IS WORKPLACE CONFLICT HEALTHY?

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"*Ninety-nine percent of all failures come from people who have a habit of making excuses.*"
– George Washington Carver

Conflict within a practice will most likely always exist when the staff is six or more, and managers who know how to turn discord into productivity can put themselves in a position to succeed. There are three texts which should be read to prepare for this subject:

- **Crucial Conversations: Tools for Talking When Stakes Are High (2nd Edition),** by Patterson, et.al
- **QBQ! The Question Behind the Question: Practicing Personal Accountability at Work and in Life,** by John Miller
- **The Blame Game: How the Hidden Rules of Credit and Blame Determine Our Success or Failure** by Ben Dattner

After you have read the three above texts, consider the following six potential approaches when there is conflict, and how to employ some of the above texts:

Competing

Being assertive and uncooperative, you try to satisfy your own concerns at others' expense. Use this approach sparingly when collaboration is not feasible such as when:

- You know you are right, and time is short
- Unpopular actions need to be taken (budget cuts, terminations, etc.)
- Quick, decisive action is required
- You are under attack
- Consensus cannot be reached

One practice variation of this is the person who brokers knowledge as a control factor, and sees themselves as a critical link-pin since they have all the answers. This is most often seen with senior nurses in an expanding practice setting.
When there is production-based compensation, there are veterinarians who will "cherry pick" the incoming cases. This is best defeated by a client relations team who stack-and-rack clients/patients by access priority and not by provider preference(s).

Collaboration

Try to find a win-win solution that completely satisfies both people's concerns and collaborate on important issues when you want to:

- Retain both concerns because they are vital to the practice
- Learn
- Merge insights from diverse perspectives
- Commit to a decision
- Improve a working relationship

This is most often seen within a specific zone, or between colleagues, when the outcome accountability requires a team effort by the practice leadership. This method initially takes longer as they test the latitude being given.

Compromising

You try to find an acceptable settlement that only partially satisfies both parties' concerns. Try not to compromise on vital issues (e.g., Standards of Care for Risk Level 1 animals), and only compromise on significant issues when competing and collaborating approaches are not practical, such as when:

- People with equal power face a win-lose issue
- You need a temporary solution to a complex issue
- You need an expedient decision under a time pressure
- The relationship needs to be sustained

This is most often seen within a team when a senior player overwhelms the new player with facts, often of unknown origin. It also is seen when the owner plays the "I am the boss" card with a new associate.

Avoiding

The avoiding approach is unassertive and uncooperative because you are sidestepping the conflict without trying to satisfy either person's concerns. This approach should rarely, if ever, be used in a healthcare delivery situation. Generally speaking, practice owners should be approachable, but they should also avoid certain emotional conflicts and issues where little can be gained, such as when issues:

- Are not important
- Are symptoms of other concerns
- Can be or should be handled by others

- Are too sensitive (e.g., politics, religion, etc.)
- Cannot be won (when you know the boss will veto the suggestion)

> An example is the scheduling process, or perceived scheduling glitches, where a staff member does not know why they got a specific shift or have to work with a specific doctor or team member. In these cases, DO NOT address the staff member gripes, just address the equitable decision process.

Accommodating

Unassertive and cooperative, you attempt to satisfy the other person's concerns at the expense of your own. This too should be used sparingly to avoid falling into a pattern of appeasement. Use it to:

- Yield a better position (when you are persuaded, or when others now more and there is little time to act).
- Concede when you are overruled
- Make a small sacrifice when it is important to others (letting people test their wings, boost other's confidence)
- Clean-up others/ hard feelings (repair damage you have caused, forgive others so you can move on)

> This is most often seen when a practice has "trained to trust", and then they have built some common respect, so they feel they can delegate accountability for an outcome to some staff member, and an overzealous starts to tell them "how to do it" instead of relying on the WHY and WHAT of the delegation to guide independent operational decisions . . . some call it "back pedaling", or just "I am sorry for interfering."

Mentoring

This is the process used after the WHY and WHAT has been shared by the leadership, and the timelines have been jointly discussed and established, as well as the measurements to identify successful completion. This is the use of one-on-one suggestions to help someone over the "people hurdles" they encounter.

- I call it "peeling the onion back", when you sit with both players are take the strife and peel it back to the underlying issue(s), and keep peeling back the issues until you get down to a common core value where both can agree.
- An astute leader then places back one layer at a time, in a configuration both can agree to at the current time.
- By the time the onion is rebuilt, 95% of the conflicts have been resolved and people are hugging and smiling.
- Great mentors know "the question is the answer", and have learned to ask leading questions that result in discovery for all parties concerned.

Mentoring is in great demand these days, but training of mentors is like trying to find hen teeth, and the new staff members know the word, but don't know how to measure effectiveness or progress efficacy of the mentoring process. Like leadership, training for team-based healthcare, and how to integrate Risk Level 1 into the well care programs of the practice, mentoring is just "words" in many practices due to lack of knowledge, experience, and/or training.

LEADERSHIP INTROSPECTION

As I observe interactions within a practice, I watch for the above factors during interactions. One very common behavior is the veterinarian handling non-clinical issues as if they were case management (i.e., where they "must" have total accountability and control). Asking a question and allowing zone teams develop the WHO and WHO to the WHAT and WHY provided by the leadership is most often considered "too time consuming". The key here is early in the QBQ process, the staff take longer because they have lived in a doctor-centered culture and are unsure of potential latitude (mind mapping brainstorming often helps overcome this, as shared in the text, *Building the Successful Veterinary Practice, Innovation & Creativity* (Vol 3), Wiley/Blackwell Publishing).

When on-site, I often have to tell someone that BLAMING is only abdicating accountability for finding a resolution. When they point a finger, there are still three fingers pointing back at them; they are accountable for redesigning the process/program so the issue(s) do not recur in the future.

THE 'TEACHING POINT' EXERCISE

Simple enough, one bag of marshmellows, and one box of straight spaghetti, teams of four, with a very simple task: **In the next 19 minutes, build your tallest free-standing tower with the materials provided. GO!**

It is an interesting team exercise for many practices – I often add one doctor per group, and if large enough, the practice manager to a group. Interestingly, I usually find someone who wants the "win" (e.g., the practice owner), or another who abdicates participation (e.g., insecure manager), while the staff members just enjoy the fun. Often, the owner directs a well-planned pyramid structure, which had the ability to expand, while the associate teams often go for a box with many cross links held together by chewed marshmellows. Often a well meaning young associate wants a grand plan, but cannot communicate his/her idea well, leaving the team looking at them instead of the structure to be built – in the end, I have seen a young doctor stick a single strand of spaghetti in their hair and stand up, to be the tallest.

At completion, all I want the staff to do is compare the structures; circulate and observe the efforts of the other teams (picture taking is allowed). Then I ask the

groups how they decided on their course of action; who led and how did input get solicited. To me as the observer, often there is abdication to the doctor evident in most groups, pointing to the traditional doctor-centered practice model, although they had told themselves they were team-centered. Anyone who wants to be declared "the winner" needs to be controlled, since I want to point out that each group selected a different model, and reached an end point within their own comfort zone, to achieve a tower. Discussion often reflects that given more time, changes would have been made by each group. Maybe someone still wants to be declared the winner; so then I reiterate "build **your** tallest free-standing tower", which made every group a winner. Then I asked them if they had fun with this exercise and what did they learn in the process of the tower exercise (these were the two winning factors).

From this point, we often move to mind-mapping (large "post it" easel board paper was used, so it could be wall posted later). ***HINT – mind mapping is brainstorming, and there is never a wrong answer when brainstorming, it kills the process and destroys initiative.*** Each person develops their own mind map of a specific wellcare/husbandry program that has client and patient impact, as well as caseload improvement potentials. For planning, they need about an hour, but I do not tell them the time limit, I just let it flow. Then we break for lunch, and when they come back, all mind maps have been placed on the walls, and the "creator" stands next to their own. I distribute the Idexx Senior brochure, with color coded age chart, and explained that at each color change, diagnostic intensity should increase. At the sound of the "chime", I have them rotate one mind map to the right, and add something, maybe from the age-specific thought process, but anything they wanted. I watch and when they seemed to be done, I ring the chime, and they rotated one more to the right. This happens until all mind maps have been annotated and they are back at their own mind-map.

Dynamics Observation

As the team members rotated, every staff member sees something they could add to every mind map, they had fun thinking about "what could be", and contributing . . . except for the doctors . . . many doctors display a mental block with at least one mind map, some more than others.
Staff shows the concept ownership with the process, doctors often show hesitation and fear, and the insecure practice manager keeps thinking no one could accomplish these projects. Yet the staff usually has no reservations – they know they can do it and they knew the clients and patients would appreciate it!

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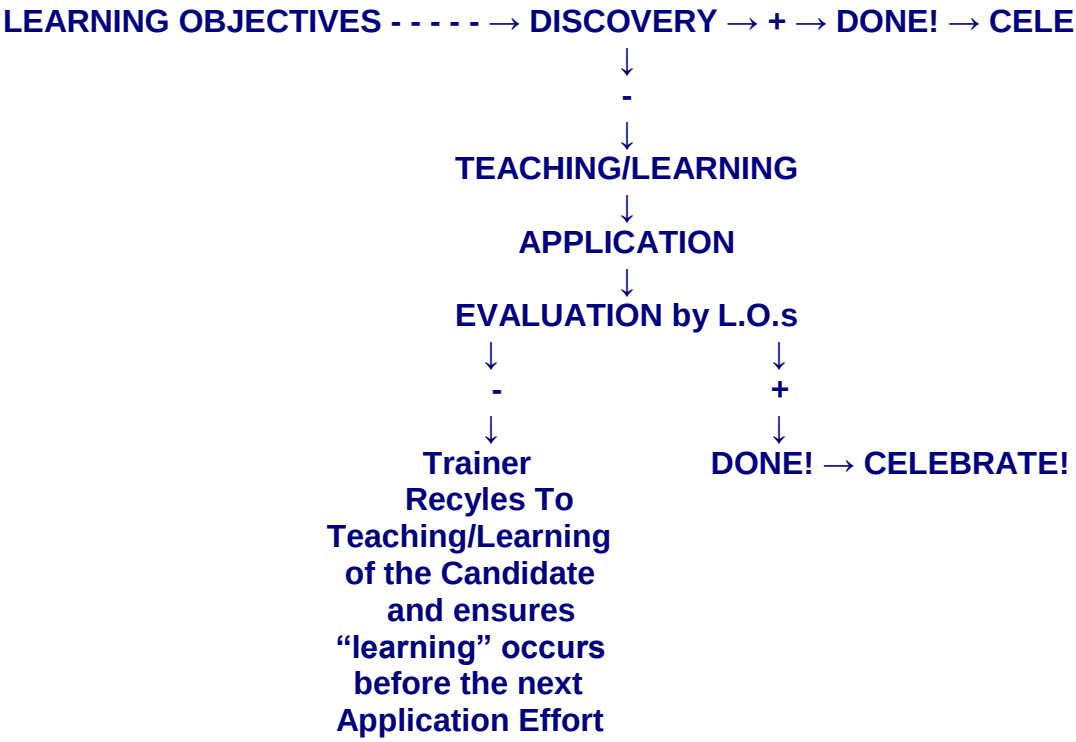
SUMMARY

Workplace conflict is common when leadership has been shared. Many times, it is caused by a person in leadership position making well meaning corrections in public. Like the exercise above, there are teaching points that make “the next time” less stressful. Different opinions can be perceived as conflict, but you must remember, there is very seldom a staff member that wants to kill the practice and/or their own employment. Staff members are adults, so maternal and paternal treatment by the leadership has NO EFFECTIVE PLACE when building a veterinary healthcare delivery team. This often requires a practice culture change, yet to change, the owner must know where they are going (no one likes stepping off into the void). Organizational behavior must be put into perspective (monograph on this subject in the VIN Bookstore (www.VIN.com) and shared leadership must be brought into the equation. These are the type factors that often gets me called in as a consultant. I have found that a full-year consult most often provides the time and acceptable learning pace for a step-by-baby-step process to the new horizon. So do not rush the process!

The EFFECTIVE TEACHING MODEL is shown below:



SKILL KEY:

LEARNING OBJECTIVE(S) = no more than five outcome elements or competencies expected from teaching/learning (see following descriptions)

DISCOVERY = teachable moment causing individual desire to learn

+ = knows it!

\- = does not know it but wants to learn it

TEACHING/LEARNING = maximum 20 minute training effort window, written lesson plan based, usually one-on-one, where participant learning occurs to level of confidence to attempt demonstration (Application)

APPLICATION = hands-on demonstration of skill/knowledge, usually behind the scenes, to minimize embarrassments – competency standard is excellence compatible with practice Standards of Care, Protocols, Duty Zone Standards, and/or personal team-based capabilities.

EVALUATION = based on outcome definitions of the Learning Objective(s)