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Power Strategy Usage Among Nurse Practitioners In Conflict Resolution With Physicians

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by

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Dedication

This thesis is presented in memory of my mother, Mrs. Marceline R. Coldiron.

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Abstract

The purpose of this study was to determine which power strategies nurse clinicians utilize in resolving conflict with physicians. A sample of 50 nurse clinicians were surveyed using the Modified Offermann and Schrier Tool. The data were analyzed using the chi-square statistical test. Findings indicate that the most frequently used strategy for conflict resolution is direct, rational power tactics. The most frequently used strategies were items such as "Openly discussing your differences and needs" or "Telling him/her you've studied the issue and know a lot about it." The strategies used the least were items such as pouting, coercion, or blackmail. The data also revealed that nurse practitioners did not change their power strategy selection according to the gender of the physician.

Recommendations for nursing include increasing the realization that power strategy utilization is a daily occurrence which lends itself, through proper utilization, to an increase in power. The researcher further recommends graduate nurses and others to incorporate direct, rational tactics for conflict resolution into their practice.

Recommendations include the replication of this study utilizing case studies of common conflicts which occur

between nurse clinicians and physicians. The researcher also recommends replicating this study in other geographic areas and in other nursing populations.

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Chapter I

The Research Problem

Managers spend at least 20% of their time dealing with conflict and conflict resolution (Douglass, 1980). Nurses and nurse managers are expected to participate in or initiate conflict resolution (Douglass, 1980). Wolcott (1983) emphasized that it is now time for the nursing profession to develop and utilize positive, constructive attitudes toward conflict and to enhance awareness of our professional skills in conflict resolution.

McClure (1985) noted that nurses previously disregarded power issues to avoid facing their own powerlessness. However, she concluded that nurses' expanding interest in power is a sign of increasing maturity and self-confidence within the profession.

Members of the nursing profession are assuming more powerful leadership roles which have only been occupied by physicians and administrators in the past. As a result, an obvious shift of power and control of nursing has occurred; therefore, probability of conflict between all the individuals involved is markedly increased (Booth, 1982).

Origin of the Problem

In the nursing profession, power has been intimately linked with many different issues, such as assuming responsibility for the practice of nursing, acting independently, developing ideas for improving patient care, and attaining professional satisfaction. Other areas of nursing which require a certain degree of power include acting as the patient's advocate and creating an atmosphere respectful of the patient's rights and needs. Regardless of how grounded power in nursing is, it continues to be a concept with little systematic study (Damrosch, Sullivan, & Haldeman, 1987).

Due to ancient stereotypes, men and women are believed to use very different types of power or influence strategies. This differential use of power strategies may have negative consequences, particularly for women (Offermann & Schrier, 1985). Johnson (1978) reported that people see men as more likely to use the strategies of reward, coercion, legitimacy, information, and expertise, whereas women are more apt to utilize referent power, helplessness, indirect or false information, nagging, and sexuality to resolve conflict. Wynd (1985) noted, "The profession of nursing, with the majority of its members being female, experience the struggle for power as conflicting with stereotyped female roles" (p. 16). Boyle noted that as females, nurses have not had opportunities to learn skills of competition

and cooperation that men obtain from activities such as team sports (Boyle, 1984). This deficit of skills not only influences the use of power strategies with fellow nurses but also with physicians and other health care personnel. The nurses' socialization as nurturers and caretakers within the health care field encourages more subservience, less assertiveness, and ultimately powerlessness (Wynd, 1985).

As conflict is constantly present, there is a sense of urgency to seek productive power strategies in conflict resolution (Booth, 1982). Conflict, either functional or dysfunctional, permeates all relationships among individuals, groups, and organizations. Attempts to eliminate conflict can result in stifling situations. "Nurses have long practiced in a vacuum of powerlessness with no foreseeable alternatives" (Persons & Wieck, 1985, p. 53). Since the 1960s, Americans have been uncomfortable with the idea of power, especially personal power. If power has negative connotations, why should nurses seek power (Persons & Wieck, 1985)? Wynd (1985) answers this question by emphasizing that the avoidance of power in nursing has contributed to a lack of progress in achieving professional and occupational goals, the greatest of which is promotion of excellence in patient care.

Thus, power has been noted to be an important element in all professional roles and may be an especially prominent one when resolving conflict between nurse clinicians and

physicians. However, despite the importance of power, there is little systematic information available on how people use power to influence their superiors (Damrosch et al., 1987).

Significance of Problem

Nurses, like other professionals, are striving for more influence in the work environment and in policy-making to promote their professional concerns. Unfortunately, nursing possesses a traditional history of servitude and dominance by other professions. An overemphasis of these historical attributes has clouded professional issues and suppressed the desire of nurses to develop more assertive skills of political activism and power (Wynd, 1985). Regardless of the past, social expectations for nurses are changing and requirements for professionalism are increasing.

Many times the opinions and decisions offered by nurses go unheeded and unrecognized. Wynd (1985) asserted that nurses must respond by shedding their political apathy and adopting power tactics to promote excellence in health care delivery. Nurses are struggling for more influence in the work place and in policymaking. Nurse leaders implore nursing professionals to take their power and put it to use (Heineken, 1985). Nurses must become aware of power as an effective and positive force in the promotion of quality care (Wynd, 1985).

Numerous Family Nurse Clinicians in North Mississippi are not involved in a valid nurse clinician role. As a

consequence these clinicians have been forced to seek employment in other areas, such as hospital administration, education, or continue the role of staff nurse. The researcher believed an understanding of power strategies could be the first step in assisting the clinician to assume his or her appropriate professional role.

The researcher also agreed with Wynd (1985) that women should be encouraged to reject traditional power strategies associated with their gender and adopt power styles which reflect concern for human dignity and welfare. Nursing can then flex its underdeveloped muscles (Persons & Wieck, 1985).

Delineation of Problem

Power is often associated with aggression and the need to control subordinates (Wynd, 1985). Nursing administrators are having difficulty uniting staff on important professional issues. Basically, this failure is due to nurses remaining divided on the fundamental issue of power as good versus power as bad (Heineken, 1985). The greatest barrier to nurse leadership is fear of power (Wynd, 1985). If nurses remain divided, they will have internal strife over issues about which they should unite (Heineken, 1985). Power is simply the right to make choices in decisions that affect themselves and others. Power is granted rather than a natural right. Every person has some valuable resource and thus some level of power. This process is dynamic,

reciprocal, and interactive and is fluid, event, or time specific (Persons & Wieck, 1985).

Historically, in decision-making, nurses have relied upon the judgments of other professional colleagues. Recently, nurses have focused on the development of independence from other professionals; therefore, power in nursing has been fragmented (Persons & Wieck, 1985).

The acknowledgement by nurses of a need and desire for power constitutes the first step in power acquisition. Recently, the benefits of gaining power through inter-dependence has been recognized by the nursing profession (Persons & Wieck, 1985). Nurses can have a major impact within health care systems through acquisition and use of power (Heineken, 1985).

Friedman (1982) found only 18% of the nurses she surveyed to describe professional relationships with physicians as workable or tolerable. Physicians and nurses need to work collaboratively to meet total patient needs. However, as nurses are patient advocates, the nurse is often viewed as an opposing force.

In recent years, there has been a growing effort to expand the scope of nursing practice beyond the traditional role. This increase in independence and responsibility has brought with it ambivalence on behalf of the principal parties in the health care system. The varying perceptions, confusion, and resulting conflict are even more obvious when

the physician-nurse clinician relationship is examined (Chacko & Wong, 1984). It seems likely that values regarding power and perceptions of relative power within a relationship affect the choice of power strategies (Falbo & Peplau, 1980).

There is little systematic information on how people use power to influence their colleagues or superiors (Kipnis, Schmidt, & Wilkinson, 1980). If this information can be systematically organized and analyzed, then it can be made accessible for use by nurse clinicians. Therefore, more time can be spent utilizing successful power strategies rather than in unstructured experimentation. The use of proven power strategies is one fundamental method for increasing power. If disagreements are resolved, the nurse clinician succeeds; when the nurse clinician succeeds, the team succeeds; and when the team succeeds, all of nursing benefits (Persons & Wieck, 1985).

Thus, the purpose of this study was to determine which power strategies nurse clinicians utilize in resolving conflict with physicians.

Study Questions

This study proposed to ascertain answers to the following questions:

1. Do nurse clinicians utilize direct, rational power strategies in resolving conflict with physicians?

2. What is the frequency and percent of total of each power strategy identified in the Offermann and Schrier Tool?

3. Which power strategies are used most frequently among nurse clinicians?

4. Which power strategies are used the least among nurse clinicians?

5. Do nurse clinicians change their power strategy choice according to the gender of the physician with which conflict is being resolved?

6. Which power strategies will at least 90% of the nurse clinicians utilize in resolving conflict?

Definition of Terms

For the purpose of this study, these terms were defined in the following manner:

1. Nurse clinician: a registered nurse who is licensed to practice in Mississippi who has expanded his/her role through continued education and therefore holds the title of nurse practitioner or clinician.

2. Power strategies/tactics: communication methods used in conflict resolution to produce intended effects as identified by the Offermann and Schrier Tool.

3. Physician: an individual granted the degree and title of medical doctor or doctor of osteopathic medicine who is recognized and licensed to practice medicine in Mississippi.

4. Conflict resolution: the outcome or result of any disagreement or discord between two or more individuals in which power strategies were utilized in the resolution process.

Assumptions

For the purposes of this study, the following assumptions were delineated:

1. Nurse clinicians have contact with physicians almost daily.

2. Conflict and conflict resolution are prevalent problems in any profession.

3. Power strategies are used in the resolution of any conflict.

4. The Modified Offermann and Schrier Tool used in this study covers the various power strategies that are implemented in nurse clinician-physician encounters.

5. The Modified Offermann and Schrier Tool has face reliability and validity within the confines of this study.

Chapter II

Theoretical Basis of the Study

The Theory of Goal Attainment by King (1981) was selected as the theoretical basis of this study. This theory is a refinement and elaboration of King's conceptual framework.

The Theory of Goal Attainment (King, 1981) emphasizes the interaction process between two or more individuals that leads to goal attainment. This concept can be applied to interactions which occur between nurse clinicians and physicians in attempts to obtain a goal, conflict resolution. The basic assumption of the theory is that individuals communicate information, set goals mutually, and then act to obtain those goals (George, 1985). This assumption is the basis of collaborative practice for nurse clinicians and physicians.

King (1981) viewed nursing as an interpersonal process of action, reaction, interaction, and transaction. Individuals are viewed as reacting, time-oriented, and social beings with the ability to perceive, think, feel, choose, set goals, select actions to meet goals, and make decisions. The system is open in order to permit feedback,

as perception is influenced by each phase of activity (George, 1985).

From the theory of goal attainment, King (1981) developed eight predictive propositions. She indicates that additional propositions may be generated. The eight propositions set forth were as follows:

1. If perceptual accuracy is present in nurse-client interactions, transactions will occur.

2. If nurse and client make transactions, goals will be attained.

3. If goals are attained, satisfactions will occur.

4. If goals are attained, effective nursing care will occur.

5. If transactions are made in nurse-client interactions, growth and development will be enhanced.

6. If role expectations and role performance as perceived by nurse and client are congruent, transactions will occur.

7. If role conflict is experienced by nurse or client or both, stress in nurse-client interactions will occur.

8. If nurses with special knowledge and skills communicate appropriate information to clients, mutual goal setting and goal attainment will occur (King, 1981).

All concepts of the theory apply to assessment. Initially a problem is identified and clearly and concisely delineated. Planning is the time for the interacting

individuals to mutually set goals and make decisions about how to achieve these goals. Implementation occurs in the activities that seek to meet the goals. Evaluation involves description of the outcomes identified as goals attained (George, 1985).

Each of the eight propositions delineated by King applies directly to the nurse clinician-physician relationship and this research study.

1. Within the nurse clinician-physician relationship, perceptual accuracy must be present for a transaction to occur and result in attainment of a set goal.

2. Within the nurse clinician-physician relationship, perceptual accuracy must be present for a transaction to occur and result in attainment of a set goal.

3. As a result of goal attainment between the nurse clinician and physician, satisfaction of both parties will result.

4. If goals are attained as set forth by the nurse clinician and physician, effective nursing and medical care will occur.

5. Through this positive interactive process between the nurse clinician and physician, growth and development of the collaborative relationship will occur.

6. If the physician and nurse clinician understand each other's role performance and role expectations

appropriately, the atmosphere is conducive for positive transactions.

7. If a conflict occurs between the nurse clinician and physician, the interaction between the two individuals will be affected.

8. If the nurse clinician and physician communicate appropriate information regarding patient care, mutual goal setting and goal attainment will occur.

Through the utilization of King's Theory of Goal Attainment, the necessary steps for a successful and effective collaboration between the nurse clinician and physician have been delineated. These propositions also can allow one to identify where a breakdown is occurring when collaboration fails and to correct this situation for the ultimate goal attainment between the nurse clinician and physician.

Chapter III

Review of the Literature

The literature reveals that power is an important element in all professional roles and may be an especially prominent one when dealing with conflict between nurse clinicians and physicians. However, despite the importance of power, there is little systematic research information available on how nursing professionals use power strategies to influence their superiors (Damrosch et al., 1987).

Review of Related Articles

Stereotypically, the nursing profession is female dominated. Women are socialized to refrain from power-seeking behaviors. Therefore, the profession of nursing experiences the struggle for power as conflicting with stereotyped female roles. In addition, the socialization of nurses as nurturers and caretakers within the health care field encourages less assertiveness, more subservience, and subsequently powerlessness. Avoidance of power in nursing contributes to a lack of progress in achieving professional, occupational goals, the greatest of which is promotion of excellence in patient care (Wynd, 1985).

Many situations arise in nursing practice in which a nurse clinician feels powerless. The situation may involve one patient, problems of policy, or control of nurse clinician practice politically. Therefore, in the world of nursing, a wide range of situations may occur which require several sources of power. Power strategy usage is one of these primary sources of power. The power the nurse clinician possesses is inadequate for the needs of next year. As such, the nurse clinician diminishes her own power and that of other nurses by not exercising and strengthening nursing's power to improve the entire profession (Boyle, 1984).

Collaboration between a nurse clinician and physician involves a commitment by the individuals to identify and to work toward achievement of common goals. When these individuals live up to this commitment they are agreeing to creative, cooperative production and management of conflict. If the nurse clinician chooses not to face conflict and not utilize any form of power strategies, then she is setting a pattern which can inhibit further growth and productivity (Kennan & Hurst, 1982).

Conflict or controversy can be a sign of a healthy organization. Controversy is a natural part of any problem-solving situation, and it should not be avoided or repressed. Conflict resolution can reduce the tension and frustration which occurs between a nurse clinician and

physician working in a collaborative practice. Difference of opinion, interests, and values must be dealt with utilizing direct, rational, power strategies. Conflict that is not resolved can lead the nurse clinician or physician to make biased, nonobjective judgments and actions. Unresolved conflict can also lead to a deteriorating relationship between the nurse clinician and physician (Nichols, 1979).

It has been estimated that managers, many of whom are women and nurses, spend at least 20% of their time dealing with conflict and conflict resolution (Douglass, 1980). This is considered to be a significant amount of time. If this time could be spent utilizing proven power strategies, then the nurse clinician could spend more time acting as the patient's advocate and delivering quality patient care. Therefore, patients and nurses would benefit from the nursing profession's development and utilization of positive power strategies and enhanced awareness of professional skills in conflict resolution (Donnelly, Mengel, & Sutterly, 1980).

The nurse clinician will continue to undergo many changes in assuming new roles and different relationships with other health professionals. Also, nurse clinicians are assuming roles that only physicians and administrators have occupied in the past. This results in a shift of power and control and increases the probability of conflict between the nurse clinician and physician. Because conflict, to

some degree, will always be present, there is a sense of urgency to seek strategies of resolution. Power strategy usage is one method of resolution that has been identified (Booth, 1982).

As a nurse clinician, one may ponder why the profession should seek power strategies appropriate for conflict resolution. The use of power strategies provides the nurse clinician with a higher degree of power and power bestows the rights to make choices and decisions. The ability to make choices and decisions is imperative within the nurse clinician-physician relationship (Persons & Wieck, 1985).

Many nurses feel uncomfortable with the notion of having and using power strategies. For some, the term has a negative connotation. For others, the idea seems alien and very separate from day-to-day activities. These nurses tend to shy away from acknowledging their sources of personal and professional power. In return, these nurses continue to lose power not only for themselves, but for their patients and the entire profession of nursing (Heineken, 1985).

Review of Research Articles

The majority of the research regarding power strategies is in the area of marriage and interpersonal relationships. Power strategy utilization has also been studied in the area of sex and role. The researcher found these areas, sex and role, to be most significant to the present research study.

Damrosch et al. (1987) conducted a descriptive study that proposed to determine which power strategies 280 graduate nursing students would utilize when resolving conflict with superordinates of different sexes. The findings of this study included:

1. The most likely strategy in trying to get their way with superordinates involved direct, rational tactics.

2. There was weak evidence that nurses were slightly more willing to use coercive power or passiveness/withdrawal with male nurse-bosses.

3. Nurses were significantly more likely to use flattery/doing favors with nurse-bosses than with medical doctors.

These researchers believed field studies involving observation of such behaviors would be an important contribution to nursing's body of knowledge in power strategy use.

Offermann and Schrier (1985), in a descriptive study utilizing 173 introductory psychology students as subjects, proposed to explore the ways in which women and men consider exercising power in an organizational interaction. These researchers hypothesized that overall sex differences consistent with sex role stereotypes would emerge, but that role would affect the type of strategies considered by both men and women equally.

The results of this study indicated that individuals considered using reasoning, negotiation, and personal

dependent strategies the most. Least consideration was given to withdrawal and reward-coercion strategies.

As the literature notes, power is a very important issue in all professional roles. Power may be especially prominent when a nurse clinician attempts to resolve conflict with a physician. Despite the importance of power, little research has been conducted with regard to how nursing professionals utilize power strategies to influence their superiors. However, numerous related articles on the subject of conflict and conflict resolution were found.

Chapter IV

Research Design and Methodology

A nonexperimental research approach was chosen for this study. Specifically, a descriptive study was conducted. Polit and Hungler (1987) define descriptive research as studies that have as their primary objective the accurate collection of specific characteristics of persons, situations, or groups, and the frequency with which certain phenomena occur.

Descriptive studies are not concerned with relationships among variables. The researcher's study is not searching for any cause-effect relationship. The researcher collected, compiled, and analyzed the data to determine the frequencies with which a certain entity occurs. The purpose of this study was to observe, describe, and document aspects of a situation. The intent of this study was not to explain or to understand the underlying causes of the variables of interest.

The setting for data collection included a wide range of areas, rural and urban, within the State of Mississippi. The subjects worked in a variety of settings from universities and private hospitals to independent practices and health departments.

The population under study included all clinicians practicing in the southeastern region of the United States. The sample included all nurse clinicians licensed with the Mississippi Board of Nursing. A list of 89 currently licensed nurse clinicians in the State of Mississippi was provided to the researcher in January 1988 by the Mississippi Board of Nursing. This group of nurse clinicians was treated as a convenience sample representative of nurse clinicians in the Southeastern United States. This procedure allowed inferential data to be drawn during the statistical analysis. All 89 nurse clinicians were sent the information packet describing the research study.

The characteristics of the sample were very broad. For example, the educational level of the subjects ranged from the associate degree level to the master's degree level. Also, the areas in which the subjects practiced ranged from neonatology and pediatrics to family and geriatrics. Therefore, the researcher believes the 89 nurse clinicians included in this study were very representative of the nurse clinicians in the Southeastern United States.

Data-Gathering Process

A packet of materials was sent to each of the 89 nurse clinicians licensed with the Mississippi Board of Nursing. This packet of materials included a cover letter (see Appendix A), the Modified Offermann and Schrier Tool (see Appendix B), a demographic data sheet (see Appendix C), and

a self-addressed stamped envelope. The completion and return of the questionnaire was considered permission for participation in the study. The study packets were mailed to the subjects on May 15, 1988. On May 29, 1988, the follow-up questionnaire was mailed in an attempt to increase respondent participation. June 18, 1988, was the day chosen by the researcher to stop accepting questionnaires and to begin data analysis. The follow-up letter (see Appendix D) was sent to all of the nurse clinicians in an attempt to increase respondent participation.

Instrumentation

The instrument utilized was the Modified Offermann and Schrier Tool. The first modification was performed by Damrosch et al. (1987) which expanded the tool to a 48-response questionnaire. Additional modifications were performed by this researcher and her statistician. These modifications included changing a 7-point Likert scale to a simple dichotomous (yes/no) response pattern. Also, the targets to be influenced, male or female nurse-boss, were excluded to increase specificity for this study. The reason for a change to a dichotomous scale permitted the researcher to identify the power strategies that would be used by the nurse clinician in a particular situation at least 90% of the time. The dichotomous items allowed for a certain degree of precision in interpreting the power strategies which would otherwise not be possible. The use of the

Likert scale would have limited the researcher's findings as only average scores could have been reported, thus preventing the documentation of exact power strategies employed in a particular situation. Through these modifications, the researcher believed respondent participation was increased as less time was required to complete the tool. Furthermore, statistical experts believed the use of the Likert scale was inappropriate in view of the items included in the tool and the normal responses which would occur.

The tool consisted of 48 actions or power strategies that could be utilized by nurse clinicians when resolving conflict with physicians. All subjects were asked to decide, by a dichotomous (yes/no) response, if they would use any of the 48 actions (power strategies) in an attempt to resolve conflict with physicians. The subjects had to choose yes/no for a female physician and for a male physician. This allowed the researcher to determine if power strategy selection changed upon the gender of the physician with which the conflict was being resolved.

In examining the Offermann and Schrier Tool in regard to reliability and validity, reliability was defined as the degree of consistency with which the tool measured the attribute it proposed to measure (Polit & Hungler, 1987). As the Offermann and Schrier tool is relatively new, it has only been utilized in two other studies. However, these

studies indicate the tool produced a low level of variation during repeated measurements of the various power strategies. Therefore, this instrument's reliability level was considered to be of a high degree. The researcher also defined reliability in terms of accuracy.

An instrument can be said to be reliable if its measures accurately reflect the "true scores" of the attributes under investigation (Polit & Hungler, 1987). The modifications made by the researcher increased reliability as it allowed the researcher to calculate exact scores. Also, the tool was refined by Offermann and Schrier using graduate nursing students' ideas after their completion of the test. The researcher believes the similarities between these subjects and the researcher's target group are numerous. Since the original group was comparable to the researcher's target group, the reliability estimate of the Offermann and Schrier tool was considered quite high by qualified experts.

In terms of validity, it is clear that the Offermann and Schrier Tool measures what it proposes to measure, the frequency with which one chooses a particular power strategy. Since only descriptive data was obtained, the researcher could simply calculate the frequencies of the different power strategies and report the findings.

Analysis

Chi-square analysis was used to answer the questions posed in this study. The particular type of chi-square application utilized is referred to as a test for Goodness of Fit. Goodness of Fit is a test which is commonly used and generally accepted when certain conditions are fulfilled. The conditions specific for this study are as follows:

1. The data must be in terms of frequencies.
2. The categories in which the data occurs are mutually exclusive.

In the case of the analysis used in this study, all conditions have been fulfilled. Specifically, chi-square analysis was employed to identify those strategies which the nurse clinicians employed at least 90% of the time when dealing with physicians in conflict resolution.

Chi-square analysis was chosen as it allowed the researcher to report the frequency with which the study population utilized specific power strategies. Through this technique, it was possible to determine those power strategies which were or were not employed by the population under study. In addition, the Yates correction factor was utilized as fewer than 100 subjects participated in this study.

Limitations

The limitations of this study have been identified as follows:

1. Dichotomous items are often considered too restrictive by respondents.

2. Limiting this study to only nurse clinicians may prevent generalization to nurses practicing in other areas.

Chapter V

Analysis of Data

The purpose of this study was to determine which power strategies nurse clinicians utilize in resolving conflict with physicians. Data were collected using the Offermann and Schrier Tool. This tool measured the frequency with which each nurse clinician utilized the various power strategies.

The subjects were the 89 nurse clinicians licensed with the Mississippi State Board of Nursing as of January 1988. Of the 89 nurse clinicians, a total of 50 participated in the study.

The educational level of the subjects varied from associate degree nurse practitioner certification through the master's degree level. Thirty-nine of the respondents had a nurse practitioner certificate and 11 were from a master's degree program. The mean years of practice as a nurse clinician was 8.44. The mean age of the subjects was 42.38. All of the respondents were female. The respondents were from many areas of specialization. The area of specialization, number, and percentage of clinicians within the area of practice are listed in Table 1.

Table 1

Areas of Specialization, Number, and Percentage of Nurse Practitioners Within the Various Areas of Practice

Area of Practice	Number	Percentage
Family Practice Nurse Practitioner	7	14
Family Nurse Practitioner	17	34
Pediatric Nurse Practitioner	12	24
Adult Nurse Practitioner	1	2
Neonate Nurse Practitioner	1	2
Primary Care Nurse Practitioner	1	2
Obstetrics and Gynecology	11	22

Descriptive Analysis

The researcher first proposed to determine the frequency and percent with which the nurse clinicians chose each of the 48 power strategies identified in the Offermann and Schrier Tool. Table 2 lists the 48 power strategies, the frequency, and percent with which the subjects chose each strategy for a male and female physician. There was a wide range of the number of nurse clinicians who would utilize each of the power strategies. None of the nurse clinicians said they would choose the following strategies: pouting, coercion, blackmail, threats, or pity. In contrast, in dealing with female physicians, 100% of the

Table 2

Frequency and Percent of Total Number of Nurse Practitioners Who Would Employ the Power Strategy When Dealing With a Physician

	Male Physician		Female Physician	
Power Strategy	Total	Percentage	Total	Percentage
Tell him/her directly what it is that I want	46	93.9	46	93.9
Go ahead and do what I want anyway	4	8.3	4	8.3
Explain the reasons why your approach is best	46	93.9	46	93.9
Simply ask him/her to do what you want	32	65.3	33	67.3
Do nothing	1	2.1	1	2.1
Try to manipulate him/her	4	8.2	3	6.1
Pout	0	0.0	0	0.0
Openly discuss your differences and needs	47	97.9	48	100.0
Refute his/her position	3	6.3	3	6.3
Tell him/her you really need help and support	46	93.9	46	93.9
Smile a lot	27	57.5	26	54.2
Argue your point logically	42	85.7	42	85.7
Drop subtle hints for what you want	13	27.1	12	25.0
In order to maintain good relations, forget it	11	22.5	11	22.5
Try to make him/her feel guilty	1	2.0	0	0.0
Tell him/her that you've studied the issue and know a lot about it	26	53.1	26	53.1
Ask for it as a personal favor	5	10.2	4	8.2
Get someone else to change the person's mind	7	14.3	7	14.3
Compromise	38	77.6	38	77.6
Back down quickly	2	4.2	2	4.2
Offer him/her rewards for cooperation	2	4.0	2	4.0
Clam up (become silent)	6	12.0	5	10.0
Try to persuade him/her that your way is right	29	59.2	29	59.2
Blow up in anger	2	4.0	2	4.0

Power Strategy	Male Physician		Female Physician	
	Total	Percentage	Total	Percentage
Indicate that you'd like him/her better for going along with you on this	2	4.0	2	4.0
Try coercion or blackmail	0	0.0	0	0.0
Don't let him/her know you disagree	5	10.2	5	10.2
Reason with the person	47	94.0	46	92.0
Tell him/her how important this is to you	36	73.5	36	73.5
Make suggestions	49	98.0	49	98.0
Repeatedly remind the person of what you want until he/she gives in	5	10.0	5	10.0
Negotiate something agreeable to both of you	46	92.0	46	92.0
Threaten the person	0	0.0	0	0.0
Provide data to back up your contentions	49	98.0	48	96.0
Flatter the person	6	12.0	4	8.0
Tell the person you'll do him/her a favor if they go along with you on this	5	10.0	3	6.0
Tell him/her that your way has worked in the past	28	56.0	29	58.0
Make the person feel sorry for you	0	0.0	0	0.0
Show the person how it's in their best interest to cooperate	21	42.0	20	40.0
Find allies elsewhere in the organization who will support your opinion	30	60.0	30	60.0
Use the technique of "partial truth," i.e. limit the information given to her to whatever makes your position stronger	6	12.0	6	12.0
As much as possible, avoid contact with him/her	8	16.0	9	18.0
Complain about her/his behaviors to others	7	14.3	7	14.3
Indicate that you'll like him/her less if she refuses to go along with you on this	1	2.0	1	2.0
Withhold all forms of communication except the bare essentials	5	10.2	5	10.2
Tell the person you'll withhold something she/he values if she refuses to go along with you on this	1	2.0	1	2.0
Make a formal complaint through proper channels	37	74.0	37	74.0
Tell her there will be unpleasant consequences if she refuses to go along with you on this	1	2.0	1	2.0

nurse clinicians chose the strategy of "Openly discussing difference and needs."

Table 3 displays those power strategies that were used most frequently (> 50% of the time) among nurse clinicians. The utilization of these power strategies ranged from 53.1%, "Tell him/her you've studied the issue and know a lot about it," to 100%, "openly discuss your differences and needs" (female physician).

Table 4 displays those power strategies used the least (< 50% of the time) among nurse clinicians. The utilization of these power strategies ranged from 0%, pouting, coercion, blackmail, threats, pity, and guilty (female physician) to 42%, "Show the person how it's in their best interest to cooperate" (male physician).

In an effort to determine if nurse clinicians change their power strategy selection according to the gender of the physician, it was found that change occurred in only 18 of the 2,400 responses. Therefore, 99.25% of the time the nurse clinicians utilized the same power strategies regardless of the gender of the physician.

The researcher proposed to identify those power strategies which were utilized by at least 90% of the nurse clinicians in resolving conflict with physicians. It was found that only 8 of the 48 power strategies were utilized by at least 90% of the nurse clinicians in conflict resolution. These eight strategies are displayed in Table

Table 3

Power Strategies and Percentages Used Most Frequently by Nurse Practitioners in Conflict Resolution with Physicians (> 50%)

Power Strategy	Percentage	
	Male Physician	Female Physician
Tell him/her directly what it is that I want	93.9	93.9
Explain the reasons why your approach is best	93.9	93.9
Simply ask him/her to do what you want	65.3	67.3
Openly discuss your differences and needs	97.9	100.0
Tell him/her you really need help and support	93.9	93.9
Smile a lot	57.5	54.2
Argue your point logically	85.7	42.0
Tell him/her that you've studied the issue and know a lot about it	53.1	53.1
Compromise	77.6	77.6
Try to persuade him/her that your way is right	59.2	59.2
Reason with the person	94.0	92.0
Tell him/her how important this is to you	73.5	73.5
Make suggestions	98.0	98.0
Negotiate something agreeable to both of you	92.0	92.0
Provide data to back up your contentions	98.0	96.0
Tell him/her that your way has worked in the past	56.0	58.0
Find allies elsewhere in the organization who will support your opinion	60.0	60.0
Make a formal complaint through proper channels	74.0	74.0

Table 4

Power Strategies and Percentages Used the Least Frequently by Nurse Practitioners When Resolving Conflict with Physicians (< 50%)

Power Strategy	Percentage	
	Male Physician	Female Physician
Go ahead and do what I want anyway	8.3	8.3
Do nothing	2.1	2.1
Try to manipulate him/her	8.3	6.1
Pout	0.0	0.0
Refute his/her position	6.3	6.3
Drop subtle hints for what you want	27.1	25.1
In order to maintain good relations, forget it	22.5	22.5
Try to make him/her feel guilty	2.0	0.0
Ask for it as a personal favor	10.2	8.2
Get someone else to change the person's mind	14.3	14.3
Back down quickly	4.2	4.2
Offer him/her rewards for cooperation	4.0	4.0
Clam up (become silent)	12.0	10.0
Blow up in anger	4.0	4.0
Indicate that you'd like him/her better for going along with you on this	4.0	4.0
Try coercion or blackmail	0.0	0.0
Don't let him/her know you disagree	10.2	10.2
Repeatedly remind the person of what you want until he/she gives in	10.0	10.0
Threaten the person	0.0	0.0
Flatter the person	12.0	8.0

Power Strategy	Percentage	
	Male Physician	Female Physician
Tell the person you'll do him/her a favor if they go along with you on this	10.0	6.0
Make the person feel sorry for you	0.0	0.0
Show the person how it's in their best interest to cooperate	42.0	40.0
Use the technique of "partial truth," i.e. limit the information given to her to whatever makes your position stronger	12.0	12.0
As much as possible, avoid contact with him/her	16.0	18.0
Complain about hers/his behaviors to others	14.3	14.3
Indicate that you'll like him/her less if she refuses to go along with you on this	2.0	2.0
Withhold all forms of communication except the bare essentials	10.2	10.2
Tell the person you'll withhold something she/he values if she refuses to go along with you on this	2.0	2.0
Tell her there will be unpleasant consequences if she refuses to go along with you on this	2.0	2.0

5. The eight power strategies utilized can be categorized, according to the Offermann and Schrier Tool, as direct, rational tactics.

Table 5

Power Strategies and Percentages Utilized by at Least 90% of the Nurse Practitioners in Resolving Conflict

	Percentage	
Power Strategy	Male Physician	Female Physician
Tell him/her directly what it is that I want	93.9	93.9
Explain the reasons why your approach is best	93.9	93.9
Openly discuss your differences and needs	97.9	100.0
Tell him/her you really need help and support	93.9	93.9
Reason with the person	94.0	92.0
Make suggestions	98.0	98.0
Negotiate something agreeable to both of you	92.0	92.0
Provide data to back up your contentions	98.0	96.0

Inferential Analysis

Assuming that the attributes and opinions of the nurse clinicians under investigation would be similar to those of

a much larger population, the researcher expanded the study by the use of inferential statistics through chi-square analysis. The study group from which the previous descriptive findings were reported was, therefore, viewed as a convenience sample. This convenience sample represents those nurse clinicians practicing within the Southeastern United States. Using appropriate statistical techniques, the researcher extended the generalizability of the study to a much larger population while holding the likelihood of error in findings to an acceptable level, $p < .05$.

Using chi-square analysis, it was determined which power strategies would be employed by at least 90% of the population of nurse clinicians when attempting to resolve conflict with a male or female physician. The results of the analysis are shown below in Table 6. As the data reveals, the power strategies utilized by at least 90% of the nurse clinicians within the Southeastern United States would be categorized as direct, rational tactics according to the Offermann and Schrier Tool. The researcher would like to note that the power strategy, "Openly discuss your differences and needs," for female physicians had a chi-square value of 4.28. This value exceeds the critical value of 3.84, which was derived from a *df* of 1 at $p = .05$. This occurred as 100% of the respondents reported they would use this power strategy when resolving conflict with female

Table 6

Chi-Square Analysis of Power Strategies Utilized at Least 90% of the Time When Dealing with Male and Female Physicians

Power Strategy	Male Physician	Female Physician
Tell him/her directly what it is that I want	$X^2 = .440$	$X^2 = .440$
Explain the reasons why your approach is best	$X^2 = .440$	$X^2 = .440$
Openly discuss your differences and needs	$X^2 = 2.520$	$X^2 = 4.280$*
Tell him/her you really need help and support	$X^2 = .440$	$X^2 = .440$
Reason with the person	$X^2 = .500$	$X^2 = .055$
Make suggestions	$X^2 = 2.720$	$X^2 = 2.720$
Negotiate something agreeable to both of you	$X^2 = .055$	$X^2 = .055$
Provide data to back up your contentions	$X^2 = 2.720$	$X^2 = 1.390$

Note. Critical value = 3.84.

*$p \leq .05$.

physicians. Therefore, it was statistically significant at a much higher level than 90%.

Using the chi-square analysis, it was determined whether or not a nurse clinician selected the same power strategy for male and female physicians at least 90% of the time when attempting to resolve a conflict. With an

obtained chi-square value of 228.17 and a critical value of 10.83 for significance at the 0.001 level, the researcher is 99.9% assured in saying the nurse clinicians would hold to a given power strategy more than 90% of the time regardless of the gender of the physician.

Chapter VI

Discussion, Implications, Recommendations, and Summary

Discussion

As discussed previously, conflict is inevitable in the nursing work places of today. One means by which one can be an efficient nurse is by being efficient in conflict resolution through the use of proper power strategies.

As discussed by Boyle (1984), females have not learned competition and cooperation from team sports. Fortunately, for the nursing professions with the majority being female, gender has not prevented nurse clinicians from learning to utilize direct, rational power strategies to resolve conflict with physicians as was noted in this study. The means through which these power strategy techniques were learned can only be postulated as having been learned through experience. These power strategies chosen by the nurse clinicians in this study contradicts the stereotypical female role (Wynd, 1985). The stereotypical role portrays women as using power strategy techniques such as referent power, helplessness, indirect or false information, nagging, and sexuality to resolve conflict (Johnson, 1978). None of

these strategies were utilized by a significant number of the respondents in this study.

Due to the large number of respondents, the researcher agrees with McClure (1985) that nurses' growing interest in power and power strategy utilization is a sign of the nursing profession's increasing maturity and self-confidence. The active involvement of these nurse clinicians has further reinforced the selection of King's Theory of Goal Attainment (1981) as being most applicable to this study. The researcher and King view nursing as an interpersonal process of action, reaction, interaction, and transaction, through an open system which allows feedback.

King developed eight predictive propositions that when adapted from the nurse-client relationship to the nurse clinician-physician relationship were supported by this study. The nurse clinician and physician must maintain perceptual accuracy in their interaction for a transaction to occur (King, 1981). This perceptual accuracy was maintained through the utilization of direct, rational power strategies. Through these transactions the nurse clinician and physician will attain their goal of an increase in the quality of patient care through productive conflict resolution. As such, satisfaction and effective nursing and medical care will occur resulting in the growth and development of the collaborative nurse clinician-physician relationship. The use of direct power strategies will

enhance the understanding of each profession's role performance and role expectations, thus avoiding a role conflict which could stress the collaborative relationship. The result will be the communication of appropriate information regarding patient care, mutual goal setting, and goal attainment between the nurse clinician and physician.

The key to King's (1981) theory is the pivotal role played by the use of direct rational power strategies. If any other power strategy technique were utilized, then perceptual accuracy would not be present and the effectiveness of King's theory would be diminished.

Implications

The results of this study of nurse clinicians, relatively advantaged in terms of education, years of experience, and presumably ability, indicated the most likely strategy utilized in resolving conflict with male and female physicians involved direct, rational tactics. These findings support the research of Damrosch et al. (1987) who studied nursing students in a master's program attempting to resolve conflict with a superordinate concerning patient care. Identification of the target as a male or female physician did not affect the power strategy selection in conflict resolution.

Power strategy techniques which were rarely or never employed by this group of professionals included negative actions such as blackmail, coercion, and flattery. The

nurse clinicians in this study demonstrated professionalism in their attempts to resolve conflicts with a physician.

Through the utilization of direct, rational tactics for conflict resolution, an increased level of quality patient care can be provided. As nurses and nurse clinicians are the primary care provider and advocate for patients, they must be prepared to face conflict. If this conflict is handled in a professional manner, the conflict will not be detrimental to the patient, the nurse or nurse clinician, or the health care profession.

Through utilization of appropriate power strategies, the profession of nursing can begin to remove the historical, subservient, stereotype which has plagued the profession for years. Research can play an invaluable role in this process as it can identify those effective as well as ineffective strategies, thereby providing nurse clinicians with those techniques which are proven effective and influential on superordinates in the health care profession.

Recommendations

Nursing

The following recommendations are made for nursing:

1. To increase realization that power strategy utilization is a daily occurrence which lends itself, through proper utilization, to an increase in power.

2. For graduate nurses and other nursing professionals to incorporate direct, rational tactics into their practice.

Research

The following recommendations for further research are made based upon the findings of this study.

1. Replication of this study utilizing case studies of common conflicts which occur between nurse clinicians and physicians.

2. Field studies involving observation of implementation of actual power strategy utilization among nurse clinicians.

3. Replication of the study in other geographic areas.

4. Replication of the study in other nursing populations.

Summary

The purpose of this study was to determine which power strategies nurse clinicians utilize in resolving conflict with physicians. The subjects of this study consisted of 89 nurse clinicians licensed with the Mississippi State Board of Nursing as of January 1988. A total of 50 nurse clinicians participated in this study.

A nonexperimental research approach was chosen for this study. Specifically, a descriptive study was conducted. The setting for data collection included a wide range, rural and urban, within the State of Mississippi.

This group of nurse clinicians was treated as a convenience sample representative of nurse clinicians in the Southeastern United States. This procedure allowed inferential data to be drawn during the statistical analysis.

The data-gathering process consisting of mailing the Offermann and Schrier Tool along with a demographic data sheet to each nurse clinician. The completion and return of the questionnaire was considered permission for participation in this study. A follow-up letter was also sent 10 working days later in an effort to increase respondent participation.

The instrument utilized was the Modified Offermann and Schrier Tool. The tool consisted of 48 power strategies that could be utilized by nurse clinicians when resolving conflict with male and female physicians.

Chi-square analysis and descriptive statistics were used to answer the questions posed in this study. The chi-square statistical test was chosen as it allowed the frequency with which a much larger population in the Southeastern United States utilized a specific power strategy at a given probability ($p < .05$) to be reported. From both the descriptive and inferential analyses, it was determined that the nurse clinicians in this study utilized direct, rational power tactics as their primary strategies in conflict resolution with physicians.

Appendix A

Cover Letter

103 Boone Street
Booneville, MS 38829
April 18, 1988

To: Licensed Nurse Practitioners
State of Mississippi

Dear Nurse Practitioner:

I am a graduate nursing student in the Family Nurse Clinician program at Mississippi University for Women in Columbus, Mississippi. I am conducting a research project as part of my graduate study. Through this study, I hope to determine the various power strategies employed by nurse practitioners in resolving conflicts with physicians. Based on these findings, future research can be conducted that will determine successful power strategy implementation and allow increased power and professionalism in nursing.

Enclosed are (a) questionnaire complete with directions and demographic data and (b) self-addressed, stamped envelope. The completion and return of this questionnaire and demographic response information will serve as your consent for participation in this project. This testing will be used for research purposes only, and all information will remain anonymous and confidential.

If you should have any questions, please feel free to contact me at the above address of call (601) 728-9272. Your prompt participation in this study is vital to its success and will be greatly appreciated.

Sincerely yours,

Marlene Hurst

Enclosures

Appendix B

Instructions

When working with physicians, male or female, conflict may occur. Please read the strategy for resolving conflict on the left, then select either "Yes, I would use this strategy" or "No, I would not use this strategy." Please circle a "Yes" or "No" response under each column marked "Male Physician" and "Female Physician." You will have two answers per question (answers may both be "Yes," both be "No," or a "Yes" and a "No" response).

The test takes approximately 10 minutes to complete.

Modified Offermann and Schrier Tool

Please circle one under each column.

Strategies	Female Physician	Male Physician
1. Tell him/her directly what it is that I want.	Yes or No	Yes or No
2. Go ahead and do what I want anyway.	Yes or No	Yes or No
3. Explain the reasons why your approach is best.	Yes or No	Yes or No
4. Simply ask him/her to do what you want.	Yes or No	Yes or No
5. Do nothing.	Yes or No	Yes or No
6. Try to manipulate him/her.	Yes or No	Yes or No
7. Pout.	Yes or No	Yes or No
8. Openly discuss your differences and needs.	Yes or No	Yes or No
9. Refute his/her position.	Yes or No	Yes or No
10. Tell him/her you really need help and support.	Yes or No	Yes or No
11. Smile a lot.	Yes or No	Yes or No
12. Argue your point logically.	Yes or No	Yes or No
13. Drop subtle hints for what you want.	Yes or No	Yes or No
14. In order to maintain good relations, forget it.	Yes or No	Yes or No

Strategies	Female Physician	Male Physician
15. Try to make him/her feel guilty.	Yes or No	Yes or No
16. Tell him/her that you've studied the issue and know a lot about it.	Yes or No	Yes or No
17. Ask for it as a personal favor.	Yes or No	Yes or No
18. Get someone else to change the person's mind.	Yes or No	Yes or No
19. Compromise.	Yes or No	Yes or No
20. Back down quickly.	Yes or No	Yes or No
21. Offer him/her rewards for cooperation.	Yes or No	Yes or No
22. Clam up (become silent).	Yes or No	Yes or No
23. Try to persuade him/her that your way is right.	Yes or No	Yes or No
24. Blow up in anger.	Yes or No	Yes or No
25. Indicate that you'd like him/her better for going along with you on this.	Yes or No	Yes or No
26. Try coercion or blackmail.	Yes or No	Yes or No
27. Don't let him/her know you disagree.	Yes or No	Yes or No
28. Reason with the person.	Yes or No	Yes or No
29. Tell him/her how important this is to you.	Yes or No	Yes or No
30. Make suggestions.	Yes or No	Yes or No
31. Repeatedly remind the person of what you want until he/she gives in.	Yes or No	Yes or No
32. Negotiate something agreeable to both of you.	Yes or No	Yes or No
33. Threaten the person.	Yes or No	Yes or No

Strategies	Female Physician	Male Physician
34. Provide data to back up your contentions.	Yes or No	Yes or No
35. Flatter the person.	Yes or No	Yes or No
36. Tell the person you'll do him/her a favor if they go along with you on this.	Yes or No	Yes or No
37. Tell him/her that your way has worked in the past.	Yes or No	Yes or No
38. Make the person feel sorry for you.	Yes or No	Yes or No
39. Show the person how it's in their best interest to cooperate.	Yes or No	Yes or No
40. Find allies elsewhere in the organization who will support your opinion.	Yes or No	Yes or No
41. Use the technique of "partial truth," i.e., limit the information given to her to whatever makes your position stronger.	Yes or No	Yes or No
42. As much as possible, avoid contact with him/her.	Yes or No	Yes or No
43. Complain about her/his behaviors to others.	Yes or No	Yes or No
44. Indicate that you'll like him/her less if she refuses to go along with you on this.	Yes or No	Yes or No
45. Withhold all forms of communication except the bar essentials.	Yes or No	Yes or No
46. Tell the person you'll withhold something she/he values if she refuses to go along with you on this.	Yes or No	Yes or No
47. Make a formal complaint through proper channels.	Yes or No	Yes or No
48. Tell her there will be unpleasant consequences if she refuses to go along with you on this.	Yes or No	Yes or No

Appendix C

Demographic Data

Age: _____

Sex: _____

Highest Degree Held: _____

Type of Nurse Practitioner Program attended: _____

Number of Years as a Nurse Practitioner: _____

Area of Specialization:

CRNA_____	NM_____
FPNP_____	PNP_____
PNP_____	ANP_____
RNA_____	NNP_____
PCNP_____	OB GYN_____

Appendix D

Follow-up Letter

103 Boone Street
Booneville, MS 38829
May 10, 1988

Licensed Nurse Practitioners
State of Mississippi

Dear Nurse Practitioner:

This is a follow-up to the questionnaire you should have received approximately 2 weeks ago. If you have completed and mailed the questionnaire, I would like to thank you for your prompt response. If you have been unable to complete the questionnaire, I do understand. However, I would like to stress the importance of this study and encourage you to complete the questionnaire and return it as soon as possible. The questionnaire takes approximately 10 minutes to complete. As stated in the previous letter, all responses are completely confidential.

If you have any questions or if your questionnaire has been misplaced, please call or write. My phone number is (601) 728-9272.

Sincerely yours,

Marlene Hurst

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