

# DEALING WITH CONFLICT — THE ROLE OF THE WARD SISTER

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## SUMMARY

In the course of her duties, the ward sister has to contend with many forms of conflict, discord and dissension.

These involve conflict of the intrapersonal, interpersonal and intergroup varieties.

Conflict is in the main, disruptive and dysfunctional. Skilful management, however, embodying co-operative effort in its reduction can produce constructive and positive results. Conflict management strategies are therefore either restrictive or constructive.

Persons in serious conflict suffer varied degrees of personality disequilibrium, which necessitates emotional first aid or crisis intervention. Such primary preventive care is applicable to patients, their relatives, and members of the nursing staff in such need.

## INTRODUCTION

Where people work together conflict is inevitable.

Rapidly advancing technology, the increasing complexities of the work situation, conflicting desires and opinions, and individual reactions to the changing system are all predisposing factors of dissension.

Conflict therefore has to be recognised and accepted as a way of life.

The ward sister encounters much conflict in every area of ward management and personnel control. She has to establish relationships not only with her subordinates and superiors, but with many other persons with whom she has interactions of a non-hierarchical nature. Often the objectives and values of these persons are so different that these relationships become difficult, viz. service managers of the catering, linen supply, compound, workshops and transport departments, to mention but a few. Such conflicts disrupt vitally necessary co-operation and co-ordination. Analysis of the origins of this conflict gives insight into how it can be avoided, or at least diminished. It can often be traced to lack of efficient communication.

Understanding the source of discord, and selecting effective resolution techniques, greatly influence the sister's effectiveness in managing conflict.

This is as important in creating a therapeutic climate and environment in her unit as is sound decision-making, planning, leading, organising and evaluating — all of which are geared towards meeting the objective of the provision of quality patient care.

Where there is dysfunctional or destructive conflict, productivity takes second place to strife. Energies are consumed by the plotting of defence and attacks.

The absence of, or too little conflict, however, can be equally demoralising and damaging.

It is usually associated with stagnation, lack of motivation and drive.

Thus conflict management involves both resolution and stimulation.

This presents a challenge to the ward sister.

## LEVELS OF HUMAN CONFLICT

There are three such levels, namely intrapersonal, interpersonal and intergroup.

The ward sister meets and has to contend with dissension at all these levels.

An understanding of these will help her to cope with them effectively.

### **Intrapersonal Conflict**

This is discord within the individual. Three categories of such conflict have been suggested:

#### *(a) Motivational Conflict*

Such discord can arise in a junior sister who is ambitious. She is threatened however by any anticipated increase in her responsibilities.

Her feelings regarding promotion are therefore ambivalent. Conflicting forces are at work within. This type of conflict becomes evident in persons who are promoted to positions in which they cannot cope. It is demoralising and results in much mental stress which needs recognition and skillful management.

#### *(b) Choice-Conflict*

This type of intrapersonal conflict arises out of decision-making. For example, a nurse observes a colleague giving a patient a wrong medication and to report or to withhold the information becomes a major intrapersonal conflicting issue.

Another example of such conflict occurs in the case of the ward sister who is confronted by a patient whom she knows to be suffering from a terminal illness, as to his prognosis. "Be honest with me Sister — am I going to die"? Such conflict can be resolved by the recognition and insight that the patient wants to talk about death and dying. In most cases it will be established that he does not want to be told that death is imminent. He already knows. He wants to be able to ventilate his feelings. He needs an empathetic and caring listener.

#### *(c) Conflicting Allegiances*

Loyalty to two or more groups can lead to conflicting allegiances.

An example might involve a newly promoted senior sister. She retains a feeling of loyalty to her fellow sisters with whom she has worked for many years; but she now also owes allegiance to the nursing management.

She is expected to evaluate the sisters' performances honestly and objectively.

This often becomes apparent in confidential report-writing, a tendency towards 'covering up' and can be described as a type of choice-conflict.

### **Interpersonal Conflict**

Such conflict arises between two or more people, or within a group.

Examples are discords between senior personnel and subordinates; such as may occur in situations where the ward personnel feel that a certain line of action is essential to achieve an objective, but the nurse administrator may think differently.

Conflict between colleagues is of the interpersonal category. One of their members may be adroitly avoiding her share of the workload.

This is a fairly common form of interpersonal conflict with which the ward sister has to deal.

### **Intergroup Conflict**

Such conflict is experienced as interdepartmental discord. It commonly occurs between the nursing and the service units, such as the catering department, the linen service department, the X-ray department and the pharmacy. Conflict may arise between nursing and medical groups.

## **THE SOURCES OF CONFLICT**

These may be traced to many different, but sometimes interrelated variables.

Let us consider the most common sources of conflict within the ward situation.

Conflict can and does occur among **markedly ambitious** staff members. It is engendered by concern to win promotion; to create the right impression, and to receive individual recognition.

Research data show that the desire among staff members for personal distinctions often overrides their sentiments for group-consciousness, and causes interstaff tensions.

**Age Conflict** is also significant in inter-staff antagonisms. Older staff members may resent the younger ones — especially when it comes to having to take orders from them. They feel threatened. These young registered nurses enter the service in the belief (and rightly so) that they have much to contribute. Many have no thought that their contributions would be unwelcome in some circles.

This can be thwarting and constricting to both parties, and results in a deadlock.

Such situations require early recognition and skilled handling, because the patients in their care suffer as a consequence.

**Undefined or maldefined boundaries of responsibility** cause conflict among ward personnel.

In order to avoid discord of this nature, individual detailed duty sheets, clearly stating boundaries of authority, are essential. The wise ward sister who applies the 'who, what, when, how, where and why' principles in task delegations and assignments will avoid confusion, dissatisfaction and friction among her staff.

**Role conflict:** Many nursing staff experience conflicting demands simultaneously.

Studies have shown that when an individual is dissatisfied with her organisational role requirements, her work performance can be significantly affected. The nurse has many varied roles to fulfill; and these may change rapidly within the course of the day.

In some nursing situations the patient's dependence on the nurse is inevitable, while in other situations the patient's independence is fostered.

This is particularly evident in a geriatric ward and in orthopaedic wards, where rehabilitative care is given. The nurse feels protective to her patient, but has to adopt a firm line for the patient's ultimate benefit.

Young and inexperienced nursing staff tend to suffer role conflict in this regard. Counselling of her young nurses by the ward sister is necessary to dispel guilt feelings due to the inner conflict thus engendered.

**Value conflict** arises out of differences in ideological or philosophical outlook. Such conflict may involve the charge sister and her deputy; or the ward sister and teaching personnel.

Here frank discussion is essential; and if possible an homogenous set of values arrived at. Priorities have to be objectively assessed and established.

**Communication** is a major source of conflict. Successful communication at all levels must be full and meaningful. Distortion or misunderstanding predisposes to discord and friction. Thus information must not only be imparted, it must also be understood.

Lack of information from the charge sister to her subordinates results in discord.

Meaningful communication, horizontal and vertical, is the core of effective ward-administration.

Closely allied to verbal communication is the non-verbal. This is intentional or unwitting communication of thoughts, attitudes, feelings and reactions by gestures, expressions and behaviour; and is a true reflection of the individual's innermost feelings. All nurses must be made aware of this, and be mindful of it constantly. Patients are vulnerable to non-verbal communication. Attitudes are exhibited in this manner. It is imperative that the attitudes of all staff members be conducive to the development of a therapeutic environment and therapeutic nurse-patient relationships. This forms the foundation of quality nursing care.

By meta-communication is meant the role expectation that persons have of each other. It embodies both verbal and non-verbal communications.

It is most important that the ward sister be aware of this form of communication; because the way she comes across to all with whom she interacts is going to have a direct bearing on the wellbeing of her patients and staff.

**Organisational differences** may cause conflict and discord. Take for example the young mother who has returned to nursing. She might wish to have her duty hours staggered to meet her family needs, whereas the ward staffing needs do not permit of this.

The ward sister has to take all such factors into account when determining the ward programming and duty structures.

**Leadership style** can cause discord. Authoritarianism and dogmatism provide a breeding-ground for staff dissension and conflict.

## CONFLICT RESOLUTION

The sister has to determine the sources of conflict within her ward. She then has to determine whether they are functional or dysfunctional.

She too has to seek out any areas of stagnation, in which a certain amount of structured conflict would be desirable. This is a continual process.

She needs, so to speak, a 'set of tools' for conflict resolution.

Some tools are more effective than others.

The tools can be listed as avoidance, smoothing, domination or forcing, compromise or bargaining, and problem-solving by confrontation and integration.

### *Avoidance*

The least line of resistance is taken. It requires each party to withhold her feelings or beliefs.

Avoidance does not resolve conflict. In fact, it helps to foster it.

### *Smoothing*

The differences between conflicting individuals or groups are minimised.

Common interests are emphasized and highlighted.

This method is ineffective. It is short-lived, because the differences almost invariably recur.

### *Domination or forcing*

A superficial method. When two parties clash, their common superior resolves the conflict and forces them to accept her decision.

The overt discord might be eliminated, but certainly not the source thereof.

Staff may retaliate with poor work, or absenteeism.

### *Compromise or Bargaining*

This method requires each party to give up something. It signifies recognition of each other's claim by the conflicting parties.

One side may gain at the expense of the other.

The outcome is seldom satisfactory or lasting.

### *Problem-solving by Confrontation and Integration*

This method requires considered thought and insight. The problem or differences must be fully revealed. Uncover the conflict. Confront it. Face the issues.

Make special time for interviewing both parties.

Take care that verbal interaction is clear and easily understood.

Reconstruct the whole from the two (or more) parts. There must be a climate of frankness. The full range of alternatives must be considered.

Work towards mutual resolution of the conflict. This requires objectivity and honesty, tempered with diplomacy.

Use a positive approach.

Help to strengthen the self-respect of the persons involved.

Continue the interview until a solution is reached which is of mutual satisfaction.

If this is not possible the matter must be referred to higher authority.

Not infrequently the ward sister has to handle an individual who is under pressure.

This can involve staff or patients, or patients' relatives.

Most people experience a common reactionary pattern to crisis. Personal and emotional crises result in disequilibrium of the personality. This disrupts the individual's emotional and functional capacities for normal everyday living. If allowed to continue unchecked or without help, serious mental stress could result.

Such individuals require urgent emotional first aid or crisis intervention.

Professor Lynn Gillis, Professor of Psychiatry, University of Cape Town, advocates a practical technique for handling the individual who is under pressure.

The ward sister can apply this technique to the resolution of any conflict situation which engenders intrapersonal stress.

The principles of **Crisis Intervention** are as follows:-

#### **Help the person to confront the crisis**

The individual must be assisted to face the issue; to think about it; to realise its dangers and consequences.

He must be able to ventilate his feelings and fears, and to give way to his emotions.

Examples may include the young father whose wife is found to be suffering from inoperable carcinoma; the student nurse who receives news, while on duty, that her fiancé has been killed on the Border; the young nurse who is confronted with the death of a patient for the first time.

#### **Help the person to find the facts**

The unknown is often much more frightening than the known even though the facts may be threatening.

Consider, for example, the mother of a newly born baby who has a hare lip and cleft palate; or of a baby with a club foot. If the child is kept from her she will conjure up imaginary horrors. It is well to bear this in mind when faced with such problems.

Rather present the person with the facts, at the same time emphasizing the positive aspects, such as what can be done for the child.

#### **Do not give false reassurance**

People in trouble crave reassurance. However to give false hope is a disservice. The person concerned does not need platitudes. Rather she needs **help** to enable her to cope with whatever is entailed.

#### **Do not encourage blaming**

Blaming constitutes a projection of feelings. It is a form of avoidance of the truth, and can lead to the development of unhealthy mental attitudes.

#### **Do not encourage denial**

Denial is form of reality avoidance, which is unhealthy and dangerous. Some people deny that a problem exists, or that they are in need of help. The difficult, unco-operative staff member may deny that she is in fact so.

The alcoholic patient denies his dependent needs.

Such individuals require help to acknowledge their shortcomings and needs, because only then will they be receptive to assistance in coming to grips with their respective problems.

#### **Limit the amount the individual has to cope with at any one time**

No person is strong enough emotionally to face a dangerous reality without a degree of respite. Persons in crisis must have rest. However the impact of the crisis must not be dampened. The issue remains and must be faced realistically.

#### **Lend a hand constructively**

Crisis disorganises the individual psychologically and in the simple routines of everyday living and constructive help is needed.

Consider, for example, the young mother whose husband dies following injuries sustained in a car accident. In this instance referral to a social agency would be constructive help.

#### **Restoration of the individual to at least the level of psychological functioning that existed before the crisis period.**

The therapeutic goal of crisis intervention is psychological resolution of the individual's immediate crisis; and restoration to at least the level of pre-crisis functioning. An example might involve the teenager admitted to the ward following a shark attack in which he has lost a limb.

The age-old adage of time being a healer is only partly true. It has been said that "facing an issue realistically is a full partner."

#### **CONCLUSION**

Conflict situations in ward administration and leadership are legion. Conflict cannot be eliminated, nor is this desirable.

Effective conflict management is essential.

The ability to use the most effective strategies at the right time is something that will be gained with practice and experience.

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