Leadership style and choice of strategy in conflict management among Israeli nurse managers in general hospitals

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Introduction
Conflict is inherent to all social life. It occurs when an individual or a group feels negatively affected by another individual or group (Wall & Callister 1995). Marquis and Huston (1996) define conflict as ‘the internal discord that results from differences in ideas, values or feelings between two or more people’ (p. 333). Fisher (2000) defines destructive conflict ‘as a social situation in which there are perceived incompatibilities in goals or values between two (or more) parties, attempts by the parties to control one another, and antagonistic feelings towards each other’ (p. 168). Whenever important differences exist between groups,
there is a potential for destructive intergroup conflict. Conflict resolution is prescribed ‘not simply as a mechanism for dealing with difficult differences within an existing social system, but also as an approach that can facilitate constructive social change towards a responsive and equitable system’ (Fisher 2000, p. 176).

Organizational conflict may occur between two individuals, within small groups and work teams, or between groups (De Dreu & Van de Vliert 1997). Conflicts in organizations appear to be associated with organizational characteristics, such as goals, values, norms or related to structural aspects such as decentralization, heterogeneity or ambiguity of tasks (Van de Vliert 1998). Conflicts in groups and organizations may also be related to power differentials, to competition over scarce resources, to tendencies to differentiate rather than converge, to negative interdependence between work units, to ambiguity over responsibility or jurisdiction, or to a denial of one’s self-image or characteristic identifications. Conflict in groups and organizations is often avoided and suppressed because we fear its negative consequences, and seek to preserve consistency, stability and harmony within the organization (De Dreu & Van de Vliert 1997, Nadler & Tushman 1999).

Conflict management has grown into a major subfield of organizational behaviour. Conflict in groups and organizations is studied in many disciplines, including nursing, and researches argue that conflict has a beneficial effect on group identity, development and function (Jones 1993, De Dreu 1997). Leadership style and choice of conflict management strategies may strongly influence outcomes of a conflict and the present study aimed at identifying these nurse manager’s characteristics and their relationship. The ability to creatively manage internal conflict in the organization is becoming a standard requirement. Today, successful organizations need to develop the processes, cultures and behaviours capable of accommodating and resolving conflicts in ways that benefit the consumers and employees (Nadler & Tushman 1999).

**Literature review**

**Leadership and conflict management in organizations**

The effective management of an organization demands the integration of providers who may vary enormously in scale and influence, who may possess contrasting cultures, and who may be dominated by professionals coming from different disciplines based upon conflicting paradigms (Bryant 2003). There is a constant interplay between culture and leadership. The presence of personal and emotional tensions – conflicts – in the organization is one dimension of organizational culture. How leaders react to problems, resolve crises, reward and punish followers is all relevant to an organization’s culture. Leaders who are concerned about organizational renewal will seek to foster organizational cultures that are hospitable and conducive to creativity, problem solving, risk taking and experimentation. Their perspectives on power tend to influence their strategies in conflict and enhance people to work together effectively. It seems logical that the employee/relations orientation of the leader has a positive correlation with trust and a negative correlation with conflicts (Bass & Avolio 1994, Ekvall 1996).

The role of group leadership in intergroup conflict is an important element. The leader influences and directs individuals and groups, and requires many qualities and skills in order to effectively handle conflicts. A facilitative leader has the capacity to help the antagonistic groups work together towards their shared goals. He/she also provides encouragement and support, releases tensions, harmonizes misunderstanding and deals with disruptive or aggressive behaviour (O’Hearn Woodliti 1987, Fisher 2000). Findings of a research by Sullivan et al. (2003) revealed that experienced and new head nurses, in describing their developmental needs, focused on conflict resolution management with multiple personalities, disciplines and cultures. In a multiphased project by Russell and Scoble (2003) nurse managers identified their future educational needs. Respondents identified knowledge and skill deficits concerning human resources management including conflict resolution.

Nurse managers deal with internal and external conflicts daily (McElhaney 1996). Swansburg (1993) lists six areas that cause conflict within nursing: defiant behaviour; stress; space; doctor authority; beliefs, values and goals; and others. Stressors include: too little responsibility, lack of participation in decision making, lack of managerial support, increasing standards of performance and coping with rapid technological change. Multiculturalism, as expressed through behaviours and attitudes, may also influence communications and affect interactions and performance in today’s work environment (Martin et al. 1994). The changing and turbulent environment in which nurse managers now operate demand from them skills and abilities to manage conflict situations towards constructive outcomes.
Strategies in conflict management

‘Conflict is... a massive growth industry. It is an integral part of the fabric of a postmodern society that is increasingly litigious, competitive, complex and alienating’ (Bryant 2003, p. 75). Too little conflict results in organizational stasis, while too much conflict reduces the organization’s effectiveness and eventually immobilizes its employees (Marquis & Huston 1996).

Conflict management refers to the modes used by either or both parties to cope with a conflict. Adler and Towne (1990) identified three possible courses of actions when faced with a conflict: (1) accepting the status quo (i.e. living with the problem); (2) using force and mandating change; (3) reaching an agreement by negotiating. Three types of outcomes result from these approaches to conflict management: Win–Lose approach, Lose–Lose approach and Win–Win approach.

Conflict management research focus is centred primarily on the conflict situation and the person–situation interaction (Knapp et al. 1988). However, there is a reason to believe that conflict behaviour is determined by both situational and dispositional influences (Sandy et al. 2000). A number of similar approaches to measuring individual modes of managing interpersonal conflict have been developed (Blake & Mouton 1964, Rahim 1983). The theoretical framework of this study rests on the work of Thomas and Kilmann (1974). Their two-dimensional framework and five predominant modes are used to define conflict management modes. Thomas and Kilmann (1978) reported reasonable support for the instrument’s substantive validity. Internal consistency coefficients are in moderate range with average \( \alpha \)-coefficient 0.60 and test–retest reliability ranging from 0.61 to 0.68 (Thomas & Kilmann 1978). The findings suggest that the instrument is able to differentiate between conflict management styles. Thomas (1976) suggested the dimensions of Assertiveness and Cooperativeness in classifying his five modes: Avoiding, Accommodating, Competing, Collaborating and Compromising (Figure 1). The instrument was used in earlier nursing studies on conflict management by O’Hearn Woodlti (1987), Barton (1991) and Cavanagh (1991).

Conflict resolution represents the one-best-way long-term approach, which emphasizes that contextual variables are changeable and that the ideal organization should be brought nearer by all manner of means. Successful conflict resolution not only removes frustration but also leads to higher effectiveness, trust and openness (Van de Vliert 1998).

Contemporary leadership styles

Within the increasingly competitive and hectic environment the nurse manager’s leadership style is more critical than ever (Dunham-Taylor 2000).

Bass (1985) applied the concepts of transactional and transformational leadership to business organizations. He identified a range of nine components representing transformational, transactional and laissez-faire leadership. The five transformational leadership components are: (1) charisma – the leader admired; (2) idealized influence – followers emulate their leader; (3) inspirational motivation – ‘provides meaning and challenge’ to the work; (4) intellectual stimulation – ‘questions assumptions’ and (5) individual consideration – individually mentor staff based on their needs. Empowerment is as important component of transformational leadership and is a primary role of leadership in a changing health systems environment (Trofino 1995). Transactional leadership has three components: (1) contingent reward – rewards staff for desired work; (2) active management by exception - monitors work performance and corrects it as needed; or (3) passive management by exception – waits until problems occur and then deals with the issue. An additional component is the non-leadership component – laissez-faire. These components of transformational and transactional leadership should predict organizational outcomes, followers’ satisfaction and leader performance. Bass (1985) observed that a leader will exhibit both styles, generally with one being more predominant. In an attempt to identify the behaviours underling these leadership styles, he developed the Multi-factor Leadership Questionnaire (MLQ). Bass and Avolio (1993) have tested their model over years. The model incorporates
essential constructs from theories of leadership, which have dominated leadership research for more than 40 years. The model has been generalized across a wide variety of organizations, cultures, levels of management within organizations, including health organizations (Bass & Avolio 1993). Several versions of the MLQ have been used. Regardless of the particular form involved, subsets of the MLQ facets have been differentially related to leader performance, organizational outcomes and followers’ satisfaction, performance appraisal, effectiveness and success in management group stimulation.

The current notion of effective leadership is commonly portrayed as a transformational or empowering paradigm (Evans 1994). Researchers have found transformational leaders to be more effective and satisfying than transactional leaders (Bycio et al. 1995, Bass 1997, 1999, Dunham-Taylor 2000). Several studies have shown that woman leaders tend to be somewhat more transformational than their male counterparts (Bass 1999). Several moderators have been identified that can significantly effect the impact of transactional and transformational leadership in predicting individual/group effort and unit performance. Among them are organizational culture, goal clarity, conflicts and resources’ availability in the unit.

Both literature and research studies related to the nature of conflict nursing management, in the last decades, is limited (Keenan et al. 1998). No research was found on leadership style and its relationship to conflict-handling modes used by head nurses.

The aim of this study was to examine the choice of strategy in conflict management among nurse managers (head nurses) in general hospitals, in central Israel, in relation to their leadership style. The following specific questions were addressed in the study:

- What is the prominent leadership style demonstrated by head nurses as perceived by them?
- What are the most frequent modes used by head nurses in conflict management?
- Does a correlation exist between leadership style and choice of strategy in conflict management?
- Does a correlation exist between demographic and/or professional background and choice of strategy in conflict management?

**Methodology**

A cross-sectional design was used in this study to associate between leadership style and choice of strategy in conflict management.

**Sample**

The sample consisted of 60 head nurses from five general teaching hospitals, in the centre of Israel. The hospitals’ size ranged from 550 to 1000 beds. In each hospital, head nurses from 10 medical/surgical wards and two intensive care units were asked to participate in the survey. A total of 54 usable responses were obtained, with return rate of 90%. A convenience sample was used; however, the study achieved variability by the diversity of five medical centres owned by three different organizations and thus maybe a more representative sample.

**Instrument**

A 3-part questionnaire was used for data collection, on the basis of the literature survey.

- The Thomas and Kilmann (1974) Conflict Mode Instrument (MODE) was adopted to measure the five conflict management modes: Avoiding, Accommodating, Competing, Collaborating and Compromising. The MODE instrument consists of 30 pairs of forced choice statements requiring respondents to identify the one they consider most characteristic of their behaviour in times of conflict. Within the MODE there are five subscales representing each of the conflict management modes. The maximum score possible of any scale is 12 (for very high use). The instrument has been reported to have satisfactory test–retest and internal consistency reliabilities.
- Leadership style was measured by the MLQ, Form 5X-Short (MLQ 5X) (Bass & Avolio 1995). This version is widely used. The questionnaire is consisted of 36-items. The items describe managerial leadership behaviours. Respondents were asked to rank their perceived frequency of using each of the described behaviours on a 5-point Likert scale (1 = never; 5 = always).
- Socio-demographic data concerning age, education, professional experience, tenure in position, clinical field, ward size and country of origin.

**Ethical approval**

Participation in the study was voluntary and anonymity was assured. Participants were informed that all data would be treated as confidential and only the researchers would have access to the data collected. Consent was given to participate with the return of the questionnaire.
**Procedure**

After receiving permission to conduct the study from the directors of nursing, a colleague from each of the five hospitals assisted with distributing the questionnaires in her working place, with a letter ensuring confidentiality. Questionnaires were collected within 2–3 weeks.

**Data analysis**

Descriptive analysis included summary measures such as mean, mode, quartiles, percentages and standard deviations. A conflict-handling profile for each respondent was determined as well as frequency count for each mode. A leadership style profile of each respondent was determined as frequency count for each style. All comparisons between the different leadership styles and between the conflict management modes were performed using Wilcoxon signed rank tests for repeated measures. This non-parametric test was used since the distribution of the variables was not normal. With multivariate analysis of variance (MANOVA) we evaluated the relationship between leadership styles (independent variables) and the five conflict management strategies (dependent variables) as the five strategies were related. The MANOVA procedure provides regression analysis for multiple-dependent variables and evaluates the effects of different independent variables on the dependent ones. The effect of demographic variables (such as education, tenure in position and clinical field) on the five conflict strategies was also evaluated by MANOVA. All statistical analyses were performed by SPSS.

**Findings**

**Sample profile**

The demographic characteristics of the respondents are shown in Table 1. Almost all (92.3%) were women; Israeli born (66.7%); most (83%) were above the age of 40 years, and approximately half (48.1%) had professional experience of over 21 years. Most (68.5%) of the head nurses were educated to at least degree level. In this group, almost half (51.4%) held a bachelor’s degree and 48.6% held a master’s degree or were still studying for an MA. One-third (33.3%) of the head nurses had <5 years of tenure in the current position.

**Leadership style**

Respondents’ scores (mean, SD) are presented in Table 2.

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**Table 1**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29–40</td>
<td>12</td>
<td>17.3</td>
</tr>
<tr>
<td>41–50</td>
<td>25</td>
<td>51.9</td>
</tr>
<tr>
<td>54+</td>
<td>17</td>
<td>30.8</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>7.7</td>
</tr>
<tr>
<td>Female</td>
<td>50</td>
<td>92.3</td>
</tr>
<tr>
<td>Nursing education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>17</td>
<td>31.5</td>
</tr>
<tr>
<td>Academic – BA</td>
<td>19</td>
<td>35.2</td>
</tr>
<tr>
<td>Academic – MA</td>
<td>18</td>
<td>33.3</td>
</tr>
<tr>
<td>Work experience (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;12</td>
<td>13</td>
<td>24.1</td>
</tr>
<tr>
<td>13–20</td>
<td>15</td>
<td>27.8</td>
</tr>
<tr>
<td>21+</td>
<td>26</td>
<td>48.1</td>
</tr>
<tr>
<td>Tenure in position (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;5</td>
<td>18</td>
<td>33.3</td>
</tr>
<tr>
<td>6–15</td>
<td>28</td>
<td>51.9</td>
</tr>
<tr>
<td>16+</td>
<td>8</td>
<td>14.8</td>
</tr>
<tr>
<td>Ward size (beds)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 15</td>
<td>7</td>
<td>13.0</td>
</tr>
<tr>
<td>15+</td>
<td>47</td>
<td>87.0</td>
</tr>
<tr>
<td>Clinical field</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>27</td>
<td>50.0</td>
</tr>
<tr>
<td>Surgical</td>
<td>17</td>
<td>31.5</td>
</tr>
<tr>
<td>Intensive care</td>
<td>8</td>
<td>14.8</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3.7</td>
</tr>
<tr>
<td>Country of origin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Israel</td>
<td>36</td>
<td>66.7</td>
</tr>
<tr>
<td>Asia</td>
<td>5</td>
<td>9.3</td>
</tr>
<tr>
<td>Africa</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>Europe</td>
<td>9</td>
<td>16.7</td>
</tr>
<tr>
<td>The former USSR</td>
<td>3</td>
<td>5.6</td>
</tr>
</tbody>
</table>

- At each of the respondents the two leadership styles – transformational and transactional – were reflected. However, results show that all head nurses perceived themselves significantly more as transformational leaders then as transactional leaders ($P < 0.0001$, Wilcoxon signed rank test, Table 2).
- The transformational leadership style components were compared, and were significantly different to the mean scores ($P < 0.001$). The ‘Individual Consideration’ was found as the dominant transformational component and achieved the highest score (mean = 4.65), significantly higher then all the rest ($P < 0.001$, Table 2). Charisma achieved the lowest (mean = 4.16), significantly lower then three components: Idealized Influence, Inspirational Motivation and Individual Consideration ($P < 0.005$ in all comparisons, Table 2).
- A significant difference was found among mean scores given by head nurses to the four components of the transactional leadership style ($P < 0.001$). Contingent reward was found as the dominant
A significant difference was found between the use of Compromising in conflict management when compared with the use of other strategies ($P < 0.05$). The Accommodating strategy was found significantly the least frequent in use when compared with the other strategies ($P < 0.05$).

### Relationship between leadership style and choice of strategy in conflict management

- Transformational leadership was found to affect significantly the conflict management strategy chosen ($P = 0.011$), whereas transactional leadership was borderline significant ($P = 0.094$). However, generally $R^2$ was found to be around 0.20, namely, other variables rather than leadership style may be involved in the relationship between leadership style and choice of strategy in conflict management.
- Within the five conflict management modes, transformational leadership was found to have significant influence mainly on the Competing mode ($P = 0.001$). Transactional leadership was found to have significant influence on the Collaborating mode ($P = 0.020$) and on the Accommodating mode ($P = 0.045$).

### Relationship between demographic characteristics and choice of strategy in conflict management

Most of the demographic characteristics were not correlated with choice of strategy in conflict management. A significant influence was found of tenure in position on choice of Collaborating mode in conflict management. The more tenure head nurse had in position, the more frequent she used the Collaborating mode as her strategy in conflict management ($P = 0.032$).

### Table 2

<table>
<thead>
<tr>
<th>Leadership style</th>
<th>Component</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trans. leader.</td>
<td>Idealized influence (attributed)– charisma</td>
<td>4.165</td>
<td>0.476</td>
</tr>
<tr>
<td></td>
<td>Idealized influence (behaviour)</td>
<td>4.385</td>
<td>0.468</td>
</tr>
<tr>
<td></td>
<td>Inspirational motivation</td>
<td>4.380</td>
<td>0.536</td>
</tr>
<tr>
<td></td>
<td>Intellectual stimulation</td>
<td>4.245</td>
<td>0.443</td>
</tr>
<tr>
<td></td>
<td>Individualized consideration</td>
<td>4.646†</td>
<td>0.291</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4.353*</td>
<td>0.342</td>
</tr>
<tr>
<td>Trans. leader.</td>
<td>Contingent rewards</td>
<td>4.100§</td>
<td>0.522</td>
</tr>
<tr>
<td></td>
<td>Management by exception – active</td>
<td>3.856</td>
<td>0.563</td>
</tr>
<tr>
<td></td>
<td>Management by exception – passive</td>
<td>1.912</td>
<td>0.690</td>
</tr>
<tr>
<td></td>
<td>Laissez-faire</td>
<td>1.759</td>
<td>0.630</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2.907*</td>
<td>0.372</td>
</tr>
</tbody>
</table>

The scores range from 1 (never) to 5 (always).

*Total transformational leadership was found significantly different from total transactional leadership ($P < 0.001$).

†Individualized consideration was found significantly higher than all the other transformational components ($P < 0.001$).

‖Idealized influence – charisma was found significantly lower than all the other transformational components ($P < 0.005$).

§Contingent rewards was found significantly higher than all the other transactional components ($P < 0.007$).

### Table 3

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Competing</th>
<th>Collaborating</th>
<th>Compromising</th>
<th>Avoiding</th>
<th>Accommodating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>5.80</td>
<td>6.04</td>
<td>7.30</td>
<td>5.70</td>
<td>4.00</td>
</tr>
<tr>
<td>Median</td>
<td>6.00</td>
<td>6.00</td>
<td>7.00</td>
<td>6.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Mode</td>
<td>6.00</td>
<td>6.00</td>
<td>7.00</td>
<td>6.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Percentiles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$p25 = Q_1$</td>
<td>4.00</td>
<td>5.00</td>
<td>6.00</td>
<td>4.00</td>
<td>2.75</td>
</tr>
<tr>
<td>$p75 = Q_3$</td>
<td>8.00</td>
<td>7.25</td>
<td>9.00</td>
<td>7.00</td>
<td>5.00</td>
</tr>
</tbody>
</table>

The strategy score range from 0 (for very low use) to 12 (for very high use).
Discussion

The use of appropriate conflict-handling modes in daily decision-making is one of many challenges facing nurse managers and is influenced both by the individual and the environment in which the person works. Resolving conflict effectively promotes an environment that stimulates personal growth and assists in providing quality patient care (Barton 1991).

The results of this study suggest that head nurses tend to choose a conflict mode which is concerned with a form of a Lose–Lose approach. The Compromising mode was found to be the most frequent mode in use by head nurses in conflict management and Collaborating was found second most frequent. These results support some earlier research findings. Research studies, aimed at identifying dominant conflict modes in conflict management in nursing, have been published, mainly in the 1970s and 1980s, and presented varied results. Booth (1978) found that Smoothing (Accommodating) was used most frequently, Bargaining (Compromising) was second most frequent used mode, followed by Avoidance, Confrontation (Collaborating) and Forcing (Competing), in that order. Bartol (in Booth 1982) found Collaboration as the most frequent mode nurses used in conflict situations. Compromise was second most frequently used mode, followed by Forcing, Accommodating and Avoiding, in that order. Barton (1991) reported study results, according which Compromising was reported as the most frequent conflict-handling mode used by nurse managers, followed by Collaborating, Avoiding, Accommodating and Competing. These findings are similar to those of Marriner (1982) and O’Hearn Woodlty (1987) in a study of deans of baccalaureate nursing programme. Hightower (1986) revealed Avoiding to be the most frequently used behaviour followed by Compromising, Collaborating and Accommodating. Cavanagh (1991) reported similar results suggesting that Avoidance is the most commonly used conflict management strategy, with Competition being the least favoured.

The optimal goal in resolving conflict, as emphasized in the literature, is creating a Win–Win solution for all involved. However, this outcome is not possible in every situation. The choice of the most appropriate strategy depends on many variables, such as the situation itself, the time urgency needed to make the decision, the power and status of the players, the importance of the issue, and the maturity of the individuals involved in the conflict (Marquis & Huston 1996). Compromise is associated with moderate concern for self coupled with a strong conciliatory tendency. In spite of being a form of a Lose–Lose approach, sometimes, because some people are willing to settle for less, a compromise may be agreed on that satisfies neither party completely (Adler & Towne 1990). A decision resulting from Compromising (Bargaining) is often a short-term solution. The same issue may need to be dealt with by confrontation at a later date. It is not the optimal strategy to resolve conflict. It may be useful when a temporary solution is needed in a complex issue. Unfortunately, this strategy often leads to antagonism between groups. Each group frequently perceives that they have given more than the other, which results in a feeling of loss (Dove 1998).

Constructive management of conflict can be viewed as a creative, cooperative problem-solving process, in which the conflict is defined as a mutual problem to be solved (Deutsch 2000). The mode of choice, as reflected in the literature, is Collaboration (Confrontation). Its true meaning is creating a Win–Win solution for all involved by openly and freely discussing the issues and sharing views about which there is a disagreement. Intervention aimed at maximizing assertive, cooperative behaviours, to promote collaboration vs. compromising would benefit nurse managers and the environments in which they work (Barton 1991, Marquis & Huston 1996). While Collaborating represent the assertive approach on the Assertive–Unassertive dimension, and the Cooperative strategy on the Uncooperative–Cooperative dimension, Compromising is intermediate in both Cooperativeness and Assertiveness.

The results of this study suggest that the nurse manager’s leadership style may influence significantly conflict-handling behaviour. We predicted that head nurses,
who perceived themselves as transformational leaders, would choose Collaborating as their preferred, frequent choice of strategy in conflict management. Our assumption was based on results of previous studies revealing that leadership style has shown substantial correlations with the climate dimensions. Transformational organizational cultures tend to be characterized by flexibility and creativity with emphasis on questioning policies, strategies and methods used, to accrue effective organizational performance. Strongly centralized decision systems are associated with climates that restrict creativity and innovation (Ekvall 1996). Transformational leaders’ futuristic focus value creativity and innovation, and they are able to create synergistic environments that enhance collaboration towards change (Wolf et al. 1994).

Organizational leadership sets the tone for conflict management. The nurse manager’s organizational work experience and her perspective on power may influence her choice of strategies in conflict management. The study results may be modified by the affect of the daily internal and external conflicts that they are involved in. The pattern of modification may be to reduce the rating of Collaboration and increase the rating of Compromising, i.e. selecting and exercising more often Compromising then Collaborating. A hierarchical structure, like our organizational structure, is associated with power relations between groups and on-going attempts by all involved to maintain their authority and status. The traditional health care hierarchy has made it difficult for head nurses to gain confidence in decision-making and skill in assertiveness and negotiation (Trofino 1995). Often, they are involved in unequal power situations and as a result of the power imbalance they tend to actively secure their interests, which may be contradictory to other members’ interests (Coleman 2000). Usually, head nurses’ behaviours are pragmatic in nature. Experienced head nurses tend to prefer strategy that will maintain relationships in the long run, and no risk or harm relations with other members who are involved in the decisions. Organizational experience may have thought head nurses that in a competitive, unstable and hectic work environment, when colleagues have often superior power, a direct competition should be avoid and a pragmatic-oriented approach and a non-confrontational style is preferred (Drory & Ritov 1997a,b). Through the process of organizational socialization, head nurses adopted, during the years, a submissive approach towards those who traditionally control the organization. Many developed a tendency not only to avoid direct confrontation, but also to prefer to adhere to none confrontational style. However, head nurses, with many years in position, who gain confidence, feel freer, than others, to use Collaborating as strategy in conflict management, as was found in the present study.

Another result of this study indicate that approximately half of the respondents use only one mode in conflict management, i.e. their behaviour characteristics in one conflict area characterized it in others. They did not adjust their choices to specific conditions and therefore may have not handle the conflict effectively. A leader should recognize which conflict management qualities and skills or solutions strategy is most appropriate for each situation (Marquis & Huston 1996). The literature emphasizes the importance that individuals and/or groups avoid becoming chronically committed to any one strategy, instead remaining skilled at each of them, particularly when trying to achieve enhanced environment or personal power (Coleman 2000).

Implications

Managing conflict effectively requires many professional qualities and skills, and changing organizations to be conflict-positive require on-going, persistent action. To become effectively and for appropriately managing conflict, head nurses must understand the causes, theories, approaches and strategies of conflict management. The question is when, and what kind of experiences in conflict management, is adequate in preparing for conflict situations facing today’s head nurses? We believe that preparation in conflict management should start early and body of knowledge should be included along the professional socialization process from the beginning. It should include, in the first stage, the knowledge of the causes of conflicts, the conflict process and the skills required. Teaching problem-solving and decision-making approaches to cooperative conflict resolution should be together in an integrated fashion. Graduate students should, through planned exercises, be able to negotiate and analyse strategies and tactics for effectively implementing their available power in conflicts. Skill and comfort in using a variety of conflict-handling modes may help to develop a repertoire of conflict resolutions skills that is essential in effectively managing the variety of conflict situations (O’Hearn Woodlti 1987). Learning in the work environment can also be done through observations. Superiors may serve as role models. Role modelling can be an effective teaching–learning strategy, providing nurse managers have the skills and abilities required.

In addition to the importance of education and skill training when conflict occurs in the unit, nurse
managers must deal appropriately with that conflict. Consistently using strategies with Win–Lose or Lose–Lose outcomes will create disharmony within the unit. The skills desired in enacting the facilitation role in resolving intergroup conflict includes counselling, cross-cultural communication, human relations and giving and receiving feedback on behaviour. We feel that only a small percentage of time is spent in true collaboration in the work environment, especially when there is a wide difference in power between individuals or groups involved. Managing effectively conflicts in a unit/ward requires using strategies as urging confrontation to encourage subordinates to attempt to handle their own problems, communicating honestly and openly, ensuring clarity of responsibility of roles, creating policies and changing if needed, and being sensitive to others and offer support.

Further research on individual’s and environment characteristics could contribute significantly to our understanding of how conflict management strategies are determined. Other variables rather than leadership style may influence choice of conflict-handling mode. More research is necessary on the effects of personality and characteristics of the organizational environment on conflict management. Another important question that should be explored is: Are conflict management abilities and skills developed during undergraduate and graduate education?

**Limitations**

Some of the limitations of the present study should be noted. In assessing head nurses’ conflict management mode, it is not possible to control for all the factors, which could influence individual’s mode. The influence of factors such as the characteristics of the organizational climate and organizational structure were not examined in this study. These characteristics include: relations with peers and subordinates, level of authority, models of care delivery and opportunities for continuous professional development. Furthermore, the actual behaviour is not observed in the study. The results consist of subjects’ self-reports on what they would be inclined to do.

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**References**


