

Conflict on interprofessional primary health care teams – can it be resolved?

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Increasingly, primary health care teams (PHCTs) depend on the contributions of multiple professionals. However, conflict is inevitable on teams. This article examines PHCTs members' experiences with conflict and responses to conflict. This phenomenological study was conducted using in-depth interviews with 121 participants from 16 PHCTs (10 urban and 6 rural) including a wide range of health care professionals. An iterative analysis process was used to examine the verbatim transcripts. The analysis revealed three main themes: sources of team conflict; barriers to conflict resolution; and strategies for conflict resolution. Sources of team conflict included: role boundary issues; scope of practice; and accountability. Barriers to conflict resolution were: lack of time and workload; people in less powerful positions; lack of recognition or motivation to address conflict; and avoiding confrontation for fear of causing emotional discomfort. Team strategies for conflict resolution included interventions by team leaders and the development of conflict management protocols. Individual strategies included: open and direct communication; a willingness to find solutions; showing respect; and humility. Conflict is inherent in teamwork. However, understanding the potential barriers to conflict resolution can assist PHCTs in developing strategies to resolve conflict in a timely fashion.

Keywords: Interprofessional teamwork; primary health care; conflict; conflict resolution; phenomenology

INTRODUCTION

Conflict in interprofessional teams is not a new phenomenon. Over the last 30 years there have been numerous publications describing conflict between professional dyads such as physicians and nurses, social workers

and nurses, family therapists and family doctors, and social workers and physicians (Abramson & Mizrahi, 1996; Hendel, Fish, & Berger, 2007; Kriesel & Rosenthal, 1986; Lowe & Herranen, 1978; Rosenstein & O'Daniel, 2005; Zwarenstein & Reeves, 2002). The majority of these studies have been in tertiary care settings with relatively few conducted in primary health care settings. The demands and expectations on primary health care teams (PHCTs) differ from specialty teams, such as stroke rehabilitation or oncology where care plans can be very disease specific and the role of team members more clearly delineated (Baxter & Brumfitt, 2008; Penson, Kyriakou, Zuckerman, Chabner, & Lynch, 2006). Interprofessional teamwork in health care is a complex enterprise and is perhaps more so in primary health care where the patient care needs are not only complex but diverse, ranging from cradle to grave. Thus, it is important to identify the sources of conflict and means to address conflict on PHCTs.

Increasingly the delivery of primary health care depends on the contributions of various team members representing different disciplines. As well there may be multiple teams working together in order to address the complex needs of the patient population. Therefore, in primary health care 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 (Drinka & Clark, 2000; Grumbach & Bodenheimer, 2004).

Sources of conflict on PHCTs can transpire at the micro, meso, and macro levels. At the micro level conflict can ensue, when for example, there are differing personalities, physical space concerns, or issues regarding scope of practice. A combination of issues at the meso and macro levels, such as patient volume, patient expectations,

financial remuneration, and new clinical practice guidelines can also be a source of conflict on PHCTs. Payne (2000) differentiates two sources of conflict on teams: substantive issues and emotional issues. Substantive issues include scope of practice and differing philosophical perspectives regarding patient care; whereas emotional issues reflect personality differences and power differentials (Payne, 2000). According to Drinka and Clarke (2000), types of patient care can be designated as “tame” (a simple flu) versus a “wicked” problem (a complex set of symptoms with no differentiated care or a patient with complex biopsychosocial issues). While the former may require minimal input by relatively few PHCT members, the latter may necessitate responses and interventions from various members of the PHCT who bring specific skills and knowledge to address the patient’s problem. But multiple interventions can create conflict if the views and opinions of the team members are in opposition regarding priorities and patient care plans.

While a growing body of literature on conflict resolution now exists, particularly between nurses and physicians, there is limited research on sources of conflict and means to address conflict on PHCTs (Bailey, Jones, & Way, 2006; Hendel et al., 2007; Zwarenstein & Reeves, 2002). This article examines sources of team conflict, barriers to conflict resolution, and strategies for conflict resolution at both the team and individual level on PHCTs.

METHODS

This study used the qualitative methodology of phenomenology to examine perceptions and experiences of health care professionals regarding conflict in PHCTs based in Ontario, Canada (Patton, 2002).

Sample selection and recruitment

The goal of the sample selection and recruitment was to secure a maximum variation sample with regard to location (urban versus rural), practice type: (Family Health Groups (FHG’s) and Family Health Networks (FHNs); Community Health Centres (CHC’s); and Family Practice Teaching Units (FPTU’s)), team composition and size (Patton, 2002). See Table I for a description of each type of team.

Potential teams were identified through a number of sources including: a list of FHG/FHNs provided by the Ministry of Health and Long Term Care; a list of all of the CHC’s in the province supplied by the Association of Ontario Health Centres and; the FPTU’s identified through academic Departments of Family Medicine in Ontario. Potential teams were mailed a letter of information detailing the study.

The final sample consisted of 16 PHCTs with 7 FHG/FHNs, 5 CHC’s and 4 FPTU’s. There were 10 urban sites and 6 rural sites. All of the teams had been in existence for more than 5 years with some having been in place for 35 years. The size of the teams ranged from 5 to 35 team members. The average age of the participants was 46 (range 25–65) and they had been a member of their team for an average of 8.8 years (range 2 months to 35 years). Almost a quarter of the participants (24.8%) were family physicians or family practice residents; ~30% were nurses, including diabetes nurses, public health nurses and nurse practitioners; 11% were receptionist/medical secretaries; and other groups such as social workers, pharmacists, office managers and health promoters each reflected on average 6% of the sample.

Data collection

A semi-structured in-depth interview was conducted with each participant at their practice site and lasted 1 h on average. The questions included for example: “How do you address conflict on your team?” “What kinds of processes do you use to resolve conflict on your team?” A definition of conflict was not provided to the participants as we sought to elicit their unique description. A profile of each practice documented the practice context.

Data analysis

Interviews were audiotaped and transcribed verbatim. The data analysis was both iterative and interpretative. In the first phase of the analysis, each transcript was independently reviewed by a minimum of two researchers to identify the key concepts and/or themes emerging from the data. The researchers then met to compare and contrast their independent review, culminating in a consensus that informed the development of the coding template which evolved over the course of the analysis.

Table I. Primary health care models.

	FHG/FHN	CHC	FPTU
Number of practices	7	5	4
Funding model	<ul style="list-style-type: none"> Family physicians had three funding models: fee for service, blended, salary* All other professionals salaried*** 	<ul style="list-style-type: none"> Not-for-profit** All professionals salaried 	<ul style="list-style-type: none"> Family physicians had funding through their respective university affiliation fee for fee service, and blended All other professionals salaried***

*FHGs and FHNs, at the time of the study, were a new funding model with the family physicians in three models of payment.

**CHCs, which are not-for-profit primary health care facilities, were all practitioners (i.e. family physicians, nurse practitioners, social workers, health promoters) are salaried and governed by a community board.

***Other salaried professionals could include, for example, nurses, nurse practitioners, social workers, pharmacists, or dietitians.

All the coded transcripts were input into the NVivo software (2007). The research team then met for further synthesis and interpretation of the themes using the techniques of immersion and crystallization (Borkan, 1999). Given the different types of PHCTs and the varied number of professionals interviewed, theme saturation was achieved by approximately the 75th interview. However, the researchers were committed to ensure all the different practice types and team members had an equal voice in the research process and thus completed the data collection and analysis on all 121 interviews. Credibility and trustworthiness of the data was enhanced through three principal means: interviews were transcribed verbatim, field notes were generated following each interview, and a minimum of two researchers read and analyzed the data independently and then came together for team analysis.

Ethics approval

Ethics approval was received from The University of Western Ontario's Review Board for Health Sciences Research (Review #10949E).

FINDINGS

The analysis revealed three main themes related to conflict experienced by PHCTs: sources of team conflict; barriers to conflict resolution; and strategies for conflict resolution. Sources of team conflict were described as role boundary issues, scope of practice, and accountability. Barriers to conflict resolution included lack of time and workload 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. Both team and individual strategies for conflict resolution were identified. Team strategies included interventions directed by team leaders and the development of conflict management protocols specific to the team. Individual strategies included open and direct communication, a willingness to find solutions, showing respect, and the practice of humility.

Sources of team conflict

There were three main sources of team conflict: role boundary issues, lack of understanding of scope of practice and accountability.

Role boundary issues

A lack of understanding of each other's roles was described as a source of conflict on PHCTs: "*people don't understand each other's role and how important each other's roles are on that interdisciplinary team*" (Social Worker). Role boundary issues were complicated and encompassed: "*who is in charge of what and who shouldn't be doing what*" (Family Physician). However, some participants described how role boundary issues were changing on their teams:

"There used to be a real 'I'm the doctor, I'm the nurse, I'm the pharmacist, I'm the social worker.' I find that those lines are blurring in the sense that people don't get uptight about delineating their role so much now" (Pharmacist).

Scope of practice

Conflict could ensue when there was a lack of understanding of the scope of practice of other professions:

"It is a problem with other people doing the things that I do now.... It's going to be a concern whether they [*nurse practitioner*] can actually do those sorts of things [well baby care] in an efficient manner as the physician and will they have the training to do it as well" (Family Physician).

Therefore, conflict related to scope of practice was amplified when new professions were added to teams, particularly when the professional roles and responsibilities of new members potentially "threatened" established scopes of practice: "*If I get the nurse practitioner to see all the simple stuff, it increases my burden, because I'm stuck with difficult stuff*" (Family Physician).

Those in more established roles were not the only participants to express frustration and concern. New professionals, such as nurse practitioners, described how a lack of sharing and collaboration impeded their integration into existing teams.

"I'm still not getting a lot of sharing [with] the physician ... I mean physicians aren't educated for collaborative practice. They are educated for solo practice and ... that's the way they think and unless structures are set up to inform them differently, then we are not going to have collaborative practice" (Nurse Practitioner).

Accountability

Issues of accountability could also be a source of conflict on PHCTs. For example, family physicians described themselves as being ultimately accountable for patient care. As one family physician stated, "*at the end of the day we as a group of physicians are accountable for anything that happens here.*" This participant went on to note that, "*somebody has to take responsibility. That's part of my role as the physician on the team.*"

Other health care professionals, however, challenged the notion of physicians being solely accountable and viewed every team member as being accountable for their tasks and responsibilities: "*we're accountable for our jobs ... we all have to take responsibility for our actions*" (Medical Secretary). When team members failed to be accountable tension could occur on the team:

"I think there are some that are willing to be accountable and others that are not. But we all have jobs that we're responsible for and we need to be accountable for them" (Nurse).

Barriers to conflict resolution

Participants identified four key barriers to conflict resolution: lack of time and workload 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.

Time and workload

Participants in busy practices with heavy workloads described a lack of time to deal with conflict which was connected to minimal opportunities to resolve conflicts and limited time for communication:

"...everybody seems to be overworked and it is definitely a team barrier because we don't always have time to communicate" (Family Physician).

When relatively simple concerns were not adequately addressed conflict could intensify. For example, a point of contention, such as an increased workload, could lead to frustration and an escalation in team conflict:

"The workloads have gone up and they leave it so long that people get frustrated and I think that causes conflict within the workplace" (Nurse).

People in less powerful positions

Another barrier to conflict resolution was team members who were in less powerful positions. These participants described feeling intimidated, resentful, and often silenced. These feelings became a barrier to communication and impeded conflict resolution, as one participant noted, "*on the surface it looks like respectful listening, but there's very little follow through or action taken*" (Nurse Practitioner). Issues of power, leadership and authority not only fueled conflict, but hindered resolution. When this occurred, those in leadership positions were experienced as failing to hear and respond to the conflict:

"Sometimes I think the team members feel like they're not being heard. They may complain about a situation and nothing happens. And then they become very frustrated and either they swallow it or just ignore it. It's not a very good solution" (Nurse).

Those in authority could then become the focus of resentment, leading to an increase in feelings of intimidation and lack of control:

"There's kind of a hierarchy with the ones that have the power have ultimately the responsibility. So if you disagree with a physician and that physician feels that he or she is right, it's going to be a problem to try and change that doctor" (Family Physician).

Lack of recognition or motivation to address conflict

Another barrier to conflict resolution included either the failure to recognize the existence of conflict or a lack of

motivation to address the conflict. Participants identified situations where a team member was unwilling to address a conflict or simply: "*the other person doesn't think there's a problem*" (Nurse). Another participant explained:

"The barrier would be when you have somebody who's not willing to listen ... It's very obvious and it's uncomfortable, awkward and unfortunate" (Administrative Assistant).

Lack of motivation to resolve conflict could take a number of forms. Some team members ignored conflict: "*if there's a conflict and two people stop talking to each other and everyone just ignores it*" (Office Manager). Participants described how "cliques" of team members could form when conflict was not addressed:

"We had gotten into patterns over the years of not confronting, tucking stuff down in, and then nattering in little groups of unhappy people" (Nurse).

Differing personalities within the team was also attributed to the lack of motivation to address conflict. Some team members were conflict avoidant: "*some people hate conflict. Or they hate confrontation*" (Receptionist). Other team members with "*strong personalities [would] stand in the way*" (Nurse). Defensiveness and anger were also response patterns to conflict mentioned by participants:

"If you approach one issue and have gotten a really defensive response, you're less apt to want to approach it the second time" (Nurse).

Avoiding confrontation for the fear of causing other emotional distress

Another major barrier to conflict resolution was not wanting to cause other team members' emotional distress either by offending them or hurting their feelings, as one participant noted:

"If there is any barrier, it would be that you don't want to hurt someone's feelings so you let things ride maybe just because it's easier to do that" (Medical Secretary).

This could also lead to avoidant behaviour:

"...it's like the white elephant in the room, nobody wants to be too vocal about it because nobody wants to hurt anybody's feelings" (Social Worker).

Participants' viewed this barrier as a consequence of working in close proximity and seeing fellow team members for many hours every day:

"We work in a really close environment here and if you're having differences with one particular person, it makes it very difficult for everybody else because the tension is there" (Receptionist).

Participants also identified how friendship or experiencing the team as family could be a barrier in addressing conflict:

"We are like a family so it is tough sometimes to deal with things on a more strictly professional basis. It's kind of a double edged sword. You want to encourage good morale, but it sometimes acts as a barrier when you have to basically enforce professional rules" (Nurse).

Strategies for conflict resolution

Both team and individual strategies for conflict resolution were identified. Team strategies for conflict resolution focused on the development of conflict resolution protocols and a reliance on the leadership of the organization to negotiate and resolve the conflict. Participants described how their teams had developed and implemented specific conflict resolution policies and procedures. This was most evident in the CHC's:

"There is a process in place that if we do have a particular conflict that we have a policy in place ... there's sort of a hierarchy of where you need to go for what particular reason" (Health Promoter).

Overwhelmingly, participants explained how conflict resolution strategies were primarily enacted by the team leads. In FHGs/FHNs and FPTUs, this leadership role was often fulfilled by the family physician(s):

"I think all the doctors here are very good facilitators, very good listeners and would probably be easy to approach and would give suggestions or may approach that person to try and resolve something" (Nurse).

However, the task of conflict management on FHGs/FHNs and FPTUs was sometimes transferred to designated staff, such as an office manager, who was empowered to address and resolve the conflict. On CHC teams, the executive director or their designate, such as a team manager provided a leadership role in conflict resolution:

"If we need to bring in our manager then we do and she's very open. She's also trained in mediation which is very helpful. She seems to be able to facilitate any disagreements and get us to be able to air what we need to air" (Nurse).

Regardless of who assumed the role in leading the conflict resolution process, participants identified the following attributes and actions as being present in a good leader:

"They've to have an open door policy, they've got to be accessible, they've got to be non-judgmental, they've got to be able to listen ... and there's got to be a certain humbleness about how leaders actually are involved" (Family Physician).

Participants described individual strategies for conflict resolution which included open and direct communica-

tion, a willingness to find solutions, showing respect, and the practice of humility. The pivotal role of communication was apparent, as one participant noted, "*you have to be open, honest and sincere with the person you are in conflict with*" (Health Promoter). Open communication also enhanced problem-solving skills. In addition, this type of communication required individuals to assume responsibility for contributing to conflict and a willingness to find a solution. As one participant stated, "*I am not shy about going and apologizing and saying 'Yes, I am sorry, look I made a mistake here'*" (Medical Secretary). A respectful stance was also key in conflict resolution: "*respect for all the parties involved and trying to ensure open communication*" (Family Physician). In addition, humility facilitated conflict resolution and was linked to listening to all the parties involved:

"Humility is a big thing. Just being willing to say that I don't know everything. And along with that goes a willingness to listen to both sides of the story" (Family Physician).

DISCUSSION

All the participants described experiencing conflict on their teams at some point in time. Sources of conflict on these PHCTs included role boundary issues, scope of practice, and accountability. Participants identified four key barriers to conflict resolution on their PHCTs: lack of time and workload 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. Finally, participants described both team and individual strategies for conflict resolution.

Role boundary issues, scope of practice and accountability, identified as sources of team conflict by the participants, have been identified previously in the literature (Bailey et al., 2006). What is perhaps disturbing about our findings is the persistence of these sources of conflict. Even though there is extensive documentation of these conflictual issues in the literature, accompanied by means and mechanisms to address them, they continue to disable team functioning. Ongoing research, education, and team development are required to eliminate these sources of conflict.

Not surprising is how participants described a barrier to conflict resolution as emanating from the context in which they conduct their daily work, such as lack of time and workload issues. While similar findings have been reported previously, for example in the hospital environment and in the cancer care setting (Grunfeld et al., 2000; Laschinger, Shamian, & Thomson, 2001), those reported in this study are unique to PHCTs. While the issues of lack of time and workload cannot be eliminated, they can be addressed through creative strategies collectively designed by the team and endorsed by the overall organization.

Participants identified how individuals in less powerful positions could be a barrier to conflict resolution. Prior work has focused primarily on the hierarchical relationship

between doctors and nurses and the inherent conflict in this dyad. With the advent of professionalism in nursing there has been a shift, with nursing acquiring an increase in status in the health care system (Bailey et al., 2006; Zwarenstein & Reeves, 2002). While nurses may have achieved more equality in the team environment, other team members with less status remain vulnerable as evidenced in this study. Mickan and Rodger's (2000), literature review on characteristics of effective team work suggests that conflict resolution is impeded when the concerns and views of team members are devalued or dismissed. The current study findings document this premise.

Participants expressed both frustration and concern about team functioning when individuals on the team either failed to recognize a conflictual situation or were not motivated to address the conflict. This was distinct from participants' active avoidance of confrontation in order to protect other team members from emotional discomfort. In this instance, the participants viewed conflict avoidance as intentional, and while it may have been at the expense of team effectiveness, it appears to have been utilized to spare a breach in team cohesion (Long, 1996). Richardson (1995) has described avoidance as an active means of conflict resolution; while the conflict is not openly confronted other strategies are employed to circumvent the situation. However, conflict avoidance can lead to alliances and behaviors which are ultimately detrimental to overall team building and sustainment (Hocking, 2006; Richardson, 1995). Payne (2000) has noted how team members avoid examining conflict because the interpersonal nature of the conflict is experienced as emotionally laden. Hence, avoidance may serve as a form of self-protection (Freeth, 2001). In contrast, conflicts which are more instrumental or procedural maybe less threatening and more amenable to resolution (Payne, 2000). Successful strategies for conflict resolution in these less affectively charged areas could potentially be transferred to those conflicts of a more interpersonal nature with greater emotional overlay.

An important team strategy described by participants in addressing for conflict was the development and active use of conflict resolution protocols. The key role of leadership in the creation and enactment of conflict resolution activities was highlighted by the participants. Positions of leadership, as reported by the participants, were frequently filled by family physicians on the PHCT. In some instances this role was designated to other personnel, most often a business manager. Unique to CHC's was the prominent role of the executive director in directing conflict resolution. Because the executive director's role is administrative with no clinical responsibilities this may provide them with more dedicated time to develop conflict resolution protocols in comparison to the family physician leaders who have substantial clinical responsibilities. Porter-O'Grady (2004) suggests that leaders must understand the essential elements of conflict in order to apply conflict resolution strategies. In addition, the participants identified specific characteristics of leaders as facilitating conflict resolution such as being accessible, non-judgmental, and employing good-listening skills. While these may be

generic to overall good-leadership style, participants viewed them as essential to addressing conflict on their teams.

At an individual level, participants highlighted open and direct communication, a willingness to find solutions, showing respect, and the practice of humility. While the first three have been reported previously in the literature, the strategy of practicing humility appears unique to this study (Craigie & Hobbs, 2004; Freeth, 2001; Lemieux-Charles & McGuire, 2006; Mickan & Rodger, 2000). Perhaps, humility is the foundation on which good communication transpires and respect is enacted. Collectively these strategies support individuals, and teams as a whole, as they engage in seeking solutions to conflictual situations. Working together PHCTs can generate creative and innovative problem-solving skills to minimize the destructive influence of conflict on their teams.

In relation to study limitations, data were collected in 2004–2005 and since that time primary health care reform in the province of Ontario has generated new models of primary health care delivery that are not reflected in this study. These new models explicitly endorse interprofessional teams and offer an opportunity for future research on team functioning, including conflict resolution. In addition, sources of conflict at the macro level, such as patient volume and financial remuneration, may be specific to the study context and not transferable to other jurisdictions. Finally, this study did not examine the specific developmental stage of the teams in relation to conflict and conflict resolution. This topic warrants future study.

In summary, conflict is inherent in team work. However, armed with an understanding of the potential barriers to conflict resolution PHCTs can be assisted in developing strategies to resolve conflict in a timely fashion and therefore improve both team functioning and patient care.

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Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

REFERENCES

- Abramson, J. S., & Mizrahi, T. (1996). When social workers and physicians collaborate: Positive and negative interdisciplinary experiences. *Social Work, 41*(3), 270–281.
- Bailey, P., Jones, L., & Way, D. (2006). Family physician/nurse practitioner: Stories of collaboration. *Journal of Advanced Nursing, 53*(4), 381–391.

- Baxter, S. K., & Brumfitt, S. M. (2008). Professional differences in interprofessional working. *Journal of Interprofessional Care*, 22(3), 239–251.
- Borkan, J. (1999). Immersion and crystallization. In B. Crabtree & W. Miller (Eds.), *Doing qualitative research* (2nd ed, pp. 179–194). London, UK: Sage Publications.
- Craigie, F. C. Jr., & Hobbs, R. F. III. (2004). Exploring the organizational culture of exemplary community health centre practices. *Family Medicine*, 36(10), 733–738.
- Drinka, T. J. K., & Clark, P. G. (2000). Developing and maintaining interdisciplinary health care teams. In *Health care teamwork: Interdisciplinary practice and teachings* (pp. 11–49). Westport, CT: Auburn House.
- Freeth, D. (2001). Sustaining interprofessional collaboration. *Journal of Interprofessional Care*, 15(1), 37–46.
- Grumbach, K., & Bodenheimer, T. (2004). Can health care teams improve primary care practice? *JAMA*, 291(10), 1246–1251.
- Grunfeld, E., Whelan, T. J., Zitzelsberger, L., Willan, A. R., Montesanto, B., & Evans, W. K. (2000). Cancer care workers in Ontario: Prevalence of burnout, job stress and job satisfaction. *Canadian Medical Association Journal*, 163(7), 166–169.
- Hendel, T., Fish, M., & Berger, O. (2007). Nurse/physician conflict management mode choices: Implications for improved collaborative practice. *Nursing Administration Quarterly*, 31(3), 244–253.
- Hocking, B. A. (2006). Using reflection to resolve conflict. *AORN Journal*, 84(2), 249–259.
- Kriesel, H. T., & Rosenthal, D. M. (1986). The family therapist and the family physician: A cooperative model. *Family Medicine*, 18(4), 197–200.
- Laschinger, H. K. S., Shamian, J., & Thomson, D. (2001). Impact of magnet hospital characteristics on nurses' perceptions of trust, burnout, quality of care, and work satisfaction. *Nursing Economics*, 19(Part 5), 209–220.
- Lemieux-Charles, L., & McGuire, W. L. (2006). What do we know about health care team effectiveness? A review of the literature. *Medical Care Research and Review*, 63(3), 263–300.
- Long, S. (1996). Primary health care team workshop: Team members' perspectives. *Journal of Advanced Nursing*, 23, 935–941.
- Lowe, J. I., & Herranen, M. (1978). Conflict in teamwork: Understanding roles and relationships. *Social Work in Health Care*, 3(3), 323–330.
- Mickan, S., & Rodger, S. (2000). Characteristics of effective teams: A literature review. *Australian Health Review*, 23(3), 201–208.
- Patton, M. (2002). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage.
- Payne, M. (2000). *Teamwork in multiprofessional care*. Chicago, IL: Lyceum Books Inc.
- Penson, R. T., Kyriakou, H., Zuckerman, D., Chabner, A., & Lynch, Jr. T. J. (2006). Teams: Communication in multidisciplinary care. *The Oncologist*, 11, 520–526.
- Porter-O'Grady, T. (2004). Embracing conflict: Building a healthy community. *Health Care Management Review*, 29, 181–187.
- QSR International. (2007). *NVivo [computer software]*. Cambridge, MA: QSR International Pty. Ltd.
- Richardson, J. (1995). Avoidance as an active mode of conflict resolution. *Team Performance Management – An International Journal*, 1(4), 19–25.
- Rosenstein, A. H., & O'Daniel, M. (2005). Disruptive behavior & clinical outcomes: Perceptions of nurses & physicians. *Nursing Management*, 36(1), 18–29.
- Zwarenstein, M., & Reeves, S. (2002). Working together but apart: Barriers and routes to nurse – Physician collaboration. *Joint Commission Journal on Qualitative Improvement*, 28(5), 242–247.

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