A literature review of conflict communication causes, costs, benefits and interventions in nursing

ROSS BRINKERT PhD

Assistant Professor of Corporate Communication, *Department of Corporate Communication, The Pennsylvania State University, Abington, PA, USA*

Correspondence
Ross Brinkert
Department of Corporate Communication
The Pennsylvania State University
1600 Woodland Road
Abington
PA 19001
USA
E-mail: rsb20@psu.edu

The author has previously received payment for conflict interventions work.

BRINKERT R. (2010) *Journal of Nursing Management* **18**, 145–156

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Aim This paper reviews the literature on conflict communication in nursing in order to prioritize research, theory and interventions that will support nurse managers and staff nurses.
Background Conflict is pervasive in nursing and has many costs, including burnout, higher absenteeism and higher turnover. Increased and more effective use of conflict management seems important in sustaining and developing the field.
Methods The literature study focused on the intersection of nursing, communication and conflict. The review primarily drew from the nursing and communication disciplines.
Results While much is known about the sources and costs of conflict in nursing, more can be done to research the benefits of conflict and intervene effectively.
Conclusions Conflict is a routine feature of nursing. Nonetheless, sources can be managed, costs decreased and benefits increased with indirect and direct interventions.
Implications for nursing management Nurse managers can support themselves and others in working through conflict by normalizing conflict, employing proven proactive and reactive interventions and by helping to build integrated conflict management systems.

Keywords: communication, conflict, intervention, manager, nurse

Accepted for publication: 12 October 2009

Introduction

Across occupations, 25% of respondents cited interpersonal issues as the most challenging workplace stressors (Smith & Sulsky 1995) with negative social interactions with others accounting for 75% of the total work situations respondents described as detrimental (Schwartz & Stone 1993). Within nursing, the ability to manage conflict effectively has been recognized as an important skill (Hillhouse & Adler 1997). As Almost (2006) documented, persistent conflict among nursing co-workers is a serious issue in the profession and one that is on the rise around the world (Farrell 1997, Hesketh *et al.* 2003). The fact that new entrants to the field get mired in conflict (McKenna *et al.* 2003) is of particular concern given ongoing efforts to improve attraction and retention figures. Unfortunately, nursing still has not broken from the past in terms of 'eating its young' (Baltimore 2006). The management of conflict among nurses and among nurses and others in the workplace are central issues to the profession that need to be further addressed in terms of theory, research and practice.

DOI: 10.1111/j.1365-2834.2010.01061.x

The purpose of this paper is to report on a conflict literature review. While Almost (2006) concentrated on conflict between nurses, this paper broadens the focus to include conflict between nurses and other health care providers as well as conflict between nurses and patients and/or patients' families. Also, while it is important to recognize conflict's sources and effects prior to exploring conflict management (Almost 2006), this study addresses these foundational matters but then emphasizes conflict management interventions.

Defining conflict

Conflict has been defined as 'the interaction of interdependent people who perceive incompatibility and the possibility of interference from others as a result of this incompatibility' (Folger *et al*. 2009 p. 4). Communication is central to conflict in that communication often creates conflict, reflects conflict and is the way in which it is productively or destructively managed (Wilmot & Hocker 2007). Although conflict is frequently viewed as negative, conflict can have positive functions, including surfacing important problems (e.g. getting individuals to address power and relationship issues underlying content concerns), clarifying individual and shared goals and helping overcome resentments and come to mutual understanding (Wilmot & Hocker 2007). Although a mixed (positive and negative) view of conflict has taken theoretical hold in recent decades, researchers have continued to concentrate on the negative (Almost 2006).

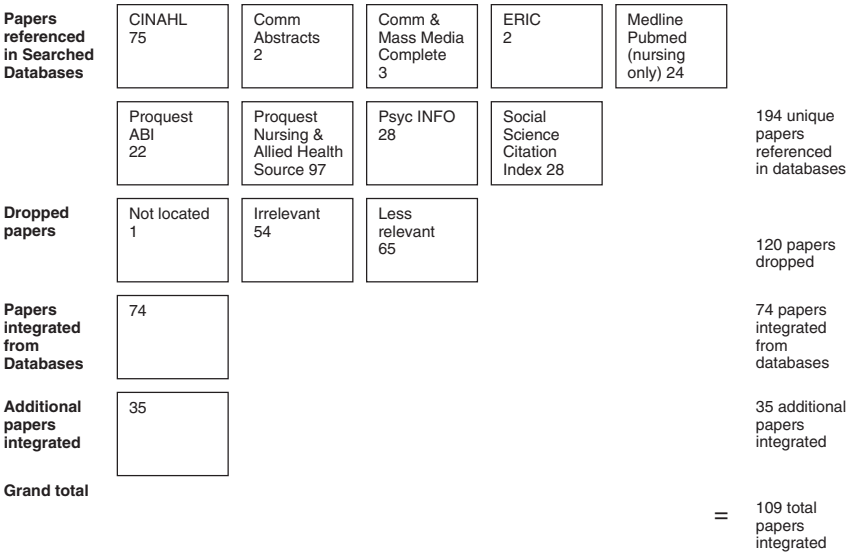
Key questions

Three basic questions guided this literature review:

- What do we know about conflict in nursing?
- What do we need to know about conflict in nursing?
- What are the implications for nurse managers?

Literature review methodology

This review emphasized the nursing and communication literatures given the central importance of the nursing literature to this area and the author's home discipline of communication. Literature from social and organizational psychology and inter-professional practice perspectives remain to be thoroughly considered. The terms communication, conflict and nurse were searched in the following databases: CINAHL, Communication Abstracts, Communication and Mass Media Complete, ERIC, Medline Pubmed (nursing journals only), Proquest ABI, Proquest Nursing and Allied Health Source, PsycINFO and Social Sciences Citation Index. The inclusion criteria were as follows: English language, peer reviewed, journal papers from 1995 to 2008 and all three search terms (or, where available, related terms) in the title and/or abstract. One hundred and ninety-four unique papers were referenced in the databases when accounting for the presence of some papers in more than one database. One referenced paper was dropped because neither the abstract nor the paper could be located. Fifty-four papers were dropped because they clearly fell outside the fundamental parameters of the literature review. For a paper to be considered it had to focus on nurses as direct conflict participants and address a hospital setting (or nurse education setting with a hospital link). The 139 remaining papers were closely considered. Given the specific purposes of this literature review and space limitations, 74 (those entries preceded



with a * in the references) were integrated. The 65 papers that were judged less relevant were tangential to the literature review in terms of content and/or redundant in terms of other more notable papers in a sub-area. An additional 35 papers (those entries proceeded with a + in the references) were incorporated based on mention as sources or previously known relevance.

Origins of conflict in nursing

Sources of conflict in nursing were previously categorized in terms of individual characteristics, interpersonal factors and organizational factors (Almost 2006). Sources of conflict are categorized here according to conflict predominantly described as developing (1) within and among nurses; (2) among nurses and other health care professionals; and (3) among nurses, patients and patients' families. While any typology of discrete sources can be illuminating, sources relate to one another in complex ways. For instance, a qualitative study of nurse anaesthetists and anaesthesiologists working side by side demonstrated how dyadic actions can perpetuate, transcend or transform a larger group conflict and therefore function at micro and macro levels (Jameson 2003).

Conflict within and among nurses

Conflict within and among nurses was described as role conflict, horizontal conflict and intergenerational conflict. A major source of conflict in nursing is the basic fact nurses have multiple professional roles. The patient advocacy role of nurses has been shown to be inherently challenging from a role conflict perspective (Martin 1998) and the basic nursing functions of caring and controlling can come into tension (Hewison 1995). To have multiple roles is to have conflicts develop regarding ethical obligations to various parties (Laabs 2003). A programme evaluation in the United Kingdom (UK) found both nurses and nurse managers experienced role conflict (Cooper 2003).

Three additional sources of conflict largely concentrating on nurses that have received considerable attention in recent years are burnout, horizontal conflict and intergenerational conflict. A study of intensive care unit (ICU) nursing staff in France indicated that 33% had severe Burnout Syndrome (BOS) with conflict cited as one important BOS area (Poncet *et al.* 2007). Espeland (2006) generated a list of causes of burnout. Some relating to conflict communication include lack of goal and expectation-related information, role overload based on an inability to set boundaries, role conflict involving competing responsibilities, problematic relations with other employees, breakdown in community, perceived unfair treatment of workers, value conflicts and self-conflicts.

Verbal abuse is communication that is perceived to be an attack that is harsh, condemnatory and either personal or private (Buback 2004). Among peers it is known as horizontal violence and tends to occur in private (Buback 2004). There is a high incidence of horizontal violence or bullying in nursing (Farrell 2000, Taylor 2001). Although it is not uncommon for nurses to get attacked by patients, nurses are most concerned about aggression from nursing colleagues (Farrell 1999, Abu AlRub 2004). Valentine (1995) noted that striving for the positive qualities of nurturing, caring and kindness may create a bind for nurses making confrontation unattractive. Yet, directly addressing important issues is much more likely to be beneficial (Baltimore 2006).

Conflict among different generations of nurses has been well established (Swearingen & Liberman 2004, Kupperschmidt 2006). The generational differences within nursing can cause conflict and be a challenge for leaders in particular (Sherman 2006). There are four generations in the present-day workforce: WWII generation, baby boomers, generation X and millennials. While no individual can be adequately understood solely in terms of his or her generation, patterns within generational cohorts and differences across cohorts can sometimes be useful for understanding conflict among people of different ages.

Conflict among nurses and other health professionals

Numerous articles reported conflict between nurses and physicians and nurses and other health care professionals. The source of many of these conflicts concern challenges in perspective-taking, including the challenge of integrating points of view. Vertical violence and tensions relating to administration, finances and patient care were also notable. Nurse–physician conflict has various sources, including different professional judgments (Chase 1995), different goals or lack of goal clarity (Weinert *et al.* 2001), different experience levels (Nicolson *et al.* 2005) and tensions around status relations (Brand 2006). Two dominant themes in the literature concerning nurse–physician conflict communication were conflict originating in the operating room and decision-making regarding end-of-life care. Aggressive tactics directed from an actual or perceived

superior towards someone of lower rank, is known as vertical violence (Buback 2004). Vertical violence often occurs in front of others, has been documented as occurring in the operating room by surgeons towards nurses (Buback 2004) and has been labelled surgical personality (Girard 2008). Whether or not it can be related to vertical violence in the development of a particular conflict, time has been shown to be a resource negotiated among health care professionals (Riley & Manias 2006) and research in operating rooms has demonstrated it is also a source of tension and conflict (Espin & Lingard 2001, Walker & Adam 2001, Lingard *et al.* 2002).

Conflict communication was a major theme for physicians and nurses in end-of-life decision-making (Oberle & Hughes 2001, Keung & Chair 2006) and life-sustaining dialysis treatment (Silen *et al.* 2008). Conflict patterns were documented among different professionals in intensive care units (Hawryluck *et al.* 2002, Halcomb *et al.* 2004). Ethical uncertainty has been linked to professional status ambiguity (Frederich *et al.* 2002) and different basic approaches were noted for nurses and physicians (Robinson *et al.* 2007).

In general, the basic differences in role-related perspectives between nurses and physicians and among nurses and other professional groups were shown to impede conflict resolution, if not an additional source of conflict. A review showed congruent expectations of the clinical nurse specialist's (CNS) role by the CNS, management, staff nurses and physicians is important in avoiding negative conflict and other undesirable outcomes (McMyler & Miller 1997). A comparison of critical care physicians' and nurses' attitudes revealed discrepant views about the level of collaboration experienced (Thomas *et al.* 2003). Role perception gaps were also found within a spinal cord rehabilitation team (Pellatt 2005). The introduction of new nursing roles, that were previously medical roles, was linked to conflict among professionals (Price & Williams 2003, Davies & Lynch 2007). Conflict between nurses and other non-physician health care professionals was documented in a study involving hospital-based midwives (Kennedy & Lyndon 2008). Racial diversity in health care teams can be a challenge for communication effectiveness (Dreachslin *et al.* 2000).

Conflict involving nurses emanated from the mix of administrative and financial perspectives present among the many categories of professionals working in health care. Different groups of health care professionals, including nurses and nurse trainees, had different views of what constituted effective hospital administration (Vlastarakos & Nikolopoulos 2008). Those working in the financial, clinical and other areas of the organization may find themselves in value conflicts, especially when facing budget constraints (Nowicki & Summers 2002). Patient-related and monetary goals clashed in perinatal (Simpson & Knox 1999) and end-of-life settings (Sorensen & Ledema 2007).

Conflict among nurses, patients and patients' families

A discourse study of palliative care nurses found emotion talk can construct patients as troubled (Li & Arber 2006). The lack of alignment between a patient's verbal and non-verbal communication can challenge nurses' abilities to comprehend effectively (Iwamitsu *et al.* 2001). Researchers have recognized the ever present intergenerational dynamic of older patients receiving health care from younger professionals, specifically the relationship between lifespan stage, conflict styles, depth of conflict and conflict satisfaction (Bergstrom & Nussbaum 1996).

A review of literature revealed parental involvement in pediatric care was poorly executed and conflict can develop when parents' actions do not meet nurses' expectations (Corlett & Twycross 2006). A year-long study of paediatric intensive care patients with prolonged stays showed conflicts were common and the majority were team–family (n = 33, 60%) and intra-team (n = 21, 38%), with breakdowns in communication reported as the top factor (Studdert *et al.* 2003).

A qualitative investigation of collaboration between nurses and relatives of frail elderly patients in Danish acute hospital wards showed that nurses explicitly value collaboration and yet it does not regularly occur (Lindhardt *et al.* 2008). Factors included organization and societal values as well as the organization of care and nurses' communication skills.

Different points of view about end-of-life care, particularly decisions involving physicians, nurses, patients and family members about whether to withhold or withdraw life-sustaining therapy, can lead to deteriorating communication and the need for a conflict resolution process involving one or more third parties (Luce & White 2007).

Evidence suggested there is often poor communication about end-of-life decisions and thus conflict occurs among clinicians as well as among clinicians and family members (Boyle *et al.* 2005). A study exploring 'good' and 'bad' deaths in the UK found the management of death in hospitals is a major point of conflict for nurses with nurses mainly focused on their own sense of control (Costello 2006).

Costs of unmanaged conflict in nursing

The review of the literature showed that unmanaged conflict was costly not only in a monetary sense and not only for nurses. Arford (2005) summarized the steep costs of nurse–physician conflict by pointing out the links to medication errors (Kohn *et al.* 2000), patient injuries (Page 2004) and patient deaths (Tammelleo 2001, 2002). Earlier Gerardi (2004) provided extensive listings of direct and indirect costs of conflict. Direct costs of conflict included litigation costs, lost management productivity, employee turnover costs, disability and worker compensation claims, regulatory fines or loss of contracts or provider status, increased care expenditures to handle adverse patient outcomes and intentional damage to property. Indirect costs of conflict included damaged team morale, lost opportunities to manage future-oriented projects, costs to patients, cost to reputation loss of market position, increased incidence of disruptive behaviour by organizational insiders and emotional costs.

The negative effects of persistent conflict are a major concern (Almost 2006). For example, workplace conflict has been linked to decreased work satisfaction and team performance in nursing (Cox 2003). It damages the work climate as well as the individual, both physically and psychologically (Danna & Griffin 1999). Nurses in conflict with other nurses in Japan reported a higher likelihood of leaving their current job (Lambert *et al.* 2004). Persistent conflict resulted in higher turnover and absenteeism, lower coordination and collaboration and lower efficiency (Spector & Jex 1998, De Dreu *et al.* 1999). Finally, given the increased attention verbal abuse has received in recent years, it is worth noting that it specifically was shown to negatively impact patient care, work satisfaction and turnover rates (Manderino & Berkey 1997) as well as morale, productivity and error rates (Watson & Steiert 2002).

Beneficial and normal conflict communication

While conflict was often referred to negatively and aberrantly within the arena of nursing communication, its positive and normal functions were highlighted at times. For example, a professional team may combine perspectives ensuring that various important interests are represented (Palmeri 2004). Studies of gossip (Waddington & Fletcher 2005) and emotion talk (Li & Arber 2006) demonstrated conflict's sometimes positive (e.g. building relationships and managing emotions) and sometimes negative nature (e.g. damaging relationships and causing emotional upset for others). Other research demonstrated that communication tensions and conflict talk are a normal part of cooperatively performing health care work. The needs for autonomy and connection are necessary for health care professionals and can themselves cause conflict (Jameson 2003, 2004). It is helpful that they can often be reconciled with the use of politeness, thereby meeting the organization's needs for collaboration (Jameson 2003, 2004).

Conflict communication interventions

The literature indicated good communication and conflict management were important in nursing. A European study found communication quality was significantly better in hospitals with good attraction and retention rates for nurses (Stordeur *et al.* 2006). A survey of nurse experiences in Lithuania found, in part, that nurse motivation increased when they were able to collaborate with physicians, when they were recognized as autonomous and when there was effective interpersonal communication and conflicts were solved constructively (Zydziunaite & Katiliute 2007). A study of six ICUs in a Belgian hospital found nursing leadership and authority, communication and conflict management most influenced perceived unit effectiveness and job satisfaction (Vandenberghe & D'hoore 1999). In the United States, enhanced communication mechanisms comprise one of the strategies for more effectively dealing with a managed care environment (Buiser 2000). A number of interventions were implemented that have improved conflict communication involving nurses. Some of these interventions advanced conflict communication as a primary goal, others as a secondary goal, and some impacted it indirectly (i.e. were not seeking to impact it and yet recorded an impact).

Conflict communication gains were documented for a number of nursing education and mentorship programmes (Langan 2003, Murphy & O'Connor 2007, Latham *et al.* 2008, Seren & Ustun 2008). A comparison study of nursing students in Turkey using a problem-based learning (PBL) curriculum showed conflict resolution skills and related skills for the PBL group were significantly higher than those using a conventional curriculum (Seren & Ustun 2008). A study of staff nurses' role experiences within a practicing and non-practicing nursing faculty demonstrated that staff nurses working within a practicing nurse faculty experienced lower levels of role overload, conflict and ambiguity (Langan 2003). A preceptorship programme intended to better transition new nurse graduates into the clinical environment was successful in preventing

conflict between new and more experienced nurses (Murphy & O'Connor 2007). It was also found that a coordinated team approach supported the preceptees, decreased the stress and workloads of preceptors and fostered confidence in the new nurses. The 3-year study of an academic hospital-registered nurse mentor and advocacy programme found the use of comprehensive mentor–mentee teams improved nurse–nurse perceptions and the perception of nurses by others, reinforced support by managers and colleagues and improved patient care outcomes (Latham *et al.* 2008). These study outcomes were expected to support better nurse retention as well as patient safety. The overall programme was carried out in partial acknowledgement of the need to improve conflict resolution and succeeded in developing a culture of support.

Evidence has accumulated regarding conflict communication, supervisory support and development opportunities for frontline nurses. Within the supervisor–employee relationship, open communication was important for the employee to negotiate his or her role and this perceived role negotiation ability was linked to the experience of reduced role conflict and increased job satisfaction (Miller *et al.* 1999). Apker (2001) developed this line of work by demonstrating that supportive and collaborative communication, especially with managers, was very important for nurses coping with ambiguities in a managed care environment. Apker (2001) also found that nurses who had the opportunity to develop their professional roles beyond their tightly worded responsibilities acquired new skills, gained confidence and appeared to have increased job satisfaction and morale. An analysis of a small programme designed to teach practical conflict management strategies to supervisors and managers in a health care organization resulted in significant differences regarding the handling of stress (Haraway & Haraway 2005). A charge nurse-development workshop that included conflict management skills was judged to have a significant return on investment (Sherman 2005). A study of a leadership development programme for front-line nurses seeking, in part, to develop conflict and communication skills found that participants self-reported understanding and ability gains both immediately and 3 months after training (Krejci & Malin 1997).

The introduction of brand new roles and protocols positively affected conflict communication. Training for the specialized new role of a paediatric nurse practitioner enhanced conflict management abilities (Davies & Lynch 2007). Implementation of dedicated charge nurses in a busy medical–surgical nursing department significantly increased perception of teamwork, especially regarding conflict resolution (Hughes & Kring 2005). The introduction of systematic conflict resolution methods, including the use of techniques and protocols, in a peri-operative setting resulted in a reduction of surgical procedure delays, efficient ordering of supplies and enhanced interpersonal relations (Pape 1999). A study of the impact of a new organ donation protocol demonstrated that all measures of role stress, particularly role ambiguity and role conflict, were significantly improved (Dodd-McCue *et al.* 2004, 2005).

Breakthroughs in the area of verbal abuse have also accumulated. Buback (2004) compiled a diverse list of interventions in order to avoid and better respond to instances of verbal abuse. Noting early indicators of verbal abuse and documenting and reporting incidents are important (Jacobs 2000). Institutions should have policies and procedures in place and respond to incidents of verbal abuse with training and tracking (Cameron 1998). Assertiveness training and communication training were found to be effective in coping with verbal abuse (Cook *et al.* 2001). Other interventions include counselling and education programmes (Anderson & Stamper 2001), with education and collaboration seeming especially important (Watson & Steiert 2002).

Additional conflict communication strategies

Research detailing the gaps between the anticipated and actual work of nurses recommended more emphasis on conflict competence in nurse education (Cheek & Jones 2003) and putting other strategies in place that reduce occupational stress, role conflict and role ambiguity, as well as increase job satisfaction (Lu *et al.* 2008). Heightened emphasis on communication and negotiation skills in nurse education was encouraged to improve paediatric care (Corlett & Twycross 2006). Negotiation and conflict resolution skills were noted as important for nurses given health care reform, changing roles, unclear lines of responsibility and other factors (Hrinkanic 1998). The ability to manage conflict effectively was identified as important for nurses in direct care roles (Rodney *et al.* 2006) and supervisory roles (Pillemer & Johnson 1998). Also, conflict prevention was identified as one area for BOS improvement (Poncet *et al.* 2007).

Developing more effective conflict communication was widely recognized as important in the professional partnerships and teams in which nurses are involved. Collaboration between physicians and nurses has become more sophisticated as nursing roles have changed and, accordingly, collaboration continues to

need to be supported in research and practice (Taylor-Seehafer 1998). Given the known costs of dysfunction, health care organizations have the responsibility to provide an environment for effective nurse–physician communication (Arford 2005). More effective conflict communication has been called for between nurses and other professionals in specific areas, including childcare health (Crowley & Sabatelli 2008), critical care (Corley 1998), end-of-life (Frederich *et al.* 2002, Keung & Chair 2006), palliative care (Weissman 2003), perinatal care (Simpson & Knox 1999, Gilliland 2002) and resuscitation (Robinson *et al.* 2007).

There have been calls for the design of health care workplace conflict communication programmes to include mediation-related and emotional intelligence-related content and skills. Gerardi (2004) proposed that mediation skills and techniques could be used to improve health care work relationships and larger health care and health system goals. The finding that high emotional intelligence was associated with the desirable nursing conflict style of collaboration suggests emotional management and conflict resolution components in training programmes for nurses and the other providers with whom they interact (Jordan & Troth 2002).

Resolving communication conflicts is important for improving access to health care for multicultural and multilingual patient populations (Brice 2000). Collaboration has been encouraged among health care professionals, patients and families (Encinares & Pullan 2003) and among all health care community members (Deutschman 2001). Better nurse conflict communication skills are valued for nurses working with patients, families and other professionals in various areas, including end of life (Halcomb *et al.* 2004, Costello 2006, Pierce 2006, Sorensen & Ledema 2007, Searle & McInerney 2008) and forensic care (Encinares & Pullan 2003).

While calls for intervention have mainly focused on the interpersonal level, some have called for a combination of efforts. For example, in order to avoid conflicts regarding end-of-life treatments, Pierce (2006) recommended the patient–provider partnership be recognized, a communication mechanism needs to be in place for clarifying patient preferences and the effective integration of hospital office-level options (such as the ethics committee and legal department) needs to occur. Nurse–physician collaboration strategies are recommended at the organization and policy levels (Corley 1998). Porter-O'Grady (2004) proposed that health care organizations develop a programmatic infrastructure and committed leadership team in order to effectively manage conflict. The programme should apply throughout the organization with the flow of conflict resolution processes and activities clearly delineated.

Discussion

A consideration of the literature on conflict communication in nursing sheds light on a number of knowledge gaps. While conflict cannot be entirely eliminated from nursing, particular sources of destructive conflict may be decreased or eliminated. For instance, teaching conflict management to supervisors and managers significantly decreased stress (Haraway & Haraway 2005). More can be done to document existing instances of controlling conflict sources, evaluate the effectiveness of these practices and design and evaluate additional such practices.

Even when wholly or largely negative conflict is unavoidable, it may still be possible to minimize the associated costs. For example, conflict between nursing colleagues may get entrenched and jeopardize nursing effectiveness and patient safety; however, the availability and use of mediation may help decrease the duration and costs of this conflict. The range of alternative dispute resolution practices, including arbitration, mediation and conflict coaching (Brinkert 2006, Jones & Brinkert 2008), were designed in part to decrease the costs of conflict. Their application and the study of their effectiveness in nursing deserve more consideration.

The benefits of conflict in nursing have only been considered lightly. There are times when conflict may be desirable. For example, conflict on an interdisciplinary team can mean the patient benefits from treatment decisions based on carefully considered and combined expertise. More can be done to identify these kinds of instances and document how to make the most of these opportunities. Effective conflict management in nursing may at times involve strategically introducing conflict where there was none in the past, such as when nurses commonly and immediately confront each other about patient care concerns thereby decreasing the potential for patient harm and more serious inter-professional conflict in the future.

Although research has established the efficacy of some direct and indirect interventions, initial findings could be verified and other interventions could be tested for the first time. Care should be taken to both learn from intervention research outside of the nursing arena and remain open to the potentially unique nature of this setting.

The many sources and steep costs of unmanaged or poorly managed conflict and the limited use of beneficial conflict suggest additional interventions may well

be helpful. Conflict communication remains an underdeveloped area of nursing. Even where conflict interventions have been shown to work (e.g. with nurse mentorship programmes), other interventions may turn out to be equally valuable. Further, a redundancy of interventions may be beneficial. Conflict interventions are needed at all nursing levels and at all relational interfaces.

There is a need to carefully evaluate the validity of findings in various nursing conflict communication subareas, especially given the use of mixed methodologies across studies. These analyses could lead to a larger yet detailed mapping of the conflict communication literature in nursing. Although the integration of work from different perspectives can be challenging, pragmatism in the nursing arena and the complexity of conflict seem well served by mix methods.

Given the reach of conflict in nursing, its documented origins and costs, its possible benefits and the fact that the vast majority of interventions to date have been discrete, there seems to be a need to manage the overall endeavour. This may help ensure programme comprehensiveness, consistency and continuity.

It is notable that Porter-O'Grady's (2004) focus on a systematic approach to conflict communication within health care is supported by more general efforts to design organizational dispute systems (Lipsky *et al.* 2003). These authors call for structuring conflict management in terms of specific principles:

- scope (include all internal organizational members);
- culture (welcome different perspectives and encourage conflict engagement and resolution at the lowest levels possible);
- multiple access points (ensure easy access to knowledge about the system and those capable of addressing the conflict in question);
- multiple options (offer interest-based and rights-based options for resolution);
- support structures (coordinate the conflict management system so it remains accessible and integrated with daily operations).

These efforts support more empowered individual employees, a more collaborative climate and can greatly lower the time and costs associated with managing conflict.

Main implications for nurse managers

- Openly acknowledging the central role of conflict in the work of nurses sets a foundation for constructively handling sources, costs and benefits. Recognition of conflict as normal makes it acceptable, arguably even obligatory, to directly address conflict and treat it as a significant matter.
- The existing literature provides solutions that can be implemented to improve conflict processes and outcomes. Despite concern with the interpersonal and evidence of its effectiveness, Vivar (2006) noted there are few conflict communication courses available for nurses and further conflict-related nursing education is greatly needed for both staff nurses and nurse managers. Efforts towards enhanced communication can be relatively easy and inexpensive for nursing leaders and other administrators to address (Buiser 2000).
- Interventions are needed within and across nursing areas and should extend beyond nursing roles. The overall depth and breadth of the programme means multiple stakeholders need to be engaged and conflict management resources need to be shared. Nurse managers almost certainly require support to carry-out these activities. Local actions should be sensitive to system guidelines. Likewise, the system should adapt in the face of local successes as well as successes beyond the organization.
- Conflict communication in nursing continues to unfold. Nurse managers can play an important role by partnering with researchers when applying new and existing interventions.

Conclusion

Conflict communication plays a central role in nursing. The sources and costs of conflict have been well established. The benefits of conflict are apparent and need to be further established. The overall impact of conflict communication in nursing suggests additional interventions are necessary for all types and stages of nursing. Nurse managers may positively address conflict communication in nursing by normalizing conflict, utilizing proven proactive and reactive interventions and helping to build integrated conflict management systems. Nurse managers can also advance this area by collaborating with researchers to study existing and emerging conflict communication efforts. Conflict communication has been tied to major contemporary issues in nursing including horizontal and vertical violence, the intergenerational workplace, burnout, turnover, better patient outcomes and financial success. Based on these connections, it should be of intensified concern to all those involved with the advancement of nursing.

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