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Managing RN/RN and RN/MD Conflict in the ICU: Productive Ways of Communicating

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Managers are in a pivotal position to decrease conflict. By their response, or lack of response, they informally create the code of behaviour for the unit. Staff members are always watching: What did the manager do when the physician yelled at the nurse? What action did the manager take after a nurse complained that a co-worker was sabotaging his or her reputation? The way these challenges are addressed on a daily basis not only forms the code of behaviour, but also essentially governs the way staff address conflict on the unit.

Significant research exists to confirm the damage caused by relationship conflict in healthcare. Relationship conflict affects morale, satisfaction and quality of care. Nurses who report the highest degree of conflict also experience the highest degree of burnout. This data is no surprise to managers who spend 30 - 40% of their workday dealing with some form of workplace conflict. Because resolving conflict can be exhausting and time-consuming, many managers tend to ignore nurse-tonurse conflict, or act like a third party and negotiate compromise in order to end an energy-draining situation quickly. But neither of these strategies is effective. What is the best way to manage nurseto- nurse and nurse-to-physician conflict in the ICU?

Nurse-to-Nurse Hostility

Hostile behaviours, whether overt or covert, are extremely hurtful. Gestures such as raised eyebrows, cliques, sarcasm and "eye-rolling" have a profound and detrimental effect on teamwork, retention, quality, safety and satisfaction and are the source of much conflict. Unfortunately, in the culture of nursing, these behaviours are viewed as "normal". Nurses do not recognise the impact this type of horizontal hostility can have, nor do they possess the skills necessary to confront each other.

Nurse-to-nurse conflict is seldom resolved as nurses' most common style of communication is passive- aggressive, and any conflict is typically dealt with by avoidance. This can undermine the positive relationships necessary for a healthy workplace. In addition, when workplace pressure escalates, people in a state of defensiveness tend to revert back to their old styles of communicating – even if they have been given the tools to communicate effectively. Therefore, the responsibility to constructively deal with conflict and create healthy relationships falls to the unit manager.

One of the most vulnerable populations is new nurses, of which up to 60% leave their first position within the first 6 months because of some form of lateral hostility. In a global nursing shortage, this statistic is particularly disheartening. However, research shows that awareness of horizontal hostility allows new grads to depersonalise the attack and continue to learn.

Solutions to Reduce Nurse-to-Nurse Conflict

In order to change the culture of a unit, the manager must set a new standard and then hold staff accountable to it. It's not easy to spot, act upon, and follow up with staff whose subtle acts of antagonism alienate co-workers, when you're juggling other more immediate priorities. But investing in a campaign to end negative and destructive behaviours has a tremendous payoff: Retention, healthy relationships, and cohesive teams.

What works? Managers who encourage nurses to resolve their own issues and who provide education on communication and confrontation skills will find that the investment far exceeds their expectations. A sense of powerlessness can be a major cause of conflict. Destructive attitudes such as "that's the way it is around here", or "nothing will change" are evidence of powerlessness. Staff members who lack authority or power will act out their frustrations toward each other. In response, the most important action a manager can take is to empower staff to take care of their

own interpersonal relationships.

Encouraging Independent Resolution

Because managers are not omnipresent, it is critical to first ensure that head nurses possess the skills to confidently address conflict on the unit before initiating staff education. Then, provide education on conflict management and assertive communication for staff or incorporate these classes as part of a staff education day.

Post a flyer that defines horizontal hostility and reminds staff of the behaviours that are unaccept able. If a staff member comes to you for help in resolving an issue, offer to role-play the conversationand provide coaching. Set the expectation that they will solve the problem and that your role is purely supportive. Another proven strategy is to ask staff to develop their own unit-based philosophy, which clearly states unit behavioural standards.Nowhere is guidance more needed than in leading staff to realise that they themselves have the power to create a work environment where every single team member is valued, appreciated and acknowledged.

The Role of the “Silent Witness”

One of the most effective strategies in dealing with nurse-to-nurse conflict has been to teach staff about the role of the “silent witness”. As one nurse recently realised, “I’ve never said anything bad about another nurse in my whole career, but on the other hand, I stand there and listen while one nurse is talking badly about another.” Witnessing gossip or backstabbing is detrimental to the psychological safety of the workplace. As managers, we can take away the secrecy and shame involved by openly discussing damaging behaviours, stopping the pretence that they are harmless and can be ignored,and setting the expectation that it is unprofessional and harmful to stand by and be a silent witness while another nurse is being criticised.

RN/MD Relations

Poor MD/RN relations inhibit communication and are detrimental to patient safety, teamwork and satisfaction. Because this has been directly linked to patient mortality, both parties have an obligation not to tolerate anything other than collegial relationships. In addition, poor physiciannurse relationships are a significant contributor to horizontal hostility because any group made to feel inadequate and powerless will always act out their frustrations towards each other. Manager intervention in holding physicians accountable for their role in any conflict is crucial if nurses are not to be negatively impacted by this sort of powerlessness.

Addressing Nurse-to-Physician Conflict

Begin by garnering commitment from the chief physician for the unit. Clearly state the impact of any poor relationships as well as the benefit of collegial relations (use specific examples). Communicate weekly with the chief, providing an update on your concerns and proposed solutions and arrange monthly standing meetings.

Empower staff to stand up for themselves and never make excuses for destructive or negative behaviours. Even the smallest of condescending mannerisms have a profound impact on the team. If staff cannot approach a physician directly, stand ready to approach the physician on their behalf. Physicians respond very positively to the words: “May I speak to you for a moment in private?” State the specific behaviour (e.g. raised voice) and its impact, while redirecting the conversation to the common goal: Safe and high quality patient care. In every single case of disruptive physician behaviour I have heard or witnessed, the physician truly does not realise the impact of his/her actions on staff and apologises immediately because these are unconscious learned behaviours.

Conclusion

A long history of power imbalance and inadequate communication skills in the healthcare culture manifests itself in nurse-to-nurse and nurse-to-physician conflict. Managers are in a pivotal position to engender new and more productive ways of communicating to resolve conflict in a positive way. Insist on professional behaviours at all times from the entire team. By refusing to let conflict go underground and empowering staff to resolve their own conflicts, managers have a powerful opportunity to create a new culture - one that is respected and acknowledged for its healthy collegial relationships.

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