ABSTRACT

THE EFFECTS OF OCCUPATIONAL CATEGORY, ORGANIZATIONAL LEVEL, ORGANIZATIONAL SIZE, SEX, AND CONFLICT OPPONENT ON THE CONFLICT HANDLING STYLES OF HOSPITAL MANAGEMENT PERSONNEL

James R. Imler

Master of Business Administration

Youngstown State University, 1980

A study was conducted to explore the relationships of occupational category, organizational level, organizational size, sex, and conflict opponent with the five conflict-handling styles of hospital management personnel. The five conflict handling styles are, Integrating (Problem-solving), Obliging (Accommodating), Dominating (Completing or Forcing), Avoiding (Withdrawal), and Compromising (Sharing).

The study found that non-clinical hospital management personnel are more dominating than clinical hospital management personnel and clinical hospital management personnel are more compromising and integrating than non-clinical hospital management personnel whether they are in conflict with superiors, peers, or subordinates.

Upper hospital management personnel are generally more dominating, integrating, and obliging than lower hospital management personnel whether they are in conflict with superiors, peers, or subordinates.

Hospital management personnel from medium-sized hospitals are more dominating and avoiding than hospital management personnel from small-sized hospitals whether they are in conflict with superiors, peers, or subordinates.

Male hospital management personnel are more dominating, while female hospital management personnel are more compromising whether they are in conflict with superiors, peers, or subordinates.

Hospital management personnel are more integrating, obliging, and compromising when in conflict with superiors than when in conflict with subordinates or peers. Hospital management personnel are more dominating when in conflict with subordinates than when in conflict with superiors or peers. A person's occupational category and conflict opponent play the most significant role in determining which conflict handling style one uses than any of the other independent variables.

TABLE OF CONTENTS

PAGE

LIST OF TABLES

CHAPTER I

INTRODUCTION

It is generally accepted that conflict is inevitable in a complex organization.[1,2] It has also been determined that a manager is likely to spend about 20% of his time dealing with some kind of conflict while performing his job.[3] More and more managers today are indicating that conflict is an important aspect of their life and their careers.

Hospital administrators are no exception. "Evidence of conflict in hospitals is readily apparent. Nurse and nonprofessional hospital employee strikes receive wide publicity. Periodically, administrator-medical staff conflicts break into public view. Furthermore, hospital-client conflicts seem to be increasing as consumers of hospital service level charges of inefficiency and inattention to consumer expectations. Internally, the administrator is continually faced with eruptions of personal or department conflicts."[4]

---

[1]P.R. Lawrence and J.W. Lorsch, Organization and environment (Homewood, Illinois: Irwin-Dorsey, 1967a), p. 6.

[2]R.E. Walton and J.M. Dutton, "The management of interdepartmental conflict: a model and review," Administrative Science Quarterly, 14, (1969), 73-84.

[3]K.W. Thomas and W.H. Schmidt, "A survey of managerial interests with respect to conflict," Academy of Management Review, 19, (1976), 315-318.

[4]R. Schulz and A.C. Johnson, "Conflict in Hospitals," Hospital Administrator, (Summer, 1971), 36-50.

Conflict in organizations is important, and since it is a fact of life, managers must learn to deal with it. If an organization does not experience some conflict, it is probably a very stagnant organization, but if it is experiencing uncontrolled conflict, it's very reason for being becomes threatened by chaos. Therefore, a moderate amount of conflict is desirable. The most important aspect about conflict, however, is not that it exists or that it should be reduced or eliminated, but rather that it should be managed properly.[5] Only then can conflict lead to innovation and change.[6,7,8]

Therefore, conflict can and does play an important part in the making of a healthy organization. But, if it is not managed properly, undesired results will almost always emerge. The following are some of the positive and negative outcomes of conflict.[9]

Positive Outcomes

Better ideas produced
People are forced to search for new approaches
Long-standing problems are dealt with
People are forced to clarify their ideas
The tension stimulates interest and creativity

---

[5]A. Rahim and T.V. Bonoma, "Managing organization conflict: a model for diagnosis and intervention," Psychological Reports, 44, (1979), 1323-1344.

[6]A. Rahim, Managing organizational conflict: a systems approach. Unpublished book from management department at Youngstown State University, 1978), p. 15.

[7]P.N. Blau and W.R. Scott, Formal Organizations (San Francisco: Chandler, 1962), p. 23.

[8]J.W. March and H.A. Simon, Organizations (New York: Wiley, 1958), p. 17.

[9]W.W. Schmidt, "Conflict: a powerful process for (good or bad) change," Management Review, (December, 1974), 4-10.

Negative Outcomes

Some people may feel defeated
Distance between people can be increased
A climate of distrust and suspicion can be developed
Where cooperation is needed, there may be an introspective withdrawal
Resistance to teamwork can develop
People may leave because of turmoil

Previous researchers have studied the amount of conflict that is useful for an organization as well as the styles that are useful for handling interpersonal conflict. The purpose of this study was not to discuss the amount of conflict, but to probe into conflict-handling styles within organization. This study specifically deals with the conflict-handling styles of the management personnel in hospitals.

Previous studies on this problem were conducted in industry, but not in hospitals or other non-profit organizations. This study is an attempt to bridge this gap. To do so effectively, however, a definition of conflict and conflict-handling styles is in order.

Rahim and Bonoma state that "Conflict occurs because one social entity perceives or is made to perceive that he (1) holds behavioral preferences, the satisfaction of which are incompatible with another person's implementation of his preferences, (2) wants some mutually desirable resources which is in short supply, such that the wants of everyone may not be satisfied, or (3) possesses values or attitudes which are salient in directing his behavior but which are perceived to be exclusive of the values or attitudes held by the other(s)."[10] Conflict can be classified into two groups---intrapersonal and interpersonal. If conflict originates with a single person, it is called intrapersonal conflict. If conflict originates between two or more persons, it is called interpersonal conflict. If interpersonal

---

[10]A. Rahim and T.V. Bonoma, "Managing organizational conflict; a model for diagnosis and intervention," Psychological Reports, 14, (1979), 1323-1344.

conflict originates within a group, or between two or more groups or organizations, they are called intragroup, intergroup, and interorganizational conflict, respectively.[11]

This study specifically deals with the interpersonal aspect of conflict. By dealing with strictly the interpersonal category of conflict, this study attempts to show significant differences in the way the people in various hospital groups generally handle their conflicts. It is the styles of handling conflict that are being studied here, not whether the actual conflicts themselves are intragroup or intergroup.

There are basically five conflict-handling styles which have emerged in literature over the years. The scheme which was used in this study is based on Blake and Mouton's managerial grid which was re-interpreted by Thomas and redefined by Rahim.[12,13,14] This study utilized the five category conflict-handling styles developed by Rahim. The styles of handling conflict were differentiated on two basic dimensions; concern for self and concern for others. The first dimension explains the degree to which a person wants to satisfy his own concern (concern for self). The second dimension explains the degree to which a person attempts to satisfy concerns of the other party (concern for others). The combination of the two dimensions result in five specific conflict-handling styles as shown in Figure 1.

---

[11]A. Rahim, Managing organizational conflict: a systems approach. (Unpublished book from management department at Youngstown State University, 1978), p. 41.

[12]R.R. Blake and J.S. Mouton, The managerial grid (Houston, Texas: Gulf Publishing, 1964), p. 10.

[13]K.W. Thomas and R.H. Kilmann, Thomas-Kilmann conflict mode instrument (New York: XiCom, 1974).

[14]A. Rahim, Managing organizational conflict: a systems approach. (Unpublished book from management department at Youngstown State University, 1978), p. 18.

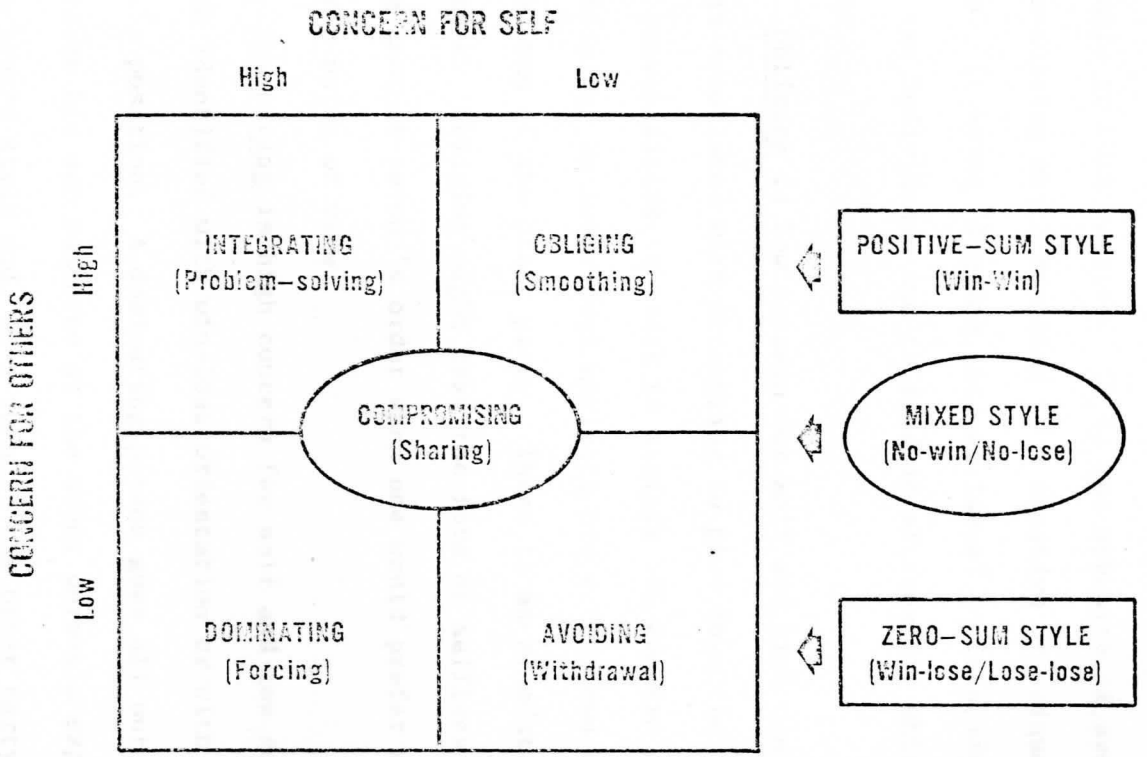


FIGURE 1 INTERPERSONAL CONFLICT-HANDLING STYLES.

Rahim reclassified integrating and obliging styles to positive-sum (win-win), dominating and avoiding styles to zero-sum (win-lose/lose-lose), and compromising style to mixed (no-win/no-lose) conflict-handling styles.[15] The descriptions of the five conflict-handling styles are shown below.

Integrating is both high concern for self and others. This involves exchange of information and confronting differences so as to reach a solution acceptable to both parties. It is the opposite of avoiding. It involves problem-solving which may lead to a creative or unique solution to a complex problem. It means "digging into an issue" to identify the underlying concerns of the two individuals and to find an alternative which meets both sets of concerns.

Obliging is low concern for self and high concern for others. This style is associated with attempting to play down the differences and emphasizing commonalities in order to satisfy the concern of the other party. When obliging, an individual neglects his or her own concerns to satisfy the concerns of the other party. There is an element of self-sacrifice in this style. Obliging might take the form of selfless generosity or charity, obeying another person's order when one would prefer not to, or yielding to another's point of view.

Dominating is high concern for self and low concern for others. It has been identified with win-lose orientation or with forcing behavior to win one's position. A dominating person goes all out to win his objective and pursues his own concerns at the other person's expense. This is a power-oriented style and, as a result, the other party's concerns are usually ignored. Dominating might mean standing up for your rights, defending a position which you believe is correct, or simply trying to win.

---

[15]A. Rahim, Managing organizational conflict: a systems approach. p. 19.

Avoiding is low concern for self and others. This style has been associated with withdrawal, buckpassing or sidestepping situations. An avoiding person fails to satisfy his own concern as well as the concern of the other party. He simply does not address the conflict. Avoiding might take the form of diplomatically sidestepping an issue, postponing an issue until a better time, or simply withdrawing from a threatening situation.

Compromising is intermediate in both concern for self and others. This is an intermediate position, whereby both parties give up something in order to make a mutually acceptable solution. Likewise, it addresses an issue more directly than avoiding, but doesn't explore it in as much depth as integrating. Compromising might mean splitting the difference, exchanging concessions, or seeking a quick middle-ground position.

Table A shows the philosophy and uses of the five conflict-handling styles or modes. This table is based on the works of Rahim and Thomas.[16,17] The proverbs in this table come from Lawrence and Lorsch's study.[18]

---

[16]A. Rahim, Managing organizational conflict: a systems approach. p. 19.

[17]K.W. Thomas, "Toward multi-dimensional values in teaching: the example of conflict behaviors," Academy of Management Review, 2 (1977).

[18]P.R. Lawrence and J.W. Lorsch, Organization and enviroment (Homewood, Illinois: Irwin-Dorsey, 19672), p. 13.

CHAPTER II

SURVEY OF RESEARCH

Conflict-Handling Styles of Clinical and Non-Clinical Staff

Schulz and Johnson found that interdependence, specialization and heterogeneity of personnel, and levels of authority appear to be related positively to conflict.[19] If these factors relate positively to conflict, then it would seem to follow that they would also relate positively to (or have direct influence on) how this conflict is handled. Hospitals consist of many departments--Nursing, Laboratory, Maintenance, X-Ray, Dietary, Accounting, to name just a few. These departments are all very specialized and diversified, yet they are highly interdependent. This interdependency may affect conflict-handling styles.

All of these departments constitute very different occupational categories which require varied backgrounds and education. Georgopoulos speaks about this matter when he compares hospitals with other larger scale organizations calling hospitals "somewhat of an anomaly."[20] It would seem then that these different educational backgrounds and disciplines could also have significant input into how conflict is handled by the people in these various occupational categories.

---

[19]R. Schulz and A.C. Johnson, "Conflict in hospitals," Hospital Administrator, (Summer, 1971), 36-50.

[20]B.S. Georgopoulos and F.C. Mann, The Community General Hospital (New York: MacMillan, 1962), p. 96.

TABLE I

DESCRIPTION OF CONFLICT-HANDLING STYLES

CONFLICT HANDLING MODES	RELATED TERMS	PROVERBS	APPROPRIATE SITUATIONS
Integrating	Problem Solving Collaborating Confronting	Come let us reason together.	To find an integrative solution when both sets of concerns are too important to be compromised. When your objective is to learn. To merge insights from people with different perspectives. To gain commitment by incorporating concerns into a consensus. To work through feelings which have interferred with a relationship.
Obliging	Accomodating Smoothing Yielding-losing Friendly helping Moving toward the other	It is better to give than to receive.	When you find you are wrong--to allow a better position to be heard, to learn, and to show your reasonableness. When issues are more important to others than yourself--to satisfy others and maintain cooperation. To build social credits for later issues. To minimize loss when you are outmatched and losing. When harmony and stability are especially important. To allow subordinates to develop by learning from mistakes.
Dominating	Competing Forcing Conflictful Moving against the other	Put your foot down where you mean to stand.	When quick, decisive action is vital--e.g., emergencies. On important issues where unpopular actions need implementing---e.g., cost cutting, enforcing unpopular rules, discipline. On issues vital to company welfare when you know you're right. Against people who take advantage of concompetitive behavior.
Avoiding	Withdrawal Losing-leaving Moving away from the other	Let sleeping dogs lie.	When the issue is trivial, or more important issues are pressing. When you perceive no chance of satisfying your concerns. When potential disruption outweighs the benefits of resolution. To let people cool down and regain perspective. When gathering information supersedes immediate decision. When others can resolve the conflict more effectively. When issues seem tangential or symptomatic of other issues.
Compromising	Sharing Splitting the difference Horse-trading	You have to give some to get some.	When goals are important, but not worth the effort or potential disruption of more assertive modes. When opponents with equal power are committed to mutually exclusive goals. To achieve temporary settlements to complex issues. To arrive at expedient solutions under time pressure. As a backup when integrating or dominating is unsuccessful.

Where else can one find the department heads and supervisors of Nursing, Dietary, Accounting, and Maintenance all under the same roof? Scott found conflict and other unpleasant forms of relations where there are marked status discrepancies between occupations.[21] Professionals in different occupational categories may handle their interpersonal conflict differently. The various occupational categories found within a hospital seem to present opportunities for differences and conflict. Since the professionals in these categories are different, one could speculate that the way in which these conflicts are handled may be significantly different also.

This study explores possible differences in the way clinical and non-clinical hospital management personnel handle their conflicts.

Conflict-Handling Styles of Upper and Lower Management

In a recent issue of the Personnel Journal, it was suggested that conflict occurs frequently between first line supervisors and managers of higher levels. "The supervisor will be seeking short-term solutions to his immediate problems, whereas the manager will be considering longer-term solutions."[22] Here we have supervisors and managers looking at and solving problems in a different way. Might they also, considering their position (level) in the organization, see conflict and how it is handled in a slightly different way? For instance, upper management hospital personnel could prove to be more dominating in their conflict-handling style than lower management simply because lower management usually isn't

---

[21]W.R. Scott, Professional in bureaucracies--areas of conflict. In H.M. Vollmer & D.L. Mills, (Eds.). Professionalization. (Englewood Cliffs, N.J.: Prentice-Hall, 1966), pp. 250-275.

[22]"The sources and resolution of conflict in management," Personnel Journal, 56, (May, 1977).

in the position to take a dominating stance. This study proposes to find out if there is a significant difference in the way upper and lower hospital management personnel handle conflict. Department heads, managers, directors, and administrators are included in upper management, whereas supervisors, assistant department heads, and assistant managers are included in lower management.

Conflict-Handling Styles of Males and Females

According to Georgopoulos, except for the medical staff, the top lay personnel and the patients, the overall work force in the community hospital is largely feminine, but is still basically under masculine dominance since most trustees, doctors and administrators are male.[23] Renwick points out that the attitudes of females regarding their work may not be shared by their male counterparts and that there are significant differences between the perceptions of males and females reported to males concerning the behavior of their supervisors.[24,25]

If such reports of incidences where males and femals have significant differences in perceiving the behavior of their supervisors are true, then it would seem very likely that males and females may also perceive conflict situations differently and therefore handle conflict with different styles.

---

[23]B.S. Georgopoulos and F.C. Mann, The Community General Hospital New York: MacMillan, 1962), p. 91.

[24]P.A. Renwick, "The effects of sex differences on the perception and management of superior-subordinate conflict: an exploratory study," Organizational Behavior and Human Performance, 19, (1977), 403-415.

[25]M.G. Pryor and R.W. Mondy, "How men and women view their jobs--- and what this means to the supervisor," Supervisory Management, (November, 1978), 17-24.

Generally, in most life situations, males, by nature, are considered to be more dominating than females. Is this true in the hospital setting where there is much greater potential for male-female and female-female conflict because of the unusual mixture of the work force? This study purposes to find out if males and females handle conflict any differently when in the hospital environment.

Conflict-Handling Styles of Superiors, Peers, and Subordinates

Watson observed that the relative power and status of two parties has an impact on their conflict behavior. "Parties may be unassertive in dealing with higher power parties out of deference or fear of punishment, while finding it easy to ignore or dominate lower-parties."[26] Thomas found that higher status individuals and departments resent and resist demands or requests by lower-status parties.[27]

These suggest the important part that the conflict opponent plays in determining which conflict-handling style one uses. This study proposes to find out just what impact the conflict opponent has in determining conflict-handling styles of hospital management personnel.

Conflict-Handling Styles of Management Personnel from Small and Medium Hospitals

As hospitals grow, they become more specialized and complex. In turn, out of necessity, hospital management personnel begin to change their behaviors to adapt to more specialized and complex situations. This change in size and complexity can also affect a change in how an individual handles his or her conflict.

---

[26] J.B. Watson, Behaviorism (Chicago: University of Chicago Press, 1958), p. 23.

[27] K.W. Thomas, "Organizational conflict", In Steven Kerr (Ed.). Organizational Behavior. (Columbus, Ohio: Grid Publishing, 1979), pp. 151-181.

Davis suggested that "increasing size develops a series of interrelated symptoms and problems."[28,29] Although Davis did not actually conduct any research on conflict-handling styles and organizational size, what he does say makes sense and is being used here to show that size of organization can possibly affect human behavior. How an individual handles his or her conflict is certainly part of their human behavior.

Since size of organization can and does change the environment in which people interrelate, and this, in turn, affects human behavior, there is a possibility that size of organization could also affect the way in which people handle conflict.

The above statements relate to possible effects that size may have on human behavior including conflict handling behavior. This study proposes to find out if there are any significant differences in how hospital management personnel from small and medium-sized hospitals handle conflict.

---

[28]K. Davis, Human Behavior at Work (New York: McGraw-Hill, 1977), p. 207.

[29]B.C. Reimann, "Dimensions of structure in effective organizations: some empirical evidence," Academy of Management Journal, (December, 1974), 693-708.

CHAPTER III

METHOD

INSTRUMENT

The method of collecting the data for this study was in the form of a questionaire designed by Rahim (see Appendix B). Two hundred and thirty-four questionaires in all were distributed out of which one hundred and fifty-three were returned in usable form. This represents a usable response rate of 65%. The questionaires were then coded, key-punched, and checked thoroughly for errors. The questionaires were taken in person to the hospitals and were thoroughly explained to most of the people who took part in filling them out. A cover letter also accompanied the questionaire (see Appendix A).

A cover letter (see Appendix C) explaining the study was mailed to the administrators of eight ordinary community general hospitals located in the Tri-State area of Ohio, West Virginia, and Pennsylvania. These hospitals are classified by the American Hospital Association in the Hospital Guide Issue as "General Medical-Surgical Short-Term not-for-profit hospitals." Of the eight hospitals contacted, four were medium-sized (from 250 beds to 500 beds) and four were small-sized (less than 250 beds). Also enclosed with each letter was a copy of the questionaire to be used in the study and a brief thesis proposal (see Appendix D). A follow-up phone call attempted to secure an appointment with the administrator of the hospital or one of his representatives. Five out of the original eight hospitals contacted agreed to take part in the study--(3 small and 2 medium) (3 from Pennsylvania, 1 from West Virginia, and 1 from Ohio).

SUBJECTS

The subjects used in this study are as follows:

Occupational Category

Clinical management: All clinical management departments along with the nursing and emergency services departments.

Non-clinical management: Hospital supportive management departments and administration not in the category of nursing or other clinical areas.

Organizational Level

Upper management: Administration, assistant administration, associate administration, directors, managers, department heads, and other heads or chiefs.

Lower management: Assistant department heads or supervisors.

Note: In nursing, supervisors become upper management and head nurses become lower management.

Sex

Male and female.

Conflict Opponent

Superiors, peers and subordinates.

Size

Small hospital: 250 beds or less.
Medium hospital: 250-500 beds.

Therefore, occupational category, organizational level, sex, conflict opponent, and hospital size are the independent variables in the study and the five conflict-handling styles become the dependent variables. In this study, the five conflict-handling styles are a function of occupational category, organizational level, sex, conflict opponent, and hospital size.

ANALYSIS

The Statistical Package for the Social Sciences computer Package was used to analyze the data in this study.[30]

Construct Validity

A factor analysis was conducted on the data relating to conflict-handling styles to determine if the item would cluster around five factors (the five conflict-handling styles). The uninterpretable items and the items which loaded at less than .40 were eliminated and a second factor analysis was run with the rest of the items. This enabled the most valid items to be used in determining five conflict-handling styles. Table 1 shows the results of the second factor analysis. Five valid factors emerged. The indices of the five conflict-handling styles were computed by adding the responses of the subjects to the items corresponding to each factor. This total was then divided by the number of items in that factor.

Reliability

The reliability of these five indices were tested through Spearman-Brown and Cronbach Alpha (Table 2). The results show that except compromising, the other four styles were reliable. Table 3 shows the inter-correlations among the five conflict-handling styles. Except the correlation between integrating and compromising, all correlations were found to be very low as was expected. This suggested that the five conflict-handling styles were quite independent of each other.

---

[30] N.H. Nie, J.G. Jenkins, K. Steinbrenner, & D.H. Bent, Statistical Package for the Social Sciences (New York: McGraw-Hill, 1975).

Table 2

Factor Analysis
Varimax Rotated Factor Matrix

Statement	Factor 1 Integrating	Factor 2 Dominating	Factor 3 Avoiding	Factor 4 Obliging	Factor 5 Compromising
Integrating					
09. Collaborate with the other party to come up with decisions acceptable to both of us.	.64	-.01	-.08	.07	.19
16. Investigate into an issue, with the collaboration of the other party, to find solution (s) acceptable to both of us.	.68	-.01	.05	.07	.33
24. Try to work with the other party to find solution (s) which fully satisfy our expectations.	.47	.09	.16	.21	.07
34. Try to integrate my ideas with the ideas of the other party to come up with a solution.	.61	-.06	-.09	.02	-.09
Obliging					
03. Back down to the other party's wishes.	-.15	-.05	.09	.48	.20
21. Accommodate the wishes of the other party.	.09	-.03	.05	.70	-.07
26. Try to satisfy the expectations of the other party.	.22	-.05	.03	.47	-.03
Dominating					
10. Use my power to win a competitive situation.	-.07	.67	.00	-.03	.10
33. Try to win the conflict situations.	.07	.63	.04	-.11	-.08
39. Use my authority to make a decision in my favor.	-.15	.76	-.05	-.03	.06
Avoiding					
11. Avoid an argument.	.08	-.11	.70	.07	.11
15. Avoid an encounter with the other party.	-.12	-.00	.46	.20	.25
19. Avoid unpleasant exchanges with the other party.	.10	.08	.61	-.01	-.07
Compromising					
32. Ignore the views of the other party.	-.34	.08	.01	.04	-.01
08. Attempt to play down the differences and emphasize commonalities.	.12	.05	-.01	.09	.49
14. Search for a solution which can reduce our disagreement for the time being.	.11	.01	.18	.16	.49

TABLE 3

Reliabilities of Varimax Rotated Factor Indices

Factors	Spearman-Brown	Cronbach Alpha
Integrating	.62	.68
Obliging	.50	.56
Dominating	.75	.72
Avoiding	.57	.60
Compromising	.36	.36

TABLE 4

Pearson Correlation Coefficients

	Integrating	Obliging	Dominating	Avoiding	Compromising
Integrating	1				
Obliging	.25	1			
Dominating	.08	.01	1		
Avoiding	.14	.20	-.03	1	
Compromising	.31	.11	.07	.22	1

One-Way Analysis of Variance

Separate one-way analysis of variance was performed for each dependent and independent variable. These tests were conducted to determine which functions, if any, would be significant enough to warrant further testing. The functions found to be significant in these tests were then used in further, more rigorous tests. The results of these tests are presented in Table 4.

Four-Way Factorial Analysis of Variance

Five, Factorial Analyses of Variance were computed with 2 x 2 x 2 x 2 (Organizational Category x Organizational Level x Size x Opponent) deigns---one for each conflict-handling style used as a dependent variable. The results are summarized in Table 5. Five multiple classifications were also performed using the above dependent and independent variables. The results are shown in Table 6.

Discriminant Analysis

A discriminant analysis was conducted to see if the five conflict-handling styles could discriminate between males and females. The results are shown in Table 7.

TABLE 5

SUMMARY OF ONE-WAY ANALYSES OF VARIANCE RESULTS

Variable	DF	Integrating F	Obligirg F	Dominating F	Avoiding F	Compromising F
Occupational Category	1,457	4.48**	4.28**	23.51****	3.15*	13.24****
Organizational Level	1,457	6.28**	1.75	11.58****	.48	3.54*
Sex	1,456	2.64	.16	20.57****	.43	6.30**
Hospital Size	1,457	1.88	.20	7.92***	5.45***	.32

* p less than .10
** p less than .05
*** p less than .01
**** p less than .001

TABLE 6
Factorial Analysis of Variance
(With Main Effects and Interaction Effects)

Source of Variation	F-Values				
	Integrating F	Obliging F	Dominating F	Avoiding F	Compromising F
Main Effects					
Occupational Category	4.64*	4.97*	19.27***	2.38	15.49***
Organizational Level	6.81**	1.67	10.86**	.53	4.83*
Hospital Size	1.10	.53	5.93*	4.37*	1.26
Conflict Opponent	4.76**	36.14***	3.88*	1.87	1.47
2-Way Interactions					
Occupational Category by Organizational Level	.16	.28	.91	.08	.23
Occupational Category by Hospital Size	1.81	.21	.18	.06	.00
Occupational Category by Conflict Opponent	1.21	.18	.60	.16	.02
Organizational Level by Hospital Size	5.42**	9.29**	2.04	5.43*	14.52***
Organizational Level by Conflict Opponent	.95	.25	.72	.03	.36
Hospital Size by Conflict Opponent	.00	3.96*	.44	.02	.04
3-Way Interactions					
Occupational Category by Organizational Level by Hospital Size	.04	5.94*	6.88**	2.56	8.40**
Occupation Category by Organizational Level by Conflict Opponent	.19	.21	.34	.19	.49
Occupational Category by Hospital Size by Conflict Opponent	1.16	.01	.03	.05	.34
Organizational Level by Hospital Size by Conflict Opponent	.81	.18	.24	.25	.36
4-Way Interactions					
Occupational Category by Organizational Level by Hospital Size by Conflict Opponent	.33	.06	.31	.00	.10

* p less than .05 ** p less than .01 *** p less than .001

TABLE 7

MULTIPLE CLASSIFICATION ANALYSIS

Variable and Category	Integrating Adjusted Deviation	Obliging Adjusted Deviation	Dominating Adjusted Deviation	Avoiding Adjusted Deviation	Compromising Adjusted Deviation
	Grand Mean (6.00)	Grand Mean (3.66)	Grand Mean (3.00)	Grand Mean (4.56)	Grand Mean (4.74)
Occupational Category					
Non-Clinical	-0.09	0.11	0.29	0.10	-0.26
Clinical	0.07	-0.10	-0.25	-0.09	0.22
Organizational Level					
Upper Management	0.08	0.05	0.16	-0.03	0.11
Lower Management	-0.12	-0.08	-0.25	0.05	-0.17
Hospital Size					
Small	0.05	0.04	-0.19	-0.16	-0.09
Medium	-0.03	-0.03	0.12	0.10	0.05
Conflict Opponent					
Superiors	0.11	0.54	-0.19	0.13	0.08
Peers	0.05	-0.14	-0.03	0.02	0.07
Subordinates	-0.16	-0.40	-0.22	-0.15	-0.15
R2	0.05	0.15	0.10	0.03	0.05

TABLE 8

Results of Discriminant Analysis with Five Factors and Two Groups--Male and Female

a) Discriminant Function

	Eigenvalue	Canonical Correlation	Wilks' Lambda	Chi-Square	DF	P-Value
Conflict with Superiors	.09	.29	.92	15.70	4	.0035
Conflict with Peers	.07	.25	.94	11.46	2	.0032
Conflict with Subordinates	.15	.37	.87	26.09	4	.0000

b) Discriminant Function Coefficients

	Factors	Standardized	Rank
Conflict with Superiors	Integrating	-.49	3
	Obliging	-.48	4
	Dominating	-.74	1
	Compromising	.65	2
Conflict with Peers	Dominating	.79	1
	Compromising	-.64	2
Conflict with Subordinates	Obliging	-.41	3
	Dominating	-.61	2
	Avoiding	-.23	4
	Compromising	.88	1

c) Centroids of Groups in Reduced Space

	Males	Females
Conflict with Superiors	-.53	.17
Conflict with Peers	.45	-.14
Conflict with Subordinates	-.69	.22

d) Prediction Results of Discriminant Analysis

	Percentage of "grouped" cases correctly classified
Conflict with Superiors	69.9
Conflict with Peers	65.4
Conflict with Subordinates	69.4

CHAPTER IV

RESULTS

The results of this study were encouraging. There were significant differences in how clinical and non-clinical; upper and lower; male and female hospital management personnel handle their conflict. There were also significant differences in one's conflict handling style when considering conflict opponent and hospital size.

Occupational Category

It was found that occupational category is one of the most influential variables in determining the conflict-handling style of hospital management personnel. Analyses of variance clearly shows that non-clinical hospital management tend to use either the compromising or the integrating conflict-handling style. These results can be found by noting which main effects from Table 5 are significant and then turning to Table 6 and adding the adjusted deviations from the mean for each category of conflict-handling style to that style's mean. For example, look across the occupational category row to the compromising column. There you will find the figure -0.26 for non-clinical and 0.22 for clinical. When these figures are added to the grand mean of that column (4.74), one can clearly see that the clinical figure is higher because it it positive. Thus clinical hospital management personnel are more compromising. (The same kind of calculation is used throughout the results of this paper when discussing analysis of variance testing.)

Organizational Level

Results were conclusive that upper hospital management personnel are generally more dominating ($F=10.86$, $p < .01$), integrating ($F=6.81$, $p < .01$), and compromising ($F=4.83$, $p < .05$) than lower hospital management personnel. But when the size of hospital is considered along with organizational level, it was found that lower hospital management personnel from small hospitals are more integrating ($F=5.42$, $p < .01$) than other management personnel in either small or medium hospitals. It was also found that when size of hospital is considered along with organizational level of hospital management personnel, upper management from medium hospitals are more avoiding ($F=14.52$, $p < .001$) and compromising ($F=5.43$, $p < .05$) than other management personnel in either small or medium hospitals.

The only three-way interaction that had any significance at all involved size of hospital, occupational category, and organizational level. With all these variables interacting, it was found that in medium-sized hospitals, the upper, non-clinical management were more dominating ($F=6.88$, $p < .01$). In small-sized hospitals, however, the lower, non-clinical management were more dominating in their handling of conflict.

Hospital Size

In addition to the above results, it was found that hospital management personnel from medium-sized hospitals were more dominating ($F=5.93$, $p < .05$) and avoiding ($F=4.37$, $p < .05$) than hospital management personnel from small-sized hospitals.

Conflict Opponent

The person with whom one is having conflict seems to be one of the most influential variables in determining which conflict-handling style one uses when in conflict. Once again, by the use of analysis

of variance testing, the results show that hospital management personnel are more integrating ($F=4.76$, $p < .01$) and obliging ($F=36.14$, $p < .001$) when in conflict with superiors than when in conflict with subordinates or peers.

Also, the results show that hospital management personnel are more dominating when in conflict with subordinates than when in conflict with superiors or peers ($F=3.88$, $p < .05$).

Sex

It was found that sex could not be used in the analysis of variance because some of the cells in the factorial design contained less than 5 subjects. This is not uncommon in the female-dominated hospital setting. Therefore, discriminant analysis was conducted to determine whether the five conflict-handling styles could discriminate between males and females. The discriminant function was statistically significant (indicating the ability to discriminate), but the discriminating power of the function was not very high.

The function designed to test the ability of the five conflict-handling styles to discriminate between males and females was found to be significant to the .01 level (see Table 7). Further analysis indicates that the discriminating power of the function was not very great. Table 7 shows, when a respondent was in conflict with a superior, the Eigenvalue was at .09; the Canonical Correlation was set at .29; the the Wilks' Lambda was at .92. These are all indicators of strength of the discriminating power of the function. The higher Wilks' Lambda, the weaker the discriminating power. Still some very interesting and significant information emerges from this analysis. Again, refering to Table 7, one can see that the factors (styles) which discriminate between male and female

the most, when in conflict with superiors (in order) were: dominating, compromising, integrating, and obliging.

Since the centroid of the males was negative, the dominating, integrating, and obliging conflict-handling styles were more predominant in males than in females. Likewise, since the centroid of the females was positive, the compromising conflict-handling style was more predominant in females than in males. This was found to be true the majority of the time, according to the test results, no matter which conflict opponent the hospital management personnel was engaged with in conflict. In summary, discriminant analysis showed that males were more dominating and integrating, while females were more compromising in the hospital management environment.

CHAPTER V

DISCUSSION AND CONCLUSION

This study explored the relationships between the five conflict-handling styles and occupational category, organizational level, organizational size, sex, and conflict opponent. Some interesting relationships emerged. In future studies, these could be tested as hypotheses. The conclusions to be drawn from this study are the following:

1. Non-Clinical hospital management personnel are more dominating than Clinical hospital management personnel.
2. Clinical hospital management personnel are more compromising and integrating than Non-Clinical hospital management personnel.
3. Upper hospital management personnel are generally more dominating, integrating, and compromising than Lower hospital management personnel.
4. However, when Size of hospital is considered along with Organizational Level, it was found that Lower hospital management personnel from Small hospitals are more integrating than other management personnel in Small or Medium hospitals. Upper management from Medium-sized hospitals are more avoiding and compromising than other management personnel in Small or Medium hospitals.
5. Also, when Size of hospital and Occupational Category are considered along with Organizational Level, it was found that in Medium-sized hospitals, it is the upper, Non-Clinical management who are more dominating. But in Small-sized hospitals, it is the Lower, Non-Clinical management who are more dominating in their handling of conflict.

6. Hospital management personnel from Medium-sized hospitals are more dominating and avoiding than hospital management personnel from Small-sized hospitals.
7. Male hospital management personnel are more dominating, whereas Female hospital management personnel are more compromising.
8. Hospital management personnel are more integrating, obliging, and compromising when in conflict with Superiors than when in conflict with Subordinates or Peers.
9. Hospital management personnel are more dominating when in conflict with Subordinates than when in conflict with Superiors or Peers.
10. The two variables, Occupational Category and Conflict Opponent, have the greatest effect on a person's conflict-handling style than the other independent variables--Sex, Organizational Size, and Organizational Level.

The objective of this study was met. This study establishes the ground-work for further empirical research studies in the area of organizational conflict in hospitals, This study has determined some insights into what conflict-handling styles different hospital management personnel use.

Now that we have these insights, whan can be done with them? First of all, one must at all times remember that these are just insights into how hospital management personnel handle their interpersonal conflict. The above named statements summarizing the results of this study must never be considered to be absolute descriptions of exactly how hospital personnel handle their conflict. Rather, these statements should be considered to be significant generalities about hospital management personnel. Nevertheless, these generalities have important meanings--meanings that can, hopefully, be used by hospital management personnel themselves to enable them to manage more effectively.

An interesting thought which surfaced during the research of this study was---if asked, possibly many hospital administrators, managers, and supervisors, would say that most of the time they use the integrating style of handling conflict, yet this style is not the one which is most predominant among these hospital personnel. This points out that the conflict instrument used in this study was free from social desirability bias. It seems to be socially desirable to be a problem-solver in the face of conflict. In the article about social desirability by Thomas and Kilmann, it was pointed out that most people tend to self-assess themselves into the socially desirable style like integrating.[31] Many of us feel that we use a certain style of handling conflict, but when tested, we may find that we don't really employ that particular style when actually faced with conflict. Possibly the answer to this phenomenon is that, "Behavioral sciences have greater impact on executive attitudes than on daily behavior."[32]

What we believe in and what we do, many times just isn't the same thing. Furthermore, what we believe others stand for or what we believe others will do when faced with certain situations, many times just isn't so either. "Both parties have a tendency to translate ongoing events into the frame of reference of their own concerns. In social interaction, actor and observer focus upon different cues and have access to different information. In conflict, both parties are occupied with their own behavior.

---

[31]K.W. Thomas and R.H. Kilmann, "The social desirability variable in organizational research: an alternative explanation for reported findings," Academay of Management Review, 18 (December, 1975), 741-752.

[32]J.S. Bowman, "The behavioral sciences: fact and fantasy in organizations," Personnel Journal, 55 (1976), 395-397.

The three most cooperative modes---collaboration, compromise, and accommodation---compose 74% of self-attributions, compared with only 12% for attributions to others. Nearly three-quarters of the executives attributed competitive intent to the other party, compared with only 21% in self-attributions."[33] This study by Thomas and Pondy is very revealing of human nature. No matter what type of conflict-handling style hospital management personnel think they use, the results clearly show that the predominant style most prevalent in small and medium-sized hospitals is the dominating style---not integrating or compromising. "People do not always do what they believe they should."[34] Who knows? Dominating as a conflict-handling style in hospitals may be just what the doctor ordered! "Some recent findings have shown that more of the successful methods for resolving interpersonal conflicts involving 'forcing' rather than problem-solving'."[35]

Another point to remember is that there is a difference between managerial influence style and managerial conflict resolution style (conflict-handling style). The fact that certain hospital personnel possess certain conflict-handling styles is only half of the story. The other half of the story is what type of influence style do they have when they are not in conflict with someone--which is, hopefully about 80% of the time? Conflict resolution or handling styles are extremely important though, because of the profound effects they can have on very delicate situations.

---

[33]K.W. Thomas and L.R. Pondy, "Toward an 'intent' model of conflict managements among principal parites," Human Relations, 30 (1977), 1089-1102.

[34]R.G. Corwin, "The professional employee: a study of conflict in nursing roles," American Journal of Sociology, 66 (1961), 407-412.

[35]R. Katz, "The influence of group conflict on leadership effectiveness," Organizational Behavior and Human Performance, 20 (1977) 265-286.

While much has been done in the area of conflict research, the area is still quite empty in hospital conflict research. Much needs to be done in this area, and soon, as the hospital world continues to become more and more complex. Between 1945 and 1970, less than 2 percent of all funds for research and development went to support the social sciences. Yet, despite this inbalance in support, social sciences research is continually discovering new, promising approaches to conflict resolution.[36]

The findings of this study are quite interesting and revealing. Future studies should further explore the relationships suggested here. As the environment becomes more complex, hospital management personnel will be demanding to know more about conflict management so that they can serve their hospitals more effectively.

---

[36]R. Likert and J.G. Likert, New ways of managing conflict (New York: McGraw-Hill, 1976), p. 6.

APPENDIX A

QUESTIONAIRE COVER LETTER

Dear Respondent:

The enclosed questionaire measures how you handle your differences with your superiors, peers and subordinates. The questionaire is valid and reliable (proven through extensive statistical tests) and is used here to see how hospital personnel manage their differences. The information collected from you will be kept in strict confidence.

It takes about 15 to 20 minutes to fill out the questionaire. Your cooperation will enable me to complete my MBA thesis for which the data is collected.

Your time and effort are greatly appreciated.

Sincerely yours,

James R. Imler

James R. Imler
MBA Candidate
Youngstown State University

Enclosure

APPENDIX B

You may have incompatibilities, disagreements, or differences (i.e., conflict) with your superiors, peers, and subordinates for some reason or other. Please rate each of the following statements thrice to indicate how you handle your interpersonal conflict with the other party (i.e., superiors, peers, or subordinates). Please think of as many conflict situations as possible in responding to these items.

7	6	5	4	3	2	1	NA
Strongly Agree	Agree	Slightly Agree	Uncertain	Slightly Disagree	Disagree	Strongly Disagree	Not Applicable

STATEMENTS	OTHER PARTY: SUPERIORS	PEERS	SUBORDINATES
In case of conflict with the other party, I:			
01. Attempt to find a middle course to reduce our disagreements	____	____	____
02. Stay away from ironing out our disagreements	____	____	____
03. Back down to the other party's wishes	____	____	____
04. Encourage the other party to work with me on solution(s) which can fully satisfy our needs and expectations	____	____	____
05. Postpone discussion of an issue until a better time	____	____	____
06. Tolerate indulgence of the other party	____	____	____
07. Am firm in pursuing my side of the issue	____	____	____
08. Attempt to play down the differences and emphasize commonalities	____	____	____
09. Collaborate with the other party to come up with decisions acceptable to both of us	____	____	____
10. Use my power to win a competitive situation	____	____	____
11. Avoid an argument	____	____	____
12. Engage in bargaining with the other party	____	____	____
13. Try not to hurt feelings of the other party	____	____	____
14. Search for a solution which can reduce our disagreement for the time being	____	____	____
15. Avoid an encounter with the other party	____	____	____
16. Investigate into an issue, with the collaboration of the other party, to find solution(s) acceptable to both of us	____	____	____
17. Allow the other party to make decisions to satisfy his/her needs	____	____	____
18. Give in a little, if the other party is willing to do the same, so that a decision can be made	____	____	____
19. Avoid unpleasant exchanges with the other party	____	____	____
20. Work with the other party to reach the best possible solution to the problem	____	____	____
21. Accommodate the wishes of the other party	____	____	____
22. Negotiate with the other party so that a decision can somehow be made	____	____	____
23. Leave the problem unresolved	____	____	____
24. Try to work with the other party to find solution(s) which fully satisfy our expectations	____	____	____
25. Try not to get involved in the resolution of conflict	____	____	____

7 Strongly Agree	6 Agree	5 Slightly Agree	4 Uncertain	3 Slightly Disagree	2 Disagree	1 Strongly Disagree	NA Not Applicable

STATEMENTS	OTHER PARTY: SUPERIORS	PEERS	SUBORDINATES
In case of conflict with the other party, I:			
26. Try to satisfy the expectations of the other party	___	___	___
27. Use "give and take" so that our conflict can be resolved	___	___	___
28. Hold on to my viewpoint on the problem	___	___	___
29. Try to be generous to the other party	___	___	___
30. Tell the otner party what must be done	___	___	___
31. Collaborate with the other party to come up with unique solutions	___	___	___
32. Ignore the views of the other party	___	___	___
33. Try to win the conflict situations	___	___	___
34. Try to integrate my ideas with the ideas of the other party to come up with a solution	___	___	___
35. Try to oblige the other party	___	___	___
36. Confront the other party to resolve our disagreements	___	___	___
37. Keep my relation with the other party at arm's length	___	___	___
38. Try to reach a compromise with the other party	___	___	___
39. Use my authority to make a decision in my favor	___	___	___
40. Strongly defend my position	___	___	___

Demographic information:

1. Occupation _____

2. Job title _____

3. Do you have supervisory or administrative responsibilities? (Please check one)

_____Yes _____No

4. Sex: _____Male _____Female

5. Full time work experience (in years)_____

APPENDIX C

INTRODUCTORY COVER LETTER

James R. Imler
315 Elm Street
Grove City, PA 16127

Dear Mr.

My name is Jim Imler. I am an MBA Candidate at Youngstown State University and am presently writing my thesis under the direction of Dr. Afzalur Rahim in the Management Department of the Graduate School of Business. Prior to going back to school, full-time, I was in hospital management for over three years and found hospital work quite interesting.

I am writing to you because I need your assistance in conducting a survey of some of your hospital personnel. (See enclosure) I would like to have your permission to ask your department heads, supervisors, and some nursing personnel for about 20 minutes of their free time--not hospital time.

My thesis is concerned with how hospital personnel deal with conflict and, as the questionaire cover letter states, cooperation in obtaining data is essential for me to arrive at any significant conclusions.

In a few days, I will be calling you to set up a convenient date and time to discuss this matter. If at that time you would like to refer me to your Personnel Department Head or one of your assistants, that would be fine.

I appreciate your consideration and cooperation and look forward to talking with you.

Sincerely yours,

James R. Imler

APPENDIX D

MBA Proposal

Jim Imler

1. OBJECTIVE

Hospitals are very unique "businesses". They are composed of many different specialized areas, all of which are independent of, yet dependent on, each other. The purpose of this study is to show that the following divisions, or categories, of hospital management will show marked differences in the way they handle their differences.

2. INDEPENDENT VARIABLES

a) *Occupational Category (Position)
   1. Non-Clinical (Supportive)
   2. Clinical

b) **Organizational Level
   1. Upper Management
   2. Lower Management

c) Sex
   1. Male
   2. Female

d) Conflict Opponent
   1. Superior
   2. Peer
   3. Subordinate

e) Size
   1. Small (250 beds or less)
   2. Medium (250-500 beds)

DEPENDENT VARIABLES

a) Five Conflict Handling Styles
   1. Integrating
   2. Obliging
   3. Dominating
   4. Avoiding
   5. Compromising

3. PROBLEM STATEMENTS

a) There is a significant difference in the way Clinical and Non-Clinical hospital management personnel handle conflict.

b) There is a significant difference in the way Upper and Lower hospital management personnel handle conflict.

c) There is a significant difference in the way Male and Female hospital management personnel handle conflict.

d) There are significant differences in the way hospital management personnel handle conflict with Superiors, Peers, and Subordinates.

e) There is a significant difference in the way hospital management personnel from small and medium-sized hospitals handle conflict.

4. STATISTICAL TESTS
   a) Factor Analysis (Validity)
   b) Task Name Analysis (Reliability)
   c) Pearson Correlation (Reliability)
   d) Five, One-Way Anova F-Tests
   e) Discriminant Analysis (Can the Five Conflict Handling Styles discriminate between males and females?)
   f) Frequency Testing
   g) Four, One-Way Anova Tests
   h) One, Four-Way Factorial Anova Test
   i) Level of Significance is at alpha level .05

5. DATA COLLECTION METHOD
   The method of data collection used will be in the form of a personal contact survey questionaire, designed and tested by Dr. Afzalur Rahim of Youngstown State University.

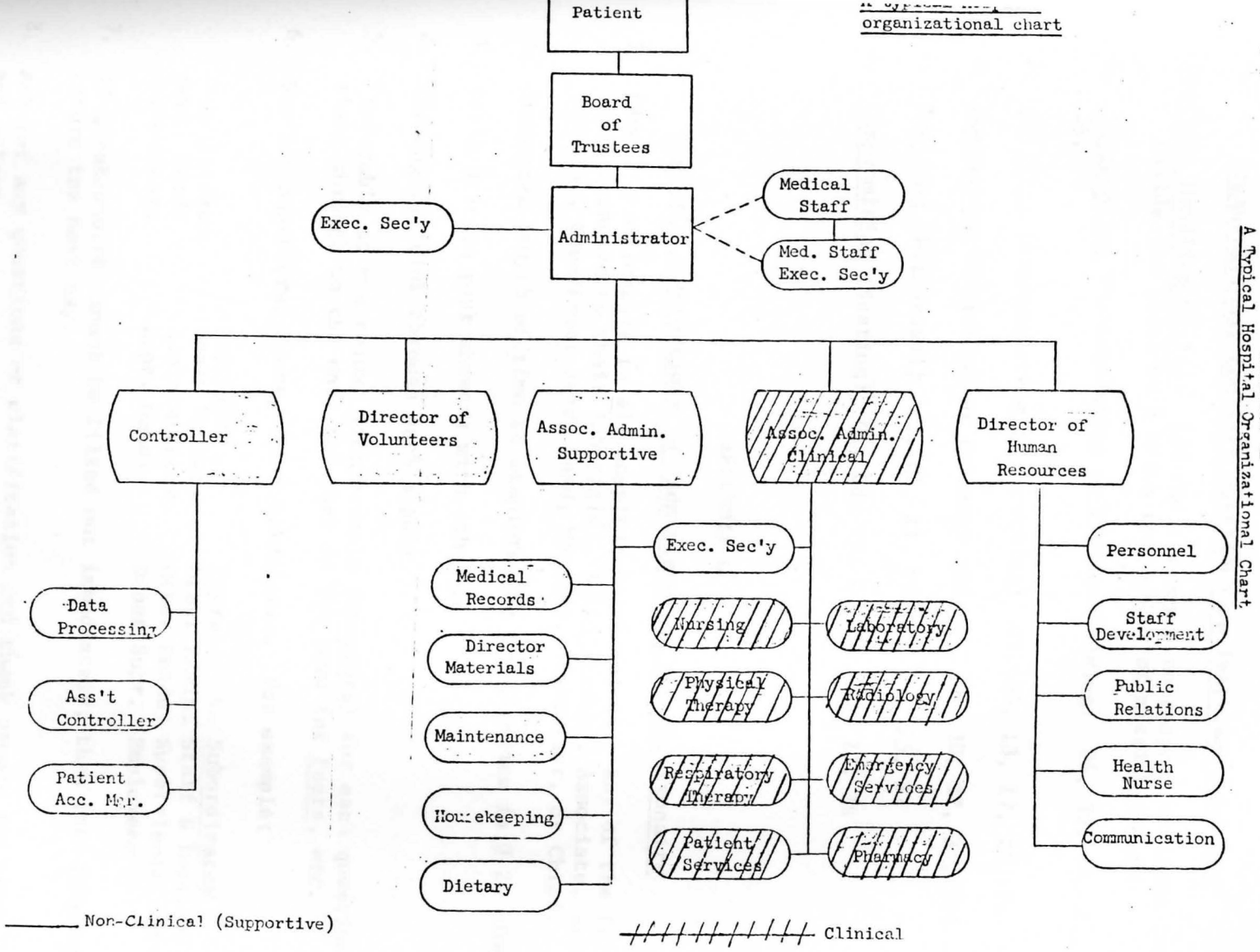
* Clinical management includes all clinical management departments along with the Nursing and Emergency Services departments. Non-Clinical management includes all supportive departments and administration not in the category of nursing or other clinical areas.

** Upper management includes all administrators, directors, managers, department heads or other heads or chiefs. Lower management includes all assistants and supervisors.

Note: In nursing, supervisors become upper management and head nurses become lower management.

APPENDIX E

A Typical Hospital Organizational Chart



APPENDIX F

Organizational Conflict Questionaire Instrument Scoring

Conflict Handling Styles: Add the responses to respective items and divide the total by 8 minus the number of missing values.

1. Integrating (Collaborating or Problem-Solving) 04, 09, 16, 20, 24, 31, 34, 36
2. Obliging (Accommodating or Smoothing) 03, 06, 13, 17, 21, 26, 29, 35
3. Dominating (Competing or Forcing) 07, 10, 28, 30, 32, 33, 39, 40
4. Avoiding (Withdrawal) 02, 05, 11, 15, 19, 23, 25, 37
5. Compromising (Sharing) 01, 08, 12, 14, 18, 22, 27, 38

APPENDIX G

Leader's Instructions for Administering the Questionaire

1. Give a questionaire to all hospital personnel with any of the following words attached to their job title: Administrator, Associate, Assistant, Director, Department Head, Head, Manager, Supervisor, or Chief.
2. Suggested length of time to complete the questionaire is @ 20 minutes.
3. Don't discuss your answers with others.
4. Thoroughly think through each answer.
5. Preferably do one column (for example Superiors) for each question right through to the end, and then do the same for Peers, etc.
6. Explain Superiors, Peers, and Subordinates. For example:

	Superiors	Peers	Subordinates
Administrator	Board Members	Other Admin.	Staff & Dept. Heads
Dept. Heads	Administrator	Other Heads	Supervisors, Employees
Supervisors	Dept. Heads	Other Supr.	Employees

7. If questionaire cannot be filled out immediately, then take home and return the next day.
8. Ask for any questions or clarification and thank people for their time and effort.

APPENDIX H

Frequency Groupings of Raw Data by Independent Variables (N=153)

		F
1.	Number of usable responses from Small Hospitals (3)	58
	Number of usable responses from Medium Hospitals (2)	95
2.	Non-Clinical Management Personnel	70
	Clinical Management Personnel	83
3.	Upper Management	93
	Lower Management	60
4.	Males	45
	Females	108

APPENDIX I

Questionaire Response Rates

1. Hospital Response Rate (62.5%)

Eight Hospitals were contacted to participate in the study. Five hospitals responded. Three out of the five responded strongly, and two responded rather weakly in terms of volume of questionaires.

The response rate for Small hospitals was 70%. The response rate for Medium hospitals was slightly less at 66%.

2. Participant Response Rate

The over-all participant response rate was 68%. 97% of all questionaires returned were usable. Thus, 234 were distributed and 153 were returned in usable form. This then, made the over-all response-usable rate 65%.

BIBLIOGRAPHY

Books

1. Blake, R.R., and Mouton, J.S. The managerial grid. Houston, Tex.: Gulf Publishing, 1964.

2. Blau, P.M., and Scott, W.R. Formal organizations. San Francisco: Chandler, 1962.

3. Davis, K. Human behavior at work. New York: McGraw-Hill, 1977.

4. Georgopoulos, B.S., and Mann, F.C. The Community General Hospital. New York: MacMillan, 1962.

5. Lawrence, P.R., and Lorsch, J.W. Organization and environment. Homewood, Illinois: Irwin-Dorsey, 1967a.

6. Likert, R., and Likert, J.G. New ways of managing conflict. New York: McGraw-Hill, 1976.

7. March, J.W., and Simon, H.S. Organizations. New York: Wiley, 1958.

8. Nie, N.H., Hull, C.H., Jenkins, J.G., Steinbrenner, K., and Bent, D.H. Statistical Package for the Social Sciences. New York: McGraw-Hill, 1975.

9. Rahim, A. Managing organizatonal conflict: a systems approach. Unpublished book from management department at Youngstown State University, 1978.

10. Scott, W.R. Professional in bureaucracies--areas of conflict. In H.M. Volmer, & D.L. Mills (Eds.). Professionalization. Englewcod Cliffs, N.J.: Prentice-Hall, 1966.

11. Thomas, K.W. Organizational conflict. In Steven Kerr (Ed.). Organizational Behavior. Columbus, Ohio: Grid Publishing, 1979.

12. Thomas, K.W., and Kilmann, R.H. Thomas-Kilmann conflict mode instrument. New York: XiCom, 1974.

13. Watson, J.B. Behaviorism. Chicago: University of Chicago Press, 1958.

Articles

1. Bowman, J.S. "The behavioral sciences: fact and fantasy in organizations." Personnel Journal, 55 (August, 1976), 395-397.

2. Corwin, R.G. "The professional employee: a study of conflict in nursing roles." American Journal of Sociology, 66 (1961), 407-412.

3. Katz, R. "The influence of group conflict on leadership effectiveness." Organizational Behavior and Human Performance, 20 (December, 1977), 265-286.

4. Pryor, M.G., and Mondy, R.W. "How men and women view their jobs --- and what this means to the supervisor." Supervisory Management, (November, 1978), 17-24.

5. Rahim, A. "Managing conflict through effective organization and design: an experimental study with the MAPS Design Technology." Psychological Reports, 44 (April, 1979), 759-764.

6. Rahim, A., and Bonoma, T.V. "Managing organizational conflict: a model for diagnosis and intervention." Psychological Reports, 44 (1979), 1323-1344.

7. Reimann, B.C. "Dimensions of structure in effective organizations: some empirical evidence." Academy of Management Journal, (December, 1974), 693-708.

8. Renwick, P.A. "The effects of sex differences on the perception and management of superior--subordinate conflict: an exploratory study." Organizational Behavior and Human Performance, 19 (1977), 403-415.

9. Schmidt, W.W. "Conflict: a powerful process for (good or bad) change." Management Review, (December, 1974), 4-10.

10. Schulz, R., and Johnson, A.C. "Conflict in hospitals." Hospital Administrator, (Summer 1971), 36-50.

11. "The sources and resolution of conflict in management." Personnel Journal, 56 (May, 1977), 225-226.

12. Thomas, K.W. "Toward multi-dimensional values in teaching: the example of conflict behaviors." Academy of Management Review, 2 (1977), 484-490.

13. Thomas, K.W., and Kilmann, R.H. "The social desirability variable in organizational research: an alternative explanation for reported findings." Academy of Management Review, 18 (December, 1975), 741-752.

14. Thomas, K.W., and Pondy, L.R. "Toward an 'intent' model of conflict management among principal parties." Human Relations, 30 (1977), 1089-1102.

15. Thomas, K.W., and Schmidt, W.H. "A survey of managerial interests with respect to conflict." Academy of Management Review, (1976), 19, 315-318.

16. Walton, R.E., and Dutton, J.M. "The mangement of interdepartmental conflict: a model and review." Administrative Science Quarterly, 14 (1969), 73-84.

REFERENCES FOR FURTHER READING

1. Appelbaum, S.H. "A Profile of Leadership and Motivation Within a Closed Hospital Climate." Health Care Management Review, 3 (Winter, 1978), 77-89.

2. Boulding, K.B. Conflict and defense. New York: Harper, 1962.

3. Burns, J.H. "Managing the profit of conflict." Management Accounting, 57 (December, 1975), 21-24.

4. Christopher, W.I. "How do employees feel about you?" Hospital Progress, 40 (November, 1959), 89.

5. Filley, A.C. Interpersonal conflict resolution. Glenview, Illinois: Scott, Foreman & Company, 1975.

6. Flynn, W.R., & Stratton, W.E. "Dealing with aggressive employee behavior." The Personnel Administrator, (February, 1978), 53-58.

7. Hill, R.E. "Managing interpersonal conflict in project teams." Sloan Management Review, 18 (Winter, 1977), 45-61.

8. Joiner, C.L., & Morris, J.O. "Management's response to the union phenomenon." Hospital Progress, 59 (May, 1978), 59-63.

9. Kerlinger, F.N. Foundations of behavioral research. New York: Holt, Rinhart and Winston, Inc., 1973.

10. Lawrence, J.R. (Ed.) Operational research and the social sciences. London: Tavistock Publications, 1966.

11. Levenstein, A. "The art and science of supervision: down the line." Supervisor Nurse, 8 (December, 1977), 56-57.

12. Morano, R.A. "Managing conflict for problem-solving." Personnel Journal, 55 (August, 1976), 393-394.

13. Rahim, A. "Organizational behavior: views from the tower and battlefield." Paper presented at the Organizational Behavior Teaching Conference, Cincinnati, Ohio, (June 22, 1979).

14. Rahim, A. "The relationships between general job satisfaction and demographic variables: a study with selected professional employees in a community general hospital." Unpublished typewritten article from the School of Business at Youngstown State University, Youngstown, Ohio, (July, 1979).

15. Ruble, T.L., & Thomas, K.W. "Support for a two dimensional model of conflict behavior." Organizational Behavior and Human Performance, 16 (1976), 143-155.

16. Sampson, E.E., & Kardush, M. "Age, sex, class, and race differences in the response to a two-person non-zero-sum game." Journal of Conflict Resolution, 9 (1965), 212-220.

17. Scheer, W.E. "Humanistics in hospital administration." Hospital Accounting, 14 (March, 1960), 12-15.

18. Schoenherr, R.A., & Fritz, J. "Some new techniques in organization research." Public Personnel Review, 28 (July, 1967), 156-161.

19. Simon, J.R., Norton, C., & Donergan, N.J. "Accounting for the conflict between line management and the controller's office." Advanced Management Journal, 44 (Winter, 1979), 4-14.

20. Starkweather, D.B. "Hospital size and organizational performance." Unpublished Ph.D. dissertation, University of California, Los Angeles, (1968).

21. Strauss, G. "Organization behavior as an aid to labor impasses resolution." Monthly Labor Review, 100 (April, 1977), 49-52.

22. Terhume, K.W. "The effects of personality in cooperation and conflict." In P. Swingle (Ed.). The Structure of Conflict. New York: Academic Press, 1970, 193-234.

23. Thamhain, H.J., & Wilemon, D.L. "Conflict management in project life cycles." Slow Management Review, 16 (Spring, 1975), 31-50.

24. Thamhain, H.J., & Wilemon, D.L. "Leadership, conflict, and program management effectiveness." Sloan Management Review, 19 (Fall, 1977), pp. 69-89.

25. Thomas, K.W. "Conflict and conflict management." In M.D. Dunnett (Ed.). Handbook of industrial and organizational psychology. Chicago: Rand McNally, (1976), 889-931.

26. Thomas, K.W., & Kilmann, R.H. "The social desirability variable in organizational research: an alternative explanation for reported findings." Academy of Management Review, 18 (Dec., 1975), 741-752.

27. Thompson, V.A. "Hierarchy, specialization, and organizational conflict." Administrative Science Quarterly, 5 (1961), 485-521.

28. Uris, A. "Confrontation---shoot out in the executive suite." Supervisory Management, (November, 1978), 11-16.