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Nursing and Conflict Communication: A Review

Anne M. Nicotera

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Abstract

The study of conflict and nursing has generated a complex set of literatures. Communication scholars prioritize interactive dynamics, offering well-developed theory. Nurse researchers prioritize dynamics of a clinical environment. This review offers a background in organizational conflict studies, summarizing social scientific advances to provide a conceptual foundation for nursing conflict research. Nursing literature frames conflict as a feature of the workplace environment, equated with emotion—particularly incivility. Communication literature frames conflict as natural and functional, focusing on issues but neglecting emotion. The most fruitful approach would rely on a communication-grounded view of conflict processes and a nursing-grounded view of workplace context. Together, communication and nursing researchers can create an approach to nursing conflict superior to either body of literature on its own. This review supports that end. First, it summarizes organizational conflict research. Next, nursing conflict research is reviewed and critiqued in light of conflict communication theory, highlighting research well-grounded in social science. The scope of this review is conflict among persons and interactive processes of conflict management, concentrating on nurses but also including other healthcare professionals (usually physicians).

Keywords: conflict, nursing, communication, workplace environment

Introduction

The study of conflict in the nursing workplace has generated a complex literature. Brinkert's (2010) focused review provides a state-of-the-art assessment of knowledge about nursing conflict, its antecedents, consequents, and interventions. The purpose at hand is to update and expand Brinkert (2010)—recommended reading for any scholar interested in nursing conflict (see also Kim et al., 2017, for a comprehensive review of conflict research across healthcare). The present review offers a broader background in the study of conflict in organizational communication studies, summarizing social scientific theoretical advances in organizational conflict studies to rest nursing conflict research on a solid conceptual foundation. The social scientific literature on conflict management is underappreciated by many who study nursing conflict. Hence, a great deal of effort is put forth asking redundant questions. Nursing research on conflict could advance far more quickly, with more sophisticated questions producing more useful results, by building on social science rather than duplicating discoveries. For example, a great deal of energy and time is expended documenting discoveries that can be drawn as conclusions from the broader conflict literature: that internal conflict in nursing units is constant (Guerra, Prochnow, Trevizan, & Guido,

2011); that is often the result of poor communication (Kaitelidou et al. 2012); that nurses find recurrent conflict frustrating (Edwards, Thronson, & Girardin, 2012); that nurse managers need education on appropriate and effective conflict management (Guerra et al., 2011; Vivar, 2006); that good communication is essential for effective conflict management (Edwards et al., 2012; Kaitelidou et al., 2012); and that poor conflict management, especially that which engenders disruptive behaviors, results in stress and low job satisfaction (Stecker & Stecker, 2014). Research well-grounded in social science can rest on these things as foundational assumptions — the starting line rather than the finish line.

The study of conflict in the workplace attracts attention from scholars in both the nursing and communication disciplines; communication, however, has a far longer and more theoretically developed history. Yet, most communication researchers have only a rudimentary understanding of clinical contexts. Although communication scholars have a more developed grasp on conflict, they lack nurse researchers' sophisticated understanding of the nursing workplace, leading to difficulty applying communication and conflict literature to the clinical setting with its unique dynamics. While there is an overwhelmingly large communication literature on organizational conflict, precious little of it is set in the healthcare context.

Nurse researchers have a superior grasp of the nuanced clinical setting, but their command of social science theory is less developed. Communication scholars' presumptions of conflict as inevitable and constructive were well established by the 1970s; yet, in the nursing literature, analyses that identify opportunities for enhanced performance from well-managed task conflicts have only recently become common (e.g., Greer, Saygi, Aldering, & de Dreu, 2012). Scholars from communication and nursing can learn much from one another about conflict in this unique workplace. A communication perspective prioritizes the interactive dynamics of human communication and offers a rich and well-developed body of theory on conflict in organizational settings. A nursing perspective prioritizes the dynamics of a clinical environment, which many social scientists have conceded is a very unique organizational setting to which much organizational theory and research may not directly apply (Ramanujam & Rousseau, 2006).

The Nursing Perspective

The nursing literature frames conflict as a feature of the workplace environment (Cao et al., 2016; Erickson et al., 2004), with conflict in practical situations seen by nurse managers as a prominent source of ethical problems (Aitamaa, Leino-Kilpi, Iltanen, & Suhonen, 2016). It is widely recognized that nursing professionals confront persistent challenges that complicate the workplace and make it particularly predisposed to conflict (e.g., cost constraints, safety concerns, role conflicts, and overload). The nursing workplace is unpredictable and highly dynamic, leading nurses to experience conflict with each other, with physicians and other professionals, and with their patients. Yet, even while the nursing literature casts this problem as environmental, it defines the solution as a matter of individual skills. Thus, conflict management skills are frequently listed as an important category of expert nursing skills (Quierós, 2015); communication with patients remains prioritized, however, with inadequate attention given to communication among nurses.

In the nursing literature, poorly managed conflict has been linked to stress (Borteyrou, Trucho & Rasclé, 2014; Galdikienė, Asikainen, Balčiūnas, & Suominen, 2014; Naholi, Nosek, & Somayaji, 2015) and burnout (Gascon et al., 2013); whereas, effective conflict management has been shown to improve both decision-making (Ek & Svedlund, 2015) and patient care (Steinmo et al., 2016). Professional publications abound with commentary about the importance of good conflict management (Center for American Nurses, 2006; Greer et al., 2012; Hocking, 2006; Okoli, 2010; Trossman, 2011; Savel & Munro, 2015), with the constructive potential of conflict only

with the constructive potential of conflict only recently routinely acknowledged. However, while collaborative conflict management skills are important, they are only a small part of the solution. It is crucial to cultivate constructive individual, group, and organizational views of conflict as a human social phenomenon.

The Communication Perspective

Communication literature frames conflict as a natural, functional human process. Communication scholars assume the potentially constructive nature of conflict. One of the field's most cited sources is Folger, Poole, and Stutman (2012). First published in 1984, its double entendre *working through conflict* immediately became widely embraced. Organizational members engage in communicative acts to *work through* conflicts; they also accomplish tasks *through conflict*. Conflict is an important vehicle through which work gets accomplished.

Early communication scholars and other social scientists viewed conflict as a necessarily negative force. Hence, conflict *resolution* was emphasized as the preferable outcome. In the 1960s, conflict took on a positive healthy aspect. Later, conflict was seen as functional and necessary (Mathur & Sayeed, 1983) and useful to organizational goals (Mathur & Sayeed, 1983; Rahim, 1983, 1985). Conflict promotes cohesiveness (Coser, 1956), maintains power balances (Blake, Shepard, & Mouton, 1964), facilitates change (Litterer, 1966), and generates creative problem solving (Hall, 1969, 1973, 1986). These assumptions shifted the focus to conflict *management*. In current communication scholarship, the term *conflict resolution* is reserved for discussion of large-scale disputes, such as union negotiations, and has been so for decades. In the nursing literature, however, this transition from a focus on *conflict resolution* to *conflict management* has only recently begun, with the two terms still largely treated as interchangeable.

Overview

The most fruitful approach to the study of conflict in the nursing workplace would rely on a communication-grounded view of human conflict processes and a nursing-grounded view of workplace context. This review is oriented to that end. First, it provides an overview of the study of organizational conflict communication. The few studies of nursing conflict research by communication scholars are included in the general review of communication literature. Next, conflict research in the nursing literature is reviewed and critiqued in light of conflict and communication theory. Research previously reviewed by Brinker (2010) is excluded, and conceptually sound nursing research well-grounded in social science is highlighted.

Before commencing, it is important to note a

striking difference between the nursing and social science literatures. Communication researchers tend to equate conflict with disagreement over substantive issues; nursing researchers tend to equate conflict with incivility and disruptiveness (Guidroz, Wang, & Perez, 2012; Hamblin et al., 2015; Padgett 2015; Stecker & Stecker, 2014). Accordingly, in communication and other social sciences, *bullying* is seen as a related but conceptually distinct area, differentiated from one-time incidents of incivility (for an excellent review, see Lutgen-Sandvik, Namie, & Namie, 2009). Yet, nurse-nurse bullying, especially as perpetrated by older nurses or managers, has been studied for decades by nurse researchers as a form of conflict (see Hutchinson et al., 2005, 2006a, 2006b, 2008 for excellent reviews of bullying in nursing; Fontes, Alarcao, Santana, Pelloso, & Carvalho, 2019, and Hampton, Tharp-Berrie, & Rayens, 2019, are recent examples). The distinction between substantive issue disagreements and incivilities is a conceptual lesson nurse researchers might learn from communication researchers. Given the enormity of both literatures on bullying, and the importance of conceptually distinguishing bullying from conflict, bullying is beyond the scope of this review. It is, however, related to conflict management in that unresolved issues or poorly managed conflict can lead to frustrations that create the conditions in which bullying flourishes (Nicotera & Mahon, 2013).

Communication and Social Science Literature on Organizational Conflict

The scope of this review is conflict among persons at the individual or group level and interactive processes of conflict management. Works focused on negotiation or formal processes of dispute resolution are excluded. Commentary on the nursing literature is provided where it differs significantly from the communication literature.

Conceptualizing Conflict and Communication

Communication researchers settled decades ago on a fairly standard definition for the term *conflict*: "The interaction of interdependent people who perceive the opposition of goals, aims, and (or) values, and who see the other party as potentially interfering with the realization of these goals (aims, or values)" (Putnam & Poole, 1987, p. 552). Three features make it unique in its importance to the field of communication: Interaction, incompatibility, and interdependence. Without *interaction*, we cannot *incompatibility* of goals, there is no opposition in that interaction. Finally, without *interdependence*, perceived opposition of goals is irrelevant to the parties' ability to accomplish their organizational task(s). Despite widespread consensus, however, research practices do

not always remain consistent. Often, communication research has operationalized conflict as simply disagreement and has relied upon self-reported recall of behavior or self-reported hypothetical behavior. Communication scholars have traditionally failed to adequately conceptualize emotion as a crucial component, likely due to the task-focus and managerial bias that pervades the organizational communication literature, which isolates study of emotion as a niche area and fails to adequately conceptualize humans as emotional beings beyond that sub-area. Conversely, nurse researchers tend to overemphasize the role of emotion, defining conflict as primarily an emotional issue (Cox, 2001, 2003, 2008), neglecting the potentially creative and productive power of conflict. This issue has only recently been directly addressed (Greer et al., 2012).

Conflict Styles and Strategies

Organizational communication scholars have pursued a variety of approaches to examining conflict, including behavioral observation, examination of responses to hypothetical conflict situations, analysis of reports of real past interaction, and most recently, analyses of discourse, language, and/or dialogue. Early organizational communication researchers approached the study of conflict from a more static perspective. Particularly in the 1970s and 1980s, the dominant pattern was the explication of predispositions for conflict management styles, usually followed by evaluation of each style's effectiveness and implications for training (Hall, 1969, 1973, 1986; Putnam & Wilson, 1982; Rahim, 1983; Ross & DeWine, 1982, 1987; Thomas & Kilmann, 1974). Although lacking a dynamic perspective, this early research generated a great deal of knowledge. Examination of managerial behaviors revealed that successful managers spend more time managing conflict than do unsuccessful managers (Luthans, Rosenkrantz, & Hennessy, 1985). Because organizations of various size and function report conflict management training to be of considerable importance (DeWine, 1994), great demand grew for conflict skills training in industry. This demand prompted scholars to identify successful strategies for managing conflict (Burke, 1970; Deutsch, 1973; Kilmann & Thomas, 1977; Putnam & Wilson, 1982; Renwick, 1977), and this approach led directly to the preponderance of models of organizational conflict management styles that typify the communication literature from the 1960s through the 1980s. Nurse researchers have made good use of this approach, largely replicating its findings in the nursing context.

Research dating back to the early 1990s is reviewed below: extensions of the styles approach, superior/subordinate conflict, culture and conflict styles, gender, and discourse/dialogue. Prior to this review of recent and contemporary literature, however, historical background

for the conflict styles approach that dominated communication theory and research through the 1990s is provided because a great deal of current nursing research follows the styles tradition. It is useful for nurse researchers to understand the conceptual history of this approach and the conceptual developments beyond it, in the hopes that nurse researchers can build upon the advances made by communication scholars. Continually asking research questions about nurses' conflict styles remains common and is no longer fruitful.

Overview of the styles/strategies predispositional approach. Blake and Mouton's (1964) Managerial Grid posits that managers communicate from two fundamental concerns: *Concern for Results* and *Concern for People*. This seminal model is the basis for a number of dual-concern theories. Five conflict styles along these two dimensions were created. *Forcing*, or dominating, is concerned with results but not with people. *Collaboration*, or confronting (a term no longer used because of ambiguous meaning), is concerned with both and is defined as an integrating style. *Smoothing*, or accommodating, is concerned with people but not results and is a form of issue avoidance. *Withdrawal* is total avoidance, concerned with neither. Finally, *compromise* aims at simple solutions with each party acquiescing the original demand, so that concern for results and concern for people compromise (weaken) one another. Compromise, therefore, is not necessarily a good thing and collaboration/integrating is considered to be the most effective style (Putnam & Wilson, 1982). (See Figure 1.)

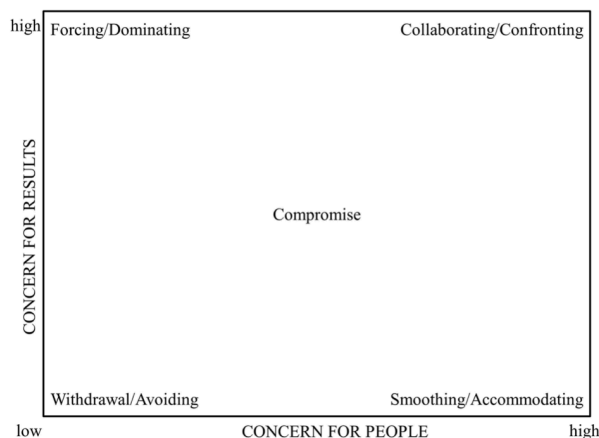


Figure 1: Blake & Mouton's (1964) managerial grid for conflict management styles

Citing inconsistent conceptual and operational distinctions, many researchers collapse *collaborating* with *compromise* and *avoiding* with *smoothing*,

reducing the taxonomy to three styles (Canary & Spitzberg, 1989; Putnam & Wilson, 1982; Ross & DeWine, 1982, 1987; Sillars, 1980a, 1980b). Whether using five or three styles, research generated a large body of knowledge about conflict from a dual-concern approach over the next three decades. The two most widely used conflict style instruments are the Thomas-Kilmann instrument (TKI) (Kilmann & Thomas, 1977; Thomas & Kilmann, 1974) and Rahim's (1983) Organizational Conflict Inventory-II (ROCI-II). The ROCI-II remains the most used by organizational scholars. Nursing scholars continue to use both the ROCI-II and the TKI. Yet, lack of attention to the social science literature is a crucial mistake. The TKI, as a forced-choice instrument, produces ipsative data inappropriate to the application of inferential statistics (Womack, 1988). Communication scholars abandoned the TKI in research, though it continues to be used in training.

While conceptually limited, the styles approach generated a great number of conclusions. The literature examining conflict styles in supervisor/subordinate relations is by far the largest, owing to a managerial bias in organizational research. For both supervisors and subordinates, collaborative styles are both preferred and more effective than others, while forcing/competing is the least preferred and least effective (Martin, Sirimangala, & Anderson, 1999; McCready, et al., 1996; Powell & Hickson, 2000; Rahim, Magner, & Shapiro, 2000; Weider-Hatfield & Hatfield, 1996). Other studies link conflict styles to cultural variables, such as self-image as interdependent or independent, with those who see themselves as interdependent much more likely to use collaborative styles (Oetzel, 1998). Yet, face concerns better predict conflict style than either self-construal and organizational position, with those who prioritize mutual face concerns (as compared to self- and other-face) far more likely to exhibit positive conflict strategies and less likely to exhibit destructive styles (Oetzel, Meares, Myers, & Lara, 2003). Individuals holding strong traditional values of conformity tend to be avoidant; whereas, those with high power values will likely be dominating (Kozan, 1999).

Gender processes are obscured by the styles tradition. Men and women do not significantly differ in their conflict management styles (Chusmir, Koberg, & Mills, 1989; Renwick, 1977; Shockley-Zalabak & Morley, 1984; Temkin & Cummings, 1986). Gendered expectations wield more explanatory power than individual characteristics (Renwick, 1977; Zammuto, London, & Rowland, 1979). This issue is of particular interest in the nursing context, gendered very differently from the corporate environment in which most organizational research takes place. Burrell, Buzzanell, and McMillan (1992) combine interpretive and quantitative metaphor analyses of conflict images held by women in government. Shuter and Turner (1997)

examine race within gender in a study of African American and European American women's perceptions of workplace conflict. Neither study attempts to identify or predict conflict styles, but rather both attempt to understand the unique viewpoints of workplace conflict held by members of gendered and racialized groups, revealing that perceptions of race and gender do not predict behavior but, rather, are a political thread in the organizational fabric that shapes our experiences and they ways in which we view and respond to others.

Utilizing a variety of methods with varying success, a number of scholars in the 1990s and early 2000s attempted to expand the styles approach, even while uncritically accepting the dual-concern conceptual structure. The most notable directions of expansion include empirically-based conceptual expansion of the dimensional structure (Nicotera, 1993); examination of variability in behavior over time (Conrad, 1991; Nicotera, 1994; Papa & Natalle, 1989); investigation into contextual influences (Friedman, Tidd, Currall, & Tsai, 2000; Marin, Sherblom, & Shipp, 1994; Ohbuchi & Suzuki, 2003); exploration of underlying personality predictors of preferred conflict style (Moberg, 2001); and the establishment of a link between conflict style and communication competence (Gross & Guerrero, 2000; Gross, Guerrero, & Alberts, 2004).

In communication research, investigation of conflict styles reached its height at the turn of the 21st century and has waned. Nursing researchers, on the other hand, continue to energetically investigate conflict styles following the dual-concern model, which has significant conceptual limitations. First, despite a complex interactional conceptualization of conflict, the styles tradition's operational definition of conflict is disagreement (ignoring interdependence and emotion) and does not account for individual variability in definitions of conflict. This set of issues is doubly problematic when paired with nursing researchers' conceptualization of conflict as emotional. Nursing's conflict literature conflates incivility and hostility with conflict; whereas, communication's conflict literature fails to account for incivility and hostility. Neither is sound, and mixing the two only increases the conceptual muddle.

Second, the styles approach is reductionist; while this is a perfectly acceptable mode of social scientific research, it is very limited. The conceptual basis of the styles tradition does not account for the unique context of the healthcare organization (HCO). The styles approach neglects context altogether. Although scholars acknowledge that situational constraints are crucial, styles measures cannot attend to choice and situational constraint. The styles approach rests on the assumption that interactants have clear goals, leading to a linear view of communication and thus a linear view of the relationship between conflict style and

communication. Moreover, the methodology operationalizes conflict style through self-reported data of recalled or hypothetical behavior. Finally, the approach rests on a presumption of dyadic communication. Group contexts and third-party discussions (i.e., co-workers, friends, family) have been overlooked — with the notable exception of Volkema, Bergmann, and Farquhar (1997) who found engaging in such third-party conversation to be related to conflict intensity and low positional power, to increase assertiveness, and to decrease cooperativeness.

The conflict styles approach rooted in a dual-concern theoretical framework monopolized the early study of organizational communication and conflict, driving it toward static and reductionist thinking. While communication scholars have conceptually developed beyond this approach, many nurse researchers continue to ground their conflict work in this tradition. Nursing scholarship, as previously mentioned, has only in the last decade begun to frame conflict as normal, natural, inevitable, and productive. In contrast, communication scholars had, by 1980, adopted the presumption that the conflict itself is neither bad nor good; rather, it is the communicative handling of conflict that predicts outcomes. The nursing literature is now making that same conceptual turn (most notably and influentially McKibben, 2017, but also Almost, 2006; Brinkert, 2010; Greer, Saygi, Aaldering, & de Dreu, 2012; and Okoli, 2010).

Communication Research on Nursing Conflict

There has been precious little communication conflict scholarship in the HCO context. Any study conducted by a communication scholar is reviewed in this section, even if it appears in a nursing publication, many of which are collaborations between communication and nursing scholars. The communication theory-based studies that exist show promising foundation for more collaborative work between nursing and communication scholars. Communication studies of nursing conflict are rare. Communication scholars far more commonly examine HCOs and medical personnel more generally. Anything involving nursing communication is included here.

Marin et al. (1994) examined nurses' responses to situations wherein interpersonal conflict is created by nurses' contradictory professional responsibilities to patients and physicians. In situations where the physician has asked that certain information be withheld from the patient when the nurse's professional ethic would preclude such secrecy, Marin et al. concluded that the respondent's perception of her role as a professional nurse is the primary function discriminating her choice of conflict management style. This study carefully defines situational constraints and fully contextualizes the nature of the interaction, revealing a rich view of contextual influences on conflict style choice. Although conflict style itself is conceptualized

and measured via the dual-concern approach, the casting of conflict style as the dependent variable represents a significant shift in thinking; traditionally conflict style has been conceptualized as an independent variable — an antecedent rather than a consequent. Marin et al. (1994) uniquely treat conflict style as an outcome variable.

Friedman, Tidd, Currall, and Tsai (2000) examine the relationship between styles and the HCO context from the other direction, arguing that conflict style shapes the social environment, specifically the level of workplace stress, defining conflict as ongoing and complex. This view extends the impact of conflict style beyond the episode to the ongoing workplace social environment. The ROCI-II and measures of the amount of task conflict (Jehn, 1997), relational conflict (Cox, 1997), and stress (Cohen, Kamarck, & Mermelstein, 1983) were administered to 82 medical personnel. Integrating style is associated with lower levels of experienced task conflict, while dominating and avoiding styles are associated with higher levels of experienced task conflict. The effects of integrating, dominating, and avoiding on relationship conflict occur through their effects on task conflict, but there is a direct effect of obliging on relationship conflict. Integrating and obliging styles are linked to lower stress, while dominating or avoiding styles are linked to higher stress. The treatment of conflict as ongoing and of different types defines conflict as something both deeper and broader than mere disagreement. The idea that conflict styles impact both experience of organizational conflict and stress levels is insightful. Yet, the measures used are highly reductionist and limited.

Although she glosses over gender politics, Jameson (2003) insightfully examines the HCO context in a qualitative study of intractable conflict among anesthesia providers. Like Marin et al. (1994), Jameson (2003) accounts for the unique context of both the HCO and the professions of the participants, offering rich context in a detailed analysis of anesthesiology practice history. Certified registered nurse anesthetists (CRNAs) and the anesthesiologists (MDs) who supervise them have a long and complicated political history manifesting in significant contemporary relational tensions. Qualitative interviews of 16 participants (eight CRNAs and eight MDs in three hospitals) trace Northrup's (1989) four stages of intractable conflict escalation (threat, distortion, rigidification, and collusion), extracting communicative themes for each stage — "The overarching theme for the 'threat' stage was *identity*" (Jameson, 2003, p. 568). For *distortion*, the predominant theme was *similarity vs. dissimilarity of perceptions*. For *rigidification*, there were three predominant themes: *separation* (physical or emotional); *differentiation*, perceived differences between the groups; and *dominance* of the anesthesiologists over the CRNAs.

Interestingly, this sense of dominance occurs not at the institutional but the individual level. Finally, for *collusion*, the predominant theme was *escalation vs. de-escalation*. Reliance on power-based strategies increases conflict. CRNAs and MDs both report situations where dishonesty fosters mistrust, escalating conflict. Conversely, strategies of collaboration transcend conflict. Jameson (2003) illustrates that organizational and professional contexts are powerful forces that impinge on the occurrence, experience, and management of interpersonal conflict in the HCO workplace.

In a secondary analysis, Jameson (2004) examines the autonomy-connection dialectic. A *dialectic* is a set of oppositional simultaneous needs characterizing human relationships (Baxter, 1988, 1990), and this particular dialectic is central to the struggle between CRNAs and anesthesiologists (Jameson, 2004). Both groups feel pressured to demonstrate unique contributions yet desire to communicate collaboratively. Politeness strategies enacted by both are supportive of themselves, the others, and the relationship between them. These strategies both repair relational disruptions and create a culture of collaboration. Jameson (2004) both identifies strategies to create collaboration and reveals a set of fundamental paradoxes inherent to the HCO that manifest in conflicts between these groups. Contradictions that foster conflict are institutionalized in the organizational fabric (Erbert, 2014; Nicotera & Clinkscales, 2010), and sustainable conflict management practices can be institutionalized (Liu, Inlow, & Feng, 2014).

While all organizations are constructed of inherently paradoxical institutional structures, the HCO has four unique contextual features (Ramanujam & Rousseau, 2006). First, hospitals have multiple and potentially *conflicting missions* such as patient care, community service, medical education, profit, health research, religious values, etc. Hence, assessment of mission achievement must be based on multiple dimensions. Second, hospitals' workforce is comprised of *multiple professions with a multitude of differing training and licensing requirements, salary structures, and power roles*. To complicate matters even more, these professionals have all been socialized in other organizational systems. According to Ramanujam and Rousseau (2006):

The socialization of HCO professionals occurs pre-employment. . . . So dominant are institutionalized pre-employment processes that many HCOs attempt little or no socialization of their own workforce. Weak organization-based socialization means that individuals can have as many different professional practices and care-giving behaviors as the institutions that educated them. . . . The result is strong professional identification and weak organizational identification (pp. 813-814).

Third, hospitals typically face a complex *external environment with multiple stakeholders* (third-party payers, individual and organizational consumers, government, and multiple professional associations). Finally, the hospital *task environment is complex, ambiguous, dynamic, and local*, subject to the simultaneous demands of standardization and flexibility. These four HCO features amplify the administrative complexity of day-to-day tasks and seem to categorize the hospital as a unique organizational type. While these contextual features cannot be identified as direct causes of conflict, they do create unique complications for the study of conflict in the HCO context.

Structurational divergence theory (SDT) has been developed by a research team of both communication and nursing scholars (Nicotera & Clinkscales, 2010; Nicotera & Mahon, 2013; Nicotera, Mahon, & Wright, 2014; Nicotera, Mahon, & Zhao, 2010; Nicotera, Zhao, Mahon, Kim, & Conway-Morana, 2015). SDT explains how such institutionalized contradictions underlie poor communication and lie at the root of recurrent conflict cycles. Structuration is a sociological term that refers to the social and cognitive processes through which we draw upon cultural and societal rules and resources to understand and act appropriately in social situations (Giddens, 1984). Divergence refers to the intersection of multiple sets of these institutionalized rules/resources, beneath the level of individuals' awareness, that are in competition with one another. As a result of these incompatible meaning structures, communication difficulties become entrenched in HCOs. For example, a nurse may be compelled by bureaucratic structures to maintain her unit's Magnet status. Yet, the demand for bedside care contradicts with the equally compelling demand for Magnet paperwork, leaving her feeling ineffective and thrusting her into interpersonal conflicts with her manager and co-workers over priorities (Nicotera et al., 2014).

While SDT has been pursued primarily in nursing, it is an institutional phenomenon (Nicotera & Mahon, 2013). As recurrent conflict rooted in incompatible social meaning structures, structurational divergence (SD) is characterized by a negative spiral: unresolved conflict, immobilization, and regressions in development that exacerbate the conflict. Because the source of SD conflict is in meaning rather than goals, normal competent conflict management strategies fail. Cognitive communication competence (mindful thinking about one's communication before, during, and after interaction) is associated with SD, suggesting either that SD contributes to rumination over communication or that thinking about interaction deepens the SD conflict (Nicotera & Mahon, 2013). Further, while undesirable conflict management styles (avoidance and controlling) are positively correlated with SD, collaborative conflict styles have no

relationship, validating conclusions that SD is not ordinary conflict. Moreover, no conflict style mediates the impact of SD on job satisfaction or intentions to leave (Nicotera et al., 2015).

We estimate 12-15% of practicing nurses encounter problematic SD (Nicotera & Mahon, 2013; Nicotera et al., 2015). Because SD resembles normal goals-based conflict, a relational approach to conflict management is recommended (Nicotera et al., 2014). Nurse researchers' emotional definition of conflict leads to a presumption that individual-level skill deficits are the main source of poor communication. While improving individual-level skill can indeed improve recurrent conflict cycles, individual-level skill deficits are not necessarily a cause of recurring or intractable conflicts. Contradictory institutional structures such as specialty training and practice, departmental norms, institutional roles (e.g., clinical, managerial, or financial), cultural background and experiences, and institutional histories create intractable differences in perceptions. These variations provide individuals with differing perspectives through which they understand the world and act in it. Socially navigating these variations is crucial to good teamwork. When structural contradictions clash to the point where a recurrent conflict cycle occurs, SD can be diagnosed. SD can be measured with a diagnostic self-report scale that identifies the three components of the cycle, as well as the cyclic connections among them (Nicotera et al., 2010). SD among nurses predicts role conflict, burnout, depression, bullying, poor organizational and professional identification, poor job satisfaction, and intention to leave (Nicotera et al., 2015). Several studies examine SD to explain unproductive conflict in HCOs (Nicotera & Mahon, 2013; Nicotera et al., 2014; Nicotera et al., 2010; Nicotera et al., 2015).

SD training interventions take a two-pronged approach: consciousness-raising and transformation. To begin, participants are sensitized to the inevitability of conflict and to its potentially positive outcomes (critical thinking, innovation, development, etc.) and taught to view conflict itself as a normal part of human interaction (see de Dreu, 2008, and Tjosvold, 2008, on the positive nature of conflict and benefits of institutionalizing this value). Then, participants are trained in conflict analysis using social science approaches to identify the root of conflict and discriminate goal opposition from meaning-structure opposition.

The second phase, transformation, teaches negotiation skills for goals-based conflict and dialogue skills for SD (For more on dialogue, see Youngbluth & Johnson, 2010, in communication and Jones, Strube, Mitchell, & Henderson, 2019, in nursing). SD dialogue skills focus on common ground — understanding and accepting each other's way of seeing the world. The goal of the transformation phase is to re-frame the other from *opponent* to *colleague with whom I share a problem* — that problem being the SD conditions in

goal of the transformation phase is to re-frame the other from *opponent* to *colleague with whom I share a problem* — that problem being the SD conditions in which they must collaborate. When dialogue cannot resolve structural differences, the pair must cope with the ensuing stress. Teaching strategies for coping with stress is paramount (Wright & Nicotera, 2015). Compared to non-participants, nurses who have participated in SD-based interventions exhibit lower feelings of persecution; higher recognition of positive relational effects; lower perceptions of negative relational effects; higher conflict liking; lower ambiguity intolerance; and less tendency to backbite or complain to other co-workers (Nicotera et al., 2014; Nicotera et al., 2010). In addition, participants report having a better understanding of, and feeling more empowered to manage, workplace conflicts to sustain healthier workplace relationships.

There is ample evidence that practicing nurses do not recognize productive aspects of conflict. After a session introducing the idea of constructive conflict, Nicotera et al.'s (2014) training participants were asked to relate stories of constructive and destructive conflicts in their workplaces. In an effort to examine nurses' perceptions of constructive conflict, Kim, Nicotera, and McNulty (2015) examine those narratives to extract situational features that distinguish the conflict as constructive or destructive. Overall, nurses identified a conflict as constructive if the interactants used constructive processes (e.g., quality patient care practices, cooperative communication). Destructive conflicts were distinguished by problematic work environment issues (e.g., time constraints, role conflict) and poor patient outcomes. This is a striking difference. First, matters that are out of the individuals' control seem to contribute to destructive perceptions of conflict. Second, for both constructive and destructive designations, patient care is central. A good process focused on patient care lends itself to a constructive distinction; whereas, a poor care outcome defines a conflict as destructive—because it damaged a patient. Patient care quality is the central motivation for the very labor of nurses, drives their perceptions ethically, and must always be considered as a central factor of conflict in this workplace. As the lead trainer for the course from which these stories were elicited, this author can also anecdotally report that the notion of a "constructive conflict" was a novel idea for these participants — one that assisted the participants in improving their collaborative skills and motivations for applying them in difficult situations.

Brinkert's (2011) comprehensive conflict coaching model (CCCM) also shows promise, providing ongoing one-on-one coaching by training nurse managers as coaches for their supervisees (seen as clients). The CCCM is well-grounded across multiple disciplines, using a social constructionist narrative framework consistent with communication theory.

The model applies large-scale dispute resolution and mediation techniques to the individual. The CCCM includes a beginning conversation that clarifies the coaching process, determines the fit of the client to the process, determines the fit between coach and client, and confirms commitment to the process. Following this preparation, a narrative process is applied. In the first stage, *discovering the story*, the coach invites the client to tell their story of the conflict. In the second stage, *exploring three perspectives*, three concepts grounded in conflict communication research and theory are used to analyze the situation: identity, emotion, and power. In stage three, *crafting the best story*, the coach and client work together to create a vision of the desired outcome, following methods of appreciative inquiry (Cooperrider & Whitney, 2005). Finally, in stage four, *enacting the best story*, the coach provides support in the form of developing communication skills, effectively applying conflict styles, preparing for negotiation, and integrating other dispute resolution processes. Along the way, there is a parallel process of learning assessment that integrates needs assessment, goal setting, reflection, feedback, and learning transfer.

The model impressively blends a standardized process with individualized analysis tailored to the situation. The program was evaluated in a 500-bed two-hospital system. Twenty nurse managers were paired with front-line nurses and other professionals. A thorough research design, including pre- and post-program surveys and interviews, applied. Results are very promising, with the obvious strength of the program through its explicit grounding in problem analysis. Nurse managers show improvement in both conflict competency and coaching skills; clients report high levels of learning and satisfaction. However, nurse managers underestimate their clients' progress, indicating the need for more training. Significant implementation difficulties were noted (e.g., missed training, failure to submit assessment materials, participant loss through turnover, and scheduling training). Brinker (2011) readily acknowledges that the evaluation component of this pilot program added to its complexity. While very promising, success of such a program would be deeply dependent upon managerial commitment and the building of an institutional infrastructure to support its consistent implementation.

Moreland and Apker (2016) examine conflict in the nursing workplace from an organizational communication perspective, using a case study approach. As part of a larger study, they explored the responses of 135 nurses to an invitation to write about their "identity, communication practices, and conflict experiences as a nurse" (p. 817). In a conceptually well-grounded analysis, they explore how conflict and communication are experienced and how nurses (mis)manage conflict and stress. They conclude that exclusionary communication (nonparticipatory and unsupportive messages) are strong contributors to conflict and stress. Not surprisingly, respect emerged as

an important concept, with nurses' management and mismanagement of conflict stemming from respectful and disrespectful discourse. The cases revealed that respectful organizational cultures are key to harnessing conflict for constructive purposes, such as innovation and critical decision-making, while at the same time preventing negative outcomes.

Nursing Research on Conflict

As previously discussed, nurse researchers impose fewer conceptual distinctions on the study of conflict than do social scientists. This review is focused on research about interpersonal conflict interaction, concentrating on nurses but also including conflict between nurses and other healthcare professionals (usually physicians). Specifically excluded is research examining conflict between nurses and patients, conflict of interest, role conflict, work-family conflict, ethical dilemma, and union disputes — each of which would fill an entire article-length review. An impressive number of nurse researchers accomplish sophisticated social scientific research. Not surprisingly, given its popularity in social science, the dual-concern styles approach is common. First, studies examining conflict style in the nursing workplace will be reviewed. Next, an overview of research that is poorly grounded in social science theory will be provided, with recommendations for better conceptual sophistication. Finally, a review is provided of the body of literature that moves beyond the styles tradition to accomplish conceptually-rich investigations that might serve to bridge nursing with social science productively.

Conflict Styles in Nursing Research

Nursing researchers have long concluded that collaborative and compromising styles produce successful conflict management; whereas, avoidance, accommodating, and competing are generally unsuccessful (Tomey & Poletti, 1991). Likewise, avoidant conflict styles contribute to stress (Johansen & Cadmus, 2016). Using the dual-concern model, nurse researchers have also examined both the antecedents and consequents of conflict style (Al-Hamdan, Nussara, & Masa'deh, 2016; Al-Hamdan, Al-Ta'amneh, Rayan, & Bawadi, 2019; Chang, Chen, & Chen, 2017; Erdenk & Altuntas, 2017). The dual-concern model, however, oversimplifies conflict management. A focus on conflict styles ignores contextual features, overestimating the power of individual skills — though undoubtedly collaborative skills are valuable. While collaborative conflict strategies are a sound recommendation, they are only one part of managing conflict. One of the most consistent findings in this body of research until very recently validates Mahon and Nicotera's (2011) report that nurses tend to be more conflict avoidant or accommodating than collaborative (Barton, 1991;

Cavanaugh, 1991; Eason & Brown, 1999; Forte, 1997; Kaitelidou et al., 2012; Kunaviktikul, Nuntasupawat, Srisuphan, & Booth, 2000; Pines et al., 2012; Pitsillidou, Farmakas, Noula, & Roupa, 2018; Vivar, 2006; Whitworth, 2008). This generalization, however, may be changing and may be culturally related. Tuncay, Yasar, and Sevimilgul (2018) concluded that collaboration was the most prevalent style in a study of nurses conducted in Turkey (using the ROCI-II). Research conducted in Israel reveals (using TKI) that compromise is the most popular style (Hendel, Fish, & Galon, 2005). Research in Spain (Iglesias & Vallejo, 2012) also reports that compromising and competing rank first, followed by avoiding, accommodating, and collaborating (using TKI). These studies connect preferred conflict style to a number of other variables. However, beyond simple description, any analysis conducted on data generated by the TKI must be considered inconclusive due to the ipsative nature of the data precluding appropriate use of inferential statistics. Other nursing research using the TKI includes Waite and McKinney's (2014) test of a training program to increase self-awareness, Morrison's (2008) study on emotional intelligence and conflict management style, and Whitworth's (2008) attempt to link conflict style to personality. Although it cannot produce other generalizable conclusions, research using the TKI has clearly replicated the finding that nurses, at least in the U.S., tend to be conflict avoidant, with collaboration highly unlikely in the absence of education and training.

A study in an Arabic context (Oman) concludes that nurses' style preferences (on the ROCI-II) are, in descending order, integrative (collaborative), compromising, obliging, dominating, and avoiding (Al-Hamdan, 2009; Al-Hamdan, Shukri, & Anthony, 2011). The sample represents a number of nationalities, education levels, and organizational ranks, yielding interesting results relevant to institutional cultural structures. Omanis and Jordanians were more likely to use a dominating style than Indians or Filipinos. Managers, and those in more senior positions, tended to have higher integrating and lower obliging styles. Lower educational levels were less likely to be dominating; whereas, those with a graduate degree were less likely to be obliging. Finally, males were more likely to be compromising than females. Al-Hamdan (2009) provides a more detailed analysis examining interactions among position level, gender, nationality, and education. Given the socio-cultural environment, preferred conflict style may be more a matter of one's position in the social system than personal predisposition. However, the ROCI-II measures general preferences and is not linked to specific issues or problems that create conflict, so it is doubtful actual behavior in authentic situations can be predicted by these results.

Moreover, recent reviews do show a promising trend with more nurses exhibiting integrating and collaborative styles (Labrague, Al-Hamdan, & McEnroe-Petitte, 2018; Labrague & McEnroe-Petitte, 2017). This may be due to a recent proliferation of attention to conflict management and to conflict as potentially constructive in nursing education and training (Arveklev, Berg, Wigert, Morrison-Helme, & Lepp, 2018; Choudhary, 2018; see also McKibben, 2017). The conflict styles approach is limited. Yet, nurse researchers also seem to be turning away from this approach, which is an encouraging sign of an emerging period of conceptual growth.

Beyond Styles: Promising Directions in Nursing Conflict Research

Resting on Rahim's (1983) dual-concern conceptual structure (but not using the ROCI-II), Leever et al. (2010) conducted interviews with nurses and physicians in multidisciplinary teams with high collaboration needs. Defining conflict as perceived interference and discord, they examine participant definitions of conflict and conflict management strategies. The conceptual mismatch between this emotionally-focused definition and the issues-focused definition of conflict assumed by the dual-concern model severely compromises their ability to build conceptually. Yet, the data reveal another interesting nuance. Participants used the term *conflict* only in seriously negative situations — those with constant discord escalating to an atmosphere where working together is impossible. The vernacular use of the term is an important aspect of studying conflict that most social scientists have not adequately considered. Leever et al. (2010) note that participants prefer the term *friction* to name situations where collaboration is less than ideal. According to their data, collaboration rests on meeting expectations of good communication (clear exchanges of information and mutual attention), mutual respect, professionalism, a collaborative climate of working toward common goals, and a shared value for quality of care. Friction (defined by the authors as conflict) occurs when these expectations are violated. At this point, conflict management takes two forms: avoiding or engaging. Those who engage in conflict appear to do so in one of two ways: discussion or forcing. Data analysis suggests that five basic factors influence whether one engages and how so: the self (personality, knowledge, experience), the other (personality, attitude, experience), nature of the conflict as structural or incidental, context (influencing timing of engagement), and personal motives. Structural conflict is defined as serious and potentially ongoing issues where confrontation is immediately pursued. Motivations that promote confrontation include desires to clarify, optimize care, improve collaboration, avoid escalation, change practices, and create learning opportunities. These data are very interesting and reveal a thoughtful and quite

well-functioning set of dynamics for when and how to engage in conflict to improve collaborative relationships.

The authors' conceptual analysis, however, does not reveal a good understanding of Rahim's dual-concern model. Although the choice to ignore the conflict is conceptually equivalent to Rahim's *avoiding*, Leever et al. (2010) claim that avoiding does not occur in their data, an obvious confusion between avoidance and prevention — "In these cases the conflict had already happened and the respondent could choose to ignore it, but avoiding the conflict was not an option any more" (p. 621). Defining conflict as perceived interference or discord prevents these authors from appropriately interpreting their data according to Rahim's strategies. For dual-concern theorists, *avoidance* means avoiding interaction about the disputed issue, not avoiding the presence of the dispute itself. They similarly misunderstand Rahim's conceptualization of *integrating*. For dual-concern theorists, *integrating* represents collaborative interaction — which is precisely what Leever et al. are investigating. Yet, they say, "*forcing* corresponds with Rahim (1983), discussing does not" (p. 62). Yet, *discussing* as articulated by Leever et al. (2010) is an excellent conceptual match to Rahim's *integrating*. Failing to see a distinction in their data between collaboration and compromise, rather than consult the literature (which would clearly indicate collapsing them as many styles theorists advocated decades ago), Leever et al. (2010) declare *discussing* a unique category. By ignoring the interaction component of Rahim's model and failing to ground themselves in the styles literature, Leever et al. compromise their own ability to apply it. Even so, their data reveal that these nurses and physicians have a firm understanding of collaborative practices, can categorize violations of expectation disrupt them, and can identify factors that influence their strategies to restore them.

In a similar research program, Skjørshammer (2001) had previously identified three fundamental strategies: avoidance, forcing, and negotiation (matching the general conflict styles literature). Further, interdependence and perceived urgency determine strategy choice. Findings from interviews with physicians and nurses also reveal a similar participant definition of conflict: being negatively affected by another. Physicians, however, were far more reticent than nurses to use the term *conflict* unless the situation were a warlike clash — attributed to negative repercussions of reputation for being perceived as a doctor who is involved in conflicts. Communication scholars should take serious heed of this recurrent theme in the nursing literature. The very term *conflict* carries political and social connotations in the healthcare workplace that are very different from the corporate settings in which social and behavioral scientists have traditionally worked. Like

many nursing scholars, Skjørshammer (2001) identifies a conflict-avoidant culture in the healthcare workplace — and he also provides an excellent explanation for that trend.

Myrick et al.'s (2006) compelling qualitative analysis identifies the same pattern in nursing education. In stark contrast to more contemporary literature (McKibben, 2017), Myrick et al.'s data reveal a culture of silence regarding conflicts among students, preceptors, and faculty members prevalent in professional discourse — perpetuating a stigmatizing notion that conflict, rather than a normal human process, is perceived to indicate unprofessional behavior and is thus taboo subject matter. Not only are nurses in this study conflict avoidant, the very culture of their training seems to have taught them that experiencing conflict is shameful and that engagement in it is to be hidden from view. This severely compromises the ability of early-career nurses to productively navigate difference and disagreement. It contributes to problems of self-esteem, defensiveness, and stress (Brinkert, 2011). Myrick et al. (2006) powerfully identify the need to establish healthier attitudes toward conflict in nursing populations, which do now seem to be developing.

In other work, Nayeri and Negarandeh (2009) identify data-driven, well-grounded factors for managers to examine in dealing with conflict among nurses, establishing a clear connection between nurses' perceptions of conflict and their reactions to it. Interview participants' definitions of conflict range from violence and aggression to a simple matter of unrealistic expectations. Some feel conflict should never occur in a humanistic profession; whereas, others see it as a normal human occurrence. Emotional and behavioral reactions to conflict situations correspond with these perceptions. Participants believe that individual characteristics (e.g., easy-going nature, individual values) predict whether conflict manifests and that conflict's chief cause is misunderstanding—highlighting the importance of cooperative environments. Other factors associated with effective conflict management include organizational structure, management style, and nature/conditions of job assignment. Uniformly, participants view conflict outcomes negatively, revealing again the persistence of a perceived equivalence of conflict and incivility.

Almost, Doran, Hall, and Laschinger (2010) provide a more sophisticated study examining antecedents, core processes, and consequences of conflict. Their conceptual model identifies core self-evaluation (self-esteem, self-efficacy, locus of control, and neuroticism), contextual characteristics (i.e., complexity of nursing care), and interpersonal characteristics (e.g., unit morale) as antecedents. Core processes include perceptions of intragroup relational conflict (disagreement, interference, and negative emotion — measured by Cox, 2008) and conflict

management style (measured by the ROCI-II). Finally, consequences include job stress and job satisfaction. Results indicate that dispositional, contextual, and interpersonal characteristics impact both intragroup relationship conflict and conflict management styles. Higher perceptions of self, lower complexity of care, and higher unit morale result in lower levels of relational conflict and more agreeable styles of conflict management (collaboration and accommodation). In addition, relational conflict directly influences job stress and job satisfaction, partially mediated by conflict management style. In the nursing workplace, it is crucial to distinguish between substantive issue conflict and relational conflict. Substantive conflict over issues is largely related to forces outside the individual's control; when occurring in a relationally conflicted environment, the individual's conflict management style will have little effect on resulting levels of stress and satisfaction. Maintaining good relationships that prevent relational conflict rests on a positive work environment built on interactional justice, positive unit morale, and good interpersonal relationships. This supportive environment of respect and collaboration promotes successful issue management and prevents escalation of relational conflict.

Cox's (1997, 2004, 2008) Intragroup Conflict Scale (IGS) rigorously measures perceptions of views of conflict, behavior, and affective states. Although Cox conceptualizes conflict as emotional and negative, the work is well-grounded in communication theory and research. Moreover, she makes a clear conceptual distinction between the ROCI-II and the IGS. Her conceptualization allows for a constructive view of conflict, but the instrument is clearly designed to measure perceptions of negative affect and behavior. The IGS consists of 26 items on a 6-point Likert-type scale, in three dimensions: Opposition processes and negative emotion; trust and freedom expression; and the views of conflict (unhealthy, constructive, and destructive). The scale is distinct from other instruments and is an excellent measure of the workplace conflict climate, grounding the conceptualization of conflict in its context and thereby improving upon communication conflict theory. Cox has accomplished impressive theoretic development unique to the nursing workplace. Communication scholars have failed to adequately account for the tendency of real people in real workplace environments, particularly nurses, to define conflict emotionally as a negative force to be avoided at all costs. Cox accounts for both productive and constructive aspects of conflict, as well as the ordinary person's emotional reactions to it. Her work exemplifies applications of communication theory to the nursing workplace.

A number of nursing conflict studies have been generated that offer excellent grounding in social science and valuable theoretic expansion. From a communication disciplinary perspective, some may

seem rudimentary; however, clinical researchers without formal social science training are increasingly attaining experience with and application of that literature. In an exemplar, Gómez-Torres, Martínez, Alves, and Ferreira (2015) examine how nurse managers socially construct their authority to resolve conflicts. Despite an obvious implicit assumption of conflict as necessarily harmful, with “conflict resolution” the language used, the potentially creative power of conflict is illustrated. Analysis of nurse managers’ interviews reveals effective conflict management to be grounded in understanding the conflict’s origins, exploration to analyze the problem accounting for all viewpoints and subsequent management of meanings. Moreover, this process allows effectively managed conflicts to serve as a resource for problem-solving and relational improvement. While hardly groundbreaking to a communication theorist, this clinical application of symbolic interaction theory is impressive. The idea that meanings are created and modified through interpretive processes during interaction is a central presumption of all communication theories, and its application to the self-concept development and sense-making processes of nurse managers is a great step in the nursing literature. Communication is treated deeply as a meaning process, rather than merely an informational one. The grounding of this “finding” in the words and experiences of nurse managers is powerful validation of communication theory in a form immediately meaningful to the nursing audience.

Based on qualitative analysis of observations and interviews in a hospice setting, Walker and Breitsameter (2013) recommend that conflict be viewed in two ways, in an elegantly simple clarification of conflict definitions and intervention strategies. First, from the role perspective (Mead, 1967), conflict occurs when interactants fail to achieve appropriate role-taking to accept differences and work to common outcome. Intervention entails discussion to clarify interpretations from various perspectives. Second, from the structural perspective, conflict occurs in the face of incompatible positions transcending individual interpretations (similar to SDT). The addition of a broader institutional intervention is necessary to adjust structural features (e.g., division of labor or procedural requirements). In either case, clear discussion and good listening are encouraged. Management has clear choices: to tolerate the conflicts that do not disrupt the organizational routine, but to change their organizational structuring in a way that integrates differing viewpoints when conflicts are indeed disruptive to routine (Walker & Breitsameter, 2013). This simple, yet sophisticated, data-driven position recognizes deeply embedded institutional structures as they manifest in daily interaction. From the institutional perspective, conflicts

are neither resolved nor managed, but rather are *regulated*.

Very recent publications reveal what may be a sea change in the nursing literature, viewing conflict not only as inevitable, but as potentially constructive and advocating for training and education in dialogue techniques to improve quality in both work life and patient care (Jones et al., 2019). Likewise, McKibben (2017) offers a conceptualization that defines conflict as unavoidable, advocating for a relational approach to create collaborative and supporting work environments. Unfortunately, her conceptual treatment of conflict is still far behind that in the communication and other social science conflict literatures, relying on Tuckman’s (1965) group development model and Pondy’s (1992) theory of conflict phases and using the language of conflict resolution (albeit, along with conflict management). Still, her argument leads to a relational approach relying on listening, problem-analysis, and situational contingencies to determine the most productive approach. Moreover, she advocates creating an environment where responses to conflict are sensitive to the need to intervene early to prevent escalation and where conflict management is seen as a process of joint problem-solving, with both grounded in a culture of mutual respect.

Conclusion

Learning from one another, nurse researchers and communication scholars might create a far more sophisticated approach to nursing conflict than either body of literature has achieved on its own. Nurse researchers’ context-sensitive body of work can help communication scholars attend to unique HCO features, as well as those of the nursing workplace environment in particular. Concomitantly, communication’s presumption that conflict is natural has already begun to seep into nursing research assumptions. Yet, both scholarly communities should heed the professional value system that traditionally cast conflict as dishonorable. Promoting a more healthy view of conflict and more nuanced distinctions among issues, tasks, emotions and behavior is crucial.

Conceptual confusion results from using *conflict* synonymously with *incivility*. Nurse researchers can benefit from a deeper understanding of the history of conflict studies in organizational social science, which this review provides. The conclusions of social scientific research can establish a fruitful ground for nursing research questions that are far more sophisticated and thus more likely to produce useful applications than are questions of what styles nurses prefer. When combined, the two literatures overwhelmingly establish several starting points: nurses (in the U.S.) have traditionally been conflict avoidant; collaboration is the most desirable approach; conflict is inevitable and can produce innovative productive outcomes; there is a

distinction between substantive and relational conflict; good conflict management can be learned; a healthy conflict culture is crucial in the HCO workplace. More collaboration between nurse researchers and communication social scientists, and more consultation of both literatures, can result in a far more robust area of study on nursing and conflict.

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