Conflict Narratives from the Health Care Frontline: A Conceptual Model

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We examined health care conflicts through interviews with health care leaders, providers, and patients. Ninety-two medical providers, nurses, technologists, hospital leaders, and patients/families shared 156 conflict stories. We identified individual, interpersonal, and organizational factors contributing to interprofessional conflicts. Individual contributors included resource depletion (i.e., stress and fatigue), perceptions of others' seemingly selfish motives, and judgment toward colleagues' competence. Interpersonal conflicts involved prior unresolved conflicts, dehumanization, power differentials, or communication breakdown. Organizational factors included navigating within complex organizational structures and noncompliance with group norms. Conflicts resulted in negative consequences for patients (safety, satisfaction), providers (career, relationships, satisfaction, morale), and organizations (performance, staff turnover).

Conflict in the workplace is ubiquitous in modern organizations. When it is unaddressed and unresolved, it has erosive and even devastating impacts on individual workers, teams, and organizational culture (de Wit, Greer, and Jehn 2012; Friedman et al. 2000). Prior research shows that unresolved team conflicts pose grave consequences for patient safety and quality of care (Azoulay et al. 2009; Catchpole et al. 2008; Christian

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et al. 2006; Maxfield et al. 2005; Rogers et al. 2011). Conflicts in hospital settings occur within professions (e.g., nurse to nurse), interprofessionally (e.g., nurse and physician), and across professional teams (e.g., critical care unit and interventional radiology) (Otero, Nallamshetty, and Rybicki 2008). Some of these conflicts can evolve to a serious level resulting in disruptive behaviors such as verbal outbursts, threats, or refusal of tasks, which the Joint Commission (2008) recognizes as an important threat to patient safety. In a large-scale survey of 3,604 medical residents who were trainees, those who personally experienced more than one source of conflict involving another resident, a supervising physician attending, or a nurse were more likely to report both serious medical errors and adverse outcomes compared to those who reported either one or no conflicts (Baldwin and Daugherty 2008). The negative effects of poorly managed conflicts within health care organizations call for better understanding of the nature of workplace conflicts to allow targeted interventions. Yet studies examining conflicts specific to health care have lacked rigorous theoretical grounding and clear conceptual frameworks (Paradis and Whitehead 2015).

A conceptual framework of workplace conflict emerging from the domain of business is the conflict-outcome moderated model, which describes moderating factors of conflict and the impact on both proximal (e.g., trust, satisfaction) and distal (e.g., performance) outcomes (de Wit et al. 2012). In this model, conflicts are largely described as task or relationship based (Barki and Hartwick 2004; Janssen, van de Vliert, and Veenstra 1999; Simons and Peterson 2000). Task-based conflicts involve workflow efficiency and quality of care, such as equipment needs or compliance with policies. Task-based conflicts may be heated, but typically they lack an emotional undertone. Relationship-based conflicts involve interpersonal dynamics such as personality frictions or differences in norms and values; examples are assigning blame to others or using disrespectful language. These conflicts are particularly challenging in health care due to complex and rigid power hierarchies that may discourage providers from speaking up (Dankoski, Bickel, and Gusic 2014; Rogers et al. 2011).

In practice, task- and relationship-based conflicts often become overlapping (Jehn 1995; Pinkley 1990; Pinkley and Northcraft 1994; Yang and Mossholder 2004). The cognitive interpretations and emotional responses of individuals can lead to the escalation of a task-oriented conflict into a personality-driven conflict. As a result, mutual goal setting and constructive problem solving become challenging (Edmondson and Smith 2006; Rogers et al. 2011). Therefore, eliciting an individual's frame for the

conflict and subsequently reframing the conflict toward resolution is key to restoring trust in teamwork and ultimately promoting a culture of safety (Tversky and Kahneman 1981).

With funding from the health system of an academic medical center, we conducted a large-scale interview study that examined key contributing factors to health care team conflicts and the impact of conflicts on patient care and teamwork. The study was grounded in a long-term vision to develop a common language around health care conflict and ultimately inform an organizational strategic framework for managing conflict (Scott and Gerardi 2011) through development of targeted, effective conflict interventions specific to health care.

Research Methodology

Subject Recruitment

After obtaining approval from the institutional Human Subjects Division, we recruited subjects based on stratified convenience sampling. We identified key contact points for recruiting four categories of participants across three local hospitals within a single health system in the Pacific Northwest: (1) recipients of care: patients and family members; (2) health care organization leaders: administrators and risk managers; (3) patient care team leaders: physicians including resident trainees, nurse practitioners, and physician assistants; and (4) patient care team members: nurses and other allied health professionals including medical technicians. Patient and family subjects were volunteer members from a hospital patient safety and quality council. Participants, excluding hospital leaders, received $25 as an incentive.

Interview Protocol

Phone and in-person interviews took place between August and December 2013. Using a critical incident method that was previously piloted for eliciting interviewees' recall of memorable events associated with interprofessional conflict (Dejesse and Zelman 2013), the interview started with an open-ended question inviting the "story" of conflicts that interviewees had encountered. A detailed interview protocol is presented in Table 1. Participants were asked to recall the most recent conflict they experienced with another provider or witnessed while providing (or receiving) patient care. This opening prompt was followed by probes to elicit information on

Table 1. Sample Interview Protocol: Physicians and Nurses

OPENING
We are doing a study to learn more about conflict within health care teams. We are interested in developing tools for helping health care professionals to address conflicts, particularly conflicts that threaten quality of patient care and safety. To help us develop these tools, we are conducting interviews with doctors, nurses, patients, and hospital leaders. Our goal for these interviews is to better understand the kinds of conflicts that occur within health care teams and how those conflicts are experienced by the various people who are affected. We plan to use this information to develop realistic teaching materials.
This conversation is confidential. We will not tape-record the interview, but will take notes. We will not write down any specific names or identifying information you might share. Specific details are not the focus of this research project. You are free to not answer any question.
The interview should take about 30 minutes. Do you have any questions before we start?
We are interested in hearing about an experience where you witnessed or became aware of conflicts among health care providers. The conflict might have been between nurses, doctors, social workers, or others. It might have been between different medical or nursing specialty groups. It might have been between two individuals or two groups. We are interested in situations where you were concerned that the conflict might affect the quality or safety of the health care. Perhaps we could start by you telling me about the situation as you remember it.
PROBES
1. What did the conflict seem to be regarding? [An elaborating question may be: How did it affect the quality of care you or your family received?]
2. Who was involved in the specified conflict you witnessed?
3. What were your specific concerns about the quality of care being delivered or the safety of the care provided to you or your family members?
4. Did the conflict seem to resolve? If so, how? If not, why not?
Further probing questions
1. In what way did the conflict affect the rest of the health care team?
2. Did you see other conflict?
CLOSURE
I really appreciated that you candidly shared your story today. Thank you for taking your time today.

antecedents and consequences of these conflicts, such as, "What contributed to the conflict?" and "How was the conflict resolved or not resolved?"

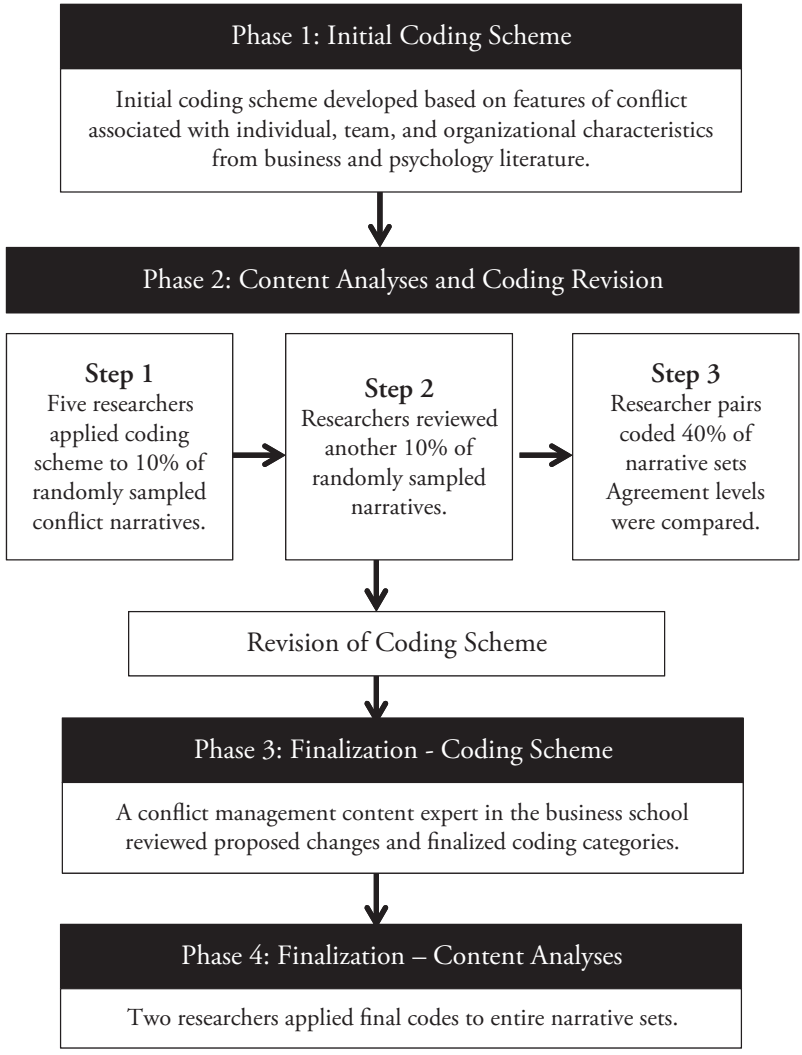
An interprofessional team of interviewers (a physician, a nursing faculty, two nurses, and a medical educator) was trained by having the

primary interviewer conduct initial phone interviews that other team members observed. This was followed by a debriefing where team members shared feedback until consensus on the interview protocol was achieved. The Human Subjects Division prohibited audiotaping of interviews due to concerns with sensitivity of information, which could involve unprofessional or even negligent behavior. To address this methodological challenge, we followed a similar protocol reported by Skjørshammer (2001), who used field notes for capturing participant data from health care providers. We took extensive notes during interviews, including quotes as much as possible, particularly to capture participants' emotional reactions to conflicts. On a weekly basis, a master file of transcribed notes was sent to the interview team for review and clarifications of unclear content.

Analyses of Interview Field Notes

Interview notes were analyzed using a directed content analysis approach (Patton 1999). The goal of this method is to validate, refine, or extend existing theory or prior research findings. This method was appropriate due to the large body of work on conflict in business, psychology, and health care. By beginning from an existing conceptual framework on conflict (de Wit et al. 2012), we sought to refine the understanding of triggering factors and consequences of conflict specific to health care environments. The process of analyzing interview narratives and developing the conceptual framework involved multiple stages of iterative coding (Figure 1). During Phase 1, a preliminary coding scheme was developed based on the business and psychology literature. Analyzing conflict narratives in Phase 2 followed three separate steps designed to maximize credibility and confirmability through triangulation of analysts and peer debriefing: (1) five researchers reviewed 10 percent of randomly sampled narratives and revised the initial coding scheme; (2) following discussions that involved reading selected conflict stories aloud, the team reviewed another 10 percent of narrative samples to refine the coding rubric; and (3) pairs were assigned approximately forty narrative sets that two team members coded. Coding agreement was compared, and proposed changes to the coding schemes were compiled. In Phase 3, a conflict management expert in the business school (R.F.) performed an external audit to increase the reliability of the data by reviewing the coding. This expert also offered terms grounded in the business and psychology literature to guide labeling the identified themes.

Figure 1. Process of Finalizing Coding Analyses



During Phase 4, two researchers (S.K., E.B.) applied the final codes to the entire set of interview narratives and discussed differences to reach 100 percent coding agreement. The final results of conflict triggers and consequences were then synthesized into a conceptual framework. To illustrate our findings, we linked theoretical underpinnings from the existing literature with the key themes in our conceptual framework and illustrated each component with examples drawn from our field notes.

Results

Overview

There were 108 respondents to e-mail invitations and 92 completed interviews (85.2 percent participation rate). The interviewees fell into four categories: (1) patient care team leaders: supervising physician attendings, residents, nurse practitioners, and physician assistants (39; 42.4 percent); (2) patient care team members: nurses and technicians (32; 34.8 percent); (3) hospital leaders, including medical directors and nursing leaders (13; 14.1 percent); and (4) patients and family members from a hospital patient council (8; 8.7 percent). Participants shared 161 conflict narratives. Six narratives were outside the scope of health care and thus were excluded, resulting in 156 conflict narratives. Most conflicts (78.2 percent) were firsthand experiences by interviewees that took place on hospital wards, operating rooms, and emergency departments (see Table 2). In Figure 2, we present the overall conceptual framework of contributing factors and consequences of workplace conflicts that are organized by individual, interpersonal, or organizational level.

Task versus Relationship-Based Conflicts

Thirty percent of stories were exclusively task-based conflicts (disagreement over protocols, policies) and 17 percent exclusively relationship-based conflicts (personality frictions, differences in norms and values). However, just over half of conflicts (53 percent) encompassed aspects of both task-based and relationship-based conflict. Hence, the concept of task- versus relationship-based conflict was validated in this sample of health care conflicts. In addition, task-based tensions were found to be a component in the majority of the conflicts, setting the stage for relationship-based conflicts.

Contributing Factors to Health Care Team Conflicts

Contributors to conflict were identified as factors that interviewees described as either causing the root conflict or magnifying the intensity of the discord. While many conflicts had multiple contributors, only one or two key factors were identified as problematic in some conflict situations. We present an overview of the conflict-triggering sources, with formal definitions that are grounded in the literature and quotes that have been made anonymous and paraphrased for the protection of participants.

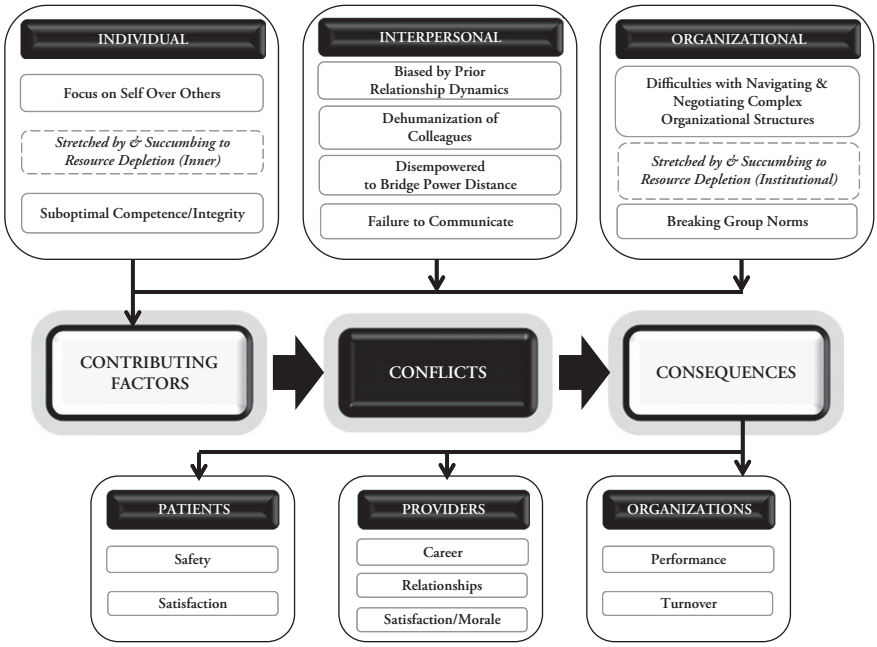
Table 2. Characteristics of Conflicts Reported in Conflict Narratives ($N = 156$)

Characteristics	*Number (% of 156 Stories)*
Conflict experienced or witnessed	
Firsthand experience	122 (78.2)
Witnessed	26 (16.7)
Top three patient care settings cited in conflict stories	
Hospital ward	46 (29.5)
Operating department	22 (14.1)
Emergency department	16 (10.3)
Professional roles involved in conflicts	
Attending–Nurse	45 (28.8)
Attending–Attending	21 (13.5)
Resident–Nurse	19 (12.2)
Nurse–Nurse	9 (5.8)
Attending–Resident/Fellow	8 (5.1)
Resident–Resident	2 (1.3)
Service–Service	23 (14.7)
Other (conflicts involving allied health providers such as medical assistants, certified nurse assistants, technicians)	29 (18.6)

Individual Factors

We identified three contributing factors at the individual level: a focus on self over others, being stretched by or succumbing to resource depletion, and suboptimal competence or integrity. A focus on self over others is rooted in tensions between self-concern versus other-orientation. This involves an individual's choosing to look out for his or her own best interests over others' interests (De Dreu and Nauta 2009; Edmondson and Smith 2006). In our study, interviewees reported their perception that another provider's motives were selfish and, as a result, other team members' and patients' interests were overshadowed. An overarching example was offered by a hospital leader: "Conflict arises when a service [e.g., orthopedic surgical team] jumps the queue by insisting that its patient takes priority over other patients who are waiting to undergo surgeries. The rationale for trumping the case is not always grounded in the high-acuity nature of the patient. It is perceived that this card is used over and over again by certain medical teams and at some point it feels manipulative."

Figure 2. Overall Conceptual Framework of Conflict in Health Care: Contributing Factors and Consequences



Being stretched by or succumbing to resource depletion is linked to reduction in an individual's ability to use self-control to regulate one's actions. When constraints are present in external (staff, facility, equipment) and internal (capacity to absorb stress) resources, we lose our ability to act in a socially acceptable way (i.e. without being angry, aggressive, sarcastic, or defensive) (Kiefer and Barclay 2012; Maslach, Schaufeli, and Leiter 2001; Muraven, Tice, and Baumeister 1998). Many conflict narratives in our study involved situations that were affected by the physical, mental, and emotional resources of the individual health care provider:

> "People are working thirty-hour shifts. When they are fatigued, respect goes down. It contributes to people not following up because they are too tired to care." (physician)

> "Provider blew up at a nurse over a very minor incident after putting in long hours after a long day, and it became quickly evident that the provider was taking things out on her." (nurse)

Suboptimal competence or integrity stems from negative perceptions or judgments providers may make toward others' professional competence

and standards. Competence is defined by the perception that an individual possesses the technical and interpersonal skills required for a job. Integrity is defined by the perception that an individual adheres to a set of principles that the perceiver finds acceptable (Kim et al. 2004):

> "We were consulting on a surgical case and were told to obtain opinions of another expert team. We believed we could handle this on our own for our patient. We felt insulted since we were competent to take care of this patient." (physician)

> "It became clear in the middle of a case that an anesthesiologist was not able to provide proper care to the patient because of her unfamiliarity with the surgery. She should have said something, but probably felt that wasn't an option." (physician)

Interpersonal Factors

Four interpersonal contributing factors were identified that involved interactions between individuals: biased by prior relationship dynamics, dehumanization of colleagues, disempowered to bridge power differential, and failure to communicate.

Biased by prior relationship dynamics involved the quality of prior interactions that shapes or distorts perception of individuals' satisfaction, professional commitment, closeness, and trust toward colleagues (Fletcher, Simpson, and Thomas 2000):

> "There were prior professional interactions between a nurse and a resident trainee that contributed to the constrained communication from the start. This led to ego clashes. I wish I could have told the resident trainee that the nurse was actually trying to look out for the patient. Later I overheard the resident telling other residents negative things about the nurse." (resident)

> "Because the conflict was there on the unit for so long, there was just no communication. If that entrenched conflict hadn't been there, there might have been a different patient outcome." (nurse)

Dehumanization of colleagues occurs when individuals perceive a person or group as lacking humanity, such as ignoring a person's individuality and preventing others from showing compassion toward a stigmatized individual or group (Friedman et al. 2000; Haslam and Loughnan 2014; Leape et al. 2012). Interviewees reported incidents such as stereotyping another person, interacting inconsiderably, or ignoring the individuality

of colleagues. This theme appeared to be particularly challenging for interviewees, including patients:

> "A new nurse was taking care of me. A nurse supervisor walked in and laid into the nurse about what she was doing. This played out in front of my family. We were so uncomfortable by how the supervisor handled the situation in a disrespectful manner. The new nurse looked horrified." (patient)

> "The phone consultations can be abusive. When I call consultants, sometimes people can be a bit short with me. The phone call depersonalizes the interaction. I prefer to communicate in person. When they see me in person, they are likely to interact with me more respectfully." (physician)

The disempowered to bridge power differentials factor stemmed from challenges that interviewees shared around speaking up against the power gradient. Power hierarchy in organizations is based on acceptance and expectations by less powerful members in organizations that power is distributed unequally, a perception that shapes the members' responses to conflict situations (French and Raven 1959; Hofstede, Hofstede, and Minkov 2010; Janss et al. 2012; Pinkley and Northcraft 1994). When shut down by those in power positions, individuals took circuitous routes to get their work done around the difficult authority figures. Interviewees reported feeling caught between two power figures or choosing to escalate the conflict up the chain of command for resolution:

> "I disagreed with a senior MD attending over a patient care plan. The senior attending made accusatory remarks and refused to make eye contact with me for a week. I decided not to confront this senior person directly out of fear that the conflict may impact my academic career. The fear that I could be reprimanded by the senior attending lingered on." (physician)

> "While discussing with a physician my course of treatment, another physician came in and didn't agree with the first physician's assessment and said to me, 'I think this may harm you [the patient].' I felt the two physicians were in clear opposition with one another. I was caught in the middle of having to vote in favor of one provider over the other." (patient)

> "After getting yelled at by an attending, I reported the incident in my evaluation after the training was completed. Looking back, I wish I

> had the courage to let the attending know how unprofessional the behavior was. I refrained from speaking up because he was a senior figure. I did not want to receive a negative evaluation of my performance." (resident trainee)

Perhaps not surprising, experiencing a failure to communicate was identified as a major contributor to conflicts. Rather than simple communication failures such as physically not hearing or mishearing a word, these are complex communication failures involving unclear role expectations, mismatched understanding of situations, lack of timely feedback, or incomplete information transfer (Duffy, Ganster, and Pagon 2002):

> "I got into this 'I am right; you are wrong' situation with a nurse over what medication to administer to a patient. I felt the nurse was hounding me and I felt disrespected. Now that I am more experienced, I try to listen to nurses, explain what I am doing, and ask for their input. I also try to use the phone to connect with them in person." (physician)

> "An operating room team member was not part of a preplanning meeting and communication about a surgery case. During the case, this team member was unsure of his role and felt there was a general lack of respect. This individual felt marginalized. When the patient [oxygen] desaturated, there was finger pointing and blaming of the team member, and the conflict quickly escalated." (hospital leader)

Organizational Factors

Two factors at the organizational level contributed to conflicts. Difficulties with navigating and negotiating within complex organizational structures involved problems with roles and responsibilities, tasks, procedures, workflow, or resource constraints such as shortage of equipment, personnel, or facilities. These challenges stem from organizational structure, including specialization of teams, tasks, hierarchies, objectives, procedures, and resources (Bresman and Zellmer-Bruhn 2013; de Wit et al. 2012):

> "Residents typically are not able to provide the care needed due to the high volume of telephone calls they have to handle throughout the night. The next morning, teams that arrive at the hospital to pick up patient care duties where the night team has left off are upset because they feel they had poor service overnight, which predisposes the conversation to go poorly. Both the patient and the staff are upset with the night shift team." (nurse)

> "Nurses felt technicians were doing work that was outside of their scope [of practice]. Techs felt nurses were taking work away from them, leaving their esteem, pride, and worth wounded." (hospital leader)

Disrespect for group norms involved behaviors and beliefs that contradicted what group members regarded as established institutional guidelines. These norms develop through interactions among group members who informally agree to them as acceptable and unacceptable behaviors (Cialdini and Trost 1998; Ehrhart and Naumann 2004):

> "I had a disagreement with a physician over a test order that I believed was the hospital standard. I felt the physician was dismissing the patient because of her socioeconomic status. I escalated the issue to my manager, who told me to directly communicate with the physician. The physician said to me, 'I am the doctor. I make the medical decision. You are just the nurse.'" (nurse)

> "I overheard a patient yelling from his room. I saw the medical assistant sitting at a computer cruising the Internet. Then the patient pushed the button to alert a staff to come to the room. The medical assistant still didn't go. So I went to check in on the patient. After I saw the patient, I told the assistant that patients' calls needed to be answered. He said, 'That patient never wants anything.' I said, 'Even if he didn't want anything, you cannot ignore him.'" (nurse)

Consequences of Health Care Team Conflicts

Negative consequences were discussed by all interviewees for the 156 conflicts reported (Table 3). They included real and feared consequences at the patient, provider, and organizational levels. Interviewees sometimes had firsthand knowledge of damaging outcomes and sometimes shared fears of negative consequences that had lingered for months or even years. While some of the consequences were tangible, such as a canceled surgery, some were less tangible, such as persistent tension in a working relationship.

Consequences to patients were particularly distressing and included negative impacts on patient safety and patients' satisfaction with their health care:

> "We can't do things in a hurried manner. Surgeons stood behind the anesthesia team and said, 'Go faster.' As a trainee, it was very difficult not knowing whether the hastened pace might jeopardize patient safety." (resident trainee)

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Table 3. Consequences of Health Care Team Conflict: Defining Characteristics and Illustrative Examples

Level	*Consequences*	*Illustrative Example from Field Note Data*
Patients	Safety	Patient care is delayed due to disagreement over how care should be advanced.
		When team members' concerns are ignored, patients are exposed to harm such as wrong medication doses.
	Satisfaction	Patients' sense of trust is compromised when they witness conflicts between caregivers. "Take the disagreement out of my earshot" was the most commonly stated phrase by patients.
		Providers in conflict with one another communicate conflicting messages to patients, resulting in confusion and frustration.
Providers	Career success	Fear of repercussion associated with conflicts (e.g., conflicts between senior and junior attendings in clinical settings spill over into academic arena).
		Self-doubt resulting from colleague's questioning of one's clinical judgment.
	Relationships	Unaddressed/unresolved conflicts erode future interactions (e.g., no eye contact, avoidance, refusal to refer patients).
		Team morale is compromised when gossiping supersedes dialogue.
	Satisfaction/morale/ well-being	Individuals criticized in public with no forthcoming team support or advocacy results in feelings of profound isolation.
		Prolonged conflicts raise questions in employees' minds about organizational culture and environment.
Organizations	Employee performance	Providers circumnavigate to avoid difficult individuals or situations even at the expense of creating added workflow.
		When poorly treated by colleagues, providers lose focus on tasks, leading to slips and errors.
	Staff turnover	New staff members are chastised by established teams, resulting in staff transfer.
		Egregious unprofessional behaviors result in termination, a process that is resource and time intensive.

> "I was in the emergency room, and it became clear that no one was taking care of me even when multiple folks were involved to figure out what I needed. The team discussed in raised voices what to do within my earshot. I was kept in the emergency room for hours before I was admitted. I am now scared to go to the emergency room." (patient)

Interviewees also shared real and feared consequences for themselves including around their career success, collegial relationships, work satisfaction, morale, and personal well-being. While some of the stories were relatively minor such as, "After a conflict with another attending who refused to negotiate changing the surgery case schedules, I stopped referring my patients to this individual" (physician), other consequences were professionally costly or damaging:

> "I started having run-ins with another colleague with whom I used to be close to. This staff constantly reported that I wasn't getting my work done. A mediated meeting somewhat improved the situation. However, I don't feel that conflict has completely resolved because I don't trust the person anymore." (allied health provider)

> "I overheard a nurse disagreeing with my decision to do a procedure. I said to the nurse, if you disagree with my clinical decision, it's okay to disagree, but you need to tell me respectfully directly and not in my earshot. The nurse said: 'I have nothing to say to you.' That interaction led to serious job dissatisfaction on my part." (physician)

At the organizational level, interviewees described consequences of professional performance and employee turnover. For some interviewees, these organizational outcomes had been borne in silence. For others, they were a source of discouragement that seemed to border on burnout:

> "I left my job after experiencing trauma following a difficult encounter with a physician, who exploded at me in public at the nurse station. Everybody just left me there. I started crying, and it was humiliating. Nothing bad happened to the patient. I left the organization about a year and half later. I couldn't accept being yelled at in that way." (nurse)

> "There was a catastrophic event. Nurses had to shoulder the responsibility. In the process of holding parties accountable, I became disheartened when people were not held accountable to the degree I thought they should. I left the institution because of my professional standards and integrity." (nurse)

Study Implications

Conflict among interprofessional health care teams is a common and complex problem. Our report from a large-scale, structured interview study makes unique and important contributions to deepen existing understanding of workplace conflict in health care settings. First, among the existing qualitative studies that have explored providers' perspectives on health care conflicts (Brown et al. 2011; Jameson 2003; Jones 2006; Leever et al. 2010; Nicotera and Clinkscales 2010; Phelan, Barlow, and Iversen 2006; Rogers et al. 2013a), Brown et al. reported the largest sample: 121 clinicians. In our study, hospital leader and patient voices were added to health care providers' perspectives, which expanded understanding of the contributing factors and consequences of health care conflict.

Second, we extended the earlier work (Rogers and Lingard 2006), which identified causes and consequences of conflict in the operating room and applied our stratified sampling across three hospitals and four categories of participants. In doing so, we were able to propose a unifying conceptual framework that links conflict narratives from health care to existing concepts from business and psychology. We found previously less explored concepts as conflict triggers, such as the role of resource depletion at the individual and institutional levels. Furthermore, we offer insight into how simple task-based conflicts evolve into the more challenging relationship-based conflicts.

Our conceptual framework shifts the characterization of contributing factors of health care conflict from generality (e.g., "That unit has a lot of conflicts") to specificity (e.g., "That unit suffers from unresolved conflicts with the nurse manager," a type of interpersonal conflict characterized by bias from prior relationship dynamics). The nine contributing factors at the individual, interpersonal, and organizational levels may be useful to guide the development of conflict interventions within a health care organization. For example, conflicts arising from staff shortages call for different interventions from conflicts associated with perceived lack of competence among providers. While foundational communication skills are at the cornerstone of teamwork, conflicts are triggered by different root causes and need targeted strategies for successful problem resolution and restoration of professional relationships.

Third, the key findings point to evidence of how conflicts break down the culture of safety that protects patients. We offer accounts of the cost

of conflicts to professionals, as well as the patients and families they care for. Far from being a benign irritation or minor nuisance, interviewees in our study described acute and sometimes long-standing, even gut-wrenching, and occasionally dangerous conflicts among colleagues. At the center of conflicts, our interviewees described colliding interests, contradictory opinions, complex communication breakdowns, careless escalation up the chain of command, confusing workflows, and cues of disrespect and humiliation. Providers doubted their judgment and competence when conflicts arose. Their professional identities were threatened. Those with less power often felt caught in the middle when they could not speak up or reconcile conflicting instructions from providers in higher positions. They circumnavigated difficult personalities and situations even if it meant increasing their workloads. Patients and families were disturbed by conflicts they witnessed between health care providers. They felt obliged to ask providers to take a disagreement out of earshot so they could focus on recovering or caring for loved ones rather than on problems among members of the health care team.

Conflict is a pervasive problem in health care and appears to be associated with persistent power gradients (Janss et al. 2012). The majority of conflict narratives shared by our participants reflected their struggles with power differentials in the organization. But the methods participants chose to address conflict were not always ideal. For example, our interviewees mentioned the hospital's patient safety net (PSN) reporting system as leverage for bridging power gradients. Although the PSN was originally designed as an anonymous channel for reporting adverse events or medical errors, we found it had inadvertently become an outlet for providers to escalate unresolved conflicts with colleagues. Being "PSN'ed" had become a method to safely confront someone with more power instead of a person-to-person dialogue.

We note that the topic of power has not been satisfactorily addressed in the health care literature. A systematic review spanning six decades highlighted only 6 of 129 articles that addressed professional hierarchy, resulting in a call for more rigorous inquiry into examining the power gradient in organizations (Paradis and Whitehead 2015). Training in speaking across power gradients is much needed and has to be buttressed by leaders' active role modeling of positive team behaviors, as well as an organizational culture that promotes employees' timely and assertive willingness to address conflict (Greer et al. 2012; Rogers et al. 2013b). Without this concerted effort,

organizations will treat legitimate concerns on the part of employees as undiscussable. Silencing employees' grievances and suppressing their authentic voices in this way compromise a culture of safety (Dankoski et al. 2014).

Conflict is a healthy and necessary part of health care, but teams must possess the skills to address conflict in ways that allow them to air important concerns, resolve inevitable disputes, and maintain positive professional relationships. Patient safety and quality of care depend on the ability not just to tolerate conflict but to embrace its critical role in human interactions and communication.

Limitations of Study

This study had several limitations. First, participants were recruited from three hospitals across a single health care system. In an effort to increase generalizability, the interview protocol is currently being replicated at an academic medical center in Geneva, Switzerland. Second, concerns regarding audiotaping interviews required using field notes with potential biases stemming from interviewers' interpretations. We addressed this limitation by adopting standard protocols for interview notes and regularly reviewing compiled notes. Third, we presumed the credibility of the storytellers but recognize possible biases in their recounting of events and attributions of others' intentions. Our story collection method did not allow us to triangulate the content by verifying the nature of the conflict with the individuals portrayed in the narratives. Fourth, interviewees may have recalled negative examples associated with conflicts more readily than positive outcomes (Dejesse and Zelman 2013), such as strengthened relationships or clarifications of hospital standards.

Conclusion

The conceptual framework we propose contributes to creating a common language around health care conflicts and points to future conflict management interventions. Much research is needed to examine the effectiveness of training interventions developed based on the recommended conceptual underpinning. However, studying health care conflict goes beyond the domain of research inquiry. Effective handling of conflicts at the individual, team, and organizational levels not only promotes patient safety but also honors the common aspiration that health care providers bring to

their workplaces: to deliver excellent care to patients and families as a well-functioning, interprofessional team.

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