting parties report (Lewicki et al., 1992). In this situation, the mediator/supervisor would have high control of both the conflict-resolution process and the outcomes. Mediators usually have high control of the conflict-resolution process and low control of the outcomes (as demonstrated by the VPMA in Case Study 14–4); whereas, arbitrators have a low control of the conflict-resolution process and high control of the outcomes.

In general, interactive negotiation is designed to facilitate a deeper analysis of the problems and issues forcing the conflict. According to Winder (2003), interactive negotiation usually begins with an analysis of the needs of each of the parties and a discussion of the constraints faced by each side that make it difficult to reach a mutually beneficial solution to the conflict. After the analytical dialogue, the parties engage in joint problem solving versus a fight to be won. Interactive negotiation is less focused on directly helping parties reach binding agreements (excluding arbitration) and is more devoted to improving the process of communication, increasing perspectives and

understanding, enabling the parties to reframe their substantive goals and priorities, and engaging in more creative problem solving. Other goals include improving the openness and accuracy of communication, improving intergroup expectancies and attitudes, reducing misperceptions and destructive patterns of interaction, inducing mutual positive motivations for creative problem solving, and ultimately, building a sustainable working relationship between the parties (Winder, 2003).

Managers need to understand and appreciate that negotiation is not a zero-sum game. Managers who demonstrate effective conflict-resolution skills are often seen as competent, effective leaders (Gross & Guerrero, 2000; Stamato, 2004). A study by Eckerd College's Management Development Institute (2003) found a significant link between a person's ability to resolve conflict effectively and his or her perceived effectiveness as a leader and suitability for promotion.

The sample for the study consisted of 172 employees (90 male, 82 female) from five different types of organizations. Approximately one-half of the participants were middle-level managers or higher in their organization; all of them participated in a program focusing on workplace conflict. The study revealed a strong correlation between certain conflict-resolution behaviors and perceived effectiveness as a leader and promotion potential. Employees who were perceived as good at creating solutions, expressing emotions, and reaching out were considered more effective. Destructive behaviors, on the other hand, such as winning at all costs, displaying anger, demeaning others, and retaliating were found to be the worst career advancement and leadership behaviors. Avoidance behaviors were found to be particularly problematic for would-be negotiators because individuals who are uncomfortable with negotiating, or perceive themselves to be unskilled or ineffective in negotiating, often avoid conflict and thus fail to manage differences effectively. Of particular significance is the study's finding that negotiation skills are an important aspect of leadership.

SUMMARY

In this chapter, we have seen that conflict can have both positive and negative outcomes, and that conflicts originate from a variety of sources. Conflict-handling behavior can be learned and managers should adapt their behavior to the situation to be resolved. Collaborative behavior is strongly desired as a way to manage conflict.

END-OF-CHAPTER DISCUSSION QUESTIONS

1.

Explain the definition of conflict.

2.

Describe the four basic types of conflict.

3.

Discuss the five levels of conflict.

4.

Describe the five conflict-handling modes.

5.

Describe the three major negotiation models.

Case Study 14–5 What Went Wrong?

Tim Hardwood, CEO of Community Health System, hung up the phone with a heavy sigh. Tim had just received the news from Mary Martin, Vice President of Human Resources, that negotiations had stalled between the health system and the service employees' union. Mary related, "As of now, the 2000 service employees at our three hospitals are without a contract and threatening to strike. But don't worry, Tim. I told the union negotiators that the health system is prepared to handle a strike." "A strike, the media will have a field day with this!" Tim wondered, "What went wrong?"

Jim Brentward, one of the union negotiators, sat across the table from Mary Martin. Jim related that his members understood that the health system was having financial difficulties because of the current state of the industry with decreasing reimbursements and increasing regulations, but the union members were not pleased with the health system's proposed offer for salary increases and benefit package over the next four years. He related that "unless the health system signed a contract by 5:00 PM Friday with acceptable salary and benefit increases, members of the union are threatening to strike." Jim continued, "The union plans to hold an informational picket on Thursday, and although the union doesn't want to strike, it's a strong possibility. After the informational picket, we will hold a strike vote and see what our members have to say about the situation."

Mary was shocked by Jim's comments. She simply could not believe that Community's service employees would threaten to strike! Because of her position as Vice President of Human Resources, Mary knew that the service employees represented by Jim's union were in the bottom-end of the health system's pay scale. These employees included patient transporters, housekeeping, and cafeteria workers. Mary also knew that union benefits paid during a strike represented only 50 percent of the employee's/member's weekly salary. Mary felt confident that because of financial restraints, the employees would never vote to strike; they had too much to lose. In addition, she knew that Community Health System was considering outsourcing its dietary departments to Thomson Healthcare Food Services. If the employees did strike, although Mary considered it very unlikely, that aspect of services would continue without interruption. Knowing this inside information, Mary decided she wasn't going to let Jim and the other union negotiators bully her. Mary responded by stating that the health system would not give in to the union's demands and it was prepared for a strike.

Explain to Tim Hardwood what went wrong. If you were hired as the mediator, how would you go about resolving the situation to achieve a win/win agreement?

Case Study 14–6 Healthy Conflict Resolution

"Cindy, please reschedule my afternoon clinic; I am going to be out for the rest of the day," says Dr. Jones, a senior physician in a hospital-owned multispecialty group.

"But, Dr. Jones," Cindy says while whipping off her telephone headset and turning away from the open patient registration window, "you are double booked for most of the afternoon because you cancelled your clinic twice this month already. Many of these patients have been waiting more than three months to see you!"

Jones glances furtively at the waiting room, and already half turned and heading toward the clinic exit says, "I'm sure you will be able to smooth things over. Just tell them that I got called to an emergency."

Cindy has a suspicion that, because the weather is nice, Jones is taking off with a couple of colleagues to go sailing or play a round of golf. After all, he always sports a darn tan, comes to clinic late, and often leaves early.

Cindy does not relish having to call and reschedule these patients, some of whom have already been rescheduled at least once in the past couple of months.

Cindy decides enough is enough. She calls her manager and requests a meeting as soon as possible. Her manager can sense that Cindy is upset and offers to have someone cover for Cindy so that they can talk privately.

Cindy tells the manager about the situation with Jones that happens "all the time," and how she is "sick of it," and will not "work another day under these conditions." After calming Cindy down, the manager promises to bring the matter up with the chief of the department.

To make a long story shorter, suffice it to say that this conflict continues to mushroom to involve several more individuals (the chief medical officer, the executive director of the clinic, the director of HR, and the union representative) before Jones is ever made aware that Cindy has filed a formal complaint about him. When he is finally confronted, in a meeting with the chief medical officer and the director of HR, he is caught completely off guard.

After all, the incident happened several weeks ago, and Cindy did not mention anything to him about it. They have continued to work together, in his opinion, as if nothing is wrong. He is also surprised to find out that Cindy has been keeping a tally of the number of times that he has cancelled his clinic, left early, or started clinic late.

Jones goes from astonishment to red-faced anger in a few minutes. It is clear to all that the relationship between Cindy and the doctor is irreparable. Jones is labeled as a disruptive physician. Cindy is not welcome in any department because the other physicians are fearful of being targeted. Cindy eventually resigns, and Jones feels betrayed and unappreciated by his staff and his employer.

If you were the manager in this case, how would you have handled the situation?

Source: Pierce, K. P. (2009, January/February). Healthy conflict resolution. *Physician Executive, 35*(1), 60–61.

Case Study 14–7 Conflict-Handling Styles

For each of the five scenarios described below, determine what is the most appropriate conflict-handling style(s).

Scenario One

A radiologist on the staff of a large community hospital was stopped after a staff meeting by a colleague in internal medicine. On Monday of the previous week, the internist referred an elderly man with chronic, productive cough for chest X-ray, with a clinical diagnosis of bronchitis. Thursday morning the internist received the radiologist's written X-ray report with a diagnosis of "probable bronchogenic carcinoma." The internist expressed his dismay that the radiologist had not called him much earlier with a verbal report. Visibly upset, the internist raised his voice, but did not use abusive language.

How should the radiologist handle this conflict with the internist?

Scenario Two

The Family and Community Medicine Division of a large-staff model HMO serves a population that is ethnically diverse. The senior management team of the HMO, spurred by repeated complaints from representatives of one racial group, has encouraged the division, all of whose physicians are white, to diversify. Several black and Hispanic physicians with strong credentials apply for the open positions, but none is hired. Weeks later, a young female family

physician learns from several colleagues that the division director has identified her as racist and the obstructionist to recruiting. The comments attributed to her are not only false but are also typical of discriminatory statements that she has heard the division chief utter. The rumors about her "behavior" have circulated widely in the division.

How should the young female family physician handle this conflict with the division chief?

Scenario Three

A manager who reports to the Vice President for Clinical Affairs (VPCA) of a tertiary-care hospital hired a young woman to supervise development of a large community outreach program. During the first four months of her employment, several behavioral problems came to the VPCA's attention: (1) complaints from community physicians that the coordinator criticizes other physicians in public; (2) concerns from two community leaders that the coordinator is not truthful; and (3) written reports about the project that label and blame others, sometimes in language that is disrespectful. The VPCA spoke several times to the manager about these problems. The manager reported other dissatisfactions with the coordinator's performance, but he showed no sign of dealing with the behavior. Two more complaints come in, one from an influential community leader.

How should the VPCA handle this conflict with the manager?

Scenario Four

The medical school in an academic health center recently implemented a problem-based curriculum, dramatically reducing the number of lectures given and substituting small-group learning that focuses on actual patient cases. Both clinical and basic science faculty are feeling stretched in their new roles. In the past, dental students took the basic course in microanatomy with medical students. The core lectures are still given but at different times that do not match with the dental-curriculum schedule. The anatomists insist that they don't have time to teach another course specifically for dental students. The dean has informed the chair of the Department of Anatomy and Cell Biology that some educational revenues will be redirected to the dental school if the faculty do not meet this need.

How should the dean handle this conflict with the chair of the Department of Anatomy and Cell Biology?

Scenario Five

The partners in a medical group practice are informed by the clinic manager that one physician member of the group has been repeatedly upcoding procedures for a specific diagnosis. This issue first came to light six months ago. At that time the partners met with him, clarified the Medicare guidelines, and outlined the threat to the practice for noncompliance. He argued with their view, but ultimately agreed to code appropriately. There were no infractions for several months, but now he has submitted several erroneous codes. One member of the office staff has asked whether Medicare would consider this behavior "fraudulent."

How should the partners handle the situation with the other physician partner?

Source: "Managing low-to-mid intensity conflict in the health care setting," by C. A. Aschenbrener-Siders, 1999, *Physician Executive, 25*(5), pp. 44–50. Reprinted with permission.

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