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The Impact of Interprofessional Conflict on Quality care – The Nurse's Role

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Abstract:

In healthcare, professionals from different disciplines are involved in the provision of quality care. Collaboration between them is a crucial determinant of the quality of care process. However, these professionals, when working together, have been found to trigger conflict. The purpose of this study is to highlight the causes of team conflict, its effects on quality of care and possible solutions to these conflicts. The research questions are: 'What is conflict in health care? What are the most common areas of conflict between nurses and other healthcare professionals? How does conflict affect quality of care? and What strategies are used for conflict resolution?'. Deborah L. Gladstein's model of task group effectiveness was used as the theoretical framework. The research method was the literature review of 10 articles which were analyzed using Graneheim & Lundman's (2003) method of qualitative content analysis. In the findings, conflict was seen to have more of negative effects (destructive effects) on team performance however, for conflict to have positive effects (constructive effects) on team performance, the healthcare professionals were supposed to prevent emotional involvement and view conflict as a means of improving team performance. Nurses played an important part in conflict resolution - acting as mediators, and team members also had a role to play in conflict resolution through communication, cooperation, and respect for one another. Nurses need to be educated on their role in conflict management and more studies should be done on factors preventing conflict resolution.

Keywords:	Conflict, Quality of Care, Nurse, Interprofessional Teamwork, Management
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1 INTRODUCTION

Teamwork in organizations is increasingly the norm, yet the challenges of working effectively in teams are considerable. One of the challenges is conflict – the process resulting from the tension between team members because of real or perceived differences (Carsten and Laurie, 2003). Delivery of quality healthcare requires different professional groups to come together as teams, share information, and reach an agreement in their work. However, not all groups of healthcare professionals collaborate effectively as teams due to conflict. Poor teamwork is associated with high levels of medical errors and adverse events for patients (Vathsala et al, 2016). In hospitals, individual professionals come from different cultural and religious backgrounds and have different values and beliefs making conflict unavoidable when working as a team hence, the method of conflict management tends to affect quality care either negatively or positively (Patton, 2014).

 Positively, conflict can improve professional know how which eventually increases quality care or negatively as expressed by dysfunctional relationships within the team members and little to no concern about patient care (Higazee, 2015). The positive effect of conflict is found to improve team work through sharing of viewpoints and increased discussions which, in turn, improves decision making and, consequently, performance (Janss et al, 2012). This usually occurs when team members can separate their emotions and personality from the conflict. However, over time, these emotions become uncontrollable making the positive effects of conflict unsustainable. When conflict is poorly managed, the entire health care organization suffers. This usually begins with poor communication among team members and ends up with poor quality of patient care (Higazee, 2015).

Because conflict is an unavoidable issue in healthcare, and the delivery of quality care relies on the contributions of multiple teams, conflict cannot only impede team function, but also decrease team effectiveness, and impact patient care (Brown et al, 2011). Nurses usually are the most affected as they are the final line of treatment administration. Hence, this study seeks to understand the factors causing the development of conflict, the appropriate methods for conflict resolution which can enhance team performance, thus, increasing quality of patient care (Higazee,2015).

2   BACKGROUND

The priority of healthcare providers is to provide quality care to their patients and this can only be achieved when different professionals come up with different ideas regarding the best possible plan of care needed for a patient. Because these professionals have different values and beliefs, when working together, their greatest challenge is conflict and conflict management. Nurses are usually the most affected due to their constant interaction with other healthcare providers. Acknowledging that conflict is a constant issue in healthcare, professionals' reaction to conflict has a great impact on quality patient care (Higazee, 2015).

Higazee (2015), continues by stressing that, there has been a great evolution on how professionals act when faced with situations of conflict. In recent years, nurse managers regard conflict as a natural phenomenon needed for the proper functioning of an organization but because there exists different types of conflicts, its effects on the health institutes varry leading to either an improvement or detororiation of quality care regardless of the methods used by the nurse manager for conflict resolution. Negatively, it has an adverse effect on productivity, morale, and patient care and may result in high employee turnover, limit staff contribution and as such impeding efficiency. The positive effect is often overlooked as society think of conflict in a negative way. Conflict can however, sometimes be an opportunity for growth and can be an effective means for individuals or groups to openly communicate, which can improve quality of care (Higazee, 2015).

2.1   The Essentials of Conflict

2.1.1   Definition of conflict

Conflict in healthcare arises due to a list factors such as poor communication, competition among professionals, and power differences. With a series of factors affecting conflict, authors have been unable to come to an agreement about a precise definition of conflict (De Dreu & Van de Vliert, 1997). Skjørshammer, (2002, p 12) regard conflict as "a vague concept lacking a fixed or precise meaning." Authors on conflict seem to have different

definitions of conflict, some of which include; Skjørshammer, (2002) who defines conflict as a state of interaction between individuals manifested through disagreements or animosity due to differences in values and beliefs. Patton, (2014) also defines conflict as "a process in which one party perceives that its interests are being opposed or negatively affected by another party." Additionally, Evans (2013) explains that conflict pertains to the opposing ideas and actions of different entities resulting in an antagonistic state. All these definitions share a common characteristic where individuals or groups feel that they have been treated unfavorably by another individual or group because of misunderstanding in certain decisions (Skjørshammer, 2002). This has led to the development of different categorizations of conflicts.

2.1.2 Types of Conflict

Individuals possess their own opinions, ideas and sets of beliefs, which arise from the different cultural backgrounds they are brought up from. This has resulted in different ways of looking at situations and acting accordingly. Hence, conflict arises in different scenarios which may involve other individuals, groups of people, or a struggle within one's self. Conflict therefore influences the actions and decisions of individuals in one way or another and it occurs in different levels, which include; Interpersonal conflict, Intrapersonal conflict, Intragroup conflict, and Intergroup conflict (Patton, 2014).

Intrapersonal conflict exists within an individual. It takes place in a person's mind; thus, it is a type of conflict that psychologically involves an individual's thoughts, values, principles, and beliefs and can profoundly influence hospital functioning. It is usually difficult to manage this type of conflict as the individual is faced with conflicting thoughts and has difficulties deciding what thought is of greater importance. In situations like this, these individuals become frustrated and tend to manifest a series of behavioral changes ranging from apathy to aggressiveness. In situations like this, communication with other people may help. When a positive change is obtained, it can facilitate individual growth (Berkovitch, 1983).

Secondly, interpersonal conflict occurs between two individuals. Coming from different cultures and professions, we have varied personalities which usually results in incompatible choices and opinions. Here, the sources of conflict are a result of two factors which are; personal and functional sources (Bercovitch, 1983). The personal source of conflict

occurs between two individuals who need to work together despite the differences in their goals and professional know how. If these individuals don't come to an understanding when performing a given task, conflict develops, and this eventually impact the quality of patient care (Bercovitch, 1983). Furthermore, the functional source of conflict occurs when role specifications for healthcare personnel are ambiguous and incomplete, making some individuals feel dissatisfied with their role or position when they are interacting with other individuals.

Also, there is intragroup conflict which happens among individuals within a team and is usually because of incompatibilities and misunderstandings among individuals working within the group (Evans, 2013). Within a team, when conflict helps in the attainment of a given objective, we say, it is functional as it involves "healthy and vigorous challenge of ideas, beliefs, and assumptions" ((Menon, Bharadwaj, & Howell, 2001, as referenced by Patron 2014). When emotions get involved in these conflict situations, not just the individual healthcare providers are affected negatively but also their performance in a team resulting in the slowing down or prevention of goal attainment. This becomes time consuming as the nurse manager instead of ensuring the accomplishment organizational goals and patient safety, spends time on conflict resolution (Greer et al, 2012).

Lastly, there is the intergroup conflict which occurs when there is a misunderstanding between different groups or teams in an organization. For example, the emergency unit and the intensive care unit. Varied sets of goals and interests of these groups or teams is usually the cause of conflict. There are other factors which fuel this type of conflict. Some of these factors may include; a rivalry for limited resources or the boundaries set by a group to others which establishes their own identity as a team different attitudes between line and staff units, organizational size, and standardization, physical or communication barriers between departments. Uncertainty generate conflict within an organization (Evans, 2013).

2.1.3 Antecedents of Conflict

Health care delivery involves the coming together of different professional disciplines such as healthcare providers (medical doctors, nurses, physiotherapists, laboratory technicians), IT technicians and civil administrators, just to name a few to identify healthcare needs of patients and develop solutions for the satisfaction of those needs. These different disciplines usually have distinct priorities which arise from the beliefs, background knowledge and values associated with individuals and their professions. When working together, especially under pressure, the uniqueness of these professionals results in conflict affecting not just the present situation but also, future decisions of the healthcare organization (Mills, 2002). Some of the factors that bring about conflict include: Individual characteristics, Ambiguous job boundaries, decision making, communication, and expectations (Patton, 2012).

Individuals have unique characteristics which can be seen from their personalities, values, goals, and culture attitudes (Moeller, et. Al, 2012). Hence, when confronted with challenges, they tend to react differently and these differences bring about animosity between team members affecting job satisfaction (Patton, 2014). To continue, there is value differences. Values are the guiding principles that are most important to an individual about their way of work. These deeply held principles help the individual choose between right and wrong ways of doing things and help in making important decisions. When values are out of alignment, people work towards different goals, with different intentions and with different outcomes. This can damage work relationships, productivity, job satisfaction and creative potential. (Mind Tools, 2017)

Secondly, ambiguous job boundaries. Health care requires interdependence among its caregivers (Patton, 2014). Healthcare workers especially nurses are usually given no precise job description and are often referred to as 'multitaskers'. Because of no clear definition of job boundaries, professionals who over work themselves most often than not develop dysfunctional behaviours which affects team performance (Jameson, 2003 as cited by Patton, 2014). Also, with the evolution of the nursing profession, due to constant change and more complex needs of patients, nurses have developed more advanced skills to care patients and some physicians who still have the old school of thought are unwilling

to accept the changing roles of nurses bringing about interprofessional conflict (Patton, 2014).

Fourthly, there is decision making. In the past, nurses were considered predominantly as assistants by surgeons and regarded as having no role in decision making (Jayasuriya-Illesinghe et al 2016). Now, with the complexity and uncertainty in healthcare, nurses are educated to become leaders and participate in decision making. This change however has led to conflict within the health system (NLN Board of Governors, 2011). Some individuals are still unwilling to accept this change and continue to under look nurses (LeTourneau, 2004, as cited by Patton, 2014). Nurses feel frustrated or devalued when their contributions are not taken into consideration by the physicians (Patton, 2014).

Furthermore, communication is major cause of interpersonal conflict among nurses and other health care professionals. Communication could be in the form of gossip, the use of harsh language, criticism, bickering and the use of degrading comments creating a severe clash between the individuals involved or sometimes, there could be lack of communication. Here the team becomes unable to attain its goals causing frustration amongst them leading to conflict within a given team (Patton, 2014).

2.2 Quality of Patient Care

2.2.1 Definition of Quality of Care

According to Mitchell (2008), "Many view quality of care as the overarching umbrella under which patient safety resides." Different work groups such as those in the Institute of Medicine define quality of health care in terms of standards which is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Mitchell, 2008). Kelly et al (2014, p 2) define health care quality as "the degree to which care, treatment, or services for individuals and populations increases the likelihood of desired health or behavioral outcomes; considerations include appropriateness, efficacy, efficiency, timeliness, accessibility and continuity of care, the safety of the care environment and the individual's personal values, practices and beliefs."

The Agency for Healthcare Research and Quality (AHRQ, 2011) further discuss quality as follows: "Doing the right thing (getting the health care services you need); at the right time (when you need them); In the right way (using the appropriate test or procedure); to achieve the best possible results." in nursing, ensuring patient safety and providing high-quality care is always at the top of the health care provider's mind. Multiple providers deliver patient care and they depend on and complement each other to support safe, high quality patient care (Kelly et al, 2014 p. 2).

2.2.2 History of Quality of Care

The issue of quality started in 1906 when Upton Sinclair published his book "the Jungle" depicting deplorable conditions in slaughterhouses and meat packing facilities. This book, along with many other calls for reform led to national concern about the quality of food and drugs consumed by Americans. President Roosevelt signed the food and Drugs Act, known as the Wiley act later that year (Department of community and Family Medicine, 2016). Shortly after the Wiley Act was signed, hospitals began to make early steps focused on quality. In 1910, Dr Ernest Codman, a Physician at Massachusetts General Hospital and one of the earliest advocates of health care quality proposed the "end result system of hospital standardization" (Department of community and Family Medicine, 2016) which the hospital used to track every patient to determine if the treatment they received was effective. To continue, Dr Codman in 1918, influenced the funding to the American College of Surgeons (ACS), which developed the Minimum Standard for Hospitals which upon inspection, only 13% of 692 hospitals met the minimum standard (Department of community and Family Medicine, 2016). The first quality manual was published in 1926, and it contained 18 pages. In the mid 1940's, Quality Improvement as a formal approach to the analysis of performance and systematic efforts to improve it began with the work of Edwards Demming and Joseph Juran. Their contribution to Quality Improvement helped improve quality in American Public and Private organizations in industry, healthcare, government, and education. In 1951, a not-for-profit organization called the Joint Commission on Accreditation of Hospitals (JCAH) was established with its primary function to provide voluntary accreditation to hospitals based on defined min-

imum quality standards. In 1965, the congress passed the Social Security Act Amendments which conferred "deemed status" for those healthcare organizations accredited by (JCAH) as meeting the requirements necessary for participating in Medicare and Medicaid (Department of community and Family Medicine, 2016).

In 1966, based on the foundations of Deming and Juran, Donabedian, He published a significant article defining quality of health care services. He divided the definition into 3 parts:

Table 1. Definition of Quality of Healthcare Services

The Structure	This included staffing levels, facility attributes, licensing, and accreditation
Proces	This stage of evaluation saw the development of medical audit, and other models that led to the creation of standards of care and clinical guidelines.
Outcome	This was defined as "the ultimate validators of the effectiveness and quality of medical care." These include assessment of whether a procedure or intervention has made a favorable difference.

Donabedian, (1966)

In 1970, the Institute of Medicine (IOM) was established and it served as a non-profit independent scientific advisor to improve the nation's health. Later in 1989, the Agency for Healthcare Research and Quality (AHRQ) was created with its mission to support research to improve quality, safety, efficiency, and effectiveness of healthcare for the nation. In 1991, the Institute of Healthcare Improvement (IHI) was founded by Dr. Don Berwick which organized campaigns for healthcare changes nationally and worldwide. Finally, in 1998, the Quality Interagency Coordination Task Force (QuIC) was established by a presidential directive to ensure that all federal agencies involved in purchasing healthcare services were working in a coordinated manner toward the common goal of improving quality care (Department of Community and Family medicine, 2016).

2.3 Relationship between Conflict and Quality Nursing Care

2.3.1 Effects of Conflict on Quality Nursing Care

Increasingly, the quality of healthcare depends on the contribution of multiple professionals. It is critical for clinicians to collaborate in inter-professional teams of nurses, physicians, pharmacists, dieticians, and so on. However, when working in teams, conflict is inevitable. It comes naturally; the clashing of thoughts and ideas is a part of the human experience (Evans, 2013). Conflict in inter-professional teams is not a new phenomenon. When providing quality patient care, contributions from multiple teams are needed but in the presence of conflict, there is decrease in team functioning and effectiveness thus a negative impact on quality care (Brown et al, 2011).

It is true that conflict can be destructive; however, it should not always be seen as something that has a negative effect on quality care. Sometimes, through conflict, opportunities in learning and understanding better methods for providing quality care arise. Hence, certain levels of conflict can lead to the creation of new of ideas as well as stimulate team togetherness, which promotes quality of care (Patton, 2014).

3   THEORITICAL FRAMEWORK

Nursing's theoretical knowledge has a rich heritage in its development dating back to the writings of Florence Nightingale and emanating from the work of many scholars of the past three decades. Although there is a continuing debate about nursing theories, as they exist, are mature enough or rigorously developed; nursing theories, large and small have become the cornerstone for understanding and guiding nursing practice in the current decade. There exist many different nursing theories each with its own assumptions, philosophies, values, perspectives, and scope making it unique in the understanding and guidance of nursing practice (Kim et. al 2006 p 1).

For this thesis, the model of task group effectiveness has been chosen. This model was chosen for this thesis because it brings out all the factors required when working as a team. It touches every aspect required for successful team work as well as what factors each individual needs to bring to ensure successful team work. Secondly, this model was chosen because, it brings up the issue of conflict. It gives the reality of what it is like working with other individuals. Nurses, Doctors, and other healthcare professionals have different educational and cultural backgrounds but must work together for the attainment of a common goal. Their relationship has difficulties and this model identifies that (Sharon and Sylvia, 2005). In the figure below, is a model that was introduced in the year 1984 by Deborah L. Gladstein.

Figure 1. General Model of Group Behavior: Constructs and Measured Variables (Deborah L.G, 1984)

This model consists of inputs, process, and outputs. The inputs are made of two levels which are the group and organizational levels. These have a direct or indirect effect on team's productivity. It provides a way to understand how teams perform and how their performance can be maximized. The process goes further to explain the group's tasks and the factors influencing them such as environmental uncertainty, interdependence and complexity of the task. Finally, the output is the effectiveness of the group and it is seen through performance (were the goals achieved) and satisfaction not just for the patients but also, the healthcare providers (Deborah L. Gladstein, 1984).

3.1 ELEMENTS OF THE GROUP BEHAVIOUR MODEL

According to Sharon and Sylvia (2005), the use of health care teams, to achieve quality and efficient patient care has become widespread. With the increasing costs and techno-logical complexity of providing health care, the resultant growth in specialization of pro-

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fessionals, there is a need to co-ordinate scarce human and financial resources to maximize patient outcomes. In the model of process-effectiveness relationship, group effectiveness is viewed as the major output of small-group behavior. Effectiveness has three components: group performance, satisfaction of group member needs and the ability of the group to exist over time (Hackman and Moris 1975 as cited by Gladstein, 1984). The model further predicts that group process (the intragroup and intergroup actions that transform resources into products) leads to effectiveness. Process behaviors are either maintenance behaviors that build, strengthen, and regulate group life or task behaviors that enable the group to "solve the objective problem to which the group is committed" (Philp and Dunphy, 1959: 162 as cited by Gladstein, 1984 p. 500).

In health care, teamwork is an important requirement for the provision of high quality, safe patient care, yet, healthcare team members do not understand the personal competencies required for team success. Per Leggat (2007), "each team member's abilities, skills experience, attitudes, values, role perceptions and personality – all things that make a person unique – determine what they are willing and able to contribute, their level of motivation, methods of interaction with other group members and degree of acceptance of group norms and organization's goals" hence, individual characteristics determine how a team functions and, thus, the effectiveness of the group. The model encourages openness and smooth interpersonal relations to improve effectiveness, thus, the need for open communication, supportiveness, and lack of interpersonal conflict (Gladstein, 1984).

The model of task as a moderator considers group process and effectiveness to vary with the nature of the task to be performed (Roby and Lanzetta, 1958; Hackman and Moris, 1975; Herold, 1980). That is, when the task is uncertain, the communication becomes more flexible, whereas, simple tasks require little to no communication. Gladstein, (1984 p. 501) gives 3 dimensions of task which include task complexity, task interdependence, and environmental uncertainty. He goes further to explain that for a group to be effective, it must have an information processing capacity that matches the information-processing of its task. Open communication, discussion of performance strategies and boundary management increase information-processing capacity (Gladstein, 1984).

There is also the model of structure, process, and effectiveness in which group structure influences effectiveness both directly and indirectly. The indirect link to effectiveness is

achieved through the influence of group structure on group processes, for example, groups with clear goals are more likely to communicate openly than groups with unclear goals. Organizational theorists suggest several group-level variables as measurable indicators of group structure which include; group's size, the clarity of its goals and member roles, specific norms about how to go about doing the work, task control, and formalized leadership (Gladstein, 1984 p 502). Goal and role clarity and specific norms about work are similar to the organization-structure-variable structuring of activities. Both the group and organizational level variables refer to the degree to which employee behavior is specified by routines, procedures, and prescribed roles (Pugh et al, 1968; Keisler, 1978; as cited by Gladstein, 1984 p 502). Task control refers to the degree of control or authority a group has over its internal work processes and this plays an important role in the delivery of quality health care (Gladstein, 1984).

4 AIMS AND RESEARCH QUESTIONS

The aim of research builds on the knowledge that health care professionals should be equipped with the tools necessary when operating as a team. However, there seems to be a gap in the ability of nurses and other healthcare professionals to collaborate with each other. Hence, this thesis intends to highlight the common causes of team conflict, their effects on quality of care and possible solutions.

Below are the four questions that were used to guide this investigation:

1. What is conflict in health care?
2. What are the most common areas of conflict between nurses and other health care professionals?
3. How does conflict affect quality of care?
4. What strategies are used for conflict resolution?

5   METHODOLOGY

This is a qualitative study using a literature review from previous publications. A comprehensive search of literature was undertaken using a variety of approaches to identify appropriate articles. The inductive approach was then used to analyze data from the different articles. Hall, (2017), defines inductive content analysis as "a qualitative method of data analysis that researchers use to develop theory and identify themes by studying documents, recordings and other printed and verbal material." Here, the methods used for the data collection will be explained in detail.
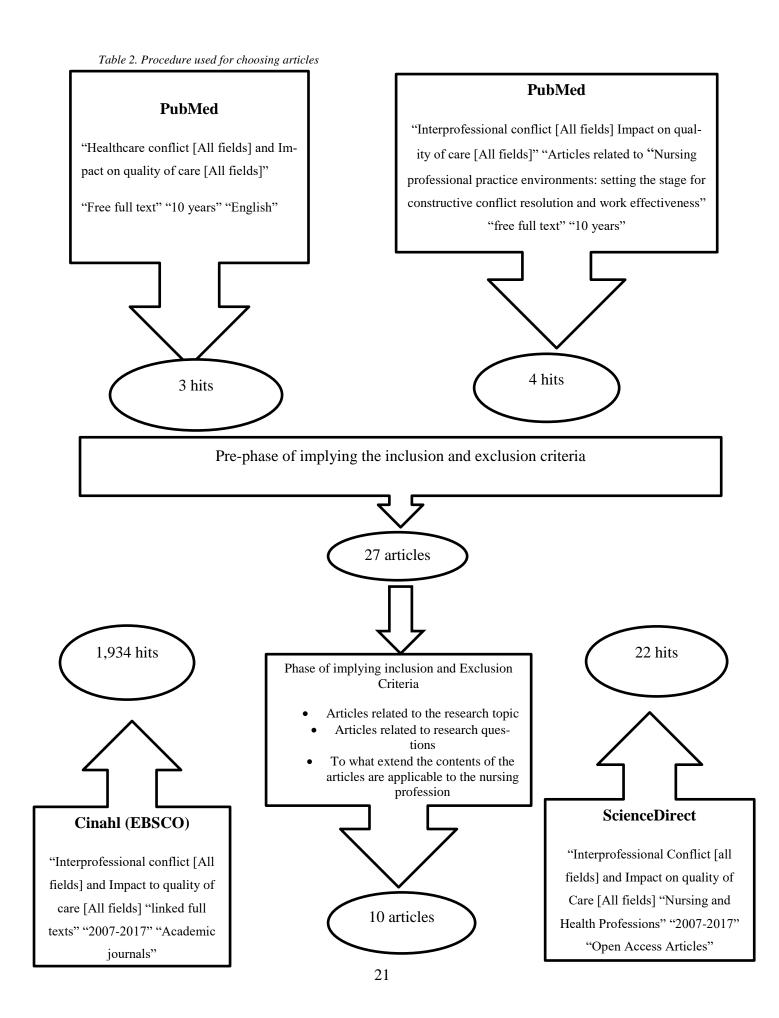
5.1   Data Collection

For the data collection process, different academic search engines were used, and various key words and phrases related to the research questions were also used. The search engines used include; Cinahl (EBSCO), PubMed, ScienceDirect, and Sage. First, the initial search was an advanced search conducted in "PubMed". The phrase "Healthcare conflict [All fields] AND impact on quality of care [All fields]" was used which resulted in 750 hits. The result was limited by choosing articles for the last 10 years, free full text and in English which resulted in 164 hits. After reading the titles and abstracts, 3 articles were chosen for the research. Due to the shortage of articles, the search phrase was changed to "Interprofessional conflict [all fields] AND impact on quality of care [All fields]" which resulted in 50 hits. Articles of interest found here were inaccessible, hence, similar articles to "Nursing professional practice environments: setting the stage for constructive conflict resolution and work effectiveness" which resulted in 1983 hits. The result was limited by choosing articles for the last 10 years, free full text and it ended in 77 hits. After applying the pre-inclusion criteria, 4 articles were chosen.

The second search was an advanced search conducted in Cinahl (EBSCO). The phrase "Interprofessional conflict [All fields] AND Impact on quality of care [All fields]". Finding all my search terms resulted in 16,627 hits. The result was then limited by choosing linked full text, articles from 2007 – 2017 and academic journals giving a total of 1,934

hits. After going through 300 articles and applying the pre-inclusion criteria, 20 articles were chosen.

A search was also conducted using advanced search ScienceDirect using the phrase "Interprofessional conflict [All fields] AND Impact on quality of Care [All fields]". Articles from 2007 to 2017 and Nursing and Health Professions were chosen, and it resulted in 686 hits. Open access articles narrowed the results to 22 hits and 0 articles were found related to any of the research questions.

5.1.1 Implying Inclusion and Exclusion Criteria

After completing the initial search, 27 articles were chosen. The articles were read carefully and those that did not meet the inclusion criteria were eliminated. The inclusion criteria included: to what extend the articles were related to the research topic, to what extend the articles were related to the research question (at least 2 research questions), and to what extend the contents of the articles are applicable to the nursing profession.

Table 2. Procedure used for choosing articles

PubMed

"Healthcare conflict [All fields] and Impact on quality of care [All fields]"

"Free full text" "10 years" "English"

PubMed

"Interprofessional conflict [All fields] Impact on quality of care [All fields]" "Articles related to "Nursing professional practice environments: setting the stage for constructive conflict resolution and work effectiveness" "free full text" "10 years"

3 hits

4 hits

Pre-phase of implying the inclusion and exclusion criteria

27 articles

1,934 hits

22 hits

Phase of implying inclusion and Exclusion Criteria

- Articles related to the research topic
- Articles related to research questions
- To what extend the contents of the articles are applicable to the nursing profession

Cinahl (EBSCO)

"Interprofessional conflict [All fields] and Impact to quality of care [All fields] "linked full texts" "2007-2017" "Academic journals"

10 articles

ScienceDirect

"Interprofessional Conflict [all fields] and Impact on quality of Care [All fields] "Nursing and Health Professions" "2007-2017" "Open Access Articles"

5.2 List of Articles Chosen for the Study

Conflict Situations Experienced at Hospital: The view of nursing technicians and auxiliaries. Carla Aparecida S, Gislene Rodrigues S, Bruno Mendes de Oliveira C, Maria Tereza M.B, Jackeline Soares V, Ana Paula de Oliveira S. *Rev. esc. enferm. USP*. 2010, vol.44, n.3 [cited 2017-03-28], pp.803-811. PubMed, Qualitative Review.

Interprofessional Work in Operating Rooms. Vathsala J, Sepali G, Bawantha G, and Sherry E. *Journal of BMC surgery vol.61*. PubMed, Qualitative Review.

Conflict on Interprofessional Primary Healthcare Teams – Can it be resolved. Brown J, Lewis L, Ellis K, Stewart M, Freeman T, & Kasperski M (2011). *Journal of Interprofessional Care*, 25, 1, pp. 4-10. CINAHL, EBSCO*host*, Qualitative Review.

Nurses' Perception of Conflict as Constructive or Destructive. Kim W, Nicotera A, & McNulty J (2015). *Journal of Advanced Nursing*, 71, 9, pp. 2073-2083. CINAHL, EBSCO*host*, Qualitative Review.

What is Happening Under the Surface? Power, Conflict, and the Performance of Medical Teams. Janss R, Rispens S, Segers M, & Jehn K (2012). *Medical Education*, 46, 9, pp. 838-849. CINAHL, EBSCO*host*, qualitative Review.

Conflict in Medical Teams, Opportunity, or Danger? Greer L, Saygi O, Aaldering H, & W de Dreu C 2012, *Medical Education*, 46, 10, pp. 935-942. CINAHL, EBSCO*host*, Qualitative Review.

Conflicts and Conflict Management in the Collaboration between Nurses and Physicians. Leever A, Hulst M, Berendsen A, Boendemaker P, Roodenburg J, & Pols J (2010) *Journal of Interprofessional Care*, 24, 6, pp. 612-624, CINAHL, EBSCO*host*, Qualitative Review.

Intergroup Relationships and Quality Improvement in Healthcare. Bartunek JM (2011). *BMJ quality & safety*. 2011;20(Suppl_1): i62-i66. doi:10.1136/bmjqs.2010.046169. PubMed, Qualitative Review.

Improving Teamwork: Impact of Structured Interdisciplinary Rounds on a Medical Teaching Unit. O'Leary KJ, Wayne DB, Haviley C, Slade ME, Lee J, Williams M (2010). Unit. *Journal of General Internal Medicine*. 2010;25(8):826-832. doi:10.1007/s11606-010-1345-6. PubMed, Qualitative Review.

Interprofessional Practice and Professional Identity Threat. McNeil K, Mitchell R, & Parker V (2013). *Health Sociology Review*, 22, 3, pp. 291-307. CINAHL, EBSCO*host*, Qualitative Review.

5.3 Content Analysis

In qualitative research, data analysis is mostly done using content analysis (Hsieh and Shannon, 2005); it focuses on the characteristics of language as communication with attention to the content or contextual meaning of the text, and it can be performed using different approaches. Hsieh and Shannon, (2005) identified three distinct approaches for qualitative content analysis which include: Conventional, directed, and summative which are all used to interpret text data from a predominately naturalistic paradigm. The conventional content analysis is generally used with a study design whose aim is to describe a phenomenon. The data enables the development of new insights and it follows an inductive approach. Secondly, the directed content analysis is the deductive use of theory based on their distinctions on the role theory (Potter and Levine-Donnerstein, 1999 as cited by Hsieh and Shannon, 2005). Here, existing theory or prior research was used, and key concepts identified and used as initial coding categories. Lastly, a summative approach to qualitative content analysis goes beyond mere word counts to include latent content analysis (Hsieh and Shannon, 2005). This approach is used to identify underlying meaning of words or content. Another form of qualitative content analysis in nursing research is described by Graneheim and Lundman (2003). Here, an inductive approach is used and involves reading the chosen texts several times to get a deeper meaning of its contents. The concerned meaning units from the texts are then condensed, coded, and classified into categories.

Data analysis in this research was done using Graneheim and Lundman (2003) form of qualitative content. Because this method of data analysis is focused on healthcare, its concepts give a better interpretation of the chosen units of analysis. These concepts usually are the obvious and hidden meanings in the chosen articles. These meanings are then summarized, coded, and developed into categories, and themes which provide answers to the research questions. The labelling of the meaning unit is referred to as the code; the categories are the core feature of qualitative content analysis. It answers the question 'what' and often includes several sub-categories. Finally, the theme which answers the question 'How' is the expression of the underlying or hidden meaning of the text.

5.3.1 Step 1: Reading and coding

Of the 23 articles selected, and carefully read, the inclusion and exclusion criteria were used to filter through the articles and get a final of 10 articles which have been used in this research. These 10 articles also known as 'the unit of analysis' were read more carefully and a pencil was used to underline interesting data and notes were written at the margin. These notes were the keywords of the underlined texts and the labeling codes. Different color highlighters were then used to highlight different codes and signs like stars were put beside the codes to show their level of importance to the thesis.

5.3.2 Step 2: Listing and categorizing of codes

In this step, after the codes were found, they were listed on a piece of paper and later read thoroughly such that each piece of information was categorized with respect to the relevance of the codes. This was done in such a way that all codes had to get into relevant categories and no code had to fall into more than one category.

Table 3 Appendix 1 shows an example of how categories were developed from several meaning units. It shows how each meaning unit in the article was condensed as short as possible while trying to maintain the words used in the text and, later, the condensed meaning was interpreted considering the whole text. The articles were read several times separately to prevent them from influencing data interpretation. The interpreted data was then coded, and the codes categorized. Notice: Table 4 Appendix 2 is an illustration of the content analysis of the 10 articles chosen for this study which resulted in the major and minor categories.

5.3.3 Emerging Sub-themes and themes from the categories

After reading and rereading the articles and developing codes, the codes were then organized and compared in terms of similarities and differences, and assigned to groups related to the research questions which led to the development of categories. The categories with recurring regularity where then grouped together to create the sub-themes and theme.

Table 5 below shows how the theme was developed from the categories above

Table 5: An Illustration of the Categories

Theme	Effects of Team conflict on quality of care and conflict management								
Sub theme	How Team Conflict Affects the Quality of Care							Conflict Management	
Categories and Sub-categories	Definition	Types of conflict	Sources of conflict	Team members reaction to conflict	Effects on Performance		Effects on Delivery of Care	Team Strategies	Nurse's Role
					Constructive	Destructive			
Units of analysis	4, 5, 6, 7	1, 5, 6	1, 2, 3, 4, 5, 6, 7, 8, 9, 10	4, 5, 6, 7, 9, 10	4, 5, 6	2, 3, 4, 5, 6, 7, 10	2, 3, 4, 5, 7, 8	1, 3, 4, 5, 6, 8, 10	1, 4

5.3.4 Ethical Consideration

According to Resnik (2015), ethical norms promote the aims of research, such as, knowledge, truth, and avoidance of error. For example, prohibition against fabricating, falsifying, or misrepresenting research data promote the truth and minimize error. Arcada University of Applied Sciences has standards and instructions on thesis writing outlined in the Writing Guide (2014) version 2.1 which was respected as much as possible by the author. Firstly, the topic of the research was chosen after discussion with the supervisor and proper guidance from the supervisor. Secondly, the author being an official student

of Arcada University of Applied Sciences, had access to articles through the official academic databases hence there is no use of falsified or fabricated information. To continue, all citations made in this thesis were referenced following Arcada's guidelines and to prevent plagiarism, most of the quotations were paraphrased, and the authors' privacy and copyright respected. During the process of content analysis, the articles were analyzed separately and independently to prevent bias.

6 FINDINGS

Here, the major categories which emerged during the process of data analysis will be presented in alphabetic order and the numbers in bracket representing the units of analysis. Appendix 2 table 2 is an illustration of how qualitative inductive data analysis resulted in the major and minor categories.

Sources of Conflict: In health care, professionals from different disciplines need to work together to provide patient care. These studies show that when these professionals come together, the potential for conflict within and between teams is amplified and could be due to substantive issues such as scope of practice, different philosophical views regarding patient care, or emotional issues such as personality differences and power differentials. [1, 2, 3, 4, 5, 6, 7, 8, 9, 10]

Effects of Performance: From these studies, conflict has either a destructive or constructive effect on team performance (team performance is directly related to the quality of patient care) depending on the type of conflict. Task related conflicts are perceived as having constructive effects on team performance. With emotions kept aside, team members are able to overcome their bias and have a clearer picture if the situation at hand which enables them to have a critical evaluation of the tasks at hand and achieve innovative solutions. Meanwhile, process and relationship conflicts, on the other hand, have more of a destructive effect on team performance because they involve emotions. These emotions elicit negative and damaging behavior. The center for American Nurses (2008) claim that disruptive behavior interferes with effective communication and negatively impacts performance and outcome. [2,3,4,5,6,7,9,10]

Effects on the Delivery of Care: Improving communication and collaboration between nurses and physicians can improve their morale, and can improve patients' satisfaction and quality of care. In contrast, poor communication and inadequate resolving of disagreement can have potentially serious consequences for patient care. Poor quality teamwork is associated with higher rates of medical errors and adverse events for patients. [2, 3, 4, 5, 7, 8]

Nurses' Role: Nurses are the mediators of the nursing/health care team in several situations of conflict, hence, they should be able to device several strategies to deal with these

situations such as open and direct communication, willingness to find solutions, respect and humility. They must be trustworthy, impartial, knowledgeable about the situation, loyal, flexible in their attitudes, and maintain confidentiality. [1, 4]

Team strategies for conflict resolution**:** Strategies used for conflict resolution are of great importance as conflict is a very sensitive issue which, if not managed properly, could lead to great crisis. The management of conflict should be done using an active, combined and versatile approach which enables that the differences of individuals are understood, accepted, and embraced in a positive manner is important. Also, conflict is, generally, seen as being detrimental to team performance but if it is recognized as an opportunity for productive growth, it could enhance team performance. [1, 3, 4, 5, 6, 8, 10]

Team members reaction to conflict: When different professionals work together and are faced with a situation of conflict, their reaction either intensifies the conflict resulting in poor team performance or brings about solution, thus, better team performance. From the articles, most team members tend to avoid or withdraw from conflicts and overall, the suppressed conflict will act as a starting point of conflict for subsequent team tasks which, in effect, affects quality of patient care. [4, 5, 6, 7, 9, 10]

Types of conflict**:** These studies have given three types of conflicts which include; task related conflict, process conflict and relationship conflict. These conflicts affect team performance in different ways. Task conflict is having some positive effects while the process and relationship conflict is considered to bring about negativity. [5, 6]. In article 1, the types of conflict are; intrapersonal, interpersonal, and intergroup conflicts which are like task, process, and relationship conflicts.

The above categories led to the formulation of two subthemes which are: **Effects of conflict** and **Conflict management** which led to the formulation of the theme; **Effects of conflict on quality of care and conflict management**.

7   DISCUSSION

After analyzing the 10 articles, the results reveal that conflict in interprofessional teams is inevitable and poses a great challenge to effective team functioning. When managed properly, it leads to constructive team performance; 'the better the collaboration, the better patient outcomes will be' (Baggs et al, 1999 as cited by Leever et al, 2010) but when managed poorly, it leads to destructive team performance. According to Jayasuriya-Illesinghe et al (2016), "poor quality of team work is associated with higher rates of medical errors and adverse events for patients" which is a negative effect on quality of care. They also reveal that nurses are mediators of the nursing/health care team in several situations of conflict and are prepared to face conflict situations using dialogue and negotiation. Appendix 3 table 3 gives an illustration of the answers to the research questions in this thesis.

7.1   Effects of Team Conflict

According to these studies, conflict is considered as having a destructive or constructive effect on team performance depending on the reasons for conflict and how they affect individual members of the team. Several reasons were given as causes of conflict some of which include; identity threat, blurred job boundaries, power, personality differences, different values, and beliefs. Once emotions get involved in conflict situations, team performance is affected negatively (relationship and process conflicts) but when emotions are kept aside, and team members see conflict as an opportunity for productive growth, it leads to a constructive team performance.

Of the 10 articles studied, just 3 of the articles suggested that conflict could have a constructive behavior on team performance while 8 articles explained that conflict has a destructive effect on team performance. It becomes destructive when the emotions of individuals are affected and resolving this type of conflict is usually time consuming. When interprofessional teams are faced with situations of conflict, it is a great challenge especially when it comes to keeping emotions aside and accepting that conflict is a means of improving team work and, thus, quality of care (Greer et al, 2012).

7.2 Effects of Team Conflict on quality of care

The articles in this study show that positive and negative team performance affect quality of care positively and negatively respectively. "Quality of teamwork among health care professionals has been linked to patient mortality, morbidity, and satisfaction with care, as well as healthcare provider job satisfaction. Poor quality team work is associated with high rates of medical errors and adverse events for patients" (Jayasuriya-Illesinghe et al, 2016). Interprofessional practice aims to bring together a range of health care professionals from different specialties and disciplines so that patients receive the highest quality of care (McNeil et al, 2013). Rifts among these groups have a negative impact on quality of care (Bartunek, 2011).

These rifts could be due to differences in views and opinions of team members about set goals and it is usually emotional or task based (Brown et al 2011). When related to the task at hand, the sharing of different views and challenging each other's perspectives improves members' ways of thinking and their approach to the given task at hand enabling a higher team performance than was imagined and improved quality of care (Greer et al, 2012). Emotion based conflict on the other hand distracts members from the task at hand and a breakdown in communication. The breakdown in information sharing and lack of or no communication between team members has been identified as having potentially serious consequences on patient care (Jayasuriya-Illesinghe et al, 2016). Team members often feel unable to approach certain individuals and are uncomfortable raising certain concerns due to conflict with these individuals.

In all these circumstances, performance should be reliable, and the prevalence of error should be low because consequences of errors may be life-threatening (Janss, 2012). With the patients being our priority in health care, the quality of care provided to them is of great importance, hence, the importance of proper team functioning. Thus, when conflicts arise in teams, team members and the nurse who is a mediator should enhance communication and see conflict as a way of bringing new information to the surface rather than a sign of group problems (Spagnol et al, 2010).

7.3 Implying the nurse's role and the team's role through theoretical framework

According to the theory of group task effectiveness, "each team member's abilities, skills experience, attitudes, values, role perceptions and personality – all things that make a person unique – determine what they are willing and able to contribute, their level of motivation, methods of interaction with other group members and degree of acceptance of group norms and organization's goals" Per Leggat (2007) hence, individual characteristics determines how a team functions and, thus, the effectiveness of the group. The model encourages openness and smooth interpersonal relations to improve effectiveness, thus, the need for open communication, supportiveness, and lack of interpersonal conflict (Gladstein, 1984 p. 500).

Nurses, also known as mediators of the nursing/health care team in several situations of conflict are in contact with different professionals practically every day and are the ones in direct contact with the patients. They get to understand the strengths and weaknesses of their team members and stand a better chance of preventing or resolving conflict. They should be able to use an active, collaborative, and integrative approach in conflict management in which they can understand, accept and incorporate individual differences in a positive manner. This builds an environment of trust and the team members, rather than expressing withdrawal behaviors, can express their concerns which results in better team performance, thus, better quality of care (Spagnol et al, 2010).

To continue, Gladstein, (1984) explains that for a group to be effective, it must have an information processing capacity that matches the information-processing of its task. Open communication, discussion of performance strategies and boundary management increases information-processing capacity. This is of great importance in quality patient care as it enables the smooth flow of information and exchange of ideas. Hence, effective team performance. In team conflict, nurses play an important role but the team members are also needed in the prevention and management of conflict. Before carrying out tasks, team members should be able respect each other's role and understand the goals set to achieve a given task (discussion of performance strategy). The authority a group has over its internal work processes play an important role in the delivery of quality of health care.

For a group to have authority over its internal work processes, there is the need for open communication, clear goals, and respect for one another (Gladstein, 1984).

From these studies, nurses lack the preparation to deal with organizational conflicts due to several factors which include: lack of professional experience, lack of interaction with the team, lack of dialogue due to difficulties to communicate, lack of authority, common sense, and wisdom. The introduction of conflict management programs for nurses can help build their confidence and better prepare them to face conflict situations in hospitals. Secondly, very little is said about factors affecting conflict resolution in these articles. More studies must be done on these so that those factors can be identified and dealt with thus facilitating the process of conflict resolution (Spagnol et al, 2010).

8 CONCLUSION

The aim of this thesis was to highlight the possible causes of conflict, their effects on quality care and possible solutions. A qualitative study using literature review from previous articles was used. 10 articles relating to the research questions were chosen using different search engines and these articles were analyzed using the inductive approach. After analyzing these articles, it showed that conflict is inevitable in healthcare. The provision of healthcare is done in complex environments of multidisciplinary professionals such as physicians, nurses, laboratory technicians, pharmacists, health administrators and others. With the need to provide quality patient care combined with the competing demands of the system, tension is created as professional care-givers seek to attain their goal. Conflict in the healthcare setting emanate from personality differences, value differences, ambiguous job boundaries, decision making, communication, and expectation. While some professionals can and do actively resolve conflict without intervention, most of the times, these professionals will rather avoid dealing with conflict which most often than not lead to greater problems (Mills, 2002).

Also, the studies showed that conflict can be constructive or destructive depending on the reasons for conflict and how they affect individual members of the team. For conflict to have a positive effect on team performance, professionals need keep their emotions aside and regard conflict as a stimulant in the accomplishment of goals because it helps to incorporate different viewpoints and promote critical thinking. However, in most situations, regardless of the cause of conflict, emotions get involved leading to a negative effect on team performance. As a result, effective team functioning relies on the effective management and resolution of conflict (Kim, Nicotera, and McNulty, 2015). Using a constructive and organized style in conflict management results in improved quality nursing care, trustworthiness and reduces work stress for the health personnel. But when conflict is poorly managed or unresolved, it has a negative influence on individuals, organizations and most importantly, quality of patient care (Leever et al, 2010).

This study shows that most team members tend to avoid or withdraw from conflicts and overall, the suppressed conflict will act as a starting point of conflict for subsequent team tasks which, in effect, affects quality of patient care. Conflict is shown to have more of a

negative than a positive effect in the delivery of quality care. When conflict arises regardless of the cause, most often than not, emotions are involved, which eventually results poor communication and collaboration thus poor quality of care. Furthermore, the method used in conflict management is of great importance. Professionals are encouraged to be open, to communicate and trust one another and nurses should be educated on their roles as mediators of conflict.

In this study, the author tried to cover as many points as possible in the content analysis of the given articles but because different individuals have different methods of interpreting data, new issues for discussion can be found. Also, there is a possibility that the articles chosen for this study do not contain all the information needed to answer the research questions, as a result, the need for more accurate studies.

9 REFERENCE

Bercovitch J, (1983). Conflict and Conflict Management in organizations: A framework for analysis. Available from: http://legacy.earlham.edu/~chriss/ConflictRes/pdf%20files/Conflict.Conflict%20Management%20in%20Organizations.pdf Accessed 20.10.2017

Brown J, Lewis L, Ellis K, Stewart M, Freeman T, & Kasperski M, (2011). Conflict on Interprofessional Primary Healthcare Teams, can it be resolved. *Journal of Interprofessional Care* 25: 4-10. Available from: Available from: CINAHL, EBSCO*host* Academic Search Elite. Accessed 28.03.2017

 Patton C M, (2014) Conflict in Health Care: A Literature Review. *The Internet Journal of Healthcare Administration*. Vol 9 Number 1. Available from: http://ispub.com/IJHCA/9/1/20081 Accessed 28.10.2017

Greer L. Lindred et al (2012) Conflict in medical teams: opportunity or danger? Medical Education. Vol 46 Pp 935 – 942 A. Available from: CINAHL, EBSCO*host* Academic Search Elite. Accessed 28.03.2017

Gladstein D L, (1984) Groups in Context: A model of task group effectiveness. Administrative Science Quarterly. Vol 29(4) Pp 499 – 517. Available from: JSTOR online http://www.jstor.org/stable/2392936#?seq=1#page_scan_tab_contents Accessed 10.10.2017

Graneheim U, Lundman B (2003) Qualitative content analysis in nursing research: concepts, procedures, and measures to achieve trustworthiness. Available from: http://citeseerx.ist.psu.edu/viewdoc/dowload?doi=10.1.1.490.2963&rep=rep1&type=pdf   Accessed 28.03.2017

Higazee M, Zeinhom A, (2015): Types and levels of conflicts experienced by nurses in the hospital settings. *Health Science Journal*. Available from: http://www.hsj.gr/medicine/types-and-levels-of-conflicts-experienced-by-nurses-in-the-hospital-settings.php?aid=7838 Accessed 20.10.2017

Hsieh Hsiu-Fang & Shannon E. Sarah (2005): Three approaches to qualitative content analysis. *Sage journals* Vol: 15 issue: 9, page(s): 1277-1288 Available from: http://journals.sagepub.com/doi/pdf/10.1177/1049732305276687
Accessed 28.03.2017

Janss R, Rispens S, Segers M, & Jehn K, (2012): What is happening under the surface? Power, conflict, and the performance of medical team. *Medical Education* Vol 46 Pp 838 – 849. Available from: CINAHL, EBSCO*host* Academic Search Elite. Accessed 28.03.2017

Vathsala J, Sepali G, Bawantha G, and Sherry E. (2016): Interprofessional work in operating rooms: a qualitative study from Sri Lanka. *Journal of BMC Surgery* (2016) 16:61. Available from: PubMed Academic Search Elite. Accessed 28.03.2017

Jean M Bartunek (2011) Intergroup relationships and quality improvement in healthcare. *BMJ Quality & Safety* Vol 20 (2011) Pp i62- i66. Available from: PubMed Academic Search Elite. Accesses 28.03.2017

Brown J, Lewis L, Ellis K, Stewart M, Freeman T, & Kasperski M, (2011): Conflict on interprofessional primary health care teams – can it be resolved? *Journal of Interprofessional Care*. Vol 25 (2011), Pp 4-10. Available from: CINAHL, EBSCO*host* Academic Search Elite. Accessed 28.03.2017

Kelly P, Vottero BA, & Christie-McAuliffe C (2014): Introduction to Quality and Safety Education for Nurses: Core Competencies, Springer Publishing Company, New York. Available from: ProQuest Ebook Central. Accessed 17.11.2017

Kim W, Nicotera A. M. & McNulty J (2015): Nurses' perceptions of conflict as constructive or destructive. *Journal of Advanced Nursing* Vol 71(9), Pp 2073 – 2083. Available from: CINAHL, EBSCO*host* Academic Search Elite. Accessed 28.03.2017

Leever A, Hulst M, Berendsen A, Boendemaker P, Roodenburg J, & Pols J, (2010): Conflicts and conflict management in the collaboration between nurses and physician – A qualitative study. *Journal of interprofessional care*. Vol 24(6) Pp 612 – 624. Available from: CINAHL, EBSCO*host* Academic Search Elite. Accessed 28.03.2017

Mary Etta C. Mills (2002) Conflict in Healthcare Organizations. *Journal of healthcare law and policy* Vol 5 Iss 2 (8). Available from: http://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1248&context=jhclp Accessed 25.02.2018

McNeil K, Mitchell R, & Parker V (2013): Interprofessional practice and professional identity threat. Health Sociology Review Vol 22(3) Pp 291 – 307. Available from CINAHL, EBSCO*host* Academic Search Elite. Accessed 28.03.2017

Skjørshammer M, (2002). Getting to Cooperation: Conflict and Conflict Management in a Norwegian Hospital. Available from https://brage.bibsys.no/xmlui/bitstream/id/316619/DoktoravhandlingMortenSkjorshammer.pdf Accessed 09.03.2018

O'Leary KJ, Wayne DB, Haviley C, Slade ME, Lee J, Williams M, (2010): Improving Teamwork: Impact of Structured Interdisciplinary Rounds on a Medical Teaching Unit. *Journal of General Internal Medicine*. Vol 25(8), Pp 826-32. Available from: PubMed Academic Search Elite. Accessed 28.03.2017

Carla Aparecida S, Gislene Rodrigues S, Bruno Mendes de Oliveira C, Maria Tereza M.B, Jackeline Soares V, Ana Paula de Oliveira S (2010): Conflict situations experienced at hospital: the view of nursing technicians and auxiliaries. Rev Esc. USP Vol 44(3) Pp 792 – 9. Available from: PubMed Academic Search Elite. Accessed 28.03.2017

APPENDICES

Appendix 1
Table 3. An Inductive Qualitative Content Analysis

Meaning unit	Condensed meaning unit using words from the text	Condensed meaning of unit's latent meaning	Codes	Categories
Both process conflict, or conflict about logistics of task accomplishment, and relationship conflict or conflict about interpersonal incompatibilities have been shown to detract from effective team functioning.	Conflict has been shown to detract from effective team functioning	Conflict leads to poor teamwork	Conflict, poor teamwork	Destructive team performance
When conflict occurs, regardless of their topic, members become emotional and distracted from the immediate task and waste energy on conflict resolution that might have been better spent on accomplishing the task	Conflict causes team members to become emotional and distracted from the immediate task at hand	Conflict causes distraction from the immediate task at hand	Conflict, distraction from work	
However, task conflicts may also cause stress and anxiety among team members, increase their cognitive load, and narrow their range of thought, there by impairing effective team outcomes.	Conflict increases cognitive load and narrows range of thought thereby impairing team outcomes	Conflict narrows range of thought thereby impairing team outcomes	Conflict, impairs team outcome	
Because of these differences in approaches to patient treatment, conflict may arise. However, it may also harm team functioning because during the debate, team members may be distracted from the immediate needs of the patient and may become	Conflict causes team members to be distracted from the immediate needs of the patient and may become emotional which may impair their decision making and performance	Conflict in teams causes members to become emotional impairing their decision making and performance	Conflict, poor decision making and performance	

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emotional which may impair their decision making and performance.				
Such interpersonal disagreements are often emotional and hostile and therefore difficult to resolve and distracts members from the task at hand and reduce collaborative problem solving.	Conflicts are often emotional and hostile and distracts members from the task at hand	Conflict leads to emotional and hostile behavior which distracts team members from their task	Conflict, distraction	
By sharing different views of the task and challenging one another's perspectives, members may be able to refine their ways of thinking and their approaches to the task, enabling higher performance than previously imagined	Conflict enables team members to refine their ways of thinking and approaches to a task thus enabling a higher performance	Conflict refines ways of thinking and approaches to a given task thus improving performance	Conflict, higher team performance	Constructive team performance
Schultz-Hardt et al showed in a now classic experimental study that when teams are in conflict, or dissent this stimulates the discussion of information and improves the quality of group decision making.	Schultz-Hardt et al showed that conflict stimulates the discussion of information and improves quality of group decision making	Conflict stimulates discussion of information and improves quality of group decision making	Conflict, improved communication, and decision making	

Appendix 2
Table 4: The development of Major and Minor Categories

Article number	Categorized condensed meaning units according to Graneheim and Lundman (2003)
1	*Sources of conflict:* the most common triggers of situations of conflict are: communication problems, organizational structure, role disputes, lack of resources, misunderstandings, lack of professional commitment, among others. *Types of conflict:* Some subjects pointed out the following types of conflict: intrapersonal, interpersonal, and intergroup. *Strategic solutions:* Literature describes the following strategies to deal with conflict at the work place: confrontation, mitigation, negotiation, retreat, and weight of authority. *Nurses' role:* The nurse is the mediator of

	the nursing/health care team in several situations of conflict, using several strategies to deal with these situations and has to be trustworthy impartial, knowledgeable about the situation, loyal, flexible in his/her attitudes, clear in language and maintain confidentiality
2	*Sources of conflict:* Lack of shared team identity. Surgeons perceived their role in the team as more important than that of other professionals and as a result, failed to recognize the interdependence nature of the team member's work. *Effects on performance:* Poor quality teamwork is associated with higher rates of medical errors and adverse events for patients. *Effects on delivery of care:* Breakdown in information-sharing and lack of or poor communication have been identified as leading to adverse events in operating rooms more so than errors in surgical technique.
3	*Sources of conflict:* Payne (2002) differentiates two sources of conflict in teams which are Substantive and Emotional issues. Substantial issues include scope of practice and differing philosophical perspectives regarding patient care; whereas, emotional issues reflect personality differences and power differentials. *Effects on Performance and delivery of care:* (destructive) In the primary healthcare settings that depend on the contributions of multiple teams, the potential for conflict within and between teams is amplified and can impede team functioning, decrease team effectiveness, and impact patient care. *Barriers to conflict resolution:* Participants identified 4 key barriers to conflict resolution: lack of time and work load issues, people in less powerful positions, lack of recognition or motivation to address conflict, and avoiding confrontation for fear of causing other team members' emotional discomfort. *Strategic solutions:* Team and individual strategies for conflict resolution were identified. Team strategies focused on the development of conflict resolution protocols and reliance on the leadership of the organization to negotiate and resolve conflict. Individual strategies included open and direct communication, willingness to find solutions, showing respect and practice of humility.
4	*Definition:* Conflict is conceptualized by communication scholars as 'the interaction of interdependent people who perceive the opposition of goals, aims and/or values and see the other party as potentially interfering with the realization of these goals. *Sources of Conflict:* Conflict is inevitable in any organization because of incompatible goals, needs, responsibilities, and values among other fundamental differences in perception. *Effects on performance: (constructive)* Social scientists have long argued that conflict is inevitable but when managed productively, is an important source of critical thinking, good decision making and innovation. *(Destructive)* Conflict elicits negative and damaging behavior. *Effects on the delivery of care*: The center for American Nurses (2008) claim that disruptive behavior interferes with effective communication and negatively impacts performance and outcome. *Team members reaction to conflict:* The most common conflict management strategy used in nursing is avoidance or withdrawal. *Strategic solutions:* The successful management of conflict depends on two basic factors: the recognition that conflict is an opportunity for productive growth and the ability to fruitfully confront issues in a socially constructive manner. *Role of the nurse*: Nurses will understand that conflict avoidance is poor conflict management that will likely serve only to perpetuate negativity.
5	*Definition:* Conflict in general is defined as the perception by parties involved for differences, discrepancies, and incompatible wishes. *Sources of conflict:* Team members from different disciplines have a shared responsibility but it is unclear

	who is in charge and this may give rise to conflict over status. ***Types of conflicts:*** Three types of conflict can be distinguished: task related conflict, relationship conflict and process conflict. ***Effects on performance: (Constructive)*** Some empirical studies have found that conflict can improve team performance. These studies support the hypothesis that conflict leads to the sharing of viewpoints and increased discussions which in turn improve team decision making and consequently team performance. ***(Destructive)*** Process and relationship conflict are generally found to be negatively related to group outcomes as they are more strongly associated with negative emotions. ***Effects on delivery of care***: Discussing different opinions about medication among members may generate constructive ideas and thereby enhance patient treatment. ***Team members reaction to conflict:*** Team members react with mimicry or withdrawal behavior and thereby intensify conflict. ***Strategic solutions***: Extending developments in medical practice and education with research programs that build on the knowledge and theories of social and organizational psychology is likely to contribute to improved performance of medical action teams.
6	***Definition:*** Intragroup conflict is defined as arising from perceived incompatibilities among team leaders. ***Sources of conflict:*** When individual team members are brought together to accomplish a task, differences in individual opinions, interests, backgrounds, and beliefs may give rise to conflict. ***Types of conflict:*** Three primary types of conflict have been identified in the team setting: task conflict, relationship conflict and process conflict. ***Effects on performance: (Constructive)*** Conflicts may improve member understanding of the task at hand, critical evaluation of task related ideas, and the ability of teams to overcome confirmatory biases and achieve innovative solutions. ***(destructive)*** However, Conflict may also cause stress and anxiety among team members, increase their cognitive load, and narrow their range of thought thereby impairing effective team outcomes. ***Team members reaction to conflict:*** this work shows that in teams facing conflict, members may try to dominate and impose their views, submit to others' views, ignore the conflict, and engage in proactive solving. ***Strategic solutions:*** scholars advocate the use of active, collaborative, integrative approaches to conflict in which individual differences are understood, accepted, and embraced in a constructive manner.
7	***Definition:*** Marquis and Huston (2006) defined conflict as the internal or external discord that results from differences in ideas, values, or feelings between two or more people. ***Effects of conflict: (destructive)*** Conflicts are seen as seriously negative events, ranging from an atmosphere of discord to a state of affairs where working together is no longer possible. ***Effects on delivery of care***: Poor communication and inadequate resolving of disagreements can have potentially serious consequences for patient care. ***Team members reaction to conflict:*** Two ways emerge from which respondents deal with conflicts. Some tend to ignore the conflict while others easily speak up and engage in the conflict.
8	***Effects on the delivery of care***: Patient care in the ICU suffers when there are differences in nurses' and physicians' knowledge bases. ***Sources of conflict***: This negative outcome was attributed in part to the fact that important knowledge boundaries as well as social or identity boundaries inhibited diffusion. ***Strategic solutions***: The use of cross-discipline Crew Resource Management training and the intent is to 'improve outcomes in patient care by enhancing communication between healthcare professionals.

9	***Sources of conflict:*** residents were aware of communication problems with nurses but, most believed that this posed no threat to patient care because the nurse's role as they saw it was one of simply following orders. ***Team members reaction to conflict***: Unfortunately, a culture of poor teamwork may lead to a work place in which team members feel unable to approach certain individuals and uncomfortable raising concerns. Strategic Solution: interdisciplinary rounds have been used as a means to assemble patient care unit team members and improve collaboration on the plan of care.
10	***Effects of on team performance: (destructive)*** Teams reporting high levels of identity threat demonstrate poor performance. ***Sources of conflict***: Where inter-professional practice has not succeeded, a key cause of failure can be attributed to interpersonal conflicts based on differences associated with, and threats to professional identities. ***Team members reaction to conflict***: Social identity threat has been empirically related to a range of negative affective responses (Cottrell and Neuberg, 2005) which in turn may result in the withdrawal of team members or the withholding of information. ***Strategic solutions***: Diverse groups working towards a common goal as well as working on interdependent tasks that necessitate the acquisition of new knowledge alleviates social identity threat.