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Managing Conflict in Institutional Nursing: A Risk or an Opportunity?

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Abstract

It was a matter of communicating bad news and it was the Director of Nursing himself who was trying to inform the nurses in the operating room of a series of extraordinary measures as a consequence of the application of the recently approved decree of cuts in the area of public administration (salary reductions, increase in working hours, suspension and readjustment of extras, incentives, etc.). The discomfort among the assistants grew as the insidious measures were explained, with the precision of a surgeon, which were going to have a decisive impact on the life of each one. Faces of perplexity and indignation when realizing that in the logic of the manager people were just numbers that were easy to square with a rudimentary balance between operators and working hours, even making it seem that some could be redundant. Any attempt at reasoning was immediately cut short by a single argument, monotonous and heavy as a slab, like the bundle of papers that she brandished in her raised fist in a mixture of indignation and hidden joy: "I did not make this decree, whatever you have to say about it, you know who is responsible." The impertinent argument of the figures frustrated any attempt at dialogue (Julian Marias said that reason is always narrative). Everything ended with an angry refusal to give further explanations. Among the nurses there were no

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more reactions than the conversations during shift changes and the refusal to collaborate with the supervisors in some activities that involved voluntary work.

Keywords:

Conflict ,Institutional Nursing, Risk , Opportunity?

Introduction

This is the scene of a conflict between professionals and their command structure, so common in healthcare organisations that it could surely be easily recognised, regardless of where each person places their work. The question is whether clinical nurses, in addition to suffering from it, are aware of the origin of the problem, whether they have the capacity to analyse it and discern a reasonable explanation. And the answer is yes, although they rarely verbalise it in public forums. To my question, this is the answer given by a clinical nurse: "In our health system there are two management models that coexist, which generate internal conflicts (with oneself) and external conflicts (with other professionals) when it comes to understanding the work, especially among nurses. This is probably because we play by the rules and requirements of one model and the convictions of another, which is causing the quality of the work to decline. Working towards objectives, as proposed by the clinical management model, can be a source of security for patients, motivation for professionals and effectiveness for the health organisation, but it is a double-edged sword when one does not believe in them, when one works towards imposed objectives and, above all, when the objectives, far from becoming a source of motivation, become a dance of numbers. To work towards objectives

one must believe in the objectives and trust in them. And to be able to believe in the objectives, one needs managers who know how to negotiate them, present them and transmit them in a coherent manner" (María Gálvez González, in an email dated 1999). 16.08.2012).

In an era in which organizational engineering advocates new formulas in people management, in which shared decision-making and the responsible participation of qualified professionals are becoming increasingly important, is it possible for nursing managers to survive stuck in outdated administrative models? How do they manage to perpetuate themselves in positions that are designed for healthy alternation? How do nursing managers who act as foremen of their company manage to fit into management styles that represent contrary values? Is it coherent that managers who were appointed based on the organizational model of other times, go through the different reforms without adapting their management style? How do emerging, highly qualified professionals, who have accessed higher education cycles and even specialized management programs, and who would opt for a performance more consistent with the times in which we live, manage to be marginalized in the sphere of decision-making? Why do knowledge and culture have such a bad press in some management styles?

Although timidly, scientific literature is providing some clues to answer these and other questions. This issue of Index de Enfermería includes two works on conflict management in the context of institutional nursing. [1,2] The topic is not new to the journal, which in recent years has been promoting alternative views on nursing management, an area that is as innovative as it is necessary. I will try to

systematize some of the latest published works with the aim of awakening interest in this suggestive line of research.

And it seems necessary to begin by mentioning the economic crisis, which affects Western countries above all. In the face of the frightening figures that economic engineering provides on a daily basis, some legitimately democratic governments are being supplanted by technocratic rulers, supported by the supposed redemptive capacities of super-managers, who hoard unusual powers and an uncommon capacity for control. These concessions to democracy would not be made without the conviction that organizations are complex entities that are highly conditioned by the model of government they adopt. Mintzberg, who has a critical position towards formulas based on the "manager who can do everything", has identified up to five possibilities of administrative management (control as a machine, performance control, government as a network, virtual government and normative control), recognizing that none of these models is better than the others and that we currently operate with all of them. [3] In fact, it is common for theoretically antagonistic management models to be juxtaposed in health institutions, which are often a source of conflict. The Spanish case may be emblematic: although the health system has been opting for a new management model of a participatory and decentralized nature for more than a decade through Clinical Management Units, which provides autonomy and responsibility to clinical professionals, [4] what predominates in health institutions is a compartmentalized and hierarchical style, with vertical power relations and excessive dependence of the members of the organization on the managers, almost always imposed by the organization itself.

And what about nurses? It has been highlighted that the health system, its resources and their distribution, the nature of health institutions and the type of management of organizations have a direct influence on nursing practice, which will impact on the patient and his/her family as the object of care. [5] In an analysis of Brazilian production, it was found that the hospital is the focus of attention of studies related to conflict management by nurses, which would refer to issues such as institutional physical conditions, work organization, logistics and the definition of action guidelines. [6] In their proposal for the edifying use of conflict in nursing work, Machado et al. identify as sources of inequality that lead professionals to express their differences, the presence of disparities in technical execution, in social position and valuation, and in autonomy in decisions. [2]

In the first aspect, the technical execution of care, is included the work of Beltrán Salazar on the meaning for patients of the rejection of nursing care, in which he shows how the absence of nurses at the bedside of patients (i.e., neglect) and the lack of interaction in care leads to mistrust and rejection. [7]

Regarding the position of nurses in the organization and their social value, the Foucauldian perspective proposed by Irigibel Uriz is enlightening, where she reflects on nursing docility, its power over individuals and communities and the weight it holds in hegemonic health systems. A disciplined nursing, which shows its usefulness as an instrument of government at the service of the State ideology, focused on the construction of heteronomous subjectivity in the health of individuals and communities, distancing the discipline from its fundamental ethical principles and its ideal goal. [8]

And the media are collaborating. Heierle Valero has observed that nurses do not identify themselves in newspapers as individuals, but are perceived as a group within the work team. The image that each nurse receives from the representation of the social collective in the media does not help to understand the skills that nurses possess or the work that nurses do. [9] This discrepancy between identity and image, according to Calvo Calvo, is due in part to the fact that nurses themselves have not been sufficiently concerned, individually and collectively, with effectively communicating their true identity to society. [10] Other authors attribute the lack of social recognition of nursing to the influence of gender in the nursing profession, as nursing care is symbolically associated with intrinsically feminine qualities. [11]

The third issue that is a source of organizational conflict (the autonomy of decisions) has yielded articles such as that of Yáñez Gallardo et al. on the emotional consequences of distrusting nursing heads, identifying anger at the perception of injustice as the main emotion and the one that triggers situations of organizational silence when associated with non-participatory management styles. [1] A silence that, if at an individual level decreases self-esteem and causes feelings of frustration or anger, at a group level can produce greater cohesion by avoiding discussions of any kind. [12]

Finally, we also find proposals that seek to balance nursing performance within the organization, such as the one that advocates informational competence (support for evidence-based practices) for the proven impact it has on the quality of care. [13] Although, without a doubt, one of the most daring is the one that proposes

to live the nursing profession reflexively from the domination of others as a risk and a challenge at the same time. [14] From Bourdieu's theory of practice, Acebedo-Urdiales et al. defend the need to work beyond the descriptions of autonomous and collaborative tasks, to place nursing practices in a culture of commitment with the capacity to promote contexts capable of offering knowledge and recognition of intentional care. [14]

Therefore, the nurses in the operating room of that hospital would do well to reflect on the symbolic capital that constitutes the experience accumulated in their professional field, which qualifies them and grants them authority, and opens up the possibility of cultivating co-responsibility with respect to their superiors, other professions and the people they care for. The "trade" and practical wisdom allow them to follow the rules with authority and autonomy. But this must be tested with courage and its consequences certified.

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