Strategies for Conflict Management in Pharmacy Practice

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(Original version published online in 2006 by PharmSafety.org, a website funded by McKesson until 2012 as free continuing education for pharmacists.)

If It Hasn’t Happened, It Will...

In any human services profession, it is inevitable that you will be seen as the enemy by some of those whom you try to help. They may become angry at you, question your intelligence and/or motivations, raise their voices and hurl insults, or even worse. When this happens, it can be very demoralizing, especially when you realize that the hostility is unfounded — that the patient is wrong and that all this could have been avoided had they just listened to you. But even more problematic, you are left with the sticky issue of how to repair the relationship with the patient and defuse potential skirmishes.

In this article, the focus will be the “why” and “what now” of conflict. Conflict is ultimately played out on a social stage, but there are numerous sources of influence that can set the stage for and/or trigger conflicts that must be understood. Further, the solutions to conflict are usually negotiated between the various players, and so successful conflict remediation must be sensitive to both the uniqueness of the individuals as well as the context within which the conflict exists. In short, pharmacists should remember that conflict is almost never caused by any one thing, and that conflict management is never a one-way street.

Defining Conflict

Conflict, at its basic level, is easy to define. Conflict occurs when Individual X suspects that Individual Y either has behaved or will behave in a manner that is not compatible with the interests of Individual X. In a social situation like the delivery of
pharmaceutical care, each party has a “horse in the race,” so to speak. The pharmacist is of course concerned with the patient’s health. Thus, from the pharmacist’s point of view, everything that she says to the patient is intended to maintain and improve that patient’s situation. However, the patient’s interests are likely to be more variable and are also more likely to include things that are not directly relevant for health maintenance. While it would be silly to suggest that the patient is unconcerned with their outcomes, it is not that much of a stretch to assert that a patient may be willing to sacrifice some of those outcomes in ways that the pharmacist may consider to be poor judgment.

Another important point to keep in mind is that conflict only becomes manifest when the involved parties believe that the interaction is more or less a “zero-sum game.” These social situations are defined by the fact that there are outcomes that cannot be shared; either you win or you lose. If there are plenty of rewards to go around, or if all parties can get what they want in its entirety, conflict rarely if ever becomes overt. In the clinical pharmacy setting, therapeutic regimens may make demands on the patient that require some sacrifices in their lives. While these sacrifices may look relatively benign to the pharmacist, they could be very precious to the patient. This difference of perspective cannot be underemphasized.

So, counseling sessions with a patient, for example, create an environment where conflict can potentially grow. There are two parties with different goals (although the superordinate goal, i.e., health maintenance, may be similar), different beliefs about how to achieve those goals, and ultimately, one party has some social power over the other due to the pharmacist’s position as a healthcare provider. Even though clinical pharmacy practice is supposed to be supportive of patient health (and research shows that it is quite promising), that does not rule out conflicts which can fester and lead to lost patients and income.

**Causes of Conflict in Social Situations**

An exhaustive list of sources of conflict is beyond the scope of this article, and there is no need to bog the reader down in excessive theory. So, we will focus on some of the more ubiquitous “suspects” in conflict initiation and maintenance, while at the same time
attempt to couch these factors in the context of pharmacy practice.

**Faulty attributions.** When events occur that affect us negatively, we often engage in cognitive searches for cause-effect linkages. We want to explain *why* the event occurred so that we might prevent it or prepare for it in the future. Unfortunately, the attribution process that we use to find these linkages is fraught with biases, and some of these can lead to conflict as we erroneously blame others for the negative outcome. This could relate to clinical pharmacy in a situation where the patient might attribute blame to the pharmacist for unintended consequences stemming from the therapy. For instance, the regimen could have effects on personal factors or family stress, and the pharmacist could be tagged as insensitive or uncaring about those issues. An unintended side effect could occur, and the pharmacist could be labeled as unconcerned or careless. On the other side, the patient could be seen as apathetic or resistant if the pharmacist finds out that there have been some compliance or adherence failures.

**Faulty communication.** The heart of a clinical-counseling approach to pharmacy practice is the communication dynamic between the pharmacist and the patient. While many of these communications will be nurturing and supportive, there may be times when the pharmacist will have to adopt a harsher tone, perhaps to correct some behavior that is improper or to warn against the consequences of compliance or adherence failures. In these communications, the possibility of conflict emerging is real. Patients may feel vulnerable or ashamed, and may react badly to admonishment, even if it is delivered as gently as possible.

**Naïve realism.** A common failing of human cognition is a tendency to see our own views on an issue as objective and well-informed, while at the same time arguing that the views of others are biased by their preconceptions or ideologies. This naïve realism leads to a discounting of the views of the other and an overemphasis on how we see things. While this tendency is one that can affect patients and pharmacists, the pharmacist is actually more at risk. This is because the effects of naïve realism are more accentuated when the individual has some degree of social power in the situation. For example, politicians are famous for arguing that their perceptions of national issues are better informed and more accurate than those of the people they serve. Pharmacists can fall into this mentality when they begin to see their patients’ perceptions as irrelevant or silly with respect to their
regimens. This can create a sense of irritation with the other person and sow the seeds for eventual conflict down the road.

*Individual characteristics.* Another factor that many pharmacists must be aware of involves a personality trait, one that many pharmacists possess with some strength. Years ago, psychologists identified a complex trait called *Type A personality*, which describes an individual that feels pressed for time, is prone to hostility, prefers to juggle multiple tasks, and/or seeks out competitive contexts. Though the idea of Type A personality, as it entered the mainstream literature, became somewhat distorted, the core ideas remain — those strong in the Type A trait are more likely to perceive a situation as conflict-inducing and more likely to engage that conflict overtly. In a clinical pharmacy practice, the strong Type A could, for example, see the patient’s health status as a competition to win; if the patient is not progressing as intended, then the Type A pharmacist might interpret that as a personal failure and become irritated at the patient.

In sum, it is important to note here that, while some conflicts do occur because of structural factors, such as scarce resources or objectively incompatible interests, many times conflict is rooted in the *perception* that these incompatibilities or scarcities exist, irrespective of whether they actually do. While this might sound like a daunting reality on the surface, it is very important for conflict resolution. It means that conflict resolutions need not change the situation (which is good, since some situations are rather inflexible, especially those pertaining to medication regimens). Instead, we can focus on changing perceptions, which is likely to be much more successful in the long run.

**Resolving Conflict: Two Tested Approaches**

In this section, we will discuss strategies that research has shown to be useful in defusing and remediating conflict in social situations. But first, we agree on what “resolution” really means. Without a proper expectation from all parties concerned, it is likely that some parties will get to a point where they consider the conflict “resolved” while other parties will disagree that resolution has indeed occurred. So, we will define “resolution” in the following way:

“A state of conflict remediation where all parties have received
satisfactory consideration of their viewpoints and have agreed that any future course of action regarding the conflict is acceptable to them.”

This definition does not require that every party in the conflict be “happy,” or that every party gets everything that they wanted. While such outcomes would be wonderful, they are rare and usually unattainable. Instead, resolution is more about voicing concerns and reaching a negotiated settlement on what each party is willing to settle for. As a case in point, civil law cases reach resolution every day in our country, but in many of those cases, parties will leave the courtroom wishing they had gotten more or believing that they shouldn’t have been penalized so harshly. If a conflict occurs between a pharmacist and a patient during a counseling session or therapy management, it is usually the case that resolution will not lead to a perfect solution for all concerned. Building on this base, we can spend time on the two conflict resolution techniques that have had the most success in practice and weigh their advantages and disadvantages with respect to pharmacy practice.

The first of these techniques is the use of superordinate goals. These are goals that can place the conflicting parties in a situation where they must work together to achieve the goal. Superordinate goals are capable of this because they appeal to values or interests that all parties share; often in the midst of conflict, these shared values become obscured (some call this the “fog of war” phenomenon). In the context of pharmacy practice, superordinate goals can be used to remind the patient and the pharmacist that the good health of the patient is in both parties’ best interests. In some cases, the patient may forget this, or never be convinced of it in the first place. Conflict may encourage the patient to perceive that the pharmacy is more interested in profit than people. Pharmacists are the powerful persons in these interactions, and so they must find ways to remind the patient that they are working toward the same end — health improvement and maintenance. Remind the patient that you are both “in this together,” and that you are a partner with him in his quest for good health, not just another expert with some impersonal and generalized advice.

The second technique is actually a collection of strategies, generally grouped under the rubric of negotiation or bargaining. These techniques generally involve the exchange of offers and counter-offers until a compromised solution is reached, or until the situation
becomes “deadlocked.” Negotiation is something that all pharmacists should be able to do effectively. Some readers might react to this with something like, “How can I negotiate with a patient’s health?” The negotiation will almost never be framed around the issue of whether the patient will or will not subscribe to the regimen in question; instead, negotiations will often target how that regimen will be followed. The successful clinical pharmacist will be able to mandate behavior from the patient while at the same time making the patient believe that they have actually made the decision to behave.

So how does someone become a good negotiator? Aside from practice, there are some skills that contribute to successful negotiation that can be learned. In the negotiation literature, these are often called tactics. Ultimately, the goal of many negotiation tactics is to manipulate the other party into a situation where they must concede part of their list of demands. Both pharmacists and patients can use these tactics, so it is beneficial not only to know how to use them but to recognize when they are being applied to you. Some examples of tactics include:

- **Door in the face** - begin the negotiation by stating an offer that has no compromise whatsoever in it, favoring you completely. Clearly this offer will normally be rejected, but you have set an anchoring point for future offers and increased the likelihood that the eventual agreement will be more to your liking. Salespersons use the door in the face in this way. He may begin by asking you to donate $5,000 to his charity; you will probably refuse. Then he will begin to negotiate downward as he accentuates the benefits of your donation. Research shows that this tactic does not necessarily increase the amount of money collected per person, but does increase the likelihood that someone will donate something.

- **The Big Lie** - set the “break-even” point in a position that is more beneficial to you than the actual “break-even” point is. Car dealers will tell you that they can’t discount the car anymore “because they will lose money.” Most times, this is a lie. Pharmacists should use this tactic to set a “break-even” point (what you would be satisfied with in terms of the issue at hand) higher than absolute minimum, increasing the chance that the patient will agree to an adherence plan that is actually more in line with pharmacist desires than has been portrayed.
- *I'll go elsewhere* - the patient may threaten to go to another pharmacy if you don’t “play ball.” This is an influence tactic intended to induce your compliance out of fear of losing business. Recognize this tactic as a last-gasp effort to avoid concessions. This gambit by the patient is really not as powerful as they will think it is, but you can use it against them as well. Take the opportunity to show them how much you have helped them in the past, how well you know their situation, and whatever other advantages your service offers them. Don’t react badly to the threat, but dodge it instead.

- *Common value misrepresentation* - sometimes in conflicts, both parties actually want the same outcome on a given point, but one party believes otherwise. If the pharmacist ever realizes that there is commonality in viewpoints between her and the patient but the patient can’t see it, the pharmacist can pretend to “concede” that point in return for another outcome she wants. The patient then believes that they have won a point, when in fact there was not a point to be won. Of course, this tactic should only be used on points that do not violate the ethical standards of pharmacy.

There are two other important things to remember about conflict management. First, perception plays a huge role and perceptual errors can cloud the process. Specifically, a particularly pervasive perceptual bias is the **incompatibility error**, where both parties assume that their interests are *entirely* incompatible (which is almost never the case, and certainly not in the typical pharmacy practice). A second bias is the **fixed sum error**. Here, both parties make the assumption that the other has the same list of priorities concerning the issues in the conflict; in other words, they each value all aspects of the conflict in the same way. Clearly, this is almost never the case. A third error is called the **transparency overestimation error**, where we believe that our goals and motives are more visible to the other parties than they actually are.

Pharmacists should take care to recognize if and when they are making these errors. The incompatibility error could lead the pharmacist to infer that the patient cares nothing about their health, is only there to cause trouble and to be difficult, etc., and the second and third errors could trigger protracted discussions over issues that the patient really doesn’t care that much about, wasting valuable time and leading the patient to believe that the
pharmacist either isn’t listening or doesn’t really care to understand the nuances of the conflict.

A second important issue in conflict management is that individuals will approach conflicts with predispositions about how to do it. You probably know this from experience: some prefer to come in fighting, others are more measured with their assertiveness, and still others simply give in and let the other party have what they want. While these predispositions do not determine single-handedly how the individual will behave in a conflict management role, they do give us information about how they would prefer to behave. Generally speaking, these conflict styles vary along a 2x2 dimensional space defined by the concern for others’ wants and the concern for one’s own wants. If both of these factors are important to the actor, collaborative behavior results. If our own interests dominate, we tend to see assertive behavior, and if the needs of the other dominate, we tend to see accommodating behavior. The more moderate we are on these two factors, the more compromising we tend to become. There are several commercially available scales that could be used as training devices for pharmacy staff to further inform them about their conflict management styles. One of the first steps to understanding conflict management at an intrapersonal level is knowing how you tend to react to conflict and how you tend to believe it should best be solved.

**Conflict Management: Skills to Possess**

Research has identified a small set of broad skills that are necessary to maximize one’s ability to manage conflict through constructive solutions. These skills include: establishing the proper relationship, option identification and expansion, and resisting escalation traps. These three broad skills are composed of a set of sub-skills that contribute to their development. These specific sub-skills are listed below.

- **Active/reflective listening.** Too often we focus on what we will say in response to an individual that we do not effectively listen to the information that is being offered. Thus, when asked to reflect that information back to ensure understanding, we are unable to do so. The active listener can resist
the urge to formulate responses before the other party has finished communicating, therefore avoiding an escalation trap that can be sprung when arguments emerge from this inefficient information transfer. Reflection simply means that the listener reports what they have understood back to the original speaker; it is not a rote memorization or mindless parroting of words, but an indication to the other party that you understood the point of what they communicated.

- **Perspective taking.** This is the skill side of what some would call “empathy.” Some psychologists assert that empathy has a fairly strong innate component, but the ability to take other perspectives is something that can be learned and practiced to the extent that your predispositions allow. Perspective taking means exactly what it sounds like; we consciously visualize the situation from the side of the other party and attempt to understand why their perspective has coalesced as it has. This can also be a useful skill for tactical behaviors, by the way.

- **Assertive communication.** Perhaps you were taught as a child, “If you can’t say anything nice, don’t say anything at all.” This is a conflict-avoidant style, and to its extreme, makes compromised or collaborative conflict solutions virtually impossible. Such motifs encourage the suppression of one’s own views or motives to the elevation of the other’s. Assertive communication does not follow this motif, nor should it be confused with “aggression.” Assertive communication adheres to certain rules: 1) the tone of the communication is firm but respectful, 2) the messages are clearly owned by the speaker and stated from their perspective (you might have heard this called “I” messages), and 3) the content of the message is focused on observable behaviors rather than blind accusations about the other party’s personality, intentions, or other characteristics.

- **Delivering/receiving feedback.** This is a closely-related skill to assertive communication, but emphasizes the timeliness and utility of the feedback as well as the regulation of negative emotions that might arise when receiving feedback. This emotion regulation is trainable and something that you can
practice.

- **Problem solving.** Once both parties have aired their desires and perceptions of the situation, problem solving behavior can ensue. Problem solving training has been used in organizations for decades and focuses on a number of important steps that are essential: for example, framing the problem properly, generating alternatives without self- or other-censorship, and developing measurable targets to determine if the implemented solution works.

**Final Thoughts**

In the preceding sections, we outlined the nature of conflict and provided ideas and directions for its successful resolution. However, there are situations where conflict may be an indicator of more underlying difficulties. In this article, we are focusing primarily on conflicts that have to do with surface issues such as how to administer medication, how often to check one's health status, whether a particular health target is appropriate, and so forth. Deeper issues concerning such things as suspicion of health care professionals, irrational paranoia or other kinds of deluded thinking, or open and hostile rebelliousness should be handled by the appropriate professionals. Fortunately, these are likely to be the exception, not the norm. Most conflict you will see in clinical pharmacy practice will be more likely about how often a diabetic is checking blood sugar rather than profound problems at home. In that event, the information presented in this article should be useful as you navigate those “field of conflict,” attempting to make the patient satisfied and attain the best health outcomes for them.