'But doctor, someone has to do something': Resolving interpersonal conflicts in the workplace

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Physicians are often called on to address interpersonal conflicts among office staff and colleagues. Because such strife can interfere with patient care, physicians should learn to diffuse these situations as adeptly and quickly as possible. The authors outline one approach, which they developed while working at the Oklahoma Department of Mental Health. Designated by the mnemonic LIFT (Listen, Inquire, ask for Feedback, Test), this approach has been used successfully to resolve interpersonal conflict in small groups.

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When the facts from a patient's history and physical examination do not paint a full clinical picture, asking just the right question can pull it all together. Current technology enables physicians to gather facts, prescribe medication, and use osteopathic manipulation and prophylactic treatments to diagnose and intervene in a disease process. But what techniques can a physician use when strife strikes the office staff or colleagues and the social worker and resident can be heard yelling at each other—again—in the hallway? How can you respond when someone says, "The receptionist said she is going to quit. We can't run the office without her. Can't you do something, doctor?"

Frustrated, many physicians are apt to have someone else look into the problem. Chances are, however, that the physician will ultimately be asked to take charge in helping to solve interpersonal problems that arise on the job, among clinical teams or committees.[1] Effective participation in conflict resolution can remove obstacles to providing quality patient care and improving morale and productivity in the workplace.

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The LIFT approach

The physician need not react to the autonomic flight-or-fight response when asked to become involved in conflict situations. Instead, a four-step approach (Listen, Inquire, ask for Feedback, and Test [LIFT]) can be used to resolve such conflicts. We developed this technique while working at the Oklahoma Department of Mental Health between 1988 and 1992. Specifically, LIFT was developed to help resolve conflicts that had occurred between clinical department heads and frontline employees while they attended management team meetings. These meetings were held to prepare a program plan for the state hospital. We later used the LIFT approach to teach supervisors how to avert an escalation of conflict among the staff in the wards and treatment teams. It is based on a body of knowledge on small groups and conflict

management,[2-4] and encompasses an atmosphere of openness, courtesy, and creativity in which everyone wins.

Understanding conflict

Before discussing the subtleties of LIFT, the nature of conflict deserves a closer look, along with its role in the workplace, how to recognize conflict, and how to decide when and how to participate in its resolution.

Simply put, conflict is a difference between two or more interests that prevents one of those interests from being attained.[5] For example, a difference of opinion may exist among clinical team members concerning a patient's rehabilitation plan. Or, a staff member may want to practice a particular form of therapy not endorsed by the healthcare organization. As a necessary component of growth, conflict is healthy; the way we *handle* conflict can be unhealthy.[6]

Recognizing conflict

Even the most experienced administrator occasionally overlooks conflict in the workplace. But physicians are even more likely to miss conflict as their focus is on the patient. Nonetheless, they can adapt their clinical skills to "diagnose" conflict when it manifests itself through unproductive, quarrelsome meetings or repeated mistakes. Overt, spontaneously expressed hostility or even suppressed communications are signs of unhealthy conditions, much like a patient's visible rash or pain. Resolving conflict removes uncomfortable conditions and promotes healthy behaviors.[7]

Scenario: The hospital social worker (Mr Bureaun) and the staff nurse (Nurse Rachen) were having difficulty obtaining records from the medical records department. Delays in obtaining this information began to increase. Tensions between the medical records department staff and the healthcare providers heightened when a billing clerk (Ms Filene) had apparently misplaced important files. This error, which delayed billing, had potential financial repercussions for the hospital.

When to intervene

Sometimes, no one on staff may directly ask the physician to intervene. Nonetheless, the physician may perceive problems and feel the need to intervene. In the aforementioned scenario, however, *both* the social worker and nurse came to Dr Smith.

Obvious circumstances that adversely affect patient care or the quality of work deserve prompt attention. So, too, does a complaint from an outside observer. If the physician is one of the quarreling parties, help should be sought from a trained mediator.

Hampered relations with the medical records personnel had a negative effect on patient care. Delays in ordering the correct medical tests became commonplace. Orders were lost for the initiation of social services, and billing was delayed.

Conflicting parties may resolve a problem independently if it is called to their attention. Sometimes, one party actually affected by the conflict may be unaware of its existence.[8] Conflict intervention aims to transform elements of the conflict, not to change the persons involved. When in doubt, it is best to obtain help to distinguish between behaviors that require administrative or clinical action and those behaviors amenable to conflict resolution.

Once recognized, conflict should not be ignored. No one can resolve interpersonal conflict without cooperation. To that end, LIFT resolves conflict by engaging persons in the process of resolving the strife.

Listen

Of the four components of LIFT, listening is most important. Listen to the words and inflections of the conflicting parties. Listen with your ears, eyes, expression, and posture. Direct eye contact and minimal interruptions foster a good listening environment. If a small group must be involved, only one person should speak at a time, without others' interruptions. They, too, will have a turn to speak.

In a sensitive conflict involving two parties, separate, consecutive meetings with each person may be appropriate. The mediator/physician should let each party know that these separate meetings are for each person's comfort and confidentiality. This time should be used to de-escalate emotions and simply to have the parties reach an agreement to meet with the mediator. Neutral statements ("Go on," "And then...") will taper the flow of emotions and enable the person to reveal all the necessary facts. Acknowledging the person—without judging the individual—enables the issues to be more readily addressed. Good listening clears the field of "emotional noise."

After first talking with the Director of Records

for a better understanding of the work flow in that department, Dr Smith calls the social worker, nurse, and records clerk into her office. She ensures the parties that the purpose of this meeting is to identify what has happened so that it will not be repeated in the future. She allows them to express their frustration (one at a time) and asks them to focus on what they know, rather than what they think *they know. She instructs them to be prepared to make suggestions for solving the problems at hand. Dr Smith is an objective listener; she does not agree or disagree with the statements being made. Rather, she acknowledges what she understands to be the facts and clarifies any unclear points.*

The elements that make up good listening continue throughout the LIFT process.

Inquire

In this step, the physician/mediator asks "who," "what," "where," and "when," acquiring all the pertinent facts. No physical checklist is present and no opinions (judgments) or speculations are made. Again, clinical insight comes into play to develop a complete picture of the situation. Everyone involved needs all the information to even the playing field.[9,10]

In reviewing the circumstances surrounding the loss of the file and the delays in retrieving records as well as the extent of the problem, Dr Smith inquires accordingly:

"Mr Bureaun, how often in the last month have you had to search for missing files on your clients?"

"Nurse Rachen, what else can happen to files when they are needed by several staff?"

"Ms Filene, do you recall when you last saw the file in question? Could another clerk or physician have taken the file?"

These questions should avoid placing blame and should serve to clarify the perceptions and facts.

Note taking is allowed during this process as long as the physician/mediator agrees to destroy the notes after the discussion. This process, after all, is not an investigation but a problem-resolution process. The notes might be used to develop a written contract of the solutions the group agreed to in the meeting.

Ask for feedback

Expressed in the physician/mediator's words and actions throughout the process, feedback reflects the parties' feelings and facts. The physician/mediator restates or reframes this information *without* adding new material.

"Nurse Rachen, you think that the documents are not lost, but that they may be in the resident's office?"

"Ms Filene, the billing on this file can still be entered within 30 days, correct?"

Feedback helps to determine whether enough information exists to make a decision, whether the physician/mediator understands the situation correctly, and whether the involved parties have expressed everything they wanted.

Perhaps more so than even oral feedback, nonverbal feedback, expressed in body language and facial expressions, can either put the parties at ease or increase the stress. Therefore, *how* feedback is expressed cannot be overemphasized. Use reassuring nonjudgmental phrases: *"It sounds as if things in the billing department have been hectic. Being short-staffed must put you under additional pressures to get things done."* If the party answers, "No, but..." or "Not really," this opening lets the physician/mediator clarify the situation: *"Can you give me a clearer picture of how things are in billing?"*

Reframing, or putting the information received in the correct context, helps to focus on the facts, clarify, and move toward solutions. *Nurse Rachen said that Ms Filene delayed filing the records and this delay increased the risk of the files getting lost. Dr Smith queried: "Nurse Rachen, do you know when the records are supposed to be filed, or does it seem to you that the records should be filed sooner than Ms Filene can do so?"*

Reframing keeps discussion focused on the relevant issues and removes emotional overtones.

Each of these feedback techniques takes time. If the physician/mediator is uncertain or confused concerning the direction of the process, it is best to take a brief break and ask everyone to think about what has just been said. What will make the situation comfortable, remove confusion, and preserve quality patient care? These are the questions for the physician/mediator to consider.

Feedback and inquiry can overlap. Such an approach enables the involved parties to express the problems in the workplace and to contribute to the solutions. *Based on Nurse Rachen's belief that one of the residents has the file, one of three parties may volunteer to ask this resident if he does indeed have the file in question. Someone*

may suggest a better system be devised to store documents until they are filed in the patient's chart.

With clinical staff disputes, the physician/mediator may have the power to manage office space better or to change a policy some way to ease conflict. When giving advice, it is best to avoid taking sides. The best way to do that is to have the parties involved take responsibility for the solutions. The "what-if" statement subtly elicits participation: *"Sometimes, in situations like this, I've seen things work best if.... So what if we .... What do you think?"*

Test

Test the situation. This component of LIFT operates on several levels. They include determining whether everyone is ready to move to the solution phase; whether everyone agrees on what the problem is; and whether enough information has been discovered to develop solutions. Assuming all these criteria have been met, the next phase is to develop solutions that match the problem; evaluate the feasibility of the solutions; and then reach an agreement on these solutions.

The parties involved agree to develop a sign-in/sign-out procedure for records, with the maximum lending time of 1 day. A trial period of 2 weeks is suggested. These and other solutions are brought to the Director of Records for approval, with the stipulation that they are trial solutions. After 2 weeks, a follow-up meeting will convene with Dr Smith and the three involved parties to see if these solutions have improved the flow between staff and the records department.

Comment

Should the physician/mediator find himself or herself in a complex situation or one that requires more than a brief intervention, it may be wise to seek help from a trained mediator. Trained mediators can be located by calling the state association for certified mediators. The office of the State Supreme Court or the Attorney General's Office may also provide a list of certified mediators. Local mental health providers may also be trained mediators.

If time for listening is limited, recognizing the existence of the problem can be accomplished in the following manner: *"I know this is hard for you, but is there any way you can help by working out something until tomorrow when we can talk more about the problem?"* The interim delay may give the staff persons involved time to develop a solution of their own, something they are apt to do anyway.

An interim solution could be reached, when time is short, as well as an agreement to seek additional outside help. This may also be a good time for the physician/mediator to remind the persons involved of their importance to the physician as well as to the patients. Such recognition reinforces the legitimacy of their concerns.

Above all, physicians should extend to the office staff and colleagues the same respect and nonjudgmental approach they use with their patients. They should extend this respect and nonjudgmental approach particularly when called on to mediate disputes. Once a solution has been reached, tested, and followed up, the physician/mediator should step aside and let the staff work. One key to successful mediating is to remain accessible and to give the work group the LIFT needed to go from a lose-lose situation to one where everyone wins.

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