Getting to Cooperation: Conflict and Conflict Management in a Norwegian Hospital

Hospital Professionals' Perceptions, Attributions and Behaviours in Conflict

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A small conflict is the beginning
of a good solution

Proverb

Abstract

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The purpose of the research was to investigate conflicts related to work coordination in hospitals. Increasing specialisation and professionalisation, coupled with high degrees of work interdependence over the past years, have greatly increased the conflict potential in hospitals. Because hospital professionals have to work together, they cannot avoid differences, disagreements and disputes that may result in conflicts. Conflict is a factor in poor communication, which causes adverse events and harm to patients. Some of the questions addressed include: How do professionals go about managing conflicts? What kind of behaviours do they use? How are conflicts perceived and what are the reasons for having conflicts? What kind of emotions accompany conflicts? How do professionals talk about their conflicts? The data are based on a nation-wide survey in 1993 of the work environment and living conditions of doctors in Norway, and an ethnographic study of a Norwegian urban hospital (from 1996 through 1999) utilising data gathered through interviews, observations and review of existing documents. One reason for using these methods is that they allow for exploration of the emotional factors in conflict, which have been neglected in previous studies. Triangulation was used to discover similar patterns in the findings produced by each method and to increase the validity of the findings.

The study found that all hospital professionals share the same attributional style related to conflict where personality factors are emphasised as opposed to situational factors. Such an attributional style encourages avoidance and deprives the organisation of learning opportunities. Anger behaviour is frequently part of conflicts and may in itself cause work conflicts. Anger behaviour, in particular from physicians, is a major stress factor in the workday of nurses, and has a negative impact on their work environment and professional cooperation and may even reduce the quality of patient care. Anger behaviour may be understood as an expression of strained interpersonal relationships where contextual factors serve to lower the threshold for keeping such feelings private.

The data from different methods converge on a number of findings. The research confirms the challenge in professional cooperation to manage disagreements, disputes and conflicts. It shows that conflict is endemic in hospitals. When in conflict, hospital professionals use three approaches to manage the situation: avoidance, forcing and negotiation, usually in that order. Avoidance behaviour or suppression is the most common reaction to an emerging conflict in Norwegian hospitals. If use of power does not re-establish a balance between the participants, one negotiates. These conflict styles are determined by two major factors: The perceived interdependence between parties

and the perceived urgency of doing something about the situation. Nurses and physicians differ considerably in their perception of what is a conflict and when to do something about it.

Storytelling in conflicts provides a way to give structure and meaning to the experience. Through constructing a story a person seems to cope better and to be better able to handle the stress and challenge of sense making that comes with a conflict. All conflict stories share the same narrative structures such as emplotment, a temporal development, diversions of plots, characterisation of participants, a struggle for the dominant storyversion, and the impact of larger stories. These concepts provide a language for working with conflicts closer to the participants' life world than allowed by other approaches.

In order to make improvements in conflict management at the study hospital, a new comprehensive system was designed to improve the study hospital's conflict resolution structures and to strengthen the negotiation skills of hospital professionals and leaders. The study suggests that conflicts represent learning opportunities in an organisation and that improvement in the conflict management competence may improve organisational learning and quality to patients.

Keywords: Conflict, cooperation, narrative, dispute system design, organisational learning.

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Introduction

The modern hospital is a complex organisation with a highly differentiated structure, characterised by extensive specialisation and division of labour. In order to carry out the core activities of the hospital which include diagnosis, treatment and care of patients, the organisation requires a high degree of coordination among a multitude of professions and professionals across a number of units (Georgopoulos & Mann, 1962; Shortell & Kaluzny, 1988; Øvretveit, 1997). A well coordinated interaction among the different actors participating in the treatment process is of critical importance in order to deliver high quality patient treatment (Gerteis, 1993; Hietanen et al., 1993; LeTourneau & Curry, 1998; Östergren & Sahlin-Andersson, 1998).

This extensive need for coordination is one of the main sources for disagreements, disputes, conflicts and feuds in hospitals that hospital professionals have to work out in order to secure quality of care and reduce costs. Many authors have pointed out that interdisciplinary cooperation is not widespread and that there is an overabundance of competition between the major groups of hospital providers like physicians and nurses (Taylor, 1996; Tjosvold & MacPherson, 1996; Keenan et al., 1998). However, the need for extensive cooperation and collaborative practice is increasingly acknowledged within the different health professions as cooperation is recognised as the foundation for quality improvement in hospitals (Clemmer et al., 1998; Nolan, 1998).

The capacity of hospital staff to interact successfully depends as much on coordinating professionals and departments as it does on individual competence. The implementation of role assignments and policies depends on the professionals' ability to negotiate differences and to work out solutions. However, the delivery of high quality care depends increasingly on "processing skills" (communication, empathy, willingness to listen, to have common goals, to analyse alternative ways of solving issues) in addition to "medical/care competence". Failure in integrating these skills may not just interfere with the efficiency of service delivery, but may also have damaging consequences for patient care (Fox, 1994; Mackay, 1993; Holm, 1995; Rosenthal, 1995).

As early as 1962, Georgopoulos & Mann (1962) noticed this challenge to hospital professionals: "The hospital is dependent very greatly upon motivations and voluntary, informal adjustments of its members for the attainment and maintenance of good coordination. Formal organisational plans, rules, regulations, and controls may ensure some minimum coordination, but themselves are incapable of producing adequate coordination, for only a fraction of all the coordinative activities required in this organisation can be programmed in advance (p.57-58)." That coordination in hospitals seems to depend on informal agreements and ways of working was further elaborated by Strauss et al. (1985), introducing the importance of negotiation: "Negotiation is a necessary cement for organisational action,…. to negotiate is to work (p.267)." Tjosvold (1989) and Tjosvold & MacPherson (1996) observed that hospital

professionals relate to this need for coordination in three different ways; they may relate to each other in a cooperative, competitive, or independent way. Each of these interactional styles may affect the dynamics and outcomes of their coordination efforts. When hospital employees interact with each other, they use the structure and values of the hospital to conclude whether their goals are cooperative, competitive, or independent. How professionals perceive their goal differences when interacting may, to a large extent, determine the quality of their coordinative efforts.

In order to facilitate such efforts, the hospital as an organisation needs institutional means (mechanisms) and skilled personnel to handle and negotiate coordination and collaboration problems and to manage disputes and conflicts arising as a result. The tasks of problem solving and conflict management are delegated to the individual professional or clinician or to leaders of units, wards or other defined systems. Today, these actors are facing higher expectations for handling these tasks with a constructive outcome and thus focusing more on this part of their professional functioning. However, many feel this is a neglected part of their training. Hospital professionals are compelled to pursue ”efficiency” and ”cost-effectiveness” at the same time they strive to maintain the humanity involved in patient care. Many professionals and managers feel the hospital as a workplace has shifted from a need to negotiate almost nothing to a need to negotiate everything.

In summary, it seems hard to overstate the importance of ”good” cooperative working relationships in hospitals. Apart from the obvious risks to patients when good working relationships fail, hospitals are important as socialising arenas for most health professions; this is where they learn their place and their attitudes toward members of other professions (Mackay, 1993).

Conflict Research: An Overview

Conflict is a widely studied phenomenon with a long research history going back to Darwin, Marx and Freud and what has been labelled social Darwinism and instinctivism dating from the early last century (Deutsch, 1990). Since the decline of these modes of explaining conflict and conflict behaviour in the late 1920s, the dominant approaches have been either the psychological mode focusing on the importance of mental processes and individual characteristics, or the socio-political-economic mode emphasising contextual, social, economic and political factors. Even though these modes of explanation are not mutually exclusive, there are few efforts to combine the perspectives. An exception to this is the work (”field theory”) of Kurt Lewin who, during the 1930s and 1940s, developed a theory of three basic types of psychological conflict: approach-approach, avoidance-avoidance and approach-avoidance (Lewin, 1948). The influence of Lewin’s ”field theory” is found in the work of Deutsch (1949)

whose theorising on cooperation-competition has found its way into research on conflict management in health care organisations (Tjosvold, 1989).

Today, conflict is an extensive and diversified research area studied in the political sciences, in business administration, in economics, in sociology and in psychology and encompassing a variety of subjects ranging from international peace and war issues, community mediation, work-organisational disputes, family therapy and divorce mediation. Within each of these disciplines, conflict and conflict behaviour is studied and analysed according to the dominant theoretical paradigm of the discipline and the specific challenges of the study field. However, there has been a predominant positivistic basis to much of conflict research that over the last years has been challenged by a post-structural and constructivistic approach (Cobb, 1991). The essence of this critique is that conflict may fruitfully be understood as ”constructed” as opposed to ”real” and includes more than what is observable behaviour, for example history, culture and impact of long term relationship. Accordingly, a negative developing interaction pattern over time may be as important to the development of a conflict as a particular misunderstanding or any difference of interests. Further, instead of viewing language as representing ”reality”, the constructivist approach emphasises language as constructing reality and thus being a source for conflict resolution as much as creating conflict. Finally, conflict resolution and change is possible through reflection, dialogue and construction of alternative or new stories and not just through logical analytic reasoning and rational decision-making related to distributional justice.

Research on Conflict in the Work Place

In the field of organisation research the different schools or approaches take different positions on issues related to cooperation, conflict, conflict behaviour, conflict management and change. Following Scott (1992), the rational, natural, and open system perspectives on how organisations work vary considerably from denial and/or attempts to handle conflict through established rules and regulations to active encouragement and management of conflict through negotiations and accommodation (Rahim, 1986b; Shortell & Kaluzny, 1988). Within the rational/classical perspective it is assumed that conflict is detrimental to organisational performance and efficiency and therefore should be minimised or avoided. The prescription for this includes construction of appropriate departmentalisation, chains of command, span of control, and having specified rules or procedures for work coordination.

The natural approach recognises that conflict is inevitable in organisations as a natural phenomenon, but nevertheless considers conflict to be disruptive of group functioning and thus bad for organisational effectiveness. Conflict is perceived to be a result of maladjustment of employees, a lack of social skills or dysfunctional group processes.

The open system approach does not necessarily view conflict as being dysfunctional, but rather sees conflict as having the potential to promote creativity and innovation. A moderate level of conflict handled in a constructive fashion is necessary for organisational development and the attainment of optimum efficiency. This is a particular predicament for leaders and managers who at the same time face the challenge of minimising disruptive conflict.

In summary, organisational research is historically dominated by approaches viewing conflict as something negative and a threat to effective group functioning and organisational performance. As it stands now, conflict is considered not only ”normal” and inevitable, but within limits is considered to be essential to productivity and may even be a positive indicator of effective organisational management (Brett et al., 1990; De Dreu & Van de Vliert, 1997).

The Concept of Conflict

In organisations, conflict may be related to competition (goals, task performance, scarce resources), lack of cooperation among/between employees, their leaders or work units, ambiguity over responsibilities or rights, power differences, and/or denial of a person’s self-image or characteristics (De Dreu & Van de Vliert, 1997). However, there is no consensus in the literature as to a precise definition of conflict; thus it is referred to as a ”fussy” concept, with a multitude of meanings. The diversity of definitions has been summarised at different times by several authors. Rahim (1986a) defines conflict as ”an interactive state manifested in incompatibility, disagreement, or difference within or between social entities, i.e. individual, group, organisation, etc (p.13).” Thomas (1992) summarises conflict to be ”the process that begins when one party perceives that the other has negatively affected, or is about to negatively affect, something that he or she cares about (p.653).” Wall & Callister (1995) concludes that “in general these definitions hold that conflict is a process in which one party perceives that its interests are being opposed or negatively affected by another party (p.517).” Finally, Van de Vliert et al. (1997) observe that ”individuals are in conflict when they are obstructed or irritated by another individual or group; they subsequently react in a beneficial or costly way (p.38).”

These summaries of definitions share a common understanding of conflict as a process that begins when an individual or group feels negatively affected by another individual or group: for example due to differences in interests, values, goals or because of incompatible behaviour. Together, the definitions seem to provide a generic format of conflict. A conflict has a core process related to social interactions between parties that is negatively perceived by at least one party. As with any social process there are precursors to the core process of a conflict as well as consequences and effects thereof that feed back to affect the precursors, thus establishing a conflict cycle that may be

either of a escalating or de-escalating nature. Such a conflict cycle takes place within a context or situation and the cycle may flow through numerous iterations. Even though it is reasonable to assume such a generic format to conflict, it is often a challenging task to identify and account for all the idiosyncratic features that may be contained in a particular conflict.

A term frequently used in conjunction with conflict is ”dispute”, either as a term for an emerging conflict or a ”mild” type of conflict. It is also used to describe a type of method for conflict management that is called dispute systems design (Moore, 1986; Brett et al. 1990). Dispute will be used here as it is used in the above references as a wider term than conflict, covering disagreements and differences in opinions and viewpoints. In disputes, people may express their different understanding of what is at stake, but may not yet act differently. Conflict is when disputes take on emotional qualities in terms of negative affects that are expressed in behaviour. Conflict refers to behaviour, whereas in disputes people may not yet act differently. However, it goes without saying that it may at times be difficult to make such a distinction.

Emotion and Conflict

The above-mentioned definitions of conflict include a component of “negative” behaviour affecting one of the parties, thus indicating the negative emotionality that is so characteristic of many work conflicts. Conflict seems to be among the most emotion arousing of phenomena in a workplace. Dewey pointed out long ago this close connection between emotion and conflict: ”Without a conflict there is no emotion, with it, there is” (Angier, 1927, p.401), thus explicating the pivotal role of emotions both as a result of conflicts and an indicator of conflict. Schipper (1996) added that emotions should be taken seriously for other reasons as well, because in part they may contain implicit judgements, and they may function in the exercise of judgmental rationality.

The many strong emotions that accompany conflicts are presumed either to be a by-product of the party’s cognitions or left over from other events that have entered the conflict episode as a mood that influences the episode. The emotions seem to have two types of influence on conflicts: the shaping of cognition and their introduction of additional motivational forces. Thomas (1992) summarised this to include the experience that negative emotions, once aroused, feed back on cognition to produce cognitive simplification, reduce trust and construe the other’s behaviour negatively, lead to either/or thinking and to reduce a party’s ability to think in an integrative fashion. Furthermore, emotions add additional forces to those produced by a party’s rational and normative reasoning. In the extreme, these urges may drive out normative and rational reasoning so that the party’s behaviour is primarily understandable in terms of emotional venting.

Anxiety and anger are the two emotions most commonly researched in relation to conflict. Sørensen & Grimsmo (1996) refer to anxiety in their discussion of conflict development. However, the emotion most commonly associated with conflict is anger (Fincham et al., 1990). Anger may be a source of conflict, and the root of the anger common to organisational conflict lies in the judgement one party makes about why another party behaved in a harmful manner. When such judgement leads a party to hold the other responsible for that negative behaviour, compassion diminishes just as anger is aroused (Allred et al., 1997). Thus, an attribution of blame is the proximal cause of this emotion. The negative consequences of anger are a tendency to depredate the relationship between the involved parties, often leading to escalation of conflict (Wall & Callister, 1995).

Person vs. Situation

Commonly, in western culture, the emergence of a conflict is explained by the parties by reference to the opponent's personality traits and not to characteristics of the situation (Norenzayan et al., 1999). Since Mischel (1968) claimed that situational factors are more important than personality factors in explaining organisational behaviour, this tendency has been labelled the fundamental attribution error or the psychodynamic fallacy. Research during the last decade has cast doubt about this position and has challenged this cursory role of individual factors and their relevance in explaining emergence and development of a conflict. Carnevale & Pruitt (1992), in their overview of studies on negotiation and mediation, noticed that research on individual differences is coming back both in terms of gender and personality, but with inconsistent results. Baron (1990) argued that a person's attribution is the key factor in understanding his behaviour in an organisational conflict and thus emphasises the importance of mental processes in conflict development. Utley et al. (1989) found that personality factors are important determinants of one's response to interpersonal conflicts and that the importance varied with the target of the conflict interaction. Appelberg et al. (1991), in a Finnish study of interpersonal conflict at work and psychosocial characteristics of employees, concluded that both occupational factors (type of work, status) and personality factors (neuroticism) are significant risk factors for interpersonal conflicts at work. Francis & Rodger (1994) found that clergy high in conflict have high scores on scales of neuroticism and psychotism. Mastekaasa (1994), in an analysis of Norwegian census data by employee background variables, found that the experience of conflicts at work has a negative effect on work satisfaction and psychological functioning, and those reporting a conflictual work place admit to more psychological complaints. However, due to the study design, the direction of personality as a variable could not be determined. The study indicates there are more conflicts among the young and well-educated employees, and that conflicts occur more often in larger organisations. However, there is no difference in the experience of conflicts across types of organisation.

It seems as if both personality and situational factors are important, and it may be as Schneider & Hough (1995) claim that situations may vary in strength and thus give variable space for the influence of personality. Personality variables would be important in predicting conflict behaviour in work settings of weak situational strength, for example, in work situations characterised by low structure, high autonomy and independence between actors.

Conflict Management

There is a close connection between the mental map or conceptualisation of how organisations work and how to understand and manage conflict (Shortell & Kaluzny 1988). As pointed out above (page 7), the different schools in organisation research take different positions on these issues and give more or less explicit normative suggestions about how to handle conflict. Regardless of preferences, the institutionalised responses to conflict vary from self-help, collaboration, negotiation, mediation and litigation to professionalised courts (Slaikeu, 1989; Brett et al., 1990). The conflict management practices prevailing in any organisation are a product of its values, its psychological imperatives, its history and culture, and its economic, political and social organisation (Thomas, 1992). The forms of conflict processes that take place depend on an availability of resources, information and competence (Slaikeu 1989; Slaikeu & Hasson, 1992). In the absence of effective informal or formal modes of handling conflicts, participants may resort to avoidance, endurance, a pattern of tolerating on-going conflict, aggressive behaviour or violence (Moore, 1986; Bergmann & Volkema, 1989).

The general research in the area of conflict management and negotiation has resulted in a number of typologies to categorise the behaviour strategies and styles of the participants involved. Such styles have been conceptualised in the literature along one (Deutsch, 1949) or two dimensions (Blake & Mouton, 1964; Thomas, 1976; Rahim & Magner, 1995), ranging in number from two to five behavioural styles or strategies.

Deutsch (1949; 1990) in his ”two-style theory” of cooperation and competition, proposes that, in cooperation, people believe their goals are positively linked and that by reaching their own goal others will be helped to reach theirs (”win-win”). In competition, goals are negatively related so that one’s success interferes with others’ (”win-lose”). With a cooperative orientation people are likely to discuss issues openly and assist and influence each other positively and participate in a constructive problem-solving process. A competitive orientation, on the other hand, may result in avoidance or conflict escalation and a destructive process that encourages the use of power tactics eventually leading to alienation, low productivity and low morale.

The most common typology used to understand conflict management in the workplace is the ”five-style-paradigm”, a paradigm that refers to responses individuals may select in handling conflicts (Blake & Mouton, 1964; Thomas, 1976; Rahim & Magner, 1995): avoiding (the person, issue, the situation), accommodating (giving in), compromising (both parties make adjustments), competing (forcing to satisfy one’s desires) and collaborating (problem solving). These styles fall along a continuum with avoidance and litigation as end points and each is capable of ending a conflict. The selection of preferred behavioural style in a given conflict is determined by two factors, ”concern for self” and ”concern for others”, and the extent these are pursued by the parties. Thus, this typology assumes that these two dimensions are the driving forces behind individuals’ behavioural choices in conflicts regardless of context and existing social relationship. The five-style paradigm has been criticised for having a ”managerial bias” and focusing too much on ”the issues” between parties and not recognising how the emotional and social relationship between parties affects the conflict style of an individual (Nicotera, 1993).

There is a great deal of uncertainty as to which conflict management techniques are successful (Wall & Callister, 1995). Actually, more is known about the steps parties take or prefer than about what works. It seems that most conflict management approaches are contingently effective; that is, they work in some situations, but not in others. However, when it comes to evaluating the outcome of a conflict resolution process, it seems that participants may value procedural justice as much as the dispute resolution. When managing a conflict, there is a tendency to fixate on it and its resolution, at the expense of procedural justice. However, as pointed out by McFarlin & Sweeney (1992), procedural justice is more important than distributive justice when it comes to fostering organisational commitment, positive evaluation of the workplace and trust in supervisors. Thus, the way conflict is managed at the workplace, in particular participants perception of procedural justice and its impact on building commitment and feelings of loyalty, has important implications for development of organisational culture (Tyler, 1986).

Over the last decade, the development of what is called dispute systems design has shifted the focus from an exclusively management approach to a more structural and institutionalised approach when it comes to handling conflicts within work organisations. Dispute systems design is an attempt to reduce cost of conflict and to realise its benefits by changing the way people handle their disputes. This is pursued through providing people more opportunities and options when facing conflicts. The approach of dispute system design is based on the assumption that conflict is inevitable within organisations and, if successfully managed, can produce high quality, creative solutions that lead to innovation and progress (Brett et al., 1990).

In summary, a range of processes exist for settling disagreements and disputes. The challenge is to provide managers and staff with an understanding of these processes and their advantages and disadvantages, and to help them to understand and use the processes that are best suited for different kinds of disputes and conflicts. Matching problems to processes in order to make sure there is a fit between them, points to the importance of not just techniques and skills, but also of appropriate forum and social arenas in order to resolve them fairly and effectively.

Three Perspectives on Conflict and Conflict Management

Even though the dominant perspective on conflict and conflict management in organisation research today is systemic as expressed by the cyclical relationship between the core process of a conflict, its precursors and outcomes (page 13) and its embeddedness in the larger organisational context, there are wide differences in the literature as to what part of the conflict cycle being emphasised. One of the key differences in the approaches involves the extent to which there is a focus on goals and defining events versus process (time) and relationships (emotions). This has broad ramifications for how conflict is understood and should be handled in organisations. These variations may be submerged into three perspectives that are applicable in terms of understanding the emergence and development of conflicts in the workplace (Robey, 1986; Thomas, 1992; Wallensteen, 1993);

- The dynamic perspective where conflict is perceived as a negatively spiralling process over time (often unpredictably) related to minor incidents and souring of relationships.
- The frustration-aggression perspective where the roots of a conflict are found in the gap between expectations and organisational ability to meet these expectations.
- The rational perspective emphasises structural causes (differentiation, work interdependence, resource sharing) or a specific situation or type of behaviour (such as the deliberate interference or blocking of the goal attainment of another party) as the origin of the conflict. The perspective focuses primarily on manifest conflicts wherein the participants are assumed to know about the issues at stake, make their calculations and search for the ripe moment to make their moves.

The first two perspectives tend to present conflicts as a dynamic process where the participants contribute to the development based on the way they handle their relationship in an escalating or de-escalating manner. The last one emphasises conflict more as an identifiable event where the participants consciously choose their roles and behaviour. None of these perspectives are mutually exclusive, and any conflict may be analysed according to each perspective, resulting in a somewhat different focus.

An important preconception of the present research was to explore and understand how hospital professionals conceive of and handle conflicts, thus transgressing each of the three perspectives as a sufficient perspective by itself. However, for the purpose of the research the following broad working definition of conflict was adopted: Conflict is a difficult disagreement related to work cooperation with another employee or group or work unit of others where ordinary problem-solving behaviours have not resulted in a solution or acceptable result. This broad definition assumes to capture the core of a conflict related to disagreements between parties that are experienced as "difficult" (for example emotionally negative, frustrating, irritating) over a period of time. Furthermore, it assumes that the prehistory of a conflict is found in a problem or concern that continues to surface or to frustrate one of the parties, and where the available solution structures and participants behaviour do not result in an acceptable outcome. This definition of conflict differentiates more short term and repetitive "sudden clashes" and "collisions" that may occur between employees based on errors and miscommunication from the concept of conflict used in this dissertation. However, as these types of social interactions take on a pattern over time, they may develop into a conflict.

Conflicts in Hospital

Even though the dominant conceptual models of hospital organisations, "negotiated order" (Strauss et al., 1985) and "human service organisation" (Hasenfeld, 1992), both emphasise negotiation as a major coordinating mechanism of such systems, there is a paucity of empirical studies addressing how hospital professionals go about negotiating differences, what kind of strategies are employed and what happens when negotiations are not working or break down. Thus, there is limited empirical knowledge as to what kind of conflicts there are between professionals and units and how these emerge, progress and become solved.

This trend is also reflected in Scandinavian research on hospitals, where over the last 25 years little attention has been paid to interdisciplinary cooperation and conflict between professionals within clinical work settings. Research and public attention have focused primarily on health care policies and planning and outcome evaluation of delivery and service systems. However, on a consultation level, there have been a number of reports dealing with how to improve cooperation and patient flow through hospital systems (Buhaug et al., 1991; Kongsli & Røise, 1993). To the extent that research on hospital organisations in Scandinavia has addressed issues of interprofessional conflicts, a review of eight major studies from Norway, Sweden and Denmark reveals that conflicts were referred to exclusively in relation to structural variables (Borum, 1976; Romedal & Karlsen, 1977; Riemer, 1982; Berggren, 1986; Thomsen et al., 1986; Lindefors, 1991; Eriksen & Larsen, 1992; Pettersen, 1993). The dominant organisational paradigm in all of these studies is Leavitt's structural model ("Leavitt's diamond"). Conflict in these studies is conceptualised as resulting from limited resources, the structuring of

work tasks, inter-role relations, professions having different goals, and how claim to turf and territoriality reduces cooperation. The perspective on conflict and cooperation in these studies is foremost a structural and rational one, with the exception of Eriksen & Larsen (1992) who introduced the concept of ”communicative rationality” as important in explaining professional cooperation, and thus introduced a focus on the dynamic interplay between participants.

From outside Scandinavia, available studies point to the pivotal role of the physician in understanding and shaping the behaviour of other hospital providers (Chacko & Wong, 1984; Spiegel et al., 1985; Katzman & Roberts, 1988; Curtis, 1994; Keenan et al., 1998). In most studies, the main explanation for the occurrence of conflict among professionals is in terms of professional or specialist territoriality, rival perspectives on patients and care, specific orders, patient disposition and competition for or disputes over such. Organisational size and conflict seem to be positively correlated, whereas gender seems to have little to do with conflict (Chacko & Wong, 1984; Spiegel et al., 1985; Keenan et al., 1998). The attribution style of the individual professional, whether external or internal, is related to self-management in conflict situations (Curtis, 1994). The leadership style and receptivity of the physician seem to be major predictors of ancillary professions´ ability to perform tasks successfully (Chacko & Wong, 1984). Physician receptivity is important not just between professions, but even within the medical profession, as indicated by Fox (1994) in his analysis of the rival perspectives on patients held by surgeons and anaesthetists.

Most of the research in recent years on conflict in hospital is within the area of surgical department, operating theatre, emergency room and intensive care (Larson & Martinson, 1990; Howard et al., 1992; Thorsness & Sayers, 1995; Taylor, 1996; Keenan et al., 1998). Of particular concern in these studies are issues related to handling of critical incidents, behavioural conduct, verbal abuse, and negative emotions like anger and hostility.

Anger is the emotion most frequently associated with conflict in clinical settings. Research refers to the physician-nurse relationship as the primary arena for anger behaviour, both in terms of frequency of occurrence as well as sources of anger (Cox, 1991; Farrell, 1999). Nurses and physicians are reportedly the professionals most angry with each other. A major precipitant of anger behaviour is competition or protection of perceived work territory (Spiegel et al., 1985; Alpert et al., 1992). Another factor is physicians’ work situation, for example tiredness, overwork, distress due to concern for patients suffering and safety (Firth-Cozens & Greenhalgh, 1997). Anger related to conflict may be expressed in a number of ways such as territorial strife (Alpert et al., 1992), behavioural rudeness, abusive language, humiliation (Larson & Martinson, 1990; Cox, 1991; Stiglich, 1994; Farrell, 1999; Simms, 1999), humour and slang (Lupton, 1997; Coombs et al., 1993a) and blaming (Lupton, 1997). Such anger behaviour may be an indicator of conflict or, in its own way, a contribution to conflict.

Among hospital professionals, common sense often attributes the cause of conflict at the workplace to individual's personality rather than to other factors. However, there are no available studies focusing directly on this issue. In so far as there is a close association between anger and conflict, the study of Coombs et al. (1993b) is of importance in pointing out physicians' personality as a source of anger behaviour, in particular surgeons who score high on measures of ”dominance” and ”aggression”. Also of importance in this respect is the conclusion of Pettersen (1993) in her study of intensive care units in Norwegian hospitals, that characteristics of the individuals are far more important in understanding conflict than initially hypothesised in her structural model. Nevertheless, on a text book level, the dominant approach to conflict in hospital organisations seems to be a combination of a natural and structural approach focusing on structural factors as determinants of coordinative needs, and internal negotiation (formal and informal) as a mechanism for solving arising conflict (Shortell & Kaluzny, 1988).

Conflict Management in Hospital

Within hospitals, the five-style paradigm of conflict management (Blake & Mouton, 1964) is most frequently used when explaining how professionals go about managing behaviour and events threatening to reduce or limit required coordination and collaboration in the treatment process (Nilsson, 1989; Keenan et al., 1998). Rogness (1987) used this typology in a study of negotiation strategies in an U.S. hospital, extending the model by adding ”alliance formation” (coalition building) and ”hierarchy” (involvement of higher level) to the number of behaviour strategies. However, a survey study of intensive care units in Norwegian hospitals, using the same typology except for ”alliance formation”, concluded with only three meaningful strategies: Compromise, confrontation and problem solving (Pettersen, 1993). Svensson (1996), in an interview study of Swedish nurses in medical and surgical wards, confirmed that nurses use these three strategies, in addition to ”alliance formation”, in negotiating with physicians. However, these studies suffer from a one-profession perspective or a managerial bias that is especially troublesome in hospitals characterised by multiple professions and a high level of professional self-management providing the management functions. Furthermore, these studies are based on the same assumption as the five-style paradigm, that the driving force behind professionals' behavioural choices in conflict are the two factors “concern for self” and “concern for others”, regardless of context, emotion and social relationship (Nicotera, 1993). Neither does this framework adequately address why a professional would select a “self-“ and/or “other-“ oriented conflict style in different organisational situations.

In the “two-style model” of conflict management formulated by Deutsch (1949; 1990), conflict behaviour is understood as resulting from either a “competitive” approach/goal-

orientation or a “cooperative” approach/goal-orientation on the part of the participants and not as a choice between “self-” or “other” orientation. This model has been used within hospital research on conflict, abeit to a much lesser extent than the five-style paradigm. Research exploring the utility of this approach has focused exclusively on the leader-employee relationship in hospital organisations and not on the lateral interprofessional relationships. Tjosvold (1989) and Tjosvold & MacPherson (1996), in their studies of the relationship between leaders/managers and physicians/nursing administrators/staff employees, conclude that there is a definite advantage to work productivity and promotion of quality care, when participants emphasise their cooperative goals and reduce their competitive ones.

In so far as available studies provide recommendations for conflict management in hospital settings, the main focus is on encouraging professionals and clinical managers to sharpen their skills in negotiation, mediation, open discussion of opposing views, use of creative problem-solving techniques and methods like ”devil’s advocate” (Preston, 1988; Slaikeu, 1992; Gupta & Labbett, 1994; Tjosvold & MacPherson, 1996, Miller, 1998). Øvretveit (1995) points out the importance of improving team functioning and, in particular, decision-making in teams in order to prevent unnecessary conflicts. Thorsness & Sayers (1995) describe the need for cultural change, in particular with regard to desired norms for behaviour conduct in conflict. There are also reports of the use of training programs in Crisis Resource Management similar to courses in cockpit resource management (CRM) conducted in commercial and military aviation (Howard et al., 1992). Slaikeu (1989) recommends using the generic model of “dispute systems design» in order to reduce the costs of conflict and realise its benefits. In summary, these studies indicate that in order to strengthen the conflict resolution capability of the hospital as an organisation, there should be a dual focus on improving organisational processes and structures as well as the negotiation skills of clinical leaders. However, there are few descriptions in the literature of efforts to introduce and assess such processes and changes.

Public Health Relevance of Conflict Research

As evidenced by the research reviewed above, conflict in hospital settings is found to affect work environment, interprofessional collaboration and treatment and care processes. Furthermore, methods to reduce conflict or to manage conflict constructively are beneficial to the empowerment of hospital professionals, organisational efficiency and quality of care. Thus, from a public health perspective, understanding and managing work conflicts is significant for the effective and efficient delivery of health care services (Aronsson, 1997; Beaglehole & Bonita, 1997; Guldvog, 1997).

Challenges to Conflict Research in Hospitals

Research on conflict, conflict management and negotiations, both in hospitals and in general, primarily utilise the cross-sectional survey design with extensive use of questionnaires. There is also considerable use of laboratory and experimental set-ups. This reflects a trend toward a dominant rational approach to the study of these phenomena, at least until the 1990s, with little focus on context and much on operationalising concepts that are generalisable across many different organisational situations (Alvesson & Billing, 1997). As pointed out by Pfeffer (1997), this is understandable in terms of negotiation and conflict management as subfields of the field of decision making, a field that is heavily rational in its approach. The studies have focused somewhat narrowly on the relationship between a few variables or pairs of variables such as individual predisposition, perceptions, tactics, roles, utility structure, expectations, intervention of third parties and situational factors, with little attention given to the complexities of how the relationships interact to affect the achievement of agreement and conflict resolution (Greenhalgh, 1987; Argote & McGrath, 1993; Jehn, 1997). The use of this approach to conflict management in hospitals has not proven to be very fruitful (Pettersen, 1993; Hernes, 1996). The upshot of this critique of the literature is that the study of conflict in organisations can only to a limited extent be studied as cross-sectional events. In order to include the many variables involved, it appears advantageous to use holistic and system-wide perspectives. Finally, the critique points to the need for exploring the use of new conceptual and methodological approaches as represented by the constructivistic and narrative approaches that hitherto have rarely been utilised in research on conflict and conflict management in organisations.

The rational approach has also been critiqued as being useless in natural settings where the inherent messiness of real-world conflicts makes it impossible to achieve the high level of precision that is typical of research in controlled settings (Klein, 1998). The naturalistic approach asserts that people handle conflicts based on experience and on the use of analogical reasoning, rather than by thinking of various behavioural alternatives to a conflict, weighing them against each other, and finally choosing the right course of action. Instead, in recognising a conflict situation, people seem to choose, within their behaviour repertoire, actions that best seem to fit their experience of an earlier, similar situation. Thus, the best way to understand how people manage conflicts is by studying them in natural settings.

Another criticism of the literature on conflict is that there is too much focus on ”the issues” between parties and not enough recognition of how the history, emotional and social relationship between parties affects their conflict behaviour styles (Nicotera, 1993). Findings have also been considered of limited value in terms of practical application. Thus, several authors (Argote & McGrath, 1993; Nicotera, 1993; Svensson,

1996; Jehn, 1997) have expressed the need for more naturalistic approaches and use of field studies. Of particular importance is the need to study how participant's behaviour shapes conflict development, how conflicts develop over time, the role of the past in the present and how conflict may be passed on from one generation of employees to another.

The five-style-paradigm of conflict management suffers from a "managerial" bias that is especially troublesome in hospitals with a high level of professional self-management providing the management functions. Rarely do such studies include participants of different professional backgrounds in the same study (Nilsson, 1989; Svensson, 1996; Keenan et al., 1998), even in the case where the topic of research is cooperation. This author, in a text search related to this dissertation with the key words of cooperation and work environment, found among 105 published Scandinavian studies, only one study that included both nurses and physicians (Petterson & Arnetz, 1997). By restricting the investigations to the experience and perspective of one profession, primarily physicians or nurses, the studies fail to investigate conflict as a dynamic and systemic interplay within the interprofessional relationship. In order to more adequately study conflict and conflict management in hospital settings, a minimum requirement should be that both parties' experiences and behaviour in such dyadic or multiple relationships are considered.

Purpose and Research Questions

The purpose of the dissertation is to gain a greater understanding of hospital professionals and their conflicts at work, partly by investigating their experiences of conflict and behaviour while in conflict and partly by studying their stories of conflict. This knowledge is intended to contribute to the development of adequate and practical approaches to conflict management and resolution among professionals in hospitals.

The study aims at answering the following research questions:

1. What are the personality and occupational characteristics of physicians high in conflict? (article I)
2. What are the important differences between hospital professionals with respect to perceptions and management of conflicts? (article II)
3. To what extent is it possible to understand conflicts meaningfully as narrative structures, and what are the implications to a narrative understanding of conflicts? (article III)

4. How do hospital professionals experience and cope with anger in professional cooperation? (article IV)
5. What changes can be made to the present ways of managing conflict at the study hospital? (article V)

Material and Method

Triangulation

In order to answer the research questions and adequately meet the critique of the literature reviewed above, the research was carried out as a predominately qualitative study, in addition to a quantitative study, using triangulation to build up patterns of evidence. Studying the finer dynamics and complexities of conflicts, including the many different variables and relationships involved as well as the consequences of these conflicts, requires access to many data sources and a wide array of data. A major ambition from the outset was for the research to come as close to live conflicts as possible and to be able to follow the development processes and resolution efforts. As a conflict develops over time, often as an unpredictable escalation process related to a multitude of variables, one avenue for exploring and recording such a development would be to use a variety of methods. This would involve research activities aimed at retrieving potentially sensitive and confidential information about the life-world of the organisation and participants' work-life, something that would represent a challenge in terms of social interaction and negotiating access to relevant and often hidden social or work arenas and participants' experiences. Furthermore, this would require selecting and using methods that would convey trust and confidence in the study and researcher, particularly in relation to physicians training in a natural science paradigm where physicians are inclined to be naturally sceptical to open and soft social science approaches.

Against this background of methodological deliberations the research was carried out as a triangulation study on three levels: In terms of *designs* by using both a survey and ethnographic case design; in terms of *perspectives* by applying multivariate analysis, grounded theory and narrative approach; and in terms of *methods* as techniques in the use of questionnaire, interview, focus group, observation, and written material. This triangulation approach is foremost an expression of a pragmatic and eclectic stance toward the research issues at hand (Denzin, 1994; Symon & Cassell, 1998).

The research started as a survey study of Norwegian physicians with the purpose of obtaining an overview of the field and focusing on some of the research questions. The material utilised in this first study was gathered through the use of a survey study of Norwegian physicians and is presented in article I. Following this work the research proceeded as an ethnographic case study of a Norwegian urban hospital, using the methods of interview, observations, focus group and written material. The remaining four articles present the findings from this ethnographic study, and the sequence of the research was completed more or less in the following presented order: Interview data of participants' experience of conflict is presented in article II and analysed according to a

grounded theory approach. Conflict stories containing the versions of opponents are presented in article III and analysed as narrative structures. Article IV on anger related to conflicts is based on material from all methods and analysed in a combination of grounded theory and narrative approach. Finally, the ethnographic study contains an action research phase described and presented in article V.

It follows that the different articles present the research findings from a selected and limited angel of the triangulation. The full results of the triangulation approach, covering all that has been seen and heard from different positions, are presented in the summary of the dissertation. Because articles II, III, IV and V all are based on the same ethnographic case study and used a combination of methods they will be described together in this chapter. In order to avoid repetition the summary of these four articles presented in the next chapter will refer to the methods discussed here.

Survey

The survey study presented in article I utilised data from a nation-wide survey in1993, of the work environment and living conditions of physicians in Norway. The material from this survey study provided a unique opportunity to utilise relatively new and available data to obtain insight into the experience of physicians on a large scale and to investigate the relative importance of personality variables versus occupational variables in physicians' experience of conflict. The data used in the survey study was accessed through the Research Department of the Norwegian Medical Association after permission was granted from the department head and the researcher responsible for the requested data of interest, Dag Hofoss who is also co-author of article I.

Ethnographic Study

The ethnographic case design used in articles II, III, IV, and V was chosen because the case design is particularly suited for studies of organisational processes and phenomena in complex and dynamic contexts where it is difficult to isolate variables or where there are multiple, influencing variables and where the boundaries between phenomenon and context are not clearly evident (Kaluzny & Veney, 1980; Bryman et al., 1988; Bryman, 1989; Yin, 1989). Further, case study provides an avenue for keeping constant such factors as culture and environment. Another attribute of case design that was important for the present study, is that within this design it is possible to employ various forms and sources of data and to use both historical and real time data. Case studies are also sensitive to the impact of local and historical contexts that are particularly important where there is a range of different stakeholders, each advancing a different version of reality as is to be expected in a conflict. Finally, case study methodology is holistic rather than reductionistic, and thus affords an opportunity for a systemic view of conflict processes.

The ethnographic aspects of the case study design are found in its intent on discovering and communicating an organisational reality (in this study, conflicts) as it is experienced by the participants in that reality, i.e. the hospital (Stablein, 1996). Furthermore, the ethnographic aspects are evident in the extensive fieldwork, the direct observations of the activities of the professional groups being studied, the communication and interaction with the employees, and the use of both informal and formal interviews (Moustakas, 1994).

Within the case of the study hospital, there are additional 101 sub-cases in the form of conflict stories that have been collected and reconstructed based on interviews, written materials and observations over the course of the study period.

All material in this ethnographic case study was analysed either by a grounded theory or a narrative approach (see below under data analysis).

Action Research

The ethnographic case study includes in its last phase the development and implementation of an intervention - a new conflict management program in the study hospital. This final part of the research was considered from the start as a desired outcome, but its development grew out of the research development and the interactions that took place between the researcher and participants. The method used to develop, implement and study the intervention falls within a participatory action research approach (Cope, 1981; Bryman, 1989; Eden & Huxham, 1996; Øvretveit, 1998; Kemmis & McTaggart, 2000). Designing and implementing changes in conflict management in an established organisation is as much a political task as it is a technical one. Thus, the design process was framed according to a participatory action research approach, characterised by creating changes through dialogue and the use of local expertise. In action research, the investigator becomes part of the arena being studied with an explicit concern for findings that can be applied in the organisation. A defining characteristic of action research therefore, is its action or intervention phase. Another distinguishing feature is the collaboration between individuals inside the system, in this case hospital employees, and individuals outside the system, herein the author as a researcher. The author's role was that of an independent researcher in gathering data and describing the action process. In addition, the author functioned as a consultant to the task force that planned and implemented the new conflict resolution program. Potential role conflicts between the author as an "independent researcher" and consultant in the "participatory action research" did not surface because the research phase preceded the "participation" phase and was completed before the task force started its work.

The Study Hospital

The ethnographic study was carried out at a middle-sized city hospital, in Norway, serving a catchment area of approximately 100.000 people. The hospital offers treatment services in general surgery, internal medicine and psychiatry. In addition to inpatient treatment, the hospital offers a number of outpatient services.

The hospital was chosen based on convenience and the author's access to the hospital through recently having directed a short management course for clinical leaders. The hospital council approved entry to the hospital after presentation of the research proposal. Entry is one thing, gaining access to informants and meeting places is another, particularly in a hospital setting where the organisation is characterised as being closed and having a number of "gatekeepers" (Bryman et al., 1988; Bryman, 1989; Bosk, 1992). This was further complicated by the sensitive and potentially confidential nature of the information being requested. Thus, a considerable amount of time and effort was used in conveying trust and confidence in the study and the researcher through social interactions and negotiating access to their experiences.

The ethnographic case study covered a time span of four years. This time frame was not designed from the onset, but developed as a result of the time perspective inherent in the conflicts studied and the time needed to prepare for the action research. In order to follow a few selected conflicts through to a state that could be called resolution, it was necessary to extend the time perspective (see data collection).

Participants

"Participants" refers to employees that were individually interviewed by appointment in the course of the study. Selection of participants was based on theoretical sampling from different units, hierarchical levels, formal roles and professional backgrounds within the systemwide hospital. Fifty-six participants were formally interviewed from one to eight times, for periods of 30 minutes up to 2 hours for each interview. Twenty-seven participants were interviewed more than two times. Altogether, a total of 115 interviews were completed. Participants represented different professional backgrounds: nurses (24), physicians (20), physical therapist/social worker/bioengineer (4), nurse aid (1), other staff (7). Participants were assured of anonymity, and identifiable cases have been clarified with participants. None of the employees declined the invitation to be interviewed. Several told their conflict story for the first time and were appreciative of this opportunity to tell of their experience. Many participants confirmed the importance of the research project and its theme and, at the outset, the department head of surgery expressed; "There should be enough to dig into". Some participants, in particular physicians, felt the research took place at a time of high tension at the surgical department, as expressed by a senior surgeon afterwards; " When we were more like

other hospitals!". Even though participants may have felt the research coincided with their units functioning on a low level, the literature review indicates that the findings represent a common trend in surgical and intensive care units.

Data Collection

Data for the ethnographic case study was collected using interviews, focus groups, observation and archive material. The collection of data encompassed four stages:

I. During the first part of 1996, 29 persons were interviewed from across the hospital, focusing on their experiences with disagreements and conflicts between professionals. Each person was then asked to give one or two stories (present or recent) that would describe an experience of conflict. Based on these interviews, the Department of Surgery, the department having the perceived "greatest" number of conflicts, was selected for more in-depth studies. In addition, two developing conflicts at the Department of Medicine were included through interviews with key informants and main participants.

II. Field observations of the surgical department and interviews with doctors, nurses, physical therapists, social workers, an additional 27 persons, were carried out during the second part of 1996. Focus group interviews (2) were also used during the fieldwork.

III. During 1997-1998, data collection consisted of follow-up of conflicts through interviews with key informants and participants in on-going conflicts. Eight conflicts were followed closely as they became manifest just before or during the fieldwork, thus making it possible to follow organisational interventions prospectively.

IV. During 1999, the development and implementation of the conflict management program was completed.

Interviews

Interviewing took place on the hospital premises at the office of the interviewee or at the interviewee's workstation. Interviews followed a standard opening procedure where the purpose of the study was explained: "To find out how professionals go about solving their disagreements and conflicts". The interviewee was named as a co-researcher in this respect. A conflict was broadly defined as a "difficult disagreement" related to another employee or group or work unit of others where ordinary problem solving behaviour did not result in an acceptable outcome (see page 12). Interviewing continued as open-ended questions related to the participants' experience with conflicts and cooperation among peers and other professionals, conflict behaviour, type and

extent of conflicts and attribution of conflict. The interviewees were also asked if they were involved in a conflict, had experienced one in the last two years or knew about conflicts at their work unit. Nearly all interviewees reported such experiences. The interviewees were encouraged to tell their stories, and the subsequent interviewing was based on follow-up questions and probing questions to give participants the opportunity to unfold their stories and to clarify episodes, characters, behaviours, emotions, development, and ending. In order to facilitate the expression of ”story performance”, participants were encouraged to tell recent stories that included themselves as actors. On several occasions interviewees started telling their conflict story at the very beginning of the interview, claiming that their reasoning and reflections required such a background.

The interviews lasted approximately 1½ hours each. Approximately half of the interviewees were re-interviewed using serial interviews either because of the extent of the refection on their experience (they had a ”thick” story requiring more time) or because they were involved in on-going conflicts outside the observation field of the author. In the latter case, the interview was used as a debriefing device and as a way of reporting social interactions that were unavailable to the author.

Interview data was recorded shorthand, writing down key words and phrases during interviews and transcribing the notes immediately afterwards or no later than the same day (Bulmer, 1988, Gabriel, 1998). Interviews were not audiotaped due to the unwillingness of participants to have sensitive information recorded in this way and due to prior negative experiences with audiotaping. Efforts were made to define the interview situation as reciprocal, speaking of issues of concern to the participant, and to establish a ”permissive atmosphere”. A major sentiment expressed by participants was that the theme of the interview was important, but rarely discussed. Participants welcomed the opportunity to approach the subject.

Focus-group

Two focus-group interviews were completed with nurses (5) and one with physicians (3) with the theme of the interview being personal experience of anger in the work setting. These lasted approximately one hour each.

Observation

In order to follow conflicts and their development as close as possible, the author carried out participant observation over a period of 6 months at the surgical ward. This included direct observation of social interactions and events conducted during various types of meetings (planning, case review, team and professional meetings), medical rounds, physicians morning meetings, nursing station, cafeteria, social interactions in

corridors, ward training events, seminars, and any ad hoc meeting connected to cooperation and coordination of clinical activities. During certain periods this involved ”hanging around” nursing stations and other work areas. Observations were recorded by writing field notes that were transcribed as soon as possible the same day. After the 6-month observation period, on-going conflicts were followed up through serial interviews with participants.

As a participant observer the researcher’s role was non-obtrusive: the researcher avoided interfering or becoming actively involved in ongoing social or communicative exchanges related to work. Between such work-related actions or events, the researcher would engage in social and communicative interactions with participants with the purpose of either ”debriefing” participants or sustaining an interpersonal perception of the researcher as being attentive and interested in what was happening. Such debriefing interactions would at times lead to a new interview or a follow-up of an earlier interview. Thus, parallel to observations, interviews were carried out. The researcher’s role was accepted as evidenced by the willingness of all those approached to participate in interviews and ”debriefing” exchanges. The positive response to the research and the researcher was most likely a reflection of the importance of the research theme to hospital professionals and the non-threatening character of the research approach.

The serial interview, together with observations, was used because of the characteristics of conflicts. Conflicts may be latent or confined to the inner world of participants, in particular if the conflict behaviour is characterised by avoidance. After becoming manifest, this feature may decrease over time and become less explicit and only to a certain degree observable, or it may happen that the conflict does manifests itself, but the researcher is not there to observe. At the end of the observation period, the head and ward nurses were interviewed regarding conflicts or latent conflicts that may have slipped the notice of the author. No such conflicts were identified.

The observation period provided an opportunity to investigate professionals’ behaviour and their interactions with each other and their environment, and to more closely look at the meanings and taken-for granted assumptions of professionals, in particular the physicians and nurses.

Written Materials

Written material used in the study included reports, letters, minutes from staff meetings, and protocols from negotiations. Such documents were made available to the author as follow-up documentation of issues brought forward in the interview.

101 Conflict Stories

Altogether, 101 conflict stories came to the attention of the researcher during the study period. Each story was categorised as a case. Any text from interviews, field notes and written material connected to a particular conflict story or event was appended to that case. Each case consists of text from one to several sources and from one to several interviews and interviewees.

The text of a conflict story varies from thin descriptions of 10 lines stating the actors, the theme, and having a beginning, culmination and end of the story, to thick descriptions of 1500 lines involving a number of characters or groups. The mean average length of a story is 120 lines.

The plot-themes of the 101 conflict stories fall into four categories of conflict types;

- task conflicts (17); Goals for treatment, level of treatment, use of resources, division of labour
- process conflicts (25); Rules, procedures, planning guidelines, mutual adjustment
- relational conflicts (40); Interprofessional cooperation, behaviour styles (anger, dominance, ignoring)
- ontological conflicts (4); Professional perspectives, professional rationality, values.

Fifteen of the 101 conflicts are mixed, mainly due to a shift in focus of the conflict in the course of its development. Twelve of these mixed conflicts also include relational conflict.

The majority of the 101 conflicts (77) are intradepartmental conflicts. Twenty-four conflicts relate to conflicts at departmental interfaces. Most conflicts involve either a physician or a nurse as one of the main actors. It is worth noting that 20 conflict stories are within the ranks of physicians and not just between physicians and other professions. Also worth noting is the virtual absence of conflicts between nurses and nurse aids. At this hospital, the nurse aid union representative confirmed that there are no professional conflicts between these two professions, something which is contrary to the public and media image in Norway.

In terms of gender, the distribution of conflict seems to follow the same distribution as found across professions and leadership positions.

Eighty-four of the 101 conflicts involve leaders as one of the main participants, and 51 are between leaders, indicating that a major arena for conflicts manifestation and management rests in the hands of leaders and management (medical and administrative). Half of the conflicts (50) are between two participants, the other 51 conflicts include more than two participants who are either another professional, a group of professionals, or a work unit. Some of the participants are ”repeaters”: For example, four persons were involved in 22 different conflict stories. A major

characteristic of these persons is their frequent or intense exhibition of anger (see article IV).

When conflicts have to be addressed because they can no longer be ignored, the usual way to handle this is by arranging a meeting(s), trying to loosen up the situation through confrontations and by using formal decision power or negotiations. In 23 stories, no such meeting was indicated. Seventeen of the conflicts ended with one of the participants quitting, being transferred to another position at the hospital or retiring from work life.

With a few exceptions, the conflicts had persisted for more than a year, and in some cases ”on and off» for up to 10 years. Categorising the stories along a temporal dimension suggests three types of temporalities; Story not yet told (10), story in the telling (40) and story told (51). Most of the conflict stories are about past conflicts. These are no longer active and the conflict is ”over”, but the conflict story is remembered and may still be retold. Stories in the telling are about manifest conflicts. These are conflicts under development as storied versions. Finally, there are stories not yet told at the hospital (to anyone other than the author). These represent latent conflicts that are difficult to talk about. This type of conflict is often experienced by only one party, the opponent not recognising or being unaware of the situation. Thus, these conflicts are particularly difficult to explore in an ethical manner, since there is a definite risk for escalating the conflict by contributing to the storytelling.

Nineteen of the 101 stories include written letters or reports. A transition of a conflict story from being exclusively oral and to include written text is an important sign of conflict escalation and is considered a worsening of the conflict.

Data Analysis

Survey

Survey data utilised in article I was analysed using a linear regression model that was constructed for each of two dependent variables: 1. Experienced serious conflict with superior in last 12 month, 2. Experienced conflict with others at work during last two weeks. Both models were based on two classes of independent variables, work related and personality, and included the same 14 predictor variables. These variables were selected on the basis of hypotheses deduced from the literature and the experience of the authors. Statistical calculations were carried out by SPSS, version 6.1. Further details are provided in article I.

Grounded Theory

Data from the ethnographic case study was analysed either according to a grounded theory approach or a narrative one. The conflict stories were analysed as narratives, whereas grounded theory was used to analyse interview data containing the interviewees' formulation of own their experience with conflicts or their meta-reflections over such experience.

In article II the analysis of interview data was a multi-step process that followed grounded theory procedures and techniques (Glaser & Strauss, 1967; Starrin et al., 1991). The first step was open coding or unitising. Data were examined line by line in order to identify codes, units or concepts related to the themes mentioned in the interviews. Next, the analytic focus turned to axial coding, sorting codes into categories using the constant comparison method. Finally, selective coding was used, fitting and linking the categories together in a theoretical model that includes three behavioural styles and rests on two core variables.

Data analysis was supported by the use of the software package NUD:IST (version 4). In terms of analysing interview text, coded segments of text were placed into designated "nodes" which corresponded either to demographic information (for example ward unit, profession, position, gender) or themes emerging from the data. This allowed for the exploration of the interrelationships between significant variables.

Data in article II are based on interviews with 29 participants before selecting and starting the fieldwork at the Department of Surgery. Saturation was achieved after 2/3 of the interviews was completed. Sampling continued due to the organisational "boundedness" of the phenomenon under study, the uncertainty regarding how representative this would be for the rest of the hospital due to the need to check out variations across the system and due to the need to identify areas of highest occurrence of conflicts for selection of field work.

Interview data from individual and focus group interviews used in article IV was analysed according to the same grounded theory approach. However, in this article the analysis only included the first two steps.

Narrative Approach

The stories utilised in article III were analysed according to a narrative approach (Holstein & Gubrium, 1994; Moustakas, 1994; Czarniawska, 1998; Symon & Cassell, 1998). The major traditions of thought related to a narrative approach to the study of organisations are: (1) Literary hermeneutics, suggesting that meaningful action is to be considered as a text (Ricoeur, 1981; 1984; 1991), (2) Phenomenology, emphasising the

intentionality of human actions and the settings in which they make sense (Schütz 1973), and (3) Ethnography, as represented by the sociological schools of symbolic interactionism and ethnomethodology, emphasising the extensive fieldwork encounter with the phenomenon. In applying the narrative approach there is no common definition, method or technique, or mode of analysis (Denzin, 1994). Thus, in a particular narrative study these will influence the analysis to varying degrees depending on the researchers own position and the field of study. In the study reported in article III, there is an emphasis on literary hermeneutics as represented by Ricoeur (1981; 1991) due to the similarity between a conflict and the story as a literary text. A recounted conflict develops into an oral story that shares the same characteristics as a written story, notably by having a meaning fixed to itself, by developing a life detached from its agents, by developing consequences of its own, by having an importance beyond its relevance to the actual situation, and by being open to an infinite range of possible ”readers”.

Analysis of the conflict stories was supported by the use of the software package NUD:IST (version 4). Each story was categorised as a case and separately coded to a particular node, thus making it possible to gather any information relevant to a story to that node and to other themes emerging from the total textbase. Any text connected to a particular conflict story or event was appended to that case. In addition, coded segments of story text were placed into other designated nodes which corresponded either to characteristics of participants (ward unit, profession, position, gender) or themes emerging from the stories (beginning, participants' behaviour, plot theme, interventions, development, end). This was achieved by posing the following questions to the text of all 101 stories: How do conflict stories start and develop? Under what conditions do conflict stories appear? When are conflict stories told? What type of conflict stories are made? Who is telling conflict stories? What purpose do conflict stories serve? Why do conflict stories continue developing? How do conflict stories end?

In article V there is no independent data analysis, as the article is based on the preceding analysis in article II, III, and IV.

Reliability and Validity

Within qualitative research there are different attitudes toward the questions of reliability and validity. To some researchers, these are rejected on the basis that they are positivist concepts anchored in a notion of the existence of ”objective universal truth” and thus not appropriate for qualitative research, whereas others have accepted the possibility of local, personal and community forms of truths (Kvale, 1996), a perspective pursued in the following discussion of the present research.

The issue of reliability pertains to the consistency of the research findings. The representativeness of the survey data utilised in article I, is discussed in detail by Aasland & Falkum (1994). For the purpose of the study reported in article I, the most important source of bias in the data was that the response rate for specialists in private practice was quite low (50 %). Also, the response rate was lower among men (69 %) than among women (80 %).

In the ethnographic case study, the issue of reliability is foremost related to the role of the researcher as a participant observer, the way questions were posed during interviews (leading questions that may influence answers), and the recording and categorising of data. As described above, interviews were performed as open ended and explorative and not hypothesis driven. Leading questions that would influence answers unduly were limited. Furthermore, approximately half of the interviewees were interviewed a second time or more and had the opportunity to make corrections. None used this opportunity to make corrections. In the case of the conflict stories, all such stories have been confirmed by at least one other party or person except in cases where the story was not yet told. To what extent the researcher in the role of a participant observer influenced professionals' conflict or conflict management behaviour that would otherwise have not happened, is difficult to assess. However, on a regular basis the researcher checked this out with key informants since such a fact would represent a major threat to the study. There was no indication that the presence of the researcher influenced the social and communicative interactions to any noticeable extent. Thus, as a conclusion on these issues of reliability, it seems reasonable to state that the conflicts, conflict behaviour and verbal reflections reported in the study were consistent on the part of the participants.

Validating Criteria

The purpose of the present study is to contribute to knowledge and practical approaches to conflict management in hospitals. One important validating criteria in this respect is the practical usefulness of the findings for the hospital community and whether it contributes to constructive actions related to conflict and conflict management. Do the research findings help people make practical improvements? Even though this view on validity is controversial, it is an important view that finds support in the qualitative research literature (Rorty, 1980; Kvale, 1996). From this perspective, validation is above all a question of what is "good knowledge" (Rorty, 1980) and to test this out in practice (Kvale 1996). According to Rorty, "good knowledge" is what is judged by a relevant community in a specific time and place to be useful, moral or beautiful. In this respect, the action research study reported in article V represents the first step in testing the validity and meaningfulness of this knowledge in a practical setting. However, a further step would be to later evaluate this new Program for Conflict Management and the changes that may have come about as a result of the program.

Triangulation as a research design is considered another important avenue for achieving validation (Denzin, 1994). Thus, the design of the ethnographic case study as a broad triangulation study was chosen to ensure the development of ”good knowledge” of professional conflict in a hospital and to apply this knowledge to develop new actions related to conflict management. Triangulation contributes to validation by building up patterns of evidence based on different methods and analytic perspectives. This is discussed in the last chapter exploring the research findings across the five articles.

In order to achieve ”good knowledge”, an important intermediary validation criteria is what Stablein (1996) has referred to as achieving two-ways correspondence. Since a major characteristic of the ethnographic study approach is that of the researcher as a creator, custom maker and ever-present interpreter, it is expected that there will be a discrepancy in interpretations between the researcher and participants. This means that the quality of an ethnographic study depends on the degree to which the fidelity of the researcher’s representation matches the native viewpoints, e.g. the experience of the hospital employees.

In order to maximise internal validity data in the sense of two-ways correspondence, data collection and data analysis were interwoven and occurred alternately. Furthermore, preliminary data was presented at four different seminars for all participants and subgroups of participants before the final analysis was done. Responses at these occasions were mostly confirmatory, but deepened the understanding and the importance of the urgency/time perspective in interprofessional exchanges. Finally, achieving two-way correspondence was a major issue in the processes that took place in developing the Program for Conflict Management, as described in article V. Without a high degree of two- ways correspondence, it would not have been possible to launch such a program.

Conflict Stories

The conflict stories narrated and analysed in this study raise a number of validity questions. Relevant questions for this study include: To what extent are such stories ”true” and representative of what actually happened? In the case of opponents having different storied versions of a conflict, what then is truth? And what are the limits of analysing such stories as literary texts?

In reconstructing the 101 conflict stories, the author functioned both as a ”narrative finder” and a ”narrative creator” (Kvale, 1996). In this work the author has been influenced by the same processes as narratives in general: Conflict stories are diversified, and the version presented is shaped according to the listener, in particular

the status of the listener. In this respect, the author made efforts to define the relationship symmetrically. Furthermore, a conflict story is not just about telling an experience and viewpoint, but also the staging of a presentation to a listener or an audience that is willing to listen and to become stirred and possibly to take action. Thus, a story elicited in interviews with a researcher may lack such performance features and essentially come out as just a summary. However, performance stories are more likely if the topic is of mutual interest, and participants have shared background and reciprocal relationships and thus shared norms for evaluation of the story. Recent events are more likely to be performed, as are stories, where the teller is the central figure. As a consequence, participants were encouraged to tell such stories.

The 101 conflict stories have all been reconstructed within the same institutional boundaries. This made it possible to cross- check the ”theme” of a conflict story and to gather the alternative versions of a conflict story told by the opposing party. Thus, taking into consideration the risk of contributing to unwanted escalation of a conflict, most of the stories have been crossed-checked in this respect. However, the very nature of conflicts involve more or less a denial of the other party’s story. The reason for this is that a conflict as a social process moves along two dimensions; history as referring to what really happened, and the story as a narrative account. The story refers to experiences, something lived on the part of the participants, whereas the history is information about factual events, actors present at different places and points in time, references to who said and did what. In terms of the factual historic flow of events, the story is ”real” regardless of being ”true”. The story is non-history and is impossible to confirm as a fact. For this very reason, the parties in a conflict most often understand the opponent’s version as ”made-up”, ”imaginary” or ”fantasy”. This raises special concerns of validity where the conflict is latent as opposed to being manifest. If only one party experiences a conflict or is unsure about the other party’s awareness of the conflict, how does one go about exploring the other version? Validating such a story raises ethical questions in terms of asking the other party about his/her version or even asking if the person knows about such a possibility. In these cases, further cross-checking was avoided.

Generally, conflict stories are oral phenomena, and only to a limited degree do these conflict stories materialise into written stories. When this does happen, the genre is the personal letter presenting complaints or the protocol summarising the complaints and the final result of negotiation or arbitration. This raises the question if it is possible to transfer insights from literary theory to an analysis of oral stories of personal experience. Literary theory has primarily focused on historical texts and fiction. It is expected that there is far greater complexity, artistry and imagination in such written work when compared to the spontaneous oral, non-fictional stories of conflicts. The position of Ricoeur and other writers is that oral stories reveal the same fundamental structures and processes as literary genres (Ricoeur 1971; Cortazzi 1993; Abma 1998). Both history as ”true” and story as ”fiction” share a common narrative structure.

To what extent a story, in order to be a story, has to have the same structural characteristics suggested by Ricoeur and applied in this study, may be an open issue. Bloom (1996) and Abma (1998) consider many of these conventions of ”proper” stories to illustrate a linearity and constancy symbolic of scientific, masculine reasoning, and that such narrative conventions are not universal, but related to a particular historical period, culture and style of thinking. However, in spite of this critique, the concepts of Ricouer seem to fit the major narrative conventions dominant in western culture (Gergen & Gergen, 1986; Cortazzi, 1993).

Although most data analysed in this study were collected in only one hospital, the analysis has implications for studies of conflict and disputing in other settings, particularly studies of other hospital organisations in Norway. As a case study, the purpose has been to illustrate more general phenomena of conflict related to cooperation in the hospital setting. In terms of generalising the findings in this respect, it is important to notice that, according to participants, the study hospital does not stand out as any ”worse” than other hospitals. There is considerable convergence in the results from both the survey study and the ethnographic case study, and these findings fit the trends reported in international literature related to conflict and conflict behaviour.

Ethical Considerations

Ethical considerations in public health research are customarily related to the use of four criteria in order to assess the ethical quality of a research project and the relationship between researcher and participants (NEM, 1994). These criteria or standards are the following: Information and openness about the research, voluntary agreement from participants, provision of confidentiality of participants (protection), and utility of the research. The following is an application of these criteria to the present study. The study was initially approved by the leadership council of the hospital, including the research co-ordinator. Later, managers of selected wards and research participants were informed about the purpose of the study. Participation was voluntary and participants were informed about the future use of their contributions. A major concern has been related to securing individual confidentiality and assuring that the researcher not contribute to conflict escalation by re-opening old conflicts. Data from the study has been presented on different occasions at the study hospital without any indication of threats to confidentiality. The utility of the study has been confirmed repeatedly by the participants throughout the study period. The utility of the study has also been confirmed through the development of the ”Program for Conflict Management” at the study hospital.

Findings

Article I

Research Questions

The study presented in this article is an investigation of physicians' conflict at work, focusing on the following research question: What are the personality and occupational characteristics of physicians high in conflict?

Material and Method

The material used in this study comes from the Norwegian Research Program on Physician Health and Welfare, a nation-wide survey of Norwegian physicians in 1993. The survey included a total of 1800 questions spread over 16 questionnaires which were distributed according to a "overlapping questionnaire design". Questionnaires were mailed to a random sample of 9266 doctors of whom 6652 responded (72%). Among the 1800 questions in the survey, there were 15 questions or statements assessing interpersonal conflicts either at work or in private life, where respondents marked their responses on a 5-point Likert scale (either measuring frequency or intensity values).

Findings

The majority (71 %) of those responding reported having had no conflict at work during the two weeks prior to filling in the questionnaire. However, almost every third respondent (29 %) did report having experienced some on-the-job conflict during the last fortnight. Of those reporting conflict with someone in the proceeding two weeks, only .9% reported more than one conflict. In relation to other professions, the physicians did not report having more conflict with nurses and other hospital professionals than with their own colleagues. Every seventh respondent (14 %) reported having experienced serious conflict with an immediate superior during the last year.

Physicians seemed not to be strongly inclined to make conflict an explicit theme in the work setting. Every second respondent admitted to avoiding addressing conflict and poor work climate, even when everybody was aware that a problem existed. The conflict management styles seemed to be evenly divided between those reporting that they avoid conflict and those reporting that they deal with conflict. Fifty-six percent of the physicians said they use dialogue and compromise to solve conflict.

Multiple linear regression disclosed frequency of conflict with someone at work to be significantly related to only one of altogether 14 explanatory variables (conflict with spouse/relatives/friends, respondent's gender, respondent's age, psychological vulnerability, psychological intensity, psychological reality weakness, psychological compulsiveness, number of jobs held per 10 years, being tenured, position of leadership, number of colleagues, hospital employed, surgeon, immediate superior having administrative education, gender of immediate superior, interaction own gender/gender of immediate superior). Other things being equal, those respondents who reported a higher rate of conflict with spouse, relatives and friends during the last fortnight also reported more frequently having experienced conflicts at work.

Frequency of conflict with immediate superior was significantly related to six of the 14 explanatory variables. Again, other things being equal, respondents reporting more conflict with friends, relatives and spouse during the last two weeks tended to report more conflict at work than others. Also, higher scores on the two personality traits of intensity and reality weakness predicted conflict with superior. Being tenured is related to having experienced conflict at work, as is having been promoted to a position of leadership. The size of place of employment (as measured by number of colleagues) also predicted conflict experience.

Conclusions

The main result is that conflict seems to be endemic to the physicians' work situation due to its frequency and its unrelatedness to most variables. Personality factors seem only to be related to conflicts characterised by "high intensity". These findings have practical implications for managers new to a job. They need to know that conflict is very much a part of leading and managing clinical work units.

Article II

Article II builds on article I in terms of exploring some of the same themes and questions, but article II focuses on all types of professions and managerial roles found in a hospital and not just on the role of physicians. Furthermore, the research reported in article II is based on a qualitative research approach designed to enrich the material and to obtain first-hand knowledge of hospital professionals' experiences of conflicts and their reflections on conflicts.

Research Questions

The aim of this study was to find out how hospital professionals go about managing their conflicts. What are the important differences between hospital professionals with respect to perceptions and management of conflicts?

Material and Methods

The material comes from the study hospital, utilising interview data collected during the first stage of the research project. All together, 29 persons throughout the hospital were interviewed, having various professional backgrounds in medicine, nursing or other ancillary support professions. The gender distributions followed traditional dividing lines in hospitals. Age-wise, participants represented a wide distribution from newly trained nurses or physicians to others close to retirement. General hospital leadership and all hospital departments were represented on various managerial and professional levels. The interviews consisted of open-ended questions related to the participants' experience with conflict (conflict behaviour, extent of conflicts, perception and attribution of conflicts) and cooperation among peers and other professional groups. Data was analysed according to a grounded theory approach, supported by the use of the NUD:IST software. Validation was carried out by presenting the research findings at various seminars.

Findings

It seems that hospital professionals have different concepts as to what is defined as a conflict. In particular, physicians seem to have a professional self-concept that allows them to tolerate higher levels of stress and conflict than others, and that provides them with a higher threshold for what they define as a conflict. Whether this is an expression of coping skills or suppression is an open question. Other hospital professionals demonstrate a less restricted concept of conflict as compared to physicians. They consider the conflicts involving physicians as the most important ones due to physician's leadership role and the physician's responsibility for initiating all treatment-related activities in the hospital.

Participants agree there are few open conflicts at the study hospital, but acknowledge that there are many latent ones. One reason for this is that they strive for pragmatic solutions or avoid being too insistent. When conflict occurs it is mainly understood as a personality issue or the result of a poor matching between persons who have to work together. This is an attribution style shared by all hospital professionals.

The analysis revealed that when in conflict, professionals use three major approaches to handling the situation: avoidance, forcing and negotiation/compromise, usually in that order. Regardless of professional background, department or hierarchical level, all participants refer to the prevalent use of avoidance. They perceive that there are few opportunities for addressing conflicts. Avoidance as a way of handling conflict is expressed through different behavioural styles: Silent withdrawal after a confrontation, keeping the issues and feelings to oneself, and actively talking with peers or own reference group (”hallway gossip”).

If avoidance behaviour does not take care of the issue, an alternative conflict style is to use forcing, which involves the use of formal or informal positional power. Forcing is not necessarily used in open formal meetings, but is often hastily used outside the formal structure.

Negotiations are usually staged when leadership levels higher up, unions or personnel department have been involved in the conflict. When leaders get involved in conflict management, as they do when negotiations are staged, it seems that they come in too late. The prior use of avoidance and forcing has often created a situation where participants at a collision course with each other have invested a lot in their positions. Even though the thrust of negotiations is to come to a compromise of a ”satisfying” nature with which all parties can live, the complexity of the situation works against this. There are now more actors and more interests to take into account, and often the conflict is more formal. Principal and legal aspects of the conflict are more in the foreground, and the precedence aspect of the outcome of the conflict becomes more important, thus restricting the number of alternative solutions.

Conflict styles as described above seem to be determined by two major factors; the perceived interdependence between parties and the perceived urgency. Even though interdependence between parties is a precondition for conflict, it is not enough to create conflict and elicit conflict behaviour. There must also be a discrepancy in perceived urgency among the parties to do something about the issue at hand. When perceived urgency between participants is aligned, interdependence promotes cooperation rather than conflict.

Urgency is expressed behaviourally through the insistence that an issue is of importance and by the strength of the arguments in favour of doing something about the situation. The perceived level of urgency by the parties is vital to how a conflict is dealt with. Professionals differ, however, in their power to define urgency and their ability to market their sense of urgency**.**

Nurses and physicians seem to have different perspectives on time and punctuality. To nurses, time seems to be spread out linearly, in a way that makes it possible to divide time and control the use of time. To physicians, time seems to come in terms of tasks.

Their challenge is not to portion time, but to prioritise the most urgent tasks at hand. This different conception of work time underlies conflicts and may be the basis for perceptual differences of urgency. Due to the higher definitional power of most physicians, there is a tendency for physician's time perception to dominate professional interactions.

Conclusions

A major challenge to hospital professionals and leaders is to identify at an early stage when avoidance as a conflict style is no longer meaningful and further to develop alternatives to forcing as a follow-up of avoidance. This may require training for leaders in negotiation skills and observation of conflict development processes. Even though hospital professionals share the same attributional styles related to conflict where personality factors are emphasised, there are considerable differences in their perceptions of conflict, particularly in the perception of urgency for doing something with the issues involved. Managers and leaders admit to giving the challenges of managing conflict lower priority and not spending sufficient time on such issues. The study hospital did not seem to have an established and easily accessible negotiation structure that could be utilised when having to stage negotiations to mediate conflicts.

Article III

This article uses a narrative perspective to analyse conflict and conflict behaviour by describing the elements of conflict stories and their function. One particular challenge in such an approach is to get access to conflict stories and the storytelling process that takes place in the development of stories. The article focuses on how the same conflict is experienced and perceived from the perspective of the opposing parties involved and not just one party as was the case in Article II. By taking actual conflicts and analysing how opponents experience the same conflict, what are the important differences? This is an approach hitherto not reported in the literature, and thus its fruitfulness is not yet explored. The end of the article describes the value and use of taking this perspective.

Research Questions

To what extent is it possible to understand conflicts meaningfully as narrative structures? What are the implications to a narrative understanding of conflicts?

Material and Methods

The material providing the background for the present study is the transcribed text of the 101 conflict stories collected at the study hospital (see page 25). One exemplary conflict story was selected from these 101 conflict stories because it illustrates common aspects resulting from a narrative analysis of the other 100 conflict stories. With a few exceptions, all stories were confirmed by at least one other person participating in the study. With regard to the exemplary conflict story, both story version a and story version b were approved by the two principals.

Findings

A conflict, by the act of telling, is presented in a narrative form. The events are sequenced according to some causal logic (plot) that establishes roles for persons (characters), creates action and leads to a value–laden outcome. The plot expresses more or less explicitly a theme, usually about breaking a value, norm or rule, that creates a foundation for further developing the story. A conflict story is characterised by always coming in at least two versions. The two storied versions of a conflict have divergent emplotments that may keep diverging if the parties seek support for their own version and strive to avoid incorporating the opponent's perceptions and thus make changes in the emplotment that may lead to a convergence of the versions. Without divergence in the emplotment, there is no conflict. Extreme divergence leads to intractable conflicts, where the versions as narrative systems are closed in relation to each other. When a conflict becomes manifest, there is a pressing need on the part of the participants to explain and defend any emotional reaction or disruptions caused by the manifestation. The presentation of divergent stories seems to fill such a function.

The conflict stories take place within existing larger stories embedded in the history and culture of the hospital and the wider professional and health political context in which the organisation belongs. Thus, the storytelling professional is ”tangled up in stories” which were created at an earlier point in time before any conflict story is recounted. This entanglement then appears as the prehistory or context of the conflict story told, the use of which is chosen by the storyteller. Such larger stories in the study hospital include the story of ”the caring values of the hospital”, a story that had been heavily focused on over the past years and one leading to hospital-wide discussions that eventually materialised into a ”value-brochure”. Other stories revolved around “patients rights”, “protection of personnel working conditions”, ”future development of the assistant nurse manager” and other similar issues. Since it is impossible to tell an audience a story it does not wish to hear, choosing an existing and legitimate larger story increases the likelihood of the event being of interest and thus being heard. In addition to providing the legitimacy for telling another smaller story, the larger story

may also provide the norms, justification and selection of arguments used in the smaller story.

People construct the emplotment of a story, and people present or express divergent versions of what has happened or is happening. Without actual people opposing each other, there seems to be no development of a conflict story, only verbal expressions of problems, differences of opinion, complaints, grievance or grudges. Characterisation of persons in a conflict story seems to be inevitable, and may contribute in its own way to escalation of the conflict. In a conflict story the divergence is foremost expressed through the affective experience of the persons involved or those who have the potential to become involved. The strength of the affective experience is the yardstick participants use when deciding whether to start a manifest storytelling process. Thus, conflicts usually involve the display of affects and emotions, and an inevitable personalization of the story.

The storied versions of a conflict are rarely on the same level and rarely have the same status. One has more clout than the other does. This is because the parties vary in their ability to position themselves in the story, to make a convincing story and to muster support from important others. In order to achieve dominance, the parties may feel compelled to enlarge the divergence. However, the struggle for dominance easily encourages efforts to marginalise the alternative version. Rarely are conflicts solved unless both parties arrive at a closure of their versions that includes accepting whatever differences are remaining. This points to the importance of the ending of a story and its impact on the storytelling process in a conflict situation. Ending gives meaning and orientation to a story, and makes it possible to arrange events in a particular order. The ending of a conflict is crucial in order to achieve closure to the story. In a process of conflict development, the perceived ending or closure of a conflict is a major determinant of participant's behaviour. This points to the danger of premature closure or too strong closure on one hand, and lack of closure or weak closure on the other hand.

Conclusions

Storytelling in conflicts seem to provide a way to give structure and meaning to the experience. Through constructing a story a person seems to cope better and to be able to handle the stress and challenge of sense making that comes with a conflict. All conflict stories share the same narrative structures like emplotment, a temporal development, diversions of plots, characterisation of participants, a struggle for the dominant story version, and the impact of larger stories. These concepts provide a language for working with conflicts closer to participants life world than allowed by other approaches. Given that a major challenge in managing conflicts is related to communication and the use of language, the narrative approach may provide new avenues in this respect.

Article IV

An analysis of the 101 conflict stories reported in article III found that there were explicit references to anger in 49 of the stories. Given the importance of feelings as part of conflict, this article is an examination of this one emotion, its expression, development and consequences for work cooperation.

Research Question

How do hospital professionals experience and cope with anger in professional cooperation?

Material and Methods

The material comes from the study hospital and is based on the 49 stories out of the 101 referring to anger. In addition to these stories, material comes from interviews (individual and focus group), observations or available written documents collected at the study hospital as part of the ethnographic study. Any reference to anger in the transcribed text from these data sources has been used. Validation is the same as for the other articles. The two cases used in the article are based on written material made available from the hospital.

Findings

Out of the 49 stories, physicians are the main actors in 33 stories. Even though other professionals also get angry with each other, and anger behaviour is not the exclusive property of the physician, it is clear that physicians are more involved in expressing anger behaviour than any other professionals. Physicians get angry with each other, but most often their anger behaviour is directed toward nurses, in part due to their work dependence and required cooperation in delivery of patient care. Nurses report that exposure to anger behaviour, and particularly anger behaviour from physicians, is the emotion most difficult to handle, being even more difficult to handle than anxiety. Nurses experience anger behaviour primarily as a stressor (physicians are aware of this), whereas physicians see it as part of their work style and a safety valve providing relief of tension in a busy work day.

The anger behaviours in the 49 conflict stories could be categorised into four major categories; strong verbal expressions, weaker verbal expressions, non-verbal expressions, and personal behaviour style. Regardless of type of anger behaviours, target persons unanimously report they experience the anger exposure

as blaming, and that it makes them feel professionally inferior. Thus, anger carries with it a judgement of the target person's professional conduct.

Both physicians and nurses report that there is a difference between understandable anger and anger that is justified. Understandable and justified anger expression is behaviour that is contextually meaningful in relation to the work situation and is associated with issues such as stress, difficult patients and long work hours. However, the experience of anger over time in a relationship is also important. Long-term perception of fairness, ability to re-establish status quo and admitting to own faults, all contribute to wider tolerance of anger behaviour.

Incomprehensible or understandable anger that is not justified is behaviour that is perceived by a target person as an overreaction, as intentionally hurtful or hostile, and as intentionally making the person feel unjustifiably blamed for errors or valued as inferior.

Physicians seem to have a wider range of acceptable anger than nurses do. For physicians, anger is acceptable as long as it doesn't leave the room. Unacceptable anger to physicians is anger that continues to influence a relationship after the exchange of anger is over in a meeting, consultation, conference room or operating theatre. Physicians are also treated more leniently than nurses are when they express unacceptable anger.

The perception of what has happened in the past or happened immediately prior to the expression of anger behaviour is a major determinant of how the anger is evaluated, and is related to the following reactions or consequences. These antecedents fall into five broader categories: the long term, wider work context of the anger behaviour, the present work situation, the relationship between the involved parties, characteristics of their professional cooperation, and personal behaviours. The level of "present work situation" (heavy work loads, seriously sick patients, shortage of personnel) seems to be a crucial threshold both in terms of expressing anger as well as tolerating anger. In other situations involving anger behaviours, participants refer to other factors such as a work culture accepting physicians anger as legitimate, as being more important.

The negative consequences of anger behaviours are identifiable in the areas of the work environment, social relationships, professional cooperation and personal functioning (motivation). However, these consequences are perceived differently by nurses and physicians. In most cases, consequences are labelled negatively by nurses. One exception is that anger may at times lead to increased attention toward a specific issue or cause. There are also examples of nurses perceiving anger as a lesser evil than being ignored. It is also an important finding that anger is not just an emotion affecting the two parties involved, but may even affect the overall work climate negatively.

Physicians recognise that anger behaviours may have a detrimental effect on work cooperation, work environment and relationships, but are less bothered by this than nurses as long as it does not affect the patient. One reason physicians are less negatively affected by anger than nurses is that the expression of anger carries many other positive effects for physicians. It provides emotional release with limited negative reactions from others. At the same time, anger behaviours function as a force that make it more likely for a physician to get her/his will and to control the work cooperation in an emergency situation or when there is a threat to patient safety. Physicians also seem to follow more lenient rules and norms related to the expression of anger than do nurses.

The experience of irritation connected to minor incidents and trifles may add up and escalate to anger that elicits more angry reactions and causes conflict. Nurses exposed to anger behaviours will succumb for a period of time to the prevailing work norm that ”this is part of the job”. However, at a certain point there is a change in perception that ”this is unfair, disrespectful treatment, and I should not be expected to put up with it”. One such turning point is when the nurses experience that their reduced professional functioning due to withdrawal and restricted communication with physicians may have a negative impact on quality of care.

Conclusions

Anger behaviour affects how people work together, has direct implications for quality or care and may be dangerous in hospital setting. There are important differences between nurses and physicians in this respect. Physicians represent the profession expressing most anger, and it is usually directed at nurses who experience such behaviour as a stressor. Anger behaviour may in itself cause work conflicts. As such, anger prevention may be as important as any other effort to improve working conditions of hospital professionals in work settings where there is a high occurrence of anger behaviour.

Article V

The article describes an action research study aimed at assessing the methods for managing conflicts at the study hospital and aimed at proposing and implementing desired changes.

Research Questions

What changes can be made to the present ways of managing conflict at the study hospital?

Material and Methods

The material comes from the study hospital and is partly presented in the preceding articles. A broad assessment (based on these finding and additional ethnographic data) of the methods and structure for managing conflict and disputes at the study hospital was carried out. As detailed in chapter 2, these data come from 56 interviews with selected representatives from all levels of the hospital hierarchy, observation of negotiation meetings and review of written material. Participants in interviews were frequently asked for ideas about alternative ways of handling conflicts and what they would choose if alternatives were available. The assessment was performed and reported by the researcher while working as an independent researcher and presented to the hospital's top echelon with the recommendation to establish a task force to create a new comprehensive conflict management system for the entire hospital. This assessment phase of the study was performed prior to the planning phase that involved the development and implementation of a new comprehensive system for conflict management. This planning was carried out by the task force. In this phase of the study the researcher functioned as a consultant to the group. The roles of the researcher as both researcher and consultant ran sequential and not parallel, and thus were clearly differentiated and, consequently, a potential conflict of interest on part of the researcher was avoided. Furthermore, the task force confirmed the research findings.

Results

The study hospital has two major types of conflict resolution systems: the employer-union system and the work process-system. As systems, these vary in terms of formalisation, the type of dispute they are designed to handle, when they are to be used, and who should be involved. The employer-union system deals with the formal relationship between employer-employee, handling demands and agreements related to employees working hours, work-shift arrangements, local wages, work environment issues, and grievances related to the interpretation of contracts and rights. This system is a well-developed formal system that ties into the Norwegian welfare state's way of structuring and handling employer-labour issues. The work process-resolution system encompasses all activities related to helping bed units/ward, teams, departments, professions and individuals to cooperate in terms of coordinating their activities and providing the continuity in medical work and patient care that is required in order to achieve the objectives of the hospital.

The assessment points, in particular, to an improvement potential in the work process resolution system and in the interface between this system and the employer-union system in case of grievances. There are no guidelines or procedures for either managers

or employees on how or where to go with their conflicts, thus leaving choice of system, procedures and selection of participants to informal and random influences. Unit/ward management, commonly the first line involved in a dispute or conflict, use primarily behaviour strategies involving avoidance and unilateral forcing and use negotiation and mediation to only a limited degree. This is often also the case for management at the departmental level. One reason for this is that clinical management experience conflicts as a fairly new challenge, and they feel their own professional background in dealing with conflicts is insufficient. Not the least, they are unclear about their role and responsibility, what means and sanctions they have at their disposition, and the limits of their action range. This results in their giving such challenges lower priority and not spending sufficient time on such issues. This may account for employees mainly using their professional union or informal helpers when striving to clarify their rights or when asking for support and advice in terms of how to proceed with a dispute or how to strengthen their position when they want to bring a dispute forward.

A common experience at all hospital levels is that managers become involved in active conflict management at too late a point. Often they don't become involved until the participants are on a collision course with each other and have already invested a lot in maintaining divergent positions.

When participants in a conflict make contact with each other in order to find a common way out of the issue at stake, the planning of a joint negotiation process is limited. Often, the participants plan their strategies in closed meetings, negotiations happen without a shared and clear framework, and there is a loose connection to what has happened before and what is going to happen next. The result may be an unnecessary escalation of the conflict.

Based on this assessment, a task force including the author developed a new system for conflict resolution having the objectives of early identification of disputes, resolving disputes by the parties themselves at the levels of negotiation and mediation and reducing the costs of conflicts by preventing poor work environment and leakage of personnel energy and motivation. The conflict resolution program has a structure composed of four levels ("open door", conference, mediation and litigation) where each level represents a different approach to conflict management. Together, these levels make up a comprehensive system similar to the flow of a potential escalation of a conflict, from avoidance to the end point of litigation/arbitration.

The basic idea of the system is that all conflict management should be processed along the "line" of the hospital organisation. That is to say, that the immediate superior is the first line to become involved and has the responsibility for initiating the management and follow up of a conflict. However, this may not work when the immediate superior is part of the conflict and the employee for his/her reasons does not want to use "the line", or when the conflict management comes to a standstill. In such situations, the system

provides alternative ways or channels around the immediate superior and provides means of breaking up a deadlock through for example asking for a conference.

The conflict management program was implemented through a training course required of all managers, and a letter was distributed to all hospital employees informing about the new policy and the program. The training course covered a step by step introduction of the new conflict management program and a description of its concepts and design principles. In addition, managers were specifically coached not to suppress conflicts, to approach conflicts early and to increase their use of negotiation. They were also exposed to the intervention method “Next Move”, which was developed for this program.

Conclusions

The study demonstrates the fruitfulness of an action research approach for developing and strengthening the conflict resolution structures in a hospital. The study shows that it is possible to make considerable changes in how to approach conflicts. The effects over time remain to be seen. The results also confirm to a large extent the validity of the research findings providing the knowledge base for the new comprehensive system.

Summary of Findings

The findings suggest that there are considerable differences between professionals, in particular physicians and nurses, in their conceptualisation and perception of what is a conflict and when to intervene in the conflict. Physicians seem to be unwilling to use the term ”conflict” and preferably reserve it for ”war-like” situations. In general, physicians hold a self-concept that says they tolerate more stress and conflict than others do, and they have a higher threshold for what they define as conflict. This discrepancy in toleration of conflict between physicians and other professionals is of importance because the two groups have different perceptions of urgency for doing something with the issues involved.

The single most important attribution factor, according to participants in the ethnographic study, is personality. A few professionals participate in conflicts more frequently than others for reasons that seem unrelated to their work role, but related to personality factors, in particular exhibition of aggressive behaviour. The survey study of physicians also provides evidence that personality factors such as ”intensity” and ”reality weakness” are related to high intensity conflict with one’s immediate superior, but not necessarily with low intensity conflict with colleagues and others. This is a finding that ties into a major discussion in the literature concerning the relative importance of person vs. situation in terms of explaining conflict development.

In the survey study of physicians, the frequency of interpersonal conflict at work was not related to gender nor to the behaviour styles used for handling conflicts. In terms of gender, participants in the ethnographic study do not report that any of the conflict styles are influenced by the gender of actors in a conflict or that any of the conflict styles are used more by one gender than the other. However, the differences accounted for in terms of physicians and nurses may be an expression of the gender distribution across the professions.

When in conflict, hospital professionals seem to use three major approaches to handling the situation: avoidance, forcing and negotiation, usually in that order. Avoidance behaviour or suppression is the most common reaction to an emerging conflict. If use of power does not re-establish a balance between the participants, one negotiates. Only to a limited extent are more processual strategies used prior to the use of power. These conflict styles seem to be determined by two major factors: the perceived interdependence between parties and the perceived urgency of doing something about the situation. In a busy hospital setting characterised by scarcity of time, the time perspective of professionals is a major factor contributing to their perception of urgency and may, in its own way, contribute to inappropriate conflict behaviour style.
When in conflict, participant's choice of conflict management style seems to follow analogical reasoning. Only to a limited extent are the conflict styles planned and premeditated actions on part of the actors, at least up to the point where negotiations are necessary.

The extensive use of avoidance is frequently explained with reference to the experience of participants that an open conflict inflicts a high toll on the work group in terms of draining energy and the fear among participants employing procedures that have a high risk for escalating the conflict. Few leaders and professionals have experience in conflict management and may feel insecure in taking on such challenges. These challenges seem to be equally important to the non-manager (e.g. professional) as to the manager since, in fact, many of the conflicts managers have to deal with are unresolved conflicts between professionals.

Anger is closely associated with conflict. Anger behaviour, in particular from physicians, is a major stress factor in the work day of nurses, and it has a negative impact on their work environment and professional cooperation. This may contribute to the use of avoidance as a conflict style, protecting the professional from emotional overload. Further, anger behaviour is not just a concomitant of conflicts but may, in its own way, instigate conflicts or contribute to conflict escalation. To a large extent, the anger behaviour in a conflict may be understood as an expression of a strained interpersonal relationship that has developed over time, where contextual factors serve to lower the threshold for keeping such feelings private.

The study of anger behaviour and the narrative conceptualisation of conflict both point to the importance of the relationship between the persons in conflict and their context and how this unfolds over time. A conflict is rarely a one event phenomenon, but develops over time through a series of incidents and is expressed through the personal narratives of the participants.

A major contribution of the narrative approach to the field of conflict management is the emphasis on the story of a conflict as an integral part of the conflict. Without a story there is no conflict, and the conflict story comes in different and divergent versions. Thus, the parties storied versions are an integral part of the conflict and solution. These aspects of conflict are to a large extent a reflection of the narrative approach as they did not stand out as salient in the grounded theory analysis of interview data.

The action research study portrays the design process and implementation of a new system for conflict management. It shows that through the use of dialogue and local expertise it is possible to create change, develop further the available dispute mechanisms and to strengthen the negotiation skills of clinical leaders and managers. Both new resolution structures and heightened processing skills of professionals seem to be required in order to make improvement in conflict management.

Discussion

The findings reported in this dissertation on hospital professionals' conflict and conflict behaviour are based on data emerging from a triangulation approach to conflict research. This approach was chosen in order to ”catch” the finer dynamics and complexity of conflicts. There is considerable convergence in the findings resulting from the triangulation. The research confirms that a major challenge in professional cooperation is to manage disagreements, disputes and conflicts and shows that conflict may be considered endemic in hospitals. The way hospital professionals go about carrying out this part of their work role is an important determinant of quality of care and effectiveness. As such, the research confirms findings from other similar studies of hospital organisations. It also confirms the high occurrence of avoidance as a conflict management style. However, as discussed below, the research challenges previous research on the subject and contributes to the field by pointing out narrative aspects of conflicts.

The Concept of Conflict: a Narrative Contribution

A conflict is a dynamic and complex social phenomenon. The dominant positivistic tradition in organisation research, “variable research”, (Alvesson & Billing, 1997; Pfeffer, 1997) has identified a number of different variables assumed to explain its development (e.g. unmet needs, difference of interests, expectations, goals, misunderstandings). However, as pointed out in the introduction of the dissertation, this variable research is characterised by focus on what is observable, manifest and measurable and is based on the view that a conflict has an objective reality with clear boundaries. There has been a tendency to focus on the conflict issues and downplay the impact of more invisible and elusive factors like emotions, time perspectives, and relationship history of participants' thoughts and actions.

The findings of the present research challenge the dominant variable research in this respect by pointing out the constructive features of conflict and how the issues and arguments are imbedded in stories and framed by the discursive structures of stories.
From a narrative perspective a conflict can be understood as a story that, when told, creates an adversarial situation where one or more persons are positioned in a negative manner. This reduces the party's access to the storytelling process of the opponent, and it opens for a struggle for gaining the dominant story version that claims to provide the ”factual” explanation.

The occurrence of storymaking in a conflict situation is nurtured by the participants' need to explain their experience of differences, to make sense out of their emotions, to meaningfully connect the present experience to what has happened before and in the larger organisational setting, and to what may happen in the future. Therefore, conflict

as a phenomenon demands storytelling that feeds on other stories in the organisation and larger stories in the institutional environment and, in turn, become a story to be used in future conflict stories. Thus, participants' conflict conceptions and behaviours occur in the context of a personal narrative and the stories they draw upon to make sense of their differences. A conflict story, however, is dynamic and develops and changes in meetings and retelling to others, whether the listeners are sympathetic or hostile. Any change in the storytelling process has a potential for changing the conflict and the perception of the issues.

The aforementioned definition of conflict gives weight to the centrality of perceptual differences and the temporal and socio-emotive processes taking place in a conflict development. If it is not possible to align or reconcile the divergent story versions of the conflict or develop a new joint version, this may lead to one party's story becoming marginalised, not believed or silenced. As such, a conflict story runs the risk of never coming to an end if no effort is made to cause the story versions to sufficiently converge. This may create a potential for continuing the storytelling and thus the conflict unless both parties can incorporate such an unfinished story as part of their version. Czarniawska (1997) suggests labelling such never-ending stories as "serials", and by that indicate that this type of organisational narrative shares the same characteristics as television's soap operas.

This narrative definition of conflict also provides space for emotions that the dominant economic and rational approaches to conflict to a large extent have eliminated from conflict development. An emotion such as anger is particularly understandable in relation to the divergence-convergence dimension of the story versions. In a conflict, the divergence is foremost expressed through the affective experience of the persons involved or those who have the potential to become involved. The strength of the affective experience is the yardstick participants use when deciding whether to start a manifest storytelling process. There is no way to measure the extent of divergence required in order to have a conflict, aside from the affective experience of the participants. Since groups and persons vary in their tolerance for negative emotions, this may account for why an issue turns into a conflict in one situation but not another.

The temporal dimension in conflict development brings forward the issue of memory selection in the construction of a conflict story. As pointed out in cognitive research, after 10 days, people stop remembering events and experiences in chronological order in terms of time and dates, and instead start placing experiences in relation to other experiences in a narrative form (Kintsch, 1998). Evidently, the experience of a conflict has to be in the memory of at least one actor to such an extent that it nourishes mental constructive activities, elaborating and transforming what is remembered into a narrative form. Such a narrative process, resulting in a story, is characterised by reconstruction and selective memory. The teller has to select; otherwise, if everything were to be remembered and recounted, the story would be inaccessible to other

listeners. This involves getting rid of memories in a more or less systematic way. What does not fit into the emplotment, or threatens its concordance, is most likely to be forgotten. The ability to make a dominant story is really the ability to reconstruct and recount what has happened or is happening in a convincing way. However, this is not just a question of remembering facts and incidents, but also selection of such.

In trying to explain a conflict incident or event and thus to make a conflict story, a person will search for precedents, general rules and principles that allow for the particularity and uniqueness of the actual case and the person's experience. Important in this respect is the use of other similar stories, past or present, smaller or larger, to make sense out of own one's experience. This is a major research challenge. Klein (1998), in his studies of decision-making among fire-fighters, suggests that these narrative thought processes are characterised by analogical reasoning, as different from rational or logical reasoning. Applying the concept of analytical reasoning to construction of conflict stories, it means that participants are searching for similarities between their here and now experiences with their personal storied experiences and the available stock of stories in their environment. In particular, past conflict stories that continue to live in the narrative culture of the hospital may provide mental maps for employees in terms of how to conceptionalise and manage their conflicts. In approaching a new conflict, past conflict stories may function as important analogies that colour the reasoning of what is not yet understood. Such similarities may be more important than any facts or arguments in constructing a meaningful story that provides a direction for action. This may be equally important when it comes to trying to alter and converge their stories.

Differences in Perception of Conflict

Before a conflict can be managed, it must be acknowledged and defined by the disputants. The research suggests that it is difficult for disputants to agree on what is in dispute in a shared conflict. The reason for this is that they experience or frame the same conflict in quite different ways. The subjective experience is their reality, regardless of whether there is an objective reality or not, and thus determines for them the nature of the conflict. The present research suggests that participants perceive and frame the conflict in a narrative mode resulting in different storied versions of the conflict. Such differences in framing or storymaking are little researched (Pinkley & Northcraft 1994) but may, according to the findings of the present study, have important consequences for the development and resolution of conflicts.

The research found important differences between hospital professionals in their perception of conflicts at work. In particular, physicians seem to have relatively little acknowledged conflict at their work place. This confirms the findings of other studies that physicians are special in terms of conflict at work and different from other hospital professionals in so far as admitting to conflict and dealing with conflict (Chacko &

Wong, 1984; Katzman & Roberts, 1988; Curtis, 1994; Gullberg et al., 1994). Mastekaasa (1994) also found that Norwegian physicians report fewer conflicts than other health and social service professionals, especially when looking at conflict between physicians and their immediate superiors.

Why do physicians perceive and report fewer conflicts than other professionals? Are physicians experiencing fewer conflicts or do they simply report them less often than others? Even though physicians belong to an autonomous profession and on the surface are independent of others or at the top of the professional hierarchy, there is enough interdependence and required cooperation that there is no reason to expect less conflict among physicians than among other hospital professionals. Given the high prevalence of avoidance as a conflict management style among physicians, one explanation may be that physicians are avoiding conflict or have a high threshold for conflict in the work place. Physicians may nourish a self-image that gives little room for admitting lack of control or lack of problem-solving skills and may have difficulty accepting that conflict somehow may be a "part of the job". There is reason to believe that physicians who see a lot of conflict around them or are associated with conflict, may be rated unfavourable by others in their interpersonal relations (Bass, 1990; Smith & Preston, 1996). This may, in turn, have a negative impact on their career and result in their downplaying conflict.

Regardless of the reasons for professionals varying in their perception of conflicts, such differences are important in terms of developing competitive vs. cooperative work processes. As pointed out by Lewin (1948) and Deutsch (1990), the action of an individual depends directly on the way in which the situation is perceived and consequently, in order to change conflict behaviour, perceptions may first have to be changed. Since participants in a conflict act on their perceptions, a major challenge in terms of fostering collaborative behaviour between professionals (for example nurses and physicians) is to reduce "biased" incongruences in their perceptions of themselves, of each other and of their work problems and needs. Such unshared incongruences in interprofessional perceptions may be an expression of competitive work attitudes or may encourage the development of competitive work processes that tend to increase participants sensitivity to unwanted differences and threats while minimising the awareness of similarities. In order to stimulate cooperative work processes among professionals characterised by an awareness of similarity and common interests, it is important to address such incongruences in perceptions. In an actual conflict, this points to the importance of assessing participants' different perceptions, and in the case of the existence of major incongruences, these should preferably be addressed before implementing other aspects of a conflict management intervention. This also suggests that one way to prevent unnecessary work conflict is by minimising the salience of biased and unshared perceptual differences between professionals.

Conflict Attribution: The Salience of Personality Factors

From all angles of the triangulation, the single most important attribution factor according to the participants, regardless of professional background, is personality. Conflicts between professionals or units in the hospital are predominantly explained with reference to the individuals involved who instigate the conflict event and keep it developing. These individuals are people who are considered by others to be ”difficult” (e.g. rigid, aggressive, disorganised, arrogant, lacking respect for others), to have an ”extreme” character, or to have personality problems. To physicians, the professional norm is that medical disagreement and problems are solved through an exchange of factual and professional knowledge and in an orderly process characterised by rational arguments. Such disagreements and problems turn into conflicts when personality factors ”get going” or get in the way. To physicians, there seems to be a close connection between their limited definition of conflict as something that is reserved for ”war-like” situations and their attribution of conflict to personality factors. This finding is supported by data from the national survey study of physicians. This study indicates that physicians operate in a work setting characterised by two different types of conflicts. Most conflicts are of a ”low intensity” nature (and may not be perceived by many physicians as such), occur frequently in the work setting, and are unrelated to personality traits or other work characteristics. ”High intensity conflict”, on the other hand, is characterised by being less frequent and more likely to be influenced by personality factors, in particular ”intensity” and ”reality weakness”. Personalities high on ”reality weakness” are characterised as having reduced ability to handle the experience of closeness to colleagues, dealing with unfairness in the work situation, managing oneself in situations where one feels unjustly treated, or working in a situation where the work structure becomes diffuse. Personalities high on ”intensity” are characterised by being sensation seekers, challenging their own boundaries, lacking patience and often showing intense emotions such as anger. Extrapolating this finding to other hospital professionals, it may be that they perceive the same relationship when attributing conflict to personality characteristics.

This finding calls for an explanation as it breaks with the dominant approach within conflict research referring to this as the attribution fallacy, even though over the last ten years there is research casting doubt about this position (see page 9). The fact that all professional groups use personality factors as the main conflict attribution, may have to do with the hospital being a work-place that is characterised by weak situational strength and giving more space to personality than work places that are highly structured in their work organisation (Schneider & Hough, 1995; Jehn, 1997). A great deal of the conflict research is carried out in formal settings such as international negotiations between countries, business negotiations, community and divorce mediation that are characterised by the use of skilled facilitators and a high awareness of interests and wants (Fisher & Ury, 1981). The type of conflict management taking place in hospitals may, as suggested by Georgopoulos & Mann (1962) and Strauss et al.

(1985), be much more informal and fluid. Thus, even though such conflicts share similarities with conflicts on other levels and in other social arenas, there may be important differences particularly along a formal-informal level, accounting for the impact of personality. In formal macro-social settings, personality factors may be less important than in the informal micro setting of work groups in a hospital.

The high prevalence of avoidance as a conflict management style may also contribute to the finding that most conflict attribution is personal and not situational. When a conflict is no longer avoidable and becomes open and manifest, it has reached a level where actors are using their emotions and interpersonal skills to get an upper hand on the situation. At this point the personal stands out as the most salient factor available in explaining the conflict. This may, in a circular way, encourage avoidance. If, as physicians claim, conflict is reserved for the more extreme cases, the most rational approach to deal with a conflict situation is to wait until the situation has calmed down.

Anger as a concomitant emotion of conflict may, in its own way, contribute to the fact that conflict attribution is mainly personal and not situational. As pointed out in research on anger, when people describe themselves as angry or perceive themselves exposed to unfairness or aggressive intents, they are likely to say that they blame someone else for it (Dallinger & Hample, 1995; Allred et al., 1997; Parkinson, 1999). Thus, a self-perception of anger or perception of anger behaviour from another is cognitively framed as having been caused by this other person or their personal differences.

The narrative perspective also contributes to explaining why personification happens in a conflict. A conflict story demands a personification of the theme and the issues. To tell a general depersonalised story does not lead to conflict. Even though a conflict may be founded in the organisation, it is manifested through persons, and the very manifestation of a conflict involves developing a personified story. Without a personification, anchoring of the story in persons, there is no story, or the story is not yet told. It follows from this position that if persons and their characteristics are a part of a conflict story, then characterisation and psychologising are integral parts of storymaking and impossible to avoid. Even if this represents a conventional narrative style of western culture, it nevertheless delivers a format to participants in a conflict on how to construct such a story.

Personality as the most important attribution factor in a conflict is a robust finding supported from all angles of the triangulation. As such, it seems to represent a cultural and psychological reality regardless of being true, a reality that influences participants' perceptions and behaviours. This attributional style may represent a real challenge when it comes to sensitising participants in a conflict to other important factors than the personal. Such an attributional style may more easily support competitive conflict

behaviour than cooperative, by giving salience to personal goals and interests and not shared purpose and common tasks.

Conflict Management Styles: High Usage of Avoidance

The conflict styles found in this study are the same as those mentioned in the literature on conflict management, but show important differences in pattern. Especially striking is the extensive use of avoidance as a conflict management style for both nurses and physicians and not just for nurses as found by Nilsson (1989) and Keenan et al. (1998). Another important finding is the sequential pattern of managing conflicts in the order of avoidance, forcing and negotiations.

The sequential use of avoidance, forcing and negotiation in managing conflict makes sense in terms of the attributional style of participants in this study. Regardless of professional background, participants refer to personality factors as the main reason for the occurrence of conflicts. This may precondition participants to think a conflict may go away if the person or the social situation is avoided or the issue/task is ignored, and that this is a more rational choice than attempting to change the person. If the conflict continues, forcing is a reasonable next response given the same attributional style and the need to do something. Forcing may, in addition, be fuelled by the anger that most likely is now present in the relationship. Anger as an emotion easily provokes anger in return, and forcing is generally perceived by the opponent as an expression of anger.

Avoidance is the behaviour style least described in the literature when compared to negotiation and forcing, and is probably the most difficult approach to understand and research due to its lack of open manifestation. The limited description of avoidance behaviour in the literature may be due to the difficulties involved in researching this strategy using survey designs. Thus, the high prevalence of avoidance found in this study may come as a result of the case design. The extent to which the use of avoidance is a reflection of the Norwegian culture of being conflict evasive (Ross, 1993) is a perspective worth considering, but it is a question that cannot be answered in this study. Thus, a deeper understanding of avoidance behaviour may require more extensive use of field research and case studies from other national settings. Robbins (1978) and Rahim (1986b) found that short-term avoidance may be a very effective way to deal with a conflict situation in order to permit time for one or both of the parties to regain their composure and to rationally think through the issues and circumstances of the conflict situation. Bergmann & Volkema (1989) observed that through avoidance one could wait-out a conflict, since the number of responses drop off significantly after the second response. However, the effect of an employee's capitulation on motivation and productivity is unclear, but in the long run it is most likely negative. This may be the case for hospital professionals as well. There are many factors in a hospital setting that makes avoidance a reasonable and meaningful conflict style as captured by the

dimension of perceived urgency. However, over time, avoidance may take its toll. Professionals most likely vary their conflict style toward their superiors and colleagues. They may initially try to discuss an issue, but if avoidance is not an effective way of dealing with the issue, it may lead to latter-stage responses such as aggressive behaviour, risk taking, talking behind the person's back, forming alliances and going to higher-ups. A professional seeing no other outlet may turn to such behaviour.

Avoidance behaviour seems to be nurtured from different sources. The autonomy and independence of physicians create weak formal structures and weak interpersonal ties among physicians and other hospital professionals. Coupled with their higher status and positional power, this easily results in silence and minimalistic bargaining when disagreements surface. In addition, avoidance makes sense if physicians perceive conflict as something ”embarrassing”, something that can hurt their career, and something that is mainly attributed to personality factors and not situational issues.

Avoidance may also receive meaning through the alternative conflict style of forcing. From other studies, we know that a factor influencing choice of conflict behaviour is how a party interprets the other's intentions (Van de Vliert & Prein, 1989). What the party in a conflict wants to know is whether others want to force their way competitively or are working to solve the problem jointly. A high prevalence of ”forcing” may thus reinforce the use of avoidance or encourage the use of forcing instead of negotiations as a matching behaviour. Why forcing is preferred over negotiation could be interpreted in different ways. One way is from an efficiency point of view; forcing, if it takes care of the conflict, is cost effective in terms of spent time and required social transactions, and it maintains the established social order. Negotiations represent a more risky approach with less control over process, outcome and the use of resources needed in order to reach a result. Reluctance to negotiate may also be nurtured by its potential to threaten the independence of involved actors. This may suggest that underlying a high usage of avoidance with forcing as a follow up style, are competitive goals and work attitudes as opposed to cooperative ones (Tjosvold & MacPherson, 1996).

From an organisational point of view, the high prevalence of avoidance and subsequent use of forcing may have a negative impact on the development of the hospital as a “negotiated order” (Strauss et al., 1985) because it reduces the opportunities for incremental changes and developments that are important for the dynamic growth of the hospital as an organisation. Hospitals have been observed recently to lag behind in the organisational development and differentiation of its structures in relation to the requirements of the treatment processes (Øvretveit, 1997). Organisational order and incremental changes emerge from explicit and implicit negotiations and bargains among its members, often prompted by disagreements, interpersonal frictions and conflicts (Morrill, 1991). Negotiation requires the existence of a conflict and the willingness to deal with the conflict. From this perspective, avoidance hinders the development of the

hospital as “negotiated order”. Avoidance in one sense contributes to ”negotiated order” in a negative way by stimulating to storytelling about what does not happen among participants and in the hospital. It follows from this that, in order to foster change, the change processes are most easily accessible through structural avenues. The program for conflict resolution at the study hospital that was developed as part of this research could be considered as such a structural effort to legitimise a wider range of conflict styles and to make them optional in a particular conflict.

Even though the research findings confirm the general behavioural styles of the conflict management literature, the research findings challenge the underlying factors, “concern for self” and “concern for others”, of the dominant “five-style-paradigm”. In a busy hospital setting the dimension of “perceived urgency” seems, in addition to interdependence, to be a major determinant of conflict style. This gives importance to professionals’ perception of time and how such differences in time perception may influence work behaviour, including conflict management, as recently pointed out by other studies (Ancona & Chong, 1996; Watkins, 1998; Carstensen et al., 1999). However, these dimensions may fit into the competitive – cooperative theory of Deutsch (1949; 1990) as perception of urgency and interdependence are very much influenced by competitive vs. cooperative goals and work attitudes.

The research did not find a relationship between gender and conflict style. Whatever gender differences there may be seem to follow the gender distribution across professions or may have been washed out by the masculine power of the hierarchy found in hospital organisations. However, this is not unexpected, since there are no clear findings in the literature that there is such a relationship between gender and conflict style (Keenan et al., 1998), and studies that claim the existence of gender differences are mostly reporting non-empirical research (Grant, 1988; Alvessson & Billing 1997).

In summary, the research suggests that a major challenge to hospital professionals and leaders is to identify at an earlier stage when avoidance as a conflict style is no longer meaningful and to develop alternatives to forcing as the follow-up to avoidance. In this respect physicians play an important role since the physician’s behavioural style often sets the precedence for the behaviour choice of other involved hospital professionals. Further, the research supports other research pointing out the importance of nurturing the development of collaborative attitudes and goal perceptions in order to change conflict behaviour styles.

Power: The Pivotal Influence of Physicians

The research confirms and deepens the pivotal role of physicians in how conflicts are dealt with in hospital organisations. It seems that the attributions, perceptions and

behaviour preferences of physicians are dominant and to a large degree influence how other hospital professionals relate to conflicts. Why this is the case raises the issue of power and the relationship of power between professionals in hospital organisations. Emotion and language are important ways in which influence is exercised in organisational settings (Pfeffer, 1997), pointing to the power inherent in the display of anger behaviour and the ability to craft and tell a convincing story. Davis (1988), in her study of power in medical interactions noticed the same function of storytelling: It may be the only way a person can break the social and institutional ”frame” and establish another kind of social relationship.

Power Exercised through Anger Behaviour

There seems to be a connection between the power of physicians and their display of anger behaviour. Physicians, when threatened, seem more ready to use power to defend whereas nurses seem more likely to submit. The higher power of physicians relative to nurses also seems to make them more amenable to the use of forcing in order to reach or dictate solutions. Several studies have pointed to high power leading to aggressive behaviours (Deutsch, 1993; Brett & Rognes, 1986), and that physicians are the major source of verbal abuse in hospital organisations (Cox, 1991). Expressed emotion such as anger, irritation and mild disapproval serve as tools of influence when such feelings induce anxiety in the other party and, by complying, the other party is able to escape such emotional discomfort (Sutton, 1991). This power structure adds to nurses' experience that working in a hospital is to work within a very pressurised system (White, 1996). The hospital setting appears to require nurses who are able to function in an unquestioning manner, to accept the stress of the workplace as normal and to accept what is being done as being right.

Power and Storytelling

In the discourse of a conflict, relations of power are often laid down according to whose experience becomes privileged and whose experience becomes marginalised in the dominant way of talking (Foucault, 1980). The narrative approach seems particularly suited to address power and the use of power in a conflict.

A conflict story tells about a relational disagreement or antagonism, and is expressed in a social situation. Power is the ability to use or control this social setting while making a believable story supported by important others. Within the narrative literature there is a recognition that any story about a phenomenon comes in different versions and that these versions vary in their relationship to each other. These storied versions are labelled differently in the literature; master story vs. marginalised story (Bloom 1996);

standard story vs. marginalised story (Abma, 1998); dominant story vs. subordinate story (Gergen & Gergen, 1986).

There are always at least three versions of a conflict story: the two storied versions of each opponent and the imaginary version of what actually happened and cannot be reconstructed, but that each claims to represent through his/her own version. Each party in a conflict tries to make a version that may represent a believable substitute of ”facts and history”. In most conflict stories there is a more or less complete denial of the alternative version of the conflict. Thus, a narrative imbalance develops in the gap between these divergent stories; a gap that opens up a struggle for the best, most believable, or dominant story as it is named here. The storytelling process that takes place in a conflict situation is not just for the storyteller to give an account of what happened, but to give a better and more convincing one than the available alternatives. Thus, the conflict development can be understood as a struggle between the parties to develop a dominant story. The struggle for delivering the dominant version may lead to efforts to deny the other party access to the social arenas of storytelling and to even deny the other party the ”right” to have another version.

Power is reflected in the ability to make and tell convincing stories. Parties do differ in their personal storytelling skills and, importantly, in the type of discourse used to frame the story. A major challenge is to make a holistic or complete story in terms of the emplotment where there is a convincing connection between what has happened and the storyteller’s final positive self-evaluation and, equally important, negative evaluation of the opponent. These evaluations fall along dimensions such as good-bad, fair-unfair, professional-unprofessional, ethical- unethical. To a large degree this value-judgement is an outcome of the type of discourse used by the storyteller and the ability to fit the concrete events and behaviours into the embedded rationality or logic of the chosen discourse. In the hospital there are four major types of discourses available; organisational/managerial, biomedical, nursing and ethical. The biomedical discourse used by physicians is the dominant discourse as a hospital is foremost a place for medical diagnosis and treatment. In this respect, physicians are more competent and skilled in the dominant discourse and more likely to use a proper discourse or mix of discourses for making a convincing story.

Even though physicians may have an advantage in crafting convincing stories through their command of the biomedical discourse, power in a narrative perspective is not restricted to this. The line of the emplotment is another determinant. Having too many details, lacking important information, being too lengthy, or having inappropriate or too demanding a causal model may all contribute to the failure of a story. In addition, the rhetoric, in terms of wording, dramaturgy, and performance features, contributes to whether the listeners are moved by the story to take action.

Professional Culture

To what extent the findings of this study are a mere reflection of Norwegian culture cannot be answered by this dissertation. Even though Norway is characterised in the literature (Ross, 1993) as a ”conflict avoiding culture”, with ”low aggression level” and ”strict self-control” and where ”even direct confrontation of others is unacceptable”, the findings indicate that hospitals may represent a somewhat different subculture. There are other rules and norms apart from those of the national culture guiding the behaviours of professionals. At least in the case of anger behaviour, this viewpoint is supported by the fact that one of the few studies of anger in hospital was done in Tasmania (Farrell, 1999) with findings remarkably similar to those of the study hospital. However, the extensive use of avoidance in the study hospital seems to express the same conflict style that characterises Norwegian culture. As reported by other studies from the U.S. (Nilsson, 1989; Keenan et al., 1998), this is a prevalent conflict style in hospital settings.

When it comes to managing conflicts, Elgstrom (1990) found that the impact of culture on negotiation is situation specific and that the earlier history of a relationship is often more important for the negotiation process. Salacuse (1998) points out that professional and occupational culture may be as important as national culture in shaping a person’s negotiating style and attitudes toward the negotiation process. Alvesson & Berg (1992) also emphasise that professional or occupational culture may be more important in explaining how various professional groups think, act and function than both national culture and the organisational culture where they are employed. Actually, to many professionals, and in particular physicians, the organisation is considered to be of secondary interest for the simple reason that in exercising their profession they are not limited to the framework of any given organisation, but go beyond the boundaries of the organisation. Thus, the professional communities are more a significant determinant of professional’s values and norms than the formal organisation. Since hospital organisations generally cover several professions/occupational communities, there is often cultural multiplicity, something which may easily give rise to conflict and antagonism. In this study this seems particularly to be the case when it comes to expressing and handling strong emotions such as anger.

Anger Display Rules of Physicians

In a human service organisation such as a hospital ward, emotional work is largely a private matter and defines the ways in which professionals manage their feelings at a personal level. In appraising his/hers own feelings, the professional may find support in existing ”feeling” rules which define how to think about and value feelings or a particular feeling (Hochschild, 1979). Display rules, on the other hand, define what emotions to encourage and use as part of the work and how to express such emotions.

Knowing which emotions to display involves norms and rules. Although professionals may have rules to follow, they can differ in the extent to which they feel that displaying emotions should be a part of their job. It goes without saying that in hospitals the expression of positive affect is the norm, if not a job requirement.

Such ”feeling” and ”display” rules are part of both the organisational culture and the occupational culture to which a professional belongs. However, occupational and organisational display rules may be difficult to separate. A physician may learn appropriate professional demeanour during medical school and display that demeanour in the next seven hospitals in which the person practices medicine. To what extent display rules are actually followed is likely to depend on various situational and individual factors, such as the professional's abilities and any reward and sanctions attached to such rules. In this respect, physicians' occupational rules seem relatively more powerful than organisational rules in shaping their anger behaviour. One reason may be that organisational norms about emotions such as anger, if they exist, are often imprecise and belong mainly to the informal part of the organisation and are thus left up to the individual to appraise and handle. Occupational rules, on the other hand, are more clearly defined.

The roots of physicians' emotional display rules seem to be the occupational culture into which they are socialised through their medical education and professional training (Spiegel et al., 1985; Lens & van der Wal, 1997). Coombs et al. (1993a; 1993b) specifically points to this in explaining how physicians learn their humour and slang in order to master the emotional demands of the job, and why surgeons seem to be high on traits such as ”dominance” and ”aggression”.

For a physician, important professional display rules include: You should tolerate the power game; it is ok. to be angry, but leave it in the room; keep it out your relationships; be quick to forgive; and practice non-criticism in relation to other colleagues. Nurses seem to follow display rules like: You should tolerate the behaviour of physicians; you should try to make up for the social and emotional short comings of physician's work; and you should accept your place in the hierarchy and not compete with physicians. Coming from a predominantly natural science background, physicians are trained in a tradition of decoupling the emotional/nonrational world of the individual from the rational and often technical world of the work exercised in diagnosis and treatment. They seem to carry this perspective over to interprofessional cooperation. Unlike the humanistic training background of nurses, where emphasising emotions is seen as an important part of care and treatment, physicians seem to be focused on non-emotional activities and aspects of the work situation. Physicians are less inclined to think that expression of emotions like anger can have much of a negative effect on the work organisation since they believe that organisational order and efficiency are more matters of rational activities.

The impact of occupational culture on conflict behaviour and display rules for emotions points to the importance of any change having to take place within early socialisation to the work role.

Conflict and Conflict Management; Theoretical Reflections

Because conflicts are expressions of what is not fitting together, it is a difficult task to make sense out of a particular conflict and even more so, on an abstract level, to make theories out of conflict phenomena. Given this precaution, on a theoretical level, the research supports an understanding of conflict as a negatively spiralling process developing over time that is related to a series of incidents and souring of relationships, and accompanied by negative emotions, in particular anger, that may in its own way contribute to further conflict development. As such, it represents a combination of the ”dynamic” and ”frustration-aggression” perspectives on conflict (Robey, 1986; Thomas, 1992; Wallensteen, 1993) presented in the introductory chapter. The importance of emotions like anger in conflict development is a neglected factor in organisation research, but interestingly enough a major one in international peace and conflict research (Galtung, 1998). The research suggests further that a narrative perspective seems especially suited to explain the complex temporal and socio-emotive processes taking place in the development of a conflict. As such, it challenges the dominant positivistic variable research in the field by indicating that a conflict may have idiosyncratic aspects that may be equally important as any shared variable with other conflicts in terms of understanding the process and development of this particular conflict.

By incorporating narrative processes (emplotment) and emotions like anger as important elements in conflict, the development process of a conflict may become less ”rational” than advocated by the dominant positivistic tradition in the field. In emphasising the story of a conflict as an integral part of the conflict, the narrative perspective brings forward a less sanitised understanding of the conflict process than conflict research from a positivistic tradition. Such approaches often suffer from a bias of looking beyond the story to the real issues and often treating stories as anecdotes. Within the narrative approach, the parties’ stories are not considered anecdotes standing in the way of the real issues and arguments, but rather an integral part of the conflict and solution. Thus, in a conflict it is to be anticipated that participants may use different rationalities or mixtures of rationalities to make sense out of the conflict situation. This may easily lead to a ”paradigm clash” of thoughts in addition to the conflictual issues, complicating the communication between the parties. According to Fisher (1987), building on Ricoeur, the ”logical rationality” found in scientific reasoning and argumentation is an extreme form of rationality that is less common than the ”narrative rationality” that dominates everyday life. Furthermore, narrative rationality as expressed through emplotment is a cognitive function that occurs prior to logical rationality and is

exercised through the use of arguments. Applying this to conflict resolution means participants perceive and frame a conflict more according to a narrative rationality than logical rationality. This may be similar to what Klein (1998) means by ”analogical reasoning” as discussed earlier in the chapter. It suggests that any resolution effort must start with the story before proceeding to the argument, because the distance required in argumentation is only achievable through the storytelling process. In the process of transforming a conflict from a narrative mode to a logical one, the conflict understanding may also move from being open to restricted and issue-focused. This transformation and the ensuing results are highly susceptible to control efforts and power differences between participants.

Any theory about conflict is useful only to the extent that such a ”larger story of conflicts”, one among several alternatives, contributes to a more constructive resolution process among the participants in a given conflict. In this respect, a narrative approach may have a useful function sensitising managers and professionals to the importance of language in constructing, and not just mirroring, reality and thus, of translating existing theories and concepts-in-use into the storied world of the participants. This may be more important in hospital organisations than in other types of organisations, as they are characterised by ”negotiated order”, and thus extra susceptible to the stories professionals use when they ”negotiate” the order and meaningfulness of their workday. Hospital professionals, particularly those in leadership positions, have important roles in terms of facilitating and structuring such negotiation processes. One role is that of the storytellers; to make reality through storytelling. In this respect, it is important to learn to listen, but equally important to be able to tell, retell and document stories, and constructively contribute to the institutional ”entanglement” of stories. Another role is that of connecting and utilising such narrative processes for the purpose of organisational learning.

Hospital organisations of the future have been given many labels, including ”learning organisations”, ”teaching organisations”, and ”high involvement organisations” (Kaluzny, 2000). In these organisations, learning has a pivotal function in terms of achieving effectiveness and ultimately organisational survival. Important in this respect is the ability of hospital organisations to move from what has been labelled ”single-loop” to ”double-loop” learning (Argyris & Schön, 1978; 1996; Senge, 1990). Single loop learning refers to the ability of individuals within the organisation to be able to follow existing rules to accomplish some prescribed tasks. Double-loop learning means not only understanding the rules but understanding the underlying assumptions and values, and the ability to use these assumptions and values to meet unforeseen challenges and situations. To create such learning processes is a particular challenge to managers and leaders. In order to be able to build learning organisations managers will have to discover how to tap into their organisation’s commitment and potential at all levels.

The present research may contribute to how conflict and conflict management can be understood in a perspective of organisational learning, and it may contribute to an understanding of how to use conflicts in moving from single loop to double loop learning.

Conflict Management and Organisational Learning

Organisational learning is different from individual learning and, according to the Theory of Action Learning, conceptualised as either Model I or single loop learning or Model II or double loop learning (Argyris & Schön, 1978; 1996; Argyris, 1985; Senge, 1990). Model I learning represents the institutionalised and established ways of learning in an organisation that are most effective for learning about routine and nonthreatening issues, for example when it comes to detecting and correcting errors in the production line. However, this learning model is not equally effective in organisational situations characterised by nonroutine or new challenges that raise complex and ambiguous questions, or that involve different viewpoints. This requires Model II learning, learning that is more effective than Model I in these types of situations as well as in situations that are threatening and involve ”defensive routines” in the organisation.

According to Argyris (1985), defensive routines are thoughts and actions used to protect individuals, groups and organisations usual ways of dealing with reality, and to protect them from pain and unpleasant change. This may be exercised in a variety of ways: for example through distortion and censoring of information, soft reasoning, overprotection, injustice, face-saving, and strict rules about expressing feelings. Above all, defensive routines seem to be expressed through avoiding taking action on difficult issues, and by avoidance these defensive routines are repeated as a result of not being discussed and openly addressed. Model II, or double loop learning, is foremost characterised by facing ”defensiveness” and ”defensive routines” in an organisation and by making necessary changes. This is an abstract learning model and one that has to be learned within the organisation.

In a learning perspective, conflicts seem to provide unique opportunities for organisational learning as they are symptoms of what is not fitting together and of shortcomings and challenges in the work situation. From this perspective, a conflict may expose a need for organisational learning, and conflict management styles may be understood as ways to manage a learning process. According to the findings of the present research, the conflicts in the study hospital seem to have been resolved mainly in terms of a Model I learning approach as evidenced by the dominance of avoidance and forcing. These two conflict management styles represent types of Model I learning because they do not provide the participants with any new insight into their situation or improve their skills in handling future conflicts. Forcing represents status quo and a continuation of what is already there, whereas avoidance actually may represent

”negative learning” by reinforcing defensive routines. Negotiation, on the other hand, represents an opportunity for participants to learn new things about each other and their shared work situation and is a type of Model II learning that can be used in future conflict situations. Unlike Model I learning that is a natural learning style for most people, competence in the use of Model II has to be learned and developed.

Given the content of the conflicts found in the present research, there is reason to assume that there is a shortage of Model II learning and that this is a particular challenge in terms of facing the organisational ”defensiveness” and ”defensive routines” that hinder organisational development. The tendency to attribute conflict to personality factors referred to earlier in this discussion, may represent defensive thought structure. It may further contribute to avoidance behaviour. In the long run, forcing may also serve organisational defensiveness since frequent use of forcing carries an element of intimidation and may prevent employees from challenging their work situation. To challenge and to change such defensive routines is obviously not easy and may require Model II learning beyond what is now available. In this respect, the action research part of the present study that resulted in the ”Program for Conflict Management” at the study hospital is an example of how to strengthen Model II and double loop learning in an organisation. This was done through the creation of new social arenas and optional procedures for conflict resolution open to all participants. In addition, efforts were made to strengthen the negotiation skills of managers and hospital professionals, since competence in managing negotiation processes has many similarities to Model II learning. In order to develop such conditions and opportunities for Model II learning, leaders, managers and employees have to be actively involved since the value of such systems rests to a large degree on the employees commitment to the system.

In organisations, it seems that the most important learning is learning that takes place in real time as a result of social action and through an on-going interpretation process (Anderson & McDaniel, 2000). In terms of conflicts as organisational learning opportunities, such real time learning will have to involve extensive use of narratives since they represent the first order of cognitive structuring of an experience. Thus, organisational learning processes may develop through storytelling and the use of narratives as discussed earlier in this section. To narrate is to explain and to give meaning to life experience in the organisation and, consequently, is the basis for learning. In this respect the narrative contribution to conflict research may represent a contribution to organisational learning theory.

Conclusions

The research study explores a topic in interprofessional working that has received less attention in the literature than it does merit. The present study is explorative in nature, and the paucity of research in this area allows for limited comparisons based on the

findings. As such, the study may raise more questions than it answers. The research presented here does suggest that the study of conflict management in natural settings, the use of the extensive field work and the utilisation of triangulation both in terms of perspective and methodology, are fruitful approaches to the study of professional cooperation and conflict. However, more field-oriented research on conflict behaviour and naturally occurring conflicts should be undertaken. The study confirms that through the use of an action research approach, it is possible to develop new and improved ways of handling conflicts. It is recommended that more practical intervention programs be developed, implemented and researched in natural settings.

The way physicians handle conflict seems to a large extent to determine how other professionals relate to conflict in hospital organisations. This pivotal role of the physician in determining the behaviour of other hospital professionals makes the physician's role and enactment a major challenge both in terms of research and in terms of changing conflict management styles. Physicians seem to have a learning potential in terms of how to work collaboratively with other health professions and how to address issues that are beyond the capabilities of the individual physician. However, in order to foster development and changes in physician conflict behaviour, current practices need to be better understood.

This study points out that conflict has direct implications for quality of care and for how professionals work together, and that conflicts can be dangerous in hospital. As such, strengthening negotiation and collaboration skills and designing conflict resolution structures that may enable organisational learning may be as important as any other effort to improve the delivery of hospital services.

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Article I

Understanding Conflicts between Health Professionals: A Narrative Approach

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Abstract

The article is an examination of one exemplary conflict story of a total of 101 conflict stories from a Norwegian urban hospital. The data comes from an ethnographic study of the hospital and was gathered through interviews, observations and existing documents. The article demonstrates how conceptualizing professional conflicts as narratives can bring new insights to understanding, explaining and resolving conflicts. A major contribution of the narrative approach to the field of conflict management is the emphasis on the story of a conflict as an integral part of the conflict. Conflict management approaches inspired by research from a positivistic tradition often suffer from a bias of looking beyond the story to the real issues and often treat the stories as anecdotes. Within the narrative approach, the parties' stories are not considered anecdotes standing in the way of the real issues and arguments, but rather an integral part of the conflict and solution.

Key words: Conflict, narrative, hospital

Introduction

In this article I will demonstrate how conceptualizing conflicts between health professionals as narratives can bring new insights to understanding, explaining and resolving conflicts. The premise of the article is that conflicts are constructed and transformed through the discursive structures of stories, and without a story there is no conflict. Stories make use of and have a separate influence on conflicts. A major challenge in professional cooperation is to manage disagreements and conflicts. How professionals go about carrying out this part of their work role is an important determinant of quality of care and effectiveness in a hospital setting. Thus, to manage professional conflicts constructively is to understand the storytelling process and how stories of conflict develop. The narrative approach seems especially suited to study temporal dimensions in human existence and consequently, the development of conflicts over time. Within research on conflict and negotiation, there are few attempts at using this narrative approach and exploring its fruitfulness.

Research on conflict, conflict management and negotiations, both in health care and in general, primarily utilize the cross-sectional survey design. These studies have focused somewhat narrowly on the relationship between a few variables or pairs of variables such as individual predisposition, perceptions, tactics, roles, utility structure, expectations, intervention of third parties and situational factors, with little attention given to the complexities of how the relationships interact to affect the achievement of agreement and conflict resolution (Greenhalgh, 1987; Argote & McGrath, 1993; Jehn, 1997). Much is related to laboratory and experiments, and until the 1990s, very little of the literature on negotiation focused on context (Pfeffer, 1997). Another criticism of the literature on conflict is that there is too much focus on ”the issues” between parties and not enough recognition of how the emotional and social relationship between parties affects their conflict behavior styles (Nicotera, 1993). Thus, the need for more naturalistic approaches and use of field studies has been expressed by several authors (Argote & McGrath, 1993; Nicotera, 1993; Svensson, 1996; Jehn, 1997). Of particular importance is the need to study how conflicts develop over time and how participants behavior shapes conflict development.

The Narrative Approach: Theoretical and Methodological Framework

The narrative approach explains conflicts as temporal and storied as opposed to factual and time-specific. Instead of viewing conflict as resulting from a situation of dysfunction that can be set right (unmet needs, difference of interests, expectations, goals, misunderstandings), the narrative approach begins with a recognition of the existence of differences between people. Professionals differ not only in the real conditions, requirements and opportunities of their work roles, but also in the stories they draw upon to make sense of these differences. Often, those stories compete or

conflict with each other. Thus, a conflict can be understood as the inevitable result of the articulation of differences. In this discourse, relations of power are often laid down according to whose experience becomes privileged, and whose experience becomes excluded in the dominant way of talking (Foucault, 1980). Further, the narrative approach is not just referring to the storytelling that might occur in a conflict, but attempts to see all events and social action as taking place within, and being shaped by, larger stories. Thus, a whole conflict process might be seen as a plot development into the story of a particular relationship, social or institutional system which endures through time.

In the health field, the narrative concept has come to be used in a variety of ways since first appearing in the late 1970s, in particular with regard to understanding clinical practice and the experiences of health professionals (Dingwall, 1977; Griffiths & Hughes, 1994), the patient-physician interaction (Webb & Stimson, 1976; Baruch, 1981; Clark & Mishler, 1992) and the patient's experience of illness and suffering (Brock & Kleiber, 1994; Mishler, 1995; Hyden, 1997; Fredriksson & Eriksson, 2001). In organizational studies, the use of the narrative form as "tales of the field" (Van Maanen, 1995) became a legitimate topic in the same period, but grew broader in the early 1990s to "accentuate the process of storytelling as the never-ending construction of meaning in organizations" (Czarniawska, 1998, p.15). Narratives, or stories, are a natural form of organizational communication and mode of knowing and learning, and thus a fruitful concept for examining and interpreting human action (Sarbin, 1986; Czarniawska, 1997; Kintsch, 1998). Narratives in organizations are nurtured from the need of employees to explain phenomenons such as dilemmas, paradoxes, changes, tensions, conflicts, and are used to create order in human affairs. This involves storymaking, the basis for treating social action as literary texts as is done within the narrative approach.

There are three major traditions of thought related to the narrative approach to the study of organizational phenomenons (Holstein & Gubrium, 1994; Moustakas, 1994; Czarniawska, 1998; Symon & Cassell 1998):
(1) Literary hermeneutics suggesting that meaningful action is to be considered as a text (Ricoeur, 1981), (2) phenomenology emphasizing the intentionality of human actions and the settings in which they make sense (Schütz, 1973), and (3) ethnography, as represented by the sociological schools of symbolic interactionism and ethnomethodology, emphasizing the extensive fieldwork- encounter with the phenomenon. In a particular narrative study, these traditions will influence the analysis to varying degrees depending on the researchers own position and the field of study. However, in applying the narrative approach there is no common definition, method, technique, or mode of analysis (Denzin, 1994). In this study there is an emphasis on literary hermeneutics due to the similarity between a conflict and the story as a literary text. A recounted conflict develops into an oral story that shares the same characteristics as a written story.

The Narrative Structure of Stories

Various literary theories have been used in analyzing social action as texts (Jensen, 1989; Cortazzi, 1993; Kvale, 1996; Woiceshyn, 1997). In this paper, the poststructural approach of Ricoeur is chosen due to his focus on the construction of stories as a primary form of mental representation and communication, and not just on the importance and impact of stories (Ricoeur, 1981, 1991). Ricoeur's perspective emphasizes the following dimensions as constituting a story: mimesis, emplotment, and concordance vs. disconcordance and characters.

Ricoeur claims, elaborating on Aristotle, that a story is constructed by ”mimesis” and emplotment. Mimesis represents cognitive ”imitatings” of events and incidents in actual life, and emplotment is a dynamic linking process whereby a succession of events, multiple incidents and heterogeneous elements are transformed into one unified story. A story imitates life by configuring the succession of actions and events into a plot, a meaningful coherent picture. This is not possible without an internal coherence in the plot, something which Ricoeur calls concordance. The plot's concordance is made up of events having a beginning, midpoint and end, and by that giving the story a wholeness. All plots are at the same time characterized by insufficient or lack of coherence in the succession of events (its disconcordance). This disconcordance threatens to break up the logic of the story or make it a poor plot by just recounting events that are not tied together. A plot is therefore at once both concordant and disconcordant, a paradox or resistance in all stories that Ricoeur calls discordant concordance. However, in the final analysis the plot represents the triumph of concordance over disconcordance.

Ricoeur argues for a relation of dynamic circularity between life and narrative, and claims that in the widest sense, our oral and written stories feed into life and the world of narratives into which we are born. According to Ricoeur, stories about life events and human action are constructed and transformed through the three levels of mimesis.

Mimesis I or pre-figuration, refers to three things:
- The capacity that is already there in the reader/listener to use a network of conceptual terms (“language”) regarding human action that separate it from mere physical movement. Command over this network represents a type of practical understanding that knows the way the terms in this network mutually specify one another. Principal among these terms is actions, goals, motives and agents.
- That action is already symbolically mediated. This refers to the fact that the cultural context of action invests these actions with a preliminary set of meanings (“preconception”) prior to any secondary attempt to articulate its meanings through saying something about it or inviting something about it.
- Finally, pre-figuration of action, the understanding that human action has built-in temporal structures. In other words, action knows itself as belonging to a ”now”, a ”before” and an ”after”.

Mimesis II or configuration, is the level of coherent stories and involves the operation of emplotment or configuration in narrative. Ricoeur calls the temporal organization of a story configuration. The term emplotment, rather than simply plot or intrigue, stresses the dynamic quality of the operation. This mimesis transforms events and incidents into stories by creating plots, drawing a configuration, a coherent picture, out of episodic events. This is an act of productive imagination rather than an act of reproductive imaginations as is the case when copying something. It acts as the crucial pivot between our pre-comprehension of human actions in mimesis I and the transfigured understanding of time and reality that may come as the story is communicated to mimesis III.

Mimesis III or the process of refiguration, involves own reflection and retelling of stories to others that creates new figuration of life and actions. In the same way that story ”imitates” our lives, it also has the power to transform our lives. Mimesis III is released through listening to or reading the story. It is in the meeting between the set of meanings proposed in the story and the life-world of the readers/listeners that lies the possibility of the listener’s world being experienced in new ways. Hence, these new experiences offer new possibilities for action.

The telling of a story to a listener, for example a researcher, about life in a hospital, refers to all three mimesis; It is composed of incidents, events and experiences in ”real life” (M I) filtered through language and cultural preconceptions; Through the storytelling process (M II) it is given a narrative structure resulting in a story that makes sense to the storyteller. In the listening and responses from a listener new figuration takes place (M III), either correcting the story or confirming it as being “true”.

Research Questions

The following research applies the aforementioned framework as a way of understanding and explaining conflicts between professionals in a hospital. The purpose of the present study is ultimately to contribute to the development of adequate and practical approaches to conflict management in such settings. In order to do so, it is necessary to understand more fully how professionals go about resolving their disagreements and conflicts. Storytelling is one way that has not been recognized. If it is possible to understand conflicts meaningfully in terms of a storytelling process which implies defining conflict as narrative structures, what does the narrative approach add to our understanding and explanation of conflicts? What are the implications of a narrative understanding of conflicts for managing conflicts?

Material and Method

Data presented in this article comes from the author's ethnographic study of professional cooperation and conflict management in a general hospital. Over a period of 3 years, from 1996 through 1998, the material was gathered through interviews, observations and existing documents that were made available.

The study was carried out at a middle-sized city hospital in Norway. The hospital serves a catchment area of approximately 100.000 people, providing treatment services in the area of general surgery, internal medicine and psychiatry. In addition to inpatient treatment, the hospital offers a number of outpatient services.

Within this case, 101 conflict stories have been collected and reconstructed. In reconstructing these stories, the author functioned both as a "narrative finder" and a "narrative creator" (Kvale, 1996), using a triangulation strategy consisting of interviewing, observation and collection of written materials. Through collecting a large number of stories and comparing these, efforts were made to achieve validation (Cortazzi, 1993).

All together, fifty-six professionals representing various professional backgrounds were interviewed regarding their experiences and reflections on professional cooperation and ways of handling disagreements and conflicts.
The author made observations in the surgical ward over a period of 6 months. Afterwards, ongoing conflicts were followed up through serial interviews with participants. Available documents that were used include letters from participants, minutes from staff meetings, and protocols from negotiations related to conflicts.

All interviews and field notes were fully transcribed and the software package NUD:IST (version 4) was used to identify and code the stories for analytic purposes. The material providing the background for the present study is the transcribed text of the 101 stories. The texts vary from thin descriptions of 10 lines stating the actors, the theme, and having a beginning, culmination and end of the story, to thick descriptions of 1500 lines involving a number of characters or groups. The mean average length of a story is 120 lines.

Story A: One out of 101 Conflict Stories

One exemplary conflict story labeled Story A has been selected from the 101 conflict stories. This was selected because it illustrates important common aspects resulting from a narrative analysis of the other 100 conflict stories. Further, this conflict manifested itself early during the fieldwork of the author and provided an opportunity to follow the storytelling process of a conflict up to its conclusion. Story A is about a

conflict between a ward nurse (WN) and the assistant ward nurse (AWN) regarding the content of her role. The story came to the author's attention through interviewing head nurse (HN) as part of the research project. The HN said early in the interview; ”the easiest for me is to talk about my experiences by way of an event that happened the other day. However, in order to do that I have to tell you about the situation and how it all started. A conflict is not one single incident, but a process with a series of incidents. Thus, it is very difficult to reduce a conflict to one eliciting event”. Later the author arranged interviews with the two principals, ward nurse and assistant ward nurse, in addition to top echelon leaders who later took over the conflict process. The conflict was followed up through serial interviews with all participants until the end 2 ½ years later. The conflict story is retold by the author. The story versions were approved by the two principals.

The head nurse (HN) continued: ”There is a conflict between a ward nurse (WN) and his assistant ward nurse (AWN) regarding the content of her role as an assistant ward nurse. They have different expectations for each other. The assistant has a restricted understanding of her duties, and I find her viewpoints inflexible, mainly due to her personality. She did a great job for several years until the after-effects of an accident started to affect her health and, subsequently, her work performance. I suggested she could take on another, less stressful position in the hospital, but she declined due to her experience of the assistant nurse position as being professionally fulfilling. Instead, she wanted a change in her work conditions, to make it less stressful, and she asked to be exempted from the weekend shift, which is required of all AWN. After checking with top management, I told her she had to make a formal application, including a doctor recommendation. When I brought this up with her she reacted with very strong negative feelings, saying that she understood this as a rejection of her, that she was disappointed with the hospital and that perhaps they did not want her as an employee. She also questioned being treated in this way given the ”values of the hospital” and everything she had done for the hospital”.

The WN tells in his interview of problems in sharing administrative tasks with the AWN during the past year: ”We have very different interpretations of her job description. Her interpretation of her management duties is that she is supposed to fill in for me when I am away or on vacation, whereas I understand that I can delegate administrative tasks to her and share the managerial duties. I have had no luck in discussing these issues with her. Also, she only wants to do nursing supervision, and tends to overdo this by helping out the nurses she is supervising. Finally, she asked to be exempted from the required weekend shift rotation, it was too physically demanding.”

AWN presented in her interview that this conflict started when, while filling in for WN during his summer vacation and feeling very stressed, she met the HN of the department in the hallway and he asked how she was doing. She voiced her frustration about work

and the working relationship with WN and, among several things, questioned the WN's competence. She understands that HN is critical of her being so direct and that he does not share her perception that she is doing more than the other assistant ward nurses do.

After the summer vacation, WN initiates talks with the HN and AWN about her functioning. After three meetings, AWN withdrew from the talks in tears, experiencing that her viewpoints were not met and that the problems causing her fatigue were not addressed. ”I did not get my viewpoints across, they did not take me seriously and they did not give any attention to my experience. There was no room for my feelings; they knew what was best for me”. The WN explained that the talks failed because: ”To meet her demands would reduce the overall management capacity of the ward, and it would have been a precedent for the other assistant ward nurses. I felt her understanding of the assistant nurse position was nurtured by a fear of assistant ward nurses becoming too much of an ”office-nurse”, a stance supported by the forum of assistant ward nurses at the hospital.”

Later, the AWN went on sick leave for two months and came back in a half time position, still wanting to continue as AWN but without the weekend shift. New talks with the WN got them nowhere. This time the WN initiated a meeting with the HN, the leader of the office of employee health services and the personnel director to discuss the issues. AWN wanted to reduce her position by 10% based on an approved medical disability in addition to dropping the weekend shift rotation as an individual adjustment based on her rights according to the Law of Work Environment. This argument was prepared and supported by the Employee health services. The AWN claimed she not only deserved this according to her legal rights, but ”also because of everything she had sacrificed for the hospital.”

Several meetings later, there is still no progression in the discussion. According to the AWN there is a lack of progress because; ”there was hardly any room for my experience and viewpoints.” It is agreed that the parties write their separate report addressed to the hospital director and leave the decision to top management. The AWN supports this as she understands the hospital director will have a better grasp on the values at stake than her immediate superiors.

The director then met with all parties including union representatives of the Nurse Association, who were now involved. In trying to work out a solution he met with the AWN separately four times. In a formal meeting with all parties gathered, the director informs that he is not able to meet AWN demands, and she has to be moved to another ward. This is a shock to AWN, who returns to her ward crying and saying the hospital is betraying its own values. She accuses the hospital director of being hard-hearted and scapegoating her for the problems. Thereafter, AWN is on sick leave for several months.

In a subsequent interview, the hospital director presented the conflict as an impossible demand on the part of the AWN in terms of changing the work rotation. It had ended up on the directors table because lower level management was not able to solve the issues.

In an interview with WN, he continues: The next day, when I informed my staff about the situation, I am heavily criticized for my behavior and that ”I used AWN health problems to get rid of her”. Fellow nurses came to me and asked, ”Is it really true that you wanted to get rid of her because she didn’t do a good job?” It was painful for me to realize that staff experienced having lost a valuable colleague and that I had initiated that process. At a staff meeting later on I presented all my arguments about the shortcomings of her functioning as an assistant ward nurse and saying that the real issue was her health problems resulting in sick leaves, absenteeism and poor functioning in her management role, and not the weekend rotation.

Nurses from the ward sent letters to the director criticizing the decision. The Employee Health Services protested, and the union threatened to bring the case in for the Authority of Work Environment and the Labor Court. The hospital top management claimed that what was done here was within their leadership jurisdiction and involved a lawyer from their employers association.

In the following period, AWN is on and off work due to her health problems. The hospital management suggests different placements at different ward units, all rejected because of being ordinary nursing positions and not assistant nurse position. Time goes by, the relationship between the lawyers is strained, resulting in problems arranging meetings and frequent postponements of meetings. There is new impetus when The Work Environment Authorities ask for a report on how the case is progressing. The hospital is now able to come up with a new position at an outpatient clinic that AWN is willing to accept. At this point it turns out that she is pregnant and is personally eager to end the conflict.

Findings

Conflicts as Narrative Structures

A conflict, by the act of telling, is presented in a narrative form. The events are sequenced according to some causal logic (plot) that establish roles for persons (characters), creates action and leads to a value –laden outcome. The plot expresses more or less explicitly a theme, usually about breaking a value, norm or rule, that makes a foundation for further developing the story. Within a story there are substories that include other minor happenings that fit, or are made to fit, into the main story in order to strengthen the plot. One such important sub-story may be the prehistory of the conflict and its precursor.

Story A presents the conflict between an assistant nurse and her leaders and is related to her work conditions. She does this by telling a sequence of events, describing the roles all participants played and by constructing a moral framework in which her superiors, and later hospital leadership, deny the caring values of the hospital by denying her requests and feelings. At the same time her superiors tell another story about a nurse who is asking for changes in her work conditions that may have serious negative precedents for other nurses in similar positions and who is making demands far beyond what she is entitled to and deserves. They build an alternative moral framework in their story; in spite of their belief that she is asking too much, they take care of her by removing her from a position that is too physically demanding.

The two storied versions of Story A are constructed both conjointly in meetings with each other and separately in the telling to other listeners. As a narrative structure, each version of the conflict functions as a system, having a narrative wholeness and functioning as an interactive system: Changes in plot generate changes in logic and changes in the interaction between characters both in the story world and in the material world. Stories regulate their own meaning and close off for alternative interpretations. The fact that conflict stories have ”closure” may contribute to escalation, because one story easily precludes others. The long lasting negotiation process of story A could be understood as an expression of this. The two storied versions of the conflict have divergent emplotments that keep diverging as the parties seek support for their own version and strive to avoid possible changes in the emplotment that may lead to a convergence of the versions.

Divergence and Convergence of Plots

A conflict story is characterized foremost by differences in the version of the plot, and not in the plot line with its beginning and end. In Story A, both the nurse and her leaders refer to the same eliciting events, even though they have different versions of the precursors and antecedent conditions. The most salient difference between the two stories is in the emplotment. Each party builds a moral order in the plot where the other’s behavior is a violation of an important value, principle or rule and, accordingly, is labeled right or wrong professionally or ethically. For the nurse it is built around caring values related to herself and the foundation of the hospital; for her leaders the values at stake are related to organizational rationality and their responsibility for securing sufficient administrative capacity in the hospital and avoiding creating precedents that could erode the management structure.

The beginning of a conflict story may provide a rationale for the actor as to why the storytelling process started in the first place. Somewhere in the story the antagonism between the parties culminates. The plot line of the story is organized around this point

of culmination and not necessarily the beginning of the story, thus dividing the story in two parts. The first part of the story leads up to the point of return (action), the other part pointing to it (reaction). In Story A, the first point of culmination (there are several over the 2 ½ years it lasted) is the meeting between the nurse and her two immediate superiors where she experienced that her feelings were not taken care of and where she ended the meeting in tears. The development of the plot line that unfolds the story over time proceeds by sequencing the events according to this point of culmination, while at the same time building an interpretative framework. The head nurse and ward nurse tell a sequence of events that involve the nurse failing to do required duties, restricting her work role inappropriately, and failing to function adequately due to health problems. At the same time, a story regulating the interpretation of these events is constructed. As leaders, it is their responsibility to set the boundaries for subordinates. The nurse wants a change in her work conditions that is not beneficial to the hospital. She does not understand this, and as leaders they have to do the necessary but unpleasant job of settling the problem. Whereas the plot line follows a linear perspective, the interpretative framework of the emplotment is hierarchically structured, relating the typical or specific in the present story with more general aspects.

Figure 1 in approx. here

Any version of a conflict contains the other version(s) to a certain extent and has room for it, but in the end rejects it. However, in order to have a conflict, parties must have different versions of the conflict that may overlap to a certain point before they then start diverging. Without an unacceptable divergence in the emplotment as perceived by at least one of the parties, there is no conflict (figure 1). Extreme divergence leads to intractable conflicts, where the versions as narrative systems are closed in relation to each other. When a conflict becomes manifest, there is a pressing need on the part of the participants to explain and defend any emotional reaction or disruptions caused by the manifestation. The presentation of divergent stories seems to fill such a function. At the same time, the participants have a need to reach an outcome of the conflict according to one's wishes. Thus, the parties often choose and use a perspective that maximizes the discrepancy between what is and what is wished. In order to strengthen one's position and the chosen perspective, it is possible to use a typical or larger story in addition to one's own more specific story. Such a typical story must be able to incorporate the actual story as a concrete and believable expression of the typical story. Thus, a conflict story requires both typical (general) traits as well as concrete and personal traits. In Story A, the nurse makes a connection between the neglect of her personal needs as an expression of a typical story and the caring values that her leaders are not emulating.

Her leaders base their reasoning regarding her work situation on issues of organizational rationality as related to administrative capacity and setting precedents.

Stories as Part of larger Organizational Stories

The conflict stories take place within existing larger stories embedded in the history and culture of the hospital and the wider professional and health political context in which the organization belongs. Thus, the storytelling professional is ”tangled up in stories” which were created at an earlier point in time before any conflict story is recounted. This entanglement then appears as the prehistory or context of the conflict story told, the use of which is chosen by the storyteller (M I). These larger stories may be used differently by a storyteller or serve different functions in relation to an actual conflict story. In many ways they may serve as a precondition for the conflict. In Story A, both the nurse and her superiors refer to such larger stories. The nurse connects her story to the larger story about ”the caring values of the hospital” that had been heavily focused on over the past years involving hospital-wide discussions that eventually materialized into a ”value-brochure”. Her superiors use another larger, more hidden story, which revolved around the ”future development of the assistant nurse manager”. Since it is impossible to tell an audience a story it does not wish to hear, choosing an existing and legitimate larger story increases the likelihood of the event being of interest and thus being heard. In addition to providing the legitimity for telling another smaller story, the larger story may also provide the norms, justification and selection of arguments, used in the smaller story.

In the early phase of a storytelling process, the pre-history of the story is what connects it to a vaster whole and gives it a background. This is a function served by the larger stories. For a professional, it is a major step to go from an experience of a difficult disagreement in M I to ”naming” such a difficult disagreement and becoming involved in an open storytelling process, that includes the adversary, in M III. Intuitively, participants know that their story version, in order to deserve attention and time, has to fit into a larger important story. Some of these larger stories in the institutional context of health care organizations are related to the professional unions’ feuds over territoriality, the struggle between physicians and nurses regarding leadership positions, the breakdown of the physician authority and its consequences for health care, internal structuring of hospitals and their units, the use of ”primary nursing”, the gender relations, as well as others. These stories are told in the news media, in the educational training settings of professionals and through the hospital/professional grapevine.

Characters

It is the individuals who construct the emplotment of a story and who present or express divergent versions of what has happened or is happening. Without actual persons opposing each other, there seems to be no development of a conflict story, only verbal expressions of problems, differences of opinion, complaints, grievance or grudges. The importance of the individuals and their characterization of what takes place in the development of a story is quite obvious in Story A. From early onset the nurse is characterized by her superiors as being inflexible while she, for her part, characterizes her superiors as uncaring. Over time, the characterizations become more extreme; in her superiors eyes she turns from being inflexible to stubborn while she experiences her superiors as changing from uncaring to lacking in integrity. Characterization of individuals in a conflict story seems to be inevitable, and may contribute in its own way to escalation of the conflict.

Struggling for the Dominant Version of the Conflict Story

The storied versions of a conflict are rarely on the same level and rarely have the same status. One has more clout than the other does. This is because the parties vary in their ability to position themselves in the story, to make a convincing story and to muster support from important others. In Story A, the nurse positions herself first as being denied benefits anchored in the values of the hospital. This later turns into being denied legal rights. On the other hand, her superiors position themselves as responsible leaders protecting the well being of the hospital. As such, their stories are built around very different positions - a managerial vs. a moral position - with different interpretative perspectives.

The struggle for the dominant version of the conflict story may explain the escalation of the conflict in Story A to personnel director, later the hospital director, and finally lawyers of the unions. Even though in the course of the conflict, there are many efforts and initiatives to bridge the versions, diminish the divergence and end the conflict, each time the outcome results in escalation to a higher hierarchical level. This could be understood in terms of Story A developing through a series of unfinished, shorter stories, where the plot is incomplete, where there is no ending and where there is a call for a continuation of the storytelling in order to achieve closure. One reason for this series of stories may be that there has not been sufficient effort on the part of the participants to converge their versions or excessive use of ”power”, threatening to marginalize the alternative version of the AWN. She, on her part, has been able to withstand this by retelling her version to new listeners and potential alliances and thus continue the storytelling. This points to the importance of the ending of a story and its impact on the storytelling processes in a conflict situation. Ending gives meaning and orientation to a story, and makes it possible to arrange events in a particular order. The

ending of a conflict is crucial in order to achieve closure of the story. In a process of conflict development, the perceived ending or closure of a conflict is a major determinant of participants behavior. This points to the danger of premature closure or too strong closure on one hand, and lack of closure or weak closure on the other hand.

Escalation of a conflict as exemplified in Story A requires a rewriting of the story: The story often becomes more complete, more sophisticated, more legitimate in its reasoning and more condensed. New events or new actors bring in new information and reasoning that has to be integrated. In Story A, there is a definite turn of the story when union representatives and the top echelon of the hospital enter. The more principal aspects of the conflict are now more emphasized and developed. Finally, when lawyers take over, the story becomes legal case and is retold according to a legal rationality.

In developing their storied versions, parties mostly tell and retell their stories to listeners that are taken for granted as being sympathetic or supportive of the teller; friends, old or close colleagues, union representatives or others. This is definitely an advantage in terms of developing a strong story from the point of view of one party, but not when it comes to developing a version that would include as much as possible of the other party's version. This splitting of the audiences may account for a large part of the discrepancies found in the divergent story versions of a conflict. Story A demonstrates that a major way of strengthening a story is through formation of alliances with more powerful actors like unions or higher level leadership. The choice of discourse is related to formation of alliances and vice versa. Support for a story requires to a large extent that the persons making up the alliances share and use the same discourse. When that is not the case, there may be a change in the use of discourse or a search for new alliances. In Story A, the nurse begins by using a nursing discourse that later changes into a legal one due to the presence of unions and lawyers requiring another framing of the story. Their value as an alliance is foremost in their storymaking power related to work regulations and law.

Discussion

Storytelling in conflicts seem to provide a way to give structure and meaning to the experience. Through constructing a story a person seems to cope better and to be better able to handle the stress and challenge of sense making that comes with a conflict. All conflict stories share the same narrative structures like emplotment, a temporal development, diversions of plots, characterization of participants, a struggle for the dominant story version, and the impact of larger stories. These concepts provide a language for working with conflicts closer to participants life world than other approaches allow. Given that a major challenge in managing conflicts is related to communication and the use of language, the narrative approach may provide new avenues in this respect.

The narrative structure of a story is above all found in the emplotment, that of drawing together heterogeneous events, behaviors, actions, persons, levels of temporality, resulting in a coherent whole, a plot. The plot signifies what is to be understood as a beginning and a development, and is an effort on the part of the storyteller to present actions and events and their succession as an expression of intentions or pointing to a purpose. In order to do this, the plot has to overcome resistance and problems in accomplishing such a construction (disconcordance). This holds for all stories, but even more for conflict stories, where the persons bring in additional resistance in terms of differences in interests and goals. Unlike the ordinary story, where the key to the plot is in the beginning and end, in conflict stories the key to the plot may be in its organization as an antagonism between actors having different interests and pursuing different purposes. Thus, argument and stories are often integrated, so that stories work as arguments and arguments develop into stories. A conflict story, therefore, is characterized foremost by differences in the version of the plot, and not the beginning, the characters or their development. It follows from this that the persuasive character of the plot-versions may vary and that the ability to craft a good plot gives power in terms of defining reality and providing the ”factual explanation”. The importance of the plot is also seen in the tight bond between plot and character. Character emerges in the plots that are made out of recounted events, and variations in the character are wholly dependent upon developments in the plot.

Within a narrative perspective, a conflict can be understood as a story that, when told, creates an adversarial situation where one or more persons are positioned in a negative manner. This reduces the party’s access to the storytelling process of the opponent, and it opens for a struggle for gaining the dominant story version that claims to provide the ”factual” explanation. If it is not possible to align or reconcile the divergent story versions of the conflict or develop a new joint version, this may lead to one party’s story becoming marginalized, not believed or silenced. As such, a conflict story runs the risk of never coming to an end if no effort is made to cause the story versions to sufficiently converge. This may create a potential for continuing the storytelling and thus the conflict unless both parties can incorporate such an unfinished story as part of their version.

An important contribution of the narrative approach to the field of conflict management is in emphasizing the story of a conflict as an integral part of the conflict. Conflict management approaches inspired by research from a positivistic tradition, often suffer from a bias of looking beyond the story to the real issues and often treat the stories as anecdotes. Within a narrative paradigm, the parties’ stories are not to be considered anecdotes standing in the way of the real issues and arguments, but an important part of it. Conflicts create stories and stories influence the conflict. That does not mean that “real issues” or “facts” are irrelevant to a narrative understanding of a conflict, or that any story can function as a substitute for “truth” or “what actually happened” when that

is central to a conflict. Merely, that within the narrative paradigm there is no clear difference between fact and fiction. Both history as ”true” and story as ”fiction” share a common narrative structure according to Ricoeur (1981, 1984, 1991). And thus, a conflict story is an effort on the part of a storyteller to describe the experienced reality with the purpose of making the person’s life and work situation meaningful.

There are several implications of the narrative approach to handling conflicts between professionals. By emphasizing the constructive features of conflict, this approach points out several opportunities to influence the development of a conflict. The main opportunity seems to be in enhancing the converging lines of story development by working in the storymaking process that takes place as an interchange between M II and M III.

The divergent storied versions of the participants results from different emplotments. However, any emplotment is a construction that is threatened by its disconcordance; that is, everything that has been dismissed, revised, narrowed or reorganized in order to make a convincing case for what the party believes he/she is entitled to. This very disconcordance opens for the possibility of either developing the existing plots or making new ones, if necessary, in order to manage the conflict. In order to achieve convergence, the stories may have to open up and the emplotments may have to be loosened in order to have the endings of the versions point more toward each other. An important step in this direction is to look for communalities in the parties’ storied versions or hidden possibilities of new themes. In the end the versions may not need to overlap, but each has to be able to have space for larger, important parts of the opponent’s story. What is of most importance for the parties in order to put a conflict behind, is to be able to live with whatever differences the versions may contain in the end.

A conflict story is framed or fitted in with other stories in the organization and larger stories in the institutional environment. Knowing which of these cultural and historical stories that is drawn upon in a particular conflict story may contribute not just to understanding the plot development of a conflict story, but also provide ideas on how to change the development course.

Since stories are developed in interaction with other people, a conflict is open to influence through listening and dialogue. A story develops and changes in meetings and retelling to others. Ordinarily, storytellers pick their listeners according to whom could provide support and alliances, and listeners usually respond to meet such expectations. However, this represents an opportunity for listeners, regardless of being a colleague, opponent or mediator, to contribute to the development of the conflict story and not just to confirm it. A particular challenge is to arrange for the storytelling to take place in social arenas, or to construct such arenas when lacking, that include the opponent parties. Furthermore, since any change in the storytelling process has a

potential for changing the conflict, a particular challenge is to be able to introduce new resources, punctuations or alternative perspectives in order to encourage adequate convergence of the storied versions. This requires the encouragement and use of creativity in order to minimize any disconcordance that may arise in connecting such new elements to an existing story.

It seems impossible to avoid characterization in a conflict story, but nevertheless, this may be important to transcend. The very personification of conflicts that comes with the storytelling process may provide a considerable hindrance when it comes to working out more converging versions. Rewriting the story's plot into a quasi-plot, which means a plot without persons, may be an alternative option. A quasi-plot may be more or less "good", but what is important is to what extent the parties will accept a quasi-plot as a substitution for their own plots. To develop a quasi-plot will depend on the participants intellectual and creative abilities to lift the plot to a more abstract level. Instead of telling the story in relation to persons, the story is depersonalized and made more abstract, and the personal is substituted by values, culture and structures. In this way, the story is made more cognitive and rational because the emotional and personal is downplayed or neutralized.

The narrative approach may also contribute to our understanding of the role of power in conflicts. The ability to craft and tell a "good" story gives power and increases the chance of the story version being perceived by others as the one most "true", "fair", "professional" or "ethical". To a large degree, such a value-judgement is an outcome of the type of discourse use by a storyteller and the ability to fit the concrete events and behaviors into the embedded rationality or logic of the chosen discourse. In a hospital, there are at least four major types of discourses available: organizational/managerial, biomedical, nursing, ethical. Using the proper discourse or mix of discourses with accompanying catching rhetoric is a major determinant for making a convincing story and thus, accumulating power.

Because conflicts are expressions of what is not fitting together, it is difficult to make theories out of conflict. Any conflict has idiosyncratic aspects that are important in terms of understanding the process and development of this particular conflict. Thus, any theory about conflict is useful only to the extent that such a "larger story of conflicts" contributes to a more constructive storytelling process among the participants in a given conflict. In this respect, a narrative approach may have a useful function sensitizing managers, professionals and mediators to the importance of language and thus, of translating existing theories and concepts-in-use into the storied world of the participants. This may be more important in hospitals than in other types of organizations, as hospitals are characterized by "negotiated order", and thus extra susceptible to the stories professionals use when they "negotiate" the order and meaningfulness of their workday.

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Anger in a Hospital: Antecedents and Consequences for Interprofessional cooperation

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Abstract

Aims. To explore anger in a hospital, how hospital professionals experience and cope with anger in professional cooperation.

Methods. The data comes from an ethnographic study of a Norwegian urban hospital and is based on 49 stories out of 101 conflict stories referring to various expressions of anger behaviour.

Findings. Anger behaviour, in particular from doctors, is a major stress factor in the work day of nurses and has a negative impact on their work environment and professional cooperation and may even reduce the quality of patient care. To a large extent, anger behaviour may be understood as an expression of strained interpersonal relationship where contextual factors serve to lower the threshold for keeping such feelings private. Hospital professionals report that there is a difference between understandable anger and anger that is justified. Understandable and justified anger expression is behaviour that is contextually meaningful in relation to the work situation and is associated with issues such as stress, difficult patients and long work hours. Incomprehensible or understandable anger that is not justified is behaviour that is perceived by a target person as an overreaction, as intentionally hurtful or hostile, and as intentionally making the person feel unjustifiably blamed for errors or valued as inferior. The findings suggest further that the way doctors handle their anger may, to a large extent, determine the functioning of anger in a ward organisation and influence how other professionals relate to anger.

Conclusion. Anger behaviour affects how people work together, has direct implications for quality of care and may be dangerous in hospital setting. Anger behaviour may in itself cause work conflicts. As such, anger prevention may be as important as any other effort to improve working conditions of hospital professionals in work settings where there is a high occurrence of anger behaviour.

Key words
Anger, interprofessional cooperation, hospital

Introduction

The hospital ward is an emotional workplace, not only with regard to the emotional labour involved in patient treatment and care, but also in terms of handling the feelings that arise between health care professionals and the groups and units to which they belong in their effort to deliver health care services. A major challenge to health professionals is to handle a diversity of emotions that come as part of the clinical work; emotions such as anxiety, fear, anger, blame, inferiority, sadness, hopelessness and disgust. Failure to tackle these high emotional demands may have a negative impact on personal functioning and work performance in a number of ways (Søderfeldt et al. 1996).

The importance of professionals' emotions in the delivery of quality care has, to the extent that it has been researched within clinical settings, focused almost exclusively on the relationship between staff and patients (Lupton 1997). Seminal in this respect is Menzies'study (1960) of nurses' experience of anxiety in their relationship to patients and how it contributes to development of social structures as an extension of intrapsychic defence mechanisms. Otherwise, health care research shares the same neglect as organisational research in general in not addressing the issue of emotions that evolve in the relationships between professionals and their work settings and how such emotions affect work performance (Pekrun & Frese 1992, Glomb & Hulin 1997, Briner 1999).

The present study is an examination of one particular emotion, anger, its expression, how it develops in the interactions that take place between health professionals and the consequences of anger for work cooperation. During the course of my ethnographic study of professional cooperation, attention was repeatedly drawn to the periodic high level of frustration, irritation and anger among staff members directed toward each other. During interviews, particularly with nurses, anger was referred to as the most important stressor. Anger was described as an emotion having a negative impact on the work climate, frequently causing conflicts, reducing cooperation and reducing quality of care. Both individual professionals and clinical managers admitted to struggling considerably with handling anger in constructive ways both personally and socially.

Anger research in health care

Research on anger in clinical settings refers to doctor-nurse relationships as the primary arena for anger behaviour, both in terms of frequency of occurrence and sources of anger (Larson & Martinson 1990, Cox 1991, Coeling & Wilcox 1994, Farrell 1999). Nurses and doctors are reportedly the professionals most angry with each other and according to Mackay (1993) it is often with good reason. A major precipitant of anger behaviour is competition or protection of perceived work territory (Spiegel et al. 1985,

Alpert et al. 1992). Another factor is doctors' work situation (Firth-Cozens & Greenhalgh 1997). Tiredness, overwork, distress due to concern for patients suffering and safety are seen to be the major causes of the incidents where doctors express negative feelings of irritation or anger. There are also studies referring to doctors personality as a source of anger behaviour, in particular surgeons that are measured high in ”dominance” and ”aggression” (Coombs et al. 1993b).

Anger may be expressed in a number of ways such as territorial strives (Alpert et al. 1992), behavioural rudeness (Stiglich 1994), abusive language (Larson & Martinson 1990, Cox 1991), humiliation (Farrell 1999), humour and slang (Lupton 1997, Coombs et al. 1993a). Anger is also often expressed through blaming. Lupton (1997) says that in today's hospitals there seems to be a strong need to blame others for all the problems and inadequacies experienced by a professional, and this blame is often unjustifiably placed on other professions (McNeese-Smith 1999). Nurses, in particular, indicate experiencing angry encounters with moderately high frequency (Farrell 1999).

Anger seems to have a number of negative impacts on cooperation among health professionals including reduced organisational commitment and trust (Hrebiniak & Alutto 1972), reduced job satisfaction (Dorr et al. 1980, McNeese-Smith 1999), reduced team functioning, increased stress and conflicts in health care teams (Sessa et al. 1993, Lens & van der Wal 1997, Antai-Otong 1997, Taylor et al. 1999). Research from outside health care settings supports these negative consequences of anger for professional cooperation even though there is little systematic research looking at anger in work situations (Pekrun & Frese 1992). Anger is often a key ingredient of work-related stress and is one of the most frequently cited stress emotions. It is found to contribute to job burnout, hypertension and cardiovascular diseases (Schnall & Landsbergis 1994). More specifically, anger may reduce work performance and work-related cognitive and motivational processes such as the following; creativity and trust (Kabanoff & Rossiter 1994), problem-solving, task-related helping and cooperative behaviour (Pekrun & Frese 1992), decision-making and strategic planning (Daniels 1999), efforts to achieve organisational goals (Nord & Fox 1996), generosity, helpfulness and cooperation (Thomas 1992), and detrimental evaluation of supervisors displaying anger (Glomb & Hulin, 1997).

Contrary to some doctors' belief that anger can be useful in a ward organisation and may function as an energiser that mobilises to action and provides mental relief of tension, there are no reports in the literature supporting a positive relationship between anger and professional cooperation and quality of care.

However, there is research from work settings outside health care suggesting that expression of anger may be considered appropriate and positive in some cases, either because it improves the mental health of the person who expresses anger (Zalenik 1989)

or because there are critical issues at stake such as time constraints, risk of danger to people, ethical or legal values at stake and resource limitations that warrant such behaviour (Price 1989).

In summary, research on anger in health care settings confirms that it is a challenge to manage anger in interprofessional cooperation and that anger behaviour results primarily in negative consequences. Positive consequences, if any, are limited. The available studies suffer from the limitation that they investigate anger from the experience and perspective of one profession, primarily the nursing profession, and fail to investigate anger as a dynamic and systemic interplay within a dyadic or multiple interprofessional relationship. In order to study more adequately the antecedents, development and consequences of anger in clinical settings, a minimum requirement should be that both parties' experiences and behaviour in such dyadic or multiple relationships are considered.

Research questions

Against this background, the present study is an examination of anger in a Norwegian hospital, the antecedents, development and consequences of anger behaviour on professional cooperation. How do hospital professionals experience and cope with anger in professional cooperation?

Methods

Data presented in this study come from my ethnographic study of professional cooperation and conflict management in a general hospital. Over a period of 3 years, from 1996 through 1998, the material was gathered through a triangulation approach using interviews, observations and existing documents that were made available by the hospital.

The study was carried out at a middle-sized city hospital in Norway. The hospital serves a catchment area of approximately 100 000 people, providing treatment services in general surgery, internal medicine and psychiatry. In addition to inpatient treatment, the hospital offers a number of outpatient services.

All together, 56 professionals were interviewed regarding their experiences and reflections on professional cooperation and ways of handling disagreements and conflicts. They were also asked if they were currently involved in a conflict or had previous experienced one during the last 2 years and were encouraged to tell their

stories. A total of 101 stories were recorded. In 49 of these stories participants referred explicitly to expressions of irritation, frustration or angry behaviour such as yelling, swearing, blaming and verbal abuse. These 49 stories provide the material for the present study.

The participants telling these stories represented various professional backgrounds, including nurses (24), doctors (20), physical therapist/social worker/bioengineer (4), nurse aid (1), and other staff (7). They were interviewed from one to eight times. Selection of participants was based on theoretical sampling from different units, hierarchical levels, formal roles and professional backgrounds within the systemwide hospital. The gender distribution of participants followed traditional dividing lines in hospitals; doctors mostly males, whereas other professions were dominated by females. Age-wise, participants represented a wide distribution from young newly trained nurses or doctors to others close to retirement. In addition, two focusgroup interviews were completed with nurses and with doctors with the theme of the interview being personal experience of anger in the work setting.

I carried out field observations in the surgical ward over a period of 6 months. This included direct observation of social interactions and events conducted during various types of meetings (planning, case review, team, professional meetings, etc.), medical rounds, doctors' morning meetings, at nursing stations, in the cafeteria, social interactions in corridors, ward training events, seminars, and any ad hoc meetings connected to cooperation and coordination of clinical activities. During certain periods this involved spending time around the nursing stations and other work areas. After the field observation period, ongoing conflicts were followed up through serial interviews with participants.

Analysis

Data analysis was performed according to a two stage procedure. Firstly, the stories were reconstructed following a narrative approach (Holstein & Gubrium 1994, Symon & Cassell 1998). Each story was categorised as a case and any text from interviews, field notes and written material connected to a particular conflict story or event was appended to that case. Secondly, all stories referring to anger behaviour were selected and then analysed by using a modified grounded theory approach (Glaser & Strauss 1967, Starrin et al. 1991) identifying general categories and specific factors across the material. The analysis was supported by the use of the software package NUD:IST (version 4). In addition to the analysis of the 49 stories, any reference to anger in the complete transcribed text of the ethnographic study was utilised for the analysis. Finally, the analysis includes two exemplary cases (out of the 49) selected by me because they illustrate common aspects of anger incidents in clinical settings and the development of anger behaviour.

Case 1: Anger in Multiple Relationships between Nurses and Doctors in a Ward Unit (details Table 5)

The case material consists of three letters from three different nurses to their clinical director, presenting their complaints related to unacceptable anger from doctors on their ward. In addition, the case includes minutes from a staff meeting where all nurses and doctors on the unit participated, trying to work out better cooperation. All three nurses, the doctors, the clinical director and nurse manager of the department were interviewed shortly thereafter.

Case 2: Anger in a Dyadic Relationship between two Doctors (details Table 2)

The case presents a conflict between a surgeon and an anaesthetist related to accusations of unprofessional behaviour. The material consists of a detailed protocol from a negotiation meeting between the doctors and their clinical directors. All four were later interviewed.

Findings

Expression of anger

There is considerable variation between doctors on the one hand and nurses and other hospital personnel on the other, as to how they express anger or are affected by anger behaviour from others. Out of the 49 stories, doctors are the main actors in 33 stories. Even though anger behaviour is not the exclusively property of the doctor, and we see that other professionals also get angry with each other, it is clear that doctors are more involved in expressing anger behaviour than any other professional group. They get angry with each other, but most often their anger behaviour is directed toward nurses, in part due to their work dependence and required cooperation in delivery of patient care. Nurses report that anger behaviour, and in particular anger behaviour from doctors, is the emotion most difficult to handle, more so than other emotions such as anxiety.
Nurses in focus group said:

It is very frustrating and stressing to be exposed to anger from doctors, especially when there seems to be no good reasons for it, like a busy floor or heated atmosphere. To be angry is very much accepted among surgeons and it's a part of their culture.

The research showed that nurses and doctors have different experiences of anger and different perspectives on the function of anger behaviour. Nurses mainly experience anger behaviour as a stressor, and this is recognised by doctors themselves, whereas doctors see it as part of their work style and a safety valve providing relief from tension in a busy work day. A senior surgeon, acknowledging his own frequent anger behaviours, said: 'Most likely my anger is stressing to the nurses around me. However, I am, for my part, not just blowing off steam resulting from private internal pressure, but also reacting to everything that is going on in a chaotic work situation.' The director of surgery said:

It is accepted that surgeons have blowouts, and all doctors are granted that right. It is an important safety valve, making it possible to avoid wasting energy tip toeing around the issues. When you are exposed to it yourself you have to tolerate the heat, without making too much of a fuss out of it. You are expected to continue with business as usual afterwards and not to let it affect the relationship to the other person. You don't bring this up with a colleague unless a major fall-out has occurred. You wait and see if the relationship has soured. The most important indicator of this is a change in humour and joking. When you participate in the social exchange of jokes, funny comments and witty humour you signal that everything is ok. Junior doctors have to learn that. This is part of the surgical jargon characterised by satire, teasing and wit. It is not meant to be personally hurtful, but you have to learn this slang and be able to tolerate the directness of it.

These viewpoints are supported by the experience of junior doctors interviewed in the study.

Anger as an emotion may be expressed in different ways and with varying degrees of intensity. The analysis of the 49 stories found that the anger behaviours in these stories could be categorised into four major categories (table 1).

Table 1 in approx. here

Strong verbal expressions leave the target person with no doubts about how to interpret the behaviour and make the target person feel like retaliating. Often these strong verbal expressions come as an escalation of prior weaker verbal expressions, or as a reaction to such expressions. Any verbal anger expression may, by itself, seem like a trifle. However, over time, a summation may occur that changes the target person's perception of this into something more than a random minor incident. Some weaker verbal expressions, such as humour, may also be difficult to interpret in terms of whether it is meant to be hurtful or to be enjoyed. Non-verbal expressions may also be either strong

or weak, and have in common that they are more difficult to address for a target person than verbal expressions due to the higher level of ambiguity in how to interpret the signals. Personal behavioural style refers to more long-term anger behaviour experienced by a target person as an expression of attitude and character trait. Regardless of type of anger behaviours, target persons unanimously report they experience the anger exposure as blaming and that it makes them feel professionally inferior. Thus, anger carries with it a judgement of the target person's professional conduct.

The analysis did not reveal gender differences that did not follow the gender distribution across professions. Thus, female doctors seem to exhibit anger behaviour more along the masculine style of the doctors' work role than the feminine style of nurses and other ancillary personnel.

Understandable Anger

The research found that both doctors and nurses report that there is a difference between understandable anger and anger that is incomprehensible. The first type appears to be more likely to be tolerated and accepted, whereas the other is unacceptable. The following excerpts indicate how nurses differentiate between types of anger on the part of doctors. A nurse manager said:

Surgeons express anger differently. We have a very competent surgeon who swears every day. He does that on behalf of the patients, most often when there is a slip in a procedure. He is attentive to the nurses and "sees" them. His anger is balanced by the fact that he is experienced as fair and that he is able to admit making errors. What is unbearable is the hostile anger. A senior nurse said:

There are different types of anger. There are two doctors here that frequently show anger. One makes it all my fault when she is angry. The other doctor, after such an incident will try to re-establish status quo. He is sincere when he sometimes asks for an apology and he is willing to take a look at himself.

Nurses in focus group reported that:

There is one senior surgeon who may be very angry in stressful situations on the ward. It is possible to live with because in those situations it is understandable. …I often understand the anger of surgeons. Their workday is often fragmented and irregular, they have a tough programme and they get easily frustrated.

Understandable anger expression is behaviour that is contextually meaningful in relation to the work situation and is associated with issues such as stress, difficult

patients and long work hours. However, the experience of anger over time in a relationship is also important. Long-term perception of fairness, ability to re-establish status quo, and admitting to one's own faults all contribute to wider tolerance of anger behaviour.

Incomprehensible and unacceptable anger is behaviour that is perceived by a target person as an overreaction, intentionally hurtful or hostile, and intentionally making the person feel unjustifiably blamed for errors or valued as inferior.

Doctors seem to have a wider range of acceptable anger than nurses do. For doctors anger is acceptable as long as it does not leave the room. As expressed by a senior surgeon: 'Ordinarily you can have a blow-out and make your point clear and there and then everything is cleared up. That did not happen here. The other person took the disagreement outside the room and involved others (referring to case 2, table 5).' Unacceptable anger to doctors is anger that continues to influence a relationship after the exchange of anger is over in a meeting, consultation, conference room or operating theatre. Doctors are also treated more leniently than nurses for expressing unacceptable anger are. As expressed by a nurse director: 'rude and rebukeable behaviour on the part of nurses leads to dismissal. However, there is much more tolerance for such behaviour on the part of doctors.'

Antecedents of Anger Behaviours

The perception of what has happened before or happened immediately prior to the expression of anger behaviour, is a major determinant of how the anger is evaluated and is related to the following reactions or consequences. By using the actor's own explanation of what happened, it was possible to categorise these perceptions. Table 2 (case 1) is a presentation of anger behaviours between two doctors, exemplifying the connections between antecedents, expression of anger and consequences. In this case the initial anger behaviour (sequence 5) is understandable in the light of what happened immediately before, whereas the second anger behaviour (sequence 9) only makes sense in terms of the relationship history and what has happened over the last 14 days.

Table 2 in approx. here

Table 3 presents an analysis of the variety of explanations of anger behaviours identified during the study period. These have been categorised into 5 broader categories: the long term broader work context of the anger behaviour, the present work situation, the relationship between the involved parties, characteristics of their professional cooperation, and personal behaviours.

Table 3 in approx. here

The reported relative importance of these factors in determining anger behaviour varies from episode to episode. However, ”present work situation” seems to be a crucial threshold in terms of both expressing and tolerating anger. As reported by a nurse manager: ‘Right now we have a very heavy work situation, with several nurses on sick leave and too many seriously ill patients. This makes staff aggressive even toward patients.’ In other situations involving anger behaviours participants refer to other factors as more important. In case 2 (table 5) a senior nurse explains the anger behaviour of doctors with reference to culture and job characteristics: ‘The reason for the high frequency of anger behaviour on this unit is that there is a culture and climate on the unit that accepts this. In addition, the culture places the doctor at the top and everybody else is supposed to assist. Unfortunately, many nurses passively support this culture.’

Consequences of Anger Behaviours

The consequences of anger behaviours are perceived differently by nurses and doctors. Table 4 presents the identified consequences at this particular hospital. All of these are labelled negatively by nurses. One exception is that anger may at times lead to increased attention toward a specific issue or cause. There are also examples of nurses perceiving anger as a lesser evil than being ignored. As expressed by a nurse manager: ‘I only get contact with him (her medical co-manager) when he is angry.’ It is also an important finding that anger is not just an emotion affecting the two parties involved. As expressed by a nurse manager: ‘Angry encounters in public influence other staff negatively. You can feel it at the nursing station. Other uninvolved staff have to listen to it and often feel obliged to take a position on the ’scolding’ and whatever may be the more substantial issues involved.’

Table 4 in approx. here

Doctors recognise that anger behaviours may have a detrimental effect on work cooperation, work environment and relationships, but are less bothered by this than nurses (table 5, sequence 9). As admitted by a senior doctor: ‘This is no problem to me as long as it does not affect the patient.’ One reason doctors are less negatively affected by anger than nurses is that the expression of anger carries many other positive effects for doctors. It provides emotional release with limited negative reactions from others.

At the same time anger behaviours function as a force that makes it more likely that a doctor will get their own way and control the work cooperation, emergency situations or when there is a threat to patient safety.

Table 5 in approx. here

Case 2 (table 5) exemplifies the negative consequences of anger behaviour for work environment, social relationships, professional cooperation and personal functioning. In addition, the case illustrates how the experience of irritation connected to minor incidents and trifles may add up and escalate to anger that elicits more angry reactions and causes conflict. As reported by one of the nurses (sequence 6): 'Each of these incidents by itself could have been considered a trifle, but not when accumulated over time. Exposed to anger behaviours, nurses will succumb for a period of time to the prevailing work norm that "this is part of the job". However, at a certain point there is a change in perception that "this is unfair, disrespectful treatment, and I should not be expected to put up with it". One such turning point is when nurses experience that their reduced professional functioning, due to withdrawal and restricted communication with doctors, may have a negative impact on quality of care.

Discussion

The findings support the view that anger behaviour in hospital settings is foremost localised to the doctor-nurse relationship and that doctors have a pivotal role in determining the anger behaviour of nurses and other hospital professionals. Thus, the following discussion will be centered around understanding doctors' anger behaviour.
Anger behaviour, in particular from doctors, is a major stress factor in the work day of nurses, has a negative impact on their work environment and professional cooperation, and may even reduce the quality of patient care. To a large extent, anger behaviour may be understood as an expression of a strained interpersonal relationship, where contextual factors serve to lower the threshold for keeping such feelings private. This provides the basis for nurses differentiating between anger behaviours and the extent of negative impact that may follow such behaviour. However, some individuals display anger more intensively, frequently and non-contextually than others, thus making their behaviour most unbearable to nurses. The positive aspects of displaying anger behaviour reported in this study are mainly localised to the experience of doctors and the function anger plays in their professional work roles. Doctors perceive anger behaviour to be less of a problem than do nurses. This may be because such behaviour provides more advantages than disadvantages to doctors. It may also be that the work situation in hospitals makes doctors more susceptible to the experience of anger and thus anger is more "normal" to them.

Anger and Doctors' Work Situation

There are reasons to assume that the very practice of hospital medicine, described as an "error-ridden activity", contributes to doctors' anger behaviour (Lens & van der Wal 1997). The basis for the assumption is that errors and mistakes are unavoidable for any doctor and can easily lead to, among other things, irritable behaviours. Such irritability may easily transform into more intense anger following only a slight degree of blaming from others (Aldwin & Sutton 1998, Parkinson 1999). Christensen et al. (1992) found that emotional reactions after mistakes often include anger at oneself or another doctor or nurse. There are studies indicating that when exposed to traumas, lack of social workplace support or proper debriefing may lead to increased irritability and a lower threshold for anger behaviour (Weiseth 1986, Landsbergis et al. 1992, Robbins 1999). Among doctors, such ameliorating factors seem to be lacking. In the present study doctors complained that there were few appropriate social arenas outside the operating theatre and the morning meeting for informal talks. Akre et al. (1997) found that among Norwegian doctors, mistakes and complications rarely were discussed in formal meetings and there was no network available to support colleagues exposed to professional traumas. Christensen et al. (1992) found that many doctors felt that they became isolated from colleagues after making a mistake. These connections between anger, lack of debriefing and social support, and medical errors have not been considered in the present study. However, such links may have important implications for better quality system work aiming at reducing medical errors.

Anger Display Rules

Display rules define what emotions to encourage and use as part of the work and how to express such emotions (Hochschild 1979, 1983). Knowing which emotions to display involves norms and rules. The findings of the present study suggest that doctors follow emotional display rules in ways that are different from nurses and other hospital professionals. The roots of emotional display rules for doctors seem to be the occupational culture into which they are socialised through their medical education and professional training (Spiegel et al. 1985, Lens & van der Wal 1997). Coombs et al. (1993a, 1993b) specifically points to this in explaining how doctors learn their humour and slang in order to master the emotional demands of the job, and why surgeons in particular seem to be high on traits such as "dominance" and "aggression". For a doctor, important professional display rules include: You should tolerate the power game; it is ok to be angry, but leave it in the room; keep it out of your relationships; be quick to forgive; and practise non-criticism in relation to peers. Coming from a predominantly natural science background, doctors are trained in a tradition of decoupling the emotional/nonrational world of the individual from the rational and often technical world of work exercised in diagnosis and treatment. They seem to carry this perspective over to interprofessional cooperation. Unlike the humanistic training

background of nurses, where emphasising emotions is seen as an important part of care and treatment, doctors seem to be focus on non-emotional activities and aspects of the work situation. Doctors are less inclined to think that expression of emotions like anger could have much of a negative effect on the work organisation since they believe that organisational order and efficiency are more matters of rational activity.

Power exercised through Anger Behaviour

The findings suggest further that the way doctors handle their anger may, to a large extent, determine the functioning of anger in a ward organisation and influence how other professionals relate to anger. Hitherto, no such studies are reported. However, the pivotal role of doctors in determining the display of anger in a hospital setting is conceivable in terms of their higher power. From a professional perspective doctors, when threatened, seem more readily to use power to defend whereas nurses seem more likely to submit. The higher power of doctors relative to nurses also seems to make them more amenable to the use of forcing in order to reach or dictate solutions. Several studies have pointed to high power leading to aggressive behaviours (Brett & Rognes 1986, Deutsch 1993), and the use of anger is an important way in which influence is exercised in organisational settings (Pfeffer 1997). Expressed emotion such as anger, irritation and mild disapproval serve as tools of influence when such feelings induce anxiety in the other party and, by complying, the other party is able to escape such emotional discomfort (Sutton 1991). This power structure adds to nurses' experience that working in a hospital is to work within a very pressurised system (White 1996). The hospital setting appears to require nurses who are able to function in an unquestioning manner, to accept the stress of the workplace as normal and to accept what is being done as being right.

This study points out that anger has direct implications for quality of care and for how people work together, and that anger can be dangerous in health care. As such, anger prevention may be as important as any other effort to improve the working conditions of hospital professionals. To what extent the findings of this study are a mere reflection of Norwegian culture cannot be answered. Even though Norway is characterised in the literature (Ross 1993) as a "conflict avoiding culture", with "low aggression level", the findings indicate that hospitals represent a somewhat different subculture. There are other rules and norms apart from those of the national culture guiding the behaviours of professionals. This viewpoint is supported by the fact that one of the few studies of anger in health care was done in Tasmania (Farrell 1999). The findings from this study are remarkably similar to a Norwegian setting. However, the cultural aspect of anger experience in health care needs to be more carefully researched.

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Table 1. Expressions of anger behaviours

General category	Specific behaviours
Strong verbal expressions	shouting, swearing, scolding, put in place, threats, blame others for neglect and faults, rejecting, criticise in public, furious, openly critical, quarrel in public, lose one's temper,
Weaker verbal expressions	blunt, snappy answers, suddenly overly strict, irritated, impatient, provocative humour
Non-verbal expressions	aggressive body language, slamming door, hitting person, take patient out of operating programme, sabotaging meetings, making contact impossible, ignoring person
Personal behavioural style	dominating, manipulating, sanctioning, showing no respect for other people, commanding, overrules, arrogant

Table 2. Case 1: Anger in a dyadic relationship between two doctors. (Numbers indicate sequence of events)

1. A surgeon, while on call at home, is called back to the hospital on a Saturday afternoon, to perform two operations. Over the phone he orders the sequence of the operations and decides the hour for when the first patient should be ready for surgery. 30 minutes before the first operation is to take place; the surgeon gets new information about the first patient and wonders if the patient rather should be transferred to another hospital. This makes the surgeon want to change the order of sequence and he orders the change.
2. When he arrives at the operating theatre, he finds to his surprise that the changed sequence has not been carried out. The patient he is hesitant about operating on is already heavily sedated and prepared for surgery.
3. He has not been informed about this and thought both patients still were in the emergency room. The surgeon asks for the change of sequence to take place.
4. The anaesthetist does not want to change the order of sequence without a good explanation to both patient and staff present about why a fully sedated patient should be wheeled out again.
5. The surgeon gets frustrated and angry due to the situation and the ”stubbornness” and ”uncooperative” attitude of the anaesthetist.
6. The surgeon decides to make the best of the situation and carries through the operation according to what he considers an adequate method and without complications.
7. Afterwards the anaesthetist is blamed for having caused the patient to be exposed to ”second best” treatment, making the anaesthetist furious and feeling a scapegoat.
8. 12 days later the surgeon observes the same anaesthetist being what he considers negligent in monitoring one of his patients in the intensive care unit. He takes action in order to protect the safety of his patient.
9. At the morning meeting the following day, the surgeon lashes out at the anaesthetist and questions the person’s professional competence. The anaesthetist is accused of ”compensating” professional insecurity by showing ”tough” manners.
10. The directors of surgery and anaesthesiology then get involved and try to negotiate a better working relationship.
11. Later communication and co-operation between the surgeon and anaesthetist are greatly reduced and managed mainly through avoidance and minimising contact with each other.

Table 3. Antecedents of anger behaviours

General category	Specific factor
	Work context, negative culture in unit, cultural difference nurses and doctors, prior conflicts, reorganisation of unit, high recent turnover at the unit, poor introduction of newly hired doctors
Present work situation	Understaffing, too many seriously sick patients, several patients dying at same time, having to take on extra work hours, having to work extra during holidays, transfer of patients at wrong times, busy unit, stressful work situation, patient journal not available
Relationships	Authoritarian leadership style, poor long -term interpersonal relationships, provocative and disruptive behaviour style, lack of pro-social behaviour, prior irritation
Professional co-operation	Disagreement with organisational model, perceived ineffective meetings, professional disagreements, not following rules and procedures, poor planning for surgery, disagreements regarding responsibility, strife over territoriality, long-term professional disagreements, unclear division of work, disagreements about indications for surgery, disagreement about treatment plan, lack of communication and consultation, disagreement about work division, critical of primary nursing model, neglect of approved rules and procedures, nurse challenges or questions doctor's decision, nurse repeating questions, colleague perceived slow in comprehension.
Personal behaviours	Not interested in the job, no interest in other persons/profession's perspective, professionally self sufficient, perceived emergency, perceived threat to patient safety, lack of flexibility or willingness to change, build-up of irritation

Table 4. Consequences of anger behaviours

General category	Specific factors
Work environment	Negative effect on work climate and atmosphere in unit, negative effect on others external to the incidents, force others to react.
Relationships	Reduce quality of relationship between parties, create conflict, reduce trust in leader-subordinate relationship
Cooperation	Reduce flow of communication, reduce team functioning, reduce co-ordination, reduce quality of care to patient, lower productivity
Personal	Reduce work motivation, increase intention to quit, termination of work contract, reduce pro-social behaviour, reduce trust and commitment, increase sick-leave, withdrawal, loss of respect, create enemy image of opponent

Table 5. Case 2: Anger in multiple relationships between nurses and doctors on a ward unit. (Numbers indicate the approximate sequence of events)

1. One nurse experienced over time that a female doctor behaved rudely toward her. The nurse perceived the doctor as lacking in manners and respect for her as a professional: ”She makes me feel like nothing”. ”I have been cut down to size in public because, according to her, I have asked a ”stupid” or ”improper” question”. When making her comments, the doctor often talks with a loud voice so everybody around can hear the corrections. When the doctor is on duty or on call, the nurse tries to avoid her and avoid calling her.
2. Late one evening the nurse had problems suctioning of the lungs of a patient on a respirator. The information in the record was not sufficient to give her clear instructions. She felt she had to call the doctor. The nurse was angrily critiqued for disturbing the doctor at this late hour, and was told that everything that was of importance was in the record and if anything was lacking it was due to failure of the nurses’ own routines.
3. The nurse writes down her experiences as a way of working through her problems. Sharing her experiences with other nurses and it turns out that several others have had similar stressful experiences with the same doctor and with another doctor.
4. This conflict started, according to the clinical directors, a few months earlier, during the autumn, when approximately one third of the nurses on the ward left and were replaced. There was a heavy workload over Christmas and many of the nurses had to work extra. In this stressful situation, two of the doctors behaved in a way the nurses found despicable. Many of the newly hired nurses were appalled to find the doctors shouting to them and, at times, correcting and critiquing their work while patients or other staff members were present.
5. The head of department took this up with the two doctors and demanded that the behaviour come to an end. For a time there was a slight improvement.
6. Continued anger behaviours on part of the doctors resulted in three nurses independently writing letters of complaint to the clinical director, referring altogether to 15 incidents of unacceptable anger involving doctors.
7. The clinical director repeated his demands and, as a follow-up, it was decided to have a joint meeting with the nurses and doctor to discuss routines and procedures in the department. A work group agreed on an agenda that included discussing how nurses and doctors cooperate. However, 6 months passed before this meeting was arranged.
8. Two hours before the meeting was to take place the most verbally abusive of the doctors dropped out due to pressing personal obligations. This made the nurses furious. During the meeting, where all nurses working that day were present, there was intense criticism of all department doctors for their poor co-operation. The nurses demanded that the verbal abuse had to stop, saying it was not enough to just say, ”excuse me” afterwards. They also demanded that the department head had to become more determined and visible. They perceived that the hospital culture was too understanding of the doctor’s anger and that it allowed improper behaviour to pass by. The nurse manager and department head swept it under the carpet by saying, ”Nurses have to put up with these minor issues”.
9. The targeted doctors, on their part, claimed that the incidents and events the nurses referred to were reflections of differences in workstyle and that some of the nurses are too easily offended. At times, irritation has come as an expression of a nurse

interrupting the work or has been related to professional concerns of what could happen to patients. Nurses sometimes ask improper and nosy questions about treatment issues that are “none of their business”, like ”Is this a resuscitation patient?” At times, the incidents are caused by failure in their own nursing procedures.

Förteckning över NHV-rapporter

NHV-Rapport	
	1983
1983:1	Hälsa för alla i Norden år 2000. Föredrag presenterade på en konferens vid Nordiska hälsovårdshögskolan 7–10 september 1982.
1983:2	Methods and Experience in Planning for Family Health – Report from a seminar. Harald Heijbel & Lennart Köhler (eds).
1983:3	Accident Prevention – Report from a seminar. Ragnar Berfenstam & Lennart Köhler (eds).
1983:4	Självmord i Stockholm – en epidemiologisk studie av 686 konsekutiva fall. Thomas Hjortsjö. Avhandling.
	1984
1984:1	Långvarigt sjuka barn – sjukvårdens effekter på barn och familj. Andersson, Harwe, Hellberg & Syréhn. (FoU-rapport/shstf:14). Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.
1984:2	Intersectoral Action for Health – Report from an International Workshop. Lennart Köhler & John Martin (eds).
1984:3	Barns hälsotillstånd i Norden. Gunborg Jakobsson & Lennart Köhler. Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.
	1985
1985:1	Hälsa för äldre i Norden år 2000. Mårten Lagergren (red).
1985:2	Socialt stöd åt handikappade barn i Norden. Mats Eriksson & Lennart Köhler. Distribueras av Allmänna Barnhuset, Box 26006, SE-100 41 Stockholm.
1985:3	Promotion of Mental Health. Per-Olof Brogren.
1985:4	Training Health Workers for Primary Health Care. John Martin (ed).
1985:5	Inequalities in Health and Health Care. Lennart Köhler & John Martin (eds).
	1986
1986:1	Prevention i primärvården. Rapport från konferens. Harald Siem & Hans Wedel (red). Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.

1986:2 Management of Primary Health Care. John Martin (ed).

1986:3 Health Implications of Family Breakdown. Lennart Köhler, Bengt Lindström, Keith Barnard & Houda Itani.

1986:4 Epidemiologi i tandvården. Dorthe Holst & Jostein Rise (red). Distribueras av Tandläkarförlaget, Box 5843, SE-102 48 Stockholm.

1986:5 Training Course in Social Pediatrics. Part I. Lennart Köhler & Nick Spencer (eds).

1987

1987:1 Children's Health and Well-being in the Nordic Countries. Lennart Köhler & Gunborg Jakobsson. Ingår i serien Clinics in Developmental Medicine, No 98 och distribueras av Blackwell Scientific Publications Ltd, Oxford. ISBN (UK) 0 632 01797X.

1987:2 Traffic and Children's Health. Lennart Köhler & Hugh Jackson (eds).

1987:3 Methods and Experience in Planning for Health. Essential Drugs. Frants Staugård (ed).

1987:4 Traditional midwives. Sandra Anderson & Frants Staugård.

1987:5 Nordiska hälsovårdshögskolan. En historik inför invigningen av lokalerna på Nya Varvet i Göteborg den 29 augusti 1987. Lennart Köhler (red).

1987:6 Equity and Intersectoral Action for Health. Keith Barnard, Anna Ritsatakis & Per-Gunnar Svensson.

1987:7 In the Right Direction. Health Promotion Learning Programmes. Keith Barnard (ed).

1988

1988:1 Infant Mortality – the Swedish Experience. Lennart Köhler.

1988:2 Familjen i välfärdsstaten. En undersökning av levnadsförhållanden och deras fördelning bland barnfamiljer i Finland och övriga nordiska länder. Gunborg Jakobsson. Avhandling.

1988:3 Aids i Norden. Birgit Westphal Christensen, Allan Krasnik, Jakob Bjørner & Bo Eriksson.

1988:4 Methods and Experience in Planning for Health – the Role of Health Systems Research. Frants Staugård (ed).

1988:5 Training Course in Social Pediatrics. Part II. Perinatal and neonatal period. Bengt Lindström & Nick Spencer (eds).

1988:6 Äldretandvård. Jostein Rise & Dorthe Holst (red). Distribueras av Tandläkarförlaget, Box 5843, SE-102 48 Stockholm.

1989

1989:1 Rights, Roles and Responsibilities. A view on Youth and Health from the Nordic countries. Keith Barnard.

1989:2 Folkhälsovetenskap. Ett nordiskt perspektiv. Lennart Köhler (red).

1989:3 Training Course in Social Pediatrics. Part III. Pre-School Period. Bengt Lindström & Nick Spencer (eds).

1989:4 Traditional Medicine in Botswana. Traditional Medicinal Plants. Inga Hedberg & Frants Staugård.

1989:5 Forsknings- och utvecklingsverksamhet vid Nordiska hälsovårdshögskolan. Rapport till Nordiska Socialpolitiska kommittén.

1989:6 Omstridda mödrar. En studie av mödrar som förtecknats som förståndshandikappade. Evy Kollberg. Avhandling.

1989:7 Traditional Medicine in a transitional society. Botswana moving towards the year 2000. Frants Staugård.

1989:8 Rapport fra Den 2. Nordiske Konferanse om Helseopplysning. Bergen 4–7 juni 1989. Svein Hindal, Kjell Haug, Leif Edvard Aarø & Carl-Gunnar Eriksson.

1990

1990:1 Barn och barnfamiljer i Norden. En studie av välfärd, hälsa och livskvalitet. Lennart Köhler (red). Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.

1990:2 Barn och barnfamiljer i Norden. Teknisk del. Lennart Köhler (red).

1990:3 Methods and Experience in Planning for Health. The Role of Women in Health Development. Frants Staugård (ed).

1990:4 Coffee and Coronary Heart Disease, Special Emphasis on the Coffee – Blood Lipids Relationship. Dag S. Thelle & Gerrit van der Stegen (eds).

1991

1991:1 Barns hälsa i Sverige. Kunskapsunderlag till 1991 års Folkhälsorapport. Gunborg Jakobsson & Lennart Köhler. Distribueras av Fritzes, Box 16356, SE-103 27 Stockholm (Allmänna Förlaget).

1991:2 Health Policy Assessment – Proceedings of an International Workshop in Göteborg, Sweden, February 26 – March 1, 1990. Carl-Gunnar Eriksson (ed). Distributed by Almqvist & Wiksell International, Box 638, SE-101 28 Stockholm.

1991:3 Children's health in Sweden. Lennart Köhler & Gunborg Jakobsson. Distributed by Fritzes, Box 16356, SE-103 27 Stockholm (Allmänna Förlaget).

1991:4 Poliklinikker og dagkirurgi. Virksomhetsbeskrivelse for ambulent helsetjeneste. Monrad Aas.

1991:5 Growth and Social Conditions. Height and weight of Stockholm schoolchildren in a public health context. Lars Cernerud. Avhandling.

1991:6 Aids in a caring society – practice and policy. Birgit Westphal Victor. Avhandling

1991:7 Resultat, kvalitet, valfrihet. Nordisk hälsopolitik på 90-talet. Mats Brommels (red). Distribueras av nomesko, Sejrøgade 11, DK-2100 København.

1992

1992:1 Forskning om psykiatrisk vårdorganisation – ett nordiskt komparativt perspektiv. Mats Brommels, Lars-Olof Ljungberg & Claes-Göran Westin (red). sou 1992:4. Distribueras av Fritzes, Box 16356, SE-103 27 Stockholm (Allmänna förlaget).

1992:2 Hepatitis virus and human immunodeficiency virus infection in dental care: occupational risk versus patient care. Flemming Scheutz. Avhandling.

1992:3 Att leda vård – utveckling i nordiskt perspektiv. Inga-Maja Rydholm. Distribueras av shstf-material, Box 49023, SE-100 28 Stockholm.

1992:4 Aktion mot alkohol och narkotika 1989–1991. Utvärderingsrapport. Athena. Ulla Marklund.

1992:5 Abortion from cultural, social and individual aspects. A comparative study, Italy – Sweden. Marianne Bengtsson Agostino. Avhandling.

1993

1993:1 Kronisk syke og funksjonshemmede barn. Mot en bedre fremtid? Arvid Heiberg (red). Distribueras av Tano Forlag, Stortorget 10, NO-0155 Oslo.

1993:2 3 Nordiske Konference om Sundhedsfremme i Aalborg 13 – 16 september 1992. Carl-Gunnar Eriksson (red).

1993:3 Reumatikernas situation i Norden. Kartläggning och rapport från en konferens på Nordiska hälsovårdshögskolan 9 – 10 november 1992. Bjarne Jansson & Dag S. Thelle (red).

1993:4 Peace, Health and Development. A Nobel seminar held in Göteborg, Sweden, December 5, 1991. Jointly organized by the Nordic School of Public Health and the University of Göteborg with financial support from SAREC. Lennart Köhler & Lars-Åke Hansson (eds).

1993:5 Hälsopolitiska jämlikhetsmål. Diskussionsunderlag utarbetat av WHOs regionkontor för Europa i Köpenhamn. Göran Dahlgren & Margret Whitehead. Distribueras gratis.

1994

1994:1 Innovation in Primary Health Care of Elderly People in Denmark. – Two Action Research Projects. Lis Wagner. Avhandling.

1994:2 Psychological stress and coping in hospitalized chronically ill elderly. Mary Kalfoss. Avhandling.

1994:3 The Essence of Existence. On the Quality of Life of Children in the Nordic countries. Theory and Pracitice. Bengt Lindström. Avhandling.

1995

1995:1 Psykiatrisk sykepleie i et folkehelseperspektiv. En studie av hvordan en holistisk-eksistensiell psykiatrisk sykepleiemodell bidrar til folkehelsearbeid. Jan Kåre Hummelvoll. Avhandling.

1995:2 Child Health in a Swedish City – Mortality and birth weight as indicators of health and social inequality. Håkan Elmén. Avhandling.

1995:3 Forebyggende arbeid for eldre – om screening, funn, kostnader og opplevd verdi. Grethe Johansen. Avhandling.

1995:4 Clinical Nursing Supervision in Health Care. Elisabeth Severinsson. Avhandling.

1995:5 Prioriteringsarbete inom hälso- och sjukvården i Sverige och i andra länder. Stefan Holmström & Johan Calltorp. Spri 1995. Distribueras av Spris förlag, Box 70487, SE-107 26 Stockholm.

1996

1996:1 Socialt stöd, livskontroll och hälsa. Raili Peltonen. Socialpolitiska institutionen, Åbo Akademi, Åbo, 1996.

1996:2 Recurrent Pains – A Public Health Concern in School – Age Children. An Investigation of Headache, Stomach Pain and Back Pain. Guðrún Kristjánsdóttir. Avhandling.

1996:3 AIDS and the Grassroots. Frants Staugård, David Pitt & Claudia Cabrera (red).

1996:4 Postgraduate public health training in the Nordic countries. Proceedings of seminar held at The Nordic School of Public Health, Göteborg, January 11 – 12, 1996.

1997

1997:1 Victims of Crime in a Public Health Perspective – some typologies and tentative explanatory models (Brottsoffer i ett folkhälsoperspektiv – några typologier och förklaringsmodeller). Barbro Renck. Avhandling. (Utges både på engelska och svenska.)

1997:2 Kön och ohälsa. Rapport från seminarium på Nordiska hälsovårdshögskolan den 30 januari 1997. Gunilla Krantz (red).

1997:3 Edgar Borgenhammar – 65 år. Bengt Rosengren & Hans Wedel (red).

1998

1998:1 Protection and Promotion of Children's Health – experiences from the East and the West. Yimin Wang & Lennart Köhler (eds).

1998:2 EU and Public Health. Future effects on policy, teaching and research. Lennart Köhler & Keith Barnard (eds) 1998:3 Gender and Tuberculosis. Vinod K. Diwan, Anna Thorson, Anna Winkvist (eds). Report from the workshop at the Nordic School of Public Health, May 24-26, 1998.

1999

1999:1 Tipping the Balance Towards Primary Healthcare Network. Proceedings of the 10th Anniversary Conference, 13-16 November 1997. Editor: Chris Buttanshaw.

1999:2 Health and Human Rights. Report from the European Conference held in Strasbourg 15-16 mars 1999. Editor: Dr. med. Stefan Winter.

1999:3 Learning about health: The pupils' and the school health nurses' assessment of the health dialogue. Ina Borup. DrPH-avhandling.

1999:4 The value of screening as an approach to cervical cancer control. A study based on the Icelandic and Nordic experience through 1995. Kristján Sigurðsson. DrPH-avhandling.

2000

2000:1 Konsekvenser av urininkontinens sett i et folkehelsevitenskapelig perspektiv. En studie om livskvalitet hos kvinner og helsepersonells holdninger. Anne G Vinsnes. DrPH-avhandling.

2000:2 A new public health in an old country. An EU-China conference in Wuhan, China, October 25-29, 1998. Proceedings from the conference. Lennart Köhler (ed)

2000:3 Med gemenskap som grund - psykisk hälsa och ohälsa hos äldre människor och psykiatrisjuksköterskans hälsofrämjande arbete. Birgitta Hedelin. DrPH-avhandling.

2000:4 ASPHER Peer Review 1999. Review Team: Jacques Bury, ASPHER, Franco Cavallo, Torino and Charles Normand, London.

2000:5 Det kan bli bättre. Rapport från en konferens om barns hälsa och välfärd i Norden. 11-12 november 1999. Lennart Köhler. (red)

2000:6 Det är bra men kan bli bättre. En studie av barns hälsa och välfärd i de fem nordiska länderna, från 1984 till 1996. Lennart Köhler, (red)

2000:7 Den svenska hälso- och sjukvårdens styrning och ledning – en delikat balansakt. Lilian Axelsson. DrPH-avhandling.

2000:8 Health and well-being of children in the five Nordic countries in 1984 and 1996. Leeni Berntsson. DrPH-avhandling.

2000:9 Health Impact Assessment: from theory to practice. Report on the Leo Kaprio Workshop, Göteborg, 28 - 30 October 1999.

2001

2001:1 The Changing Public-Private Mix in Public Health Care and Analyzis. John Øvretveit.

2001:2 Hälsokonsekvensbedömningar – från teori till praktik. Rapport från ett internationellt arbetsmöte på Nordiska hälsovårdshögskolan den 28-31 oktober 1999. Björn Olsson, (red)

2001:3 Children with asthma and their families. Coping, adjustment and quality of life. Kjell Reichenberg. DrPH-avhandling.

2001:4 Studier av bruket av dextropropoxifen ur ett folkhälsoperspektiv. Påverkan av ett regelverk. Ulf Jonasson. DrPH-avhandling.

2001:5 Protection – Prevention – Promotion. The development and future of Child Health Services. Proceedings from a conference. Lennart Köhler, Gunnar Norvenius, Jan Johansson, Göran Wennergren (eds).

2001:6 Ett pionjärarbete för ensamvargar. Enkät- och intervjuundersökning av nordiska folkhälsodoktorer examinerade vid Nordiska hälsovårdshögskolan under åren 1987 – 2000. Lillemor Hallberg (red).

2002

2002:1 Attitudes to prioritisation in health services. The views of citizens, patients, health care politicians, personnel, and administrators. Per Rosén. DrPH-avhandling.

2002:2 Getting to cooperation: Conflict and conflict management in a Norwegian hospital. Morten Skjørshammer. DrPH-avhandling.