Organizational structure of nursing services: reflections on the influence of the organizational power and culture

ESTRUTURA ORGANIZACIONAL DO SERVIÇO DE ENFERMAGEM: REFLEXÕES SOBRE A INFLUÊNCIA DO PODER E DA CULTURA ORGANIZACIONAL

ESTRUCTURA ORGANIZACIONAL DEL SERVICIO DE ENFERMERÍA: REFLEXIONES SOBRE LA INFLUENCIA DEL PODER Y DE LA CULTURA ORGANIZACIONAL

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ABSTRACT

This study addresses the culture and power influencing the organizational structure of the nursing services at a teaching hospital. The Nursing Service organizational structure (organization chart) was outlined due to the need of the general management of the hospital to standardize the nursing procedures. Due to this situation, the nursing managers' interest has arisen to widen the power setting, strengthening nursing in an intra-institutional environment.

KEY WORDS
Nursing.
Nursing services.
Power (Psychology).
Organizational culture.
Negotiation.
Conflict (Psychology).

RESUMO

Este estudo discute a cultura e o poder influenciando a estrutura organizacional do serviço de enfermagem em um hospital de ensino. A partir da necessidade de padronizar os procedimentos de enfermagem por parte da administração geral do hospital, foi desenhada a estrutura organizacional (organograma) do Serviço de Enfermagem. Por causa desta situação, veio à tona o interesse dos enfermeiros gestores em ampliar o espaço de poder, fortalecendo a Enfermagem no ambiente intra-institucional.

DESCRITORES
Enfermagem.
Serviços de enfermagem.
Poder (Psicologia).
Cultura organizacional.
Negociação.
Conflito (Psicologia).

RESUMEN

Este artículo analiza cómo la cultura y el poder influyen en la estructura organizacional del servicio de enfermería en un hospital-escuela. Basados en la necesidad de protocolizar los procedimientos de enfermería, por parte de la administración general del hospital, se diseñó la estructura organizacional (organigrama) del Servicio de Enfermería. De esta forma fue evidenciado el interés de los enfermeros-jefes por ampliar el poder, fortaleciendo el sector de enfermería dentro del ámbito institucional.

DESCRIPTORES
Enfermería.
Servicios de enfermería.
Poder (Psicología).
Cultura organizacional.
Negociación.
Conflicto (Psicología).

INTRODUCTION

Health organizations are shaped by the beliefs and values of those who constitute them (founders or chiefs) and who, collectively, in a certain context, make up and express their opinions, establish rules, designs that outline their structures and technical and procedure guides. They also use resources and generate production – the healthcare service, achieving the organizational purposes. Thus, the organizational culture results from the beliefs and values that guide the manager's decisions in all levels of the organizational structure, indicating the path to be taken in face of several action alternatives.

The recognition of the organizational environment allows the detection and deepening of the analysis of contingency factors that interfere, either direct or indirectly, in the planning, execution, control and evaluation of the nursing activities. The identification of the formal and informal structures, present in all organizations facilitate the participation in the communication flow, in the planning and development of more flexible actions, which allow the satisfaction in the work process.

The formal structure is based on the rational division of work, specializing departments, organs and people in certain activities[1]. The way of integrating the group is generally planned and exposed in a structure with roles, hierarchy and the classification of defined positions[2].

On the other hand, the informal structure has a social nature, which is not limited by the organization; it needs planning and is kept undercover[2]. Its appearance is spontaneous and natural, mainly among the employees in formal positions who make use of the several human relationships generated from their *status*[1]. These informal groups are not identified in the organization chart, and should not be disregarded. The participation of the employees is broader in institutions that stimulate this structure, as well as the arrival of new leaderships that end up constituting a strong work group.

The reason for developing this study stands on the need of bringing the discussion about the influences of culture and power relations on the organization of nursing services through an experience report. It aims to help nurses face the constant challenges of building a formal structure that guarantees horizontal power relations in the working environment, through a reflection generated from this experience.

Therefore, the purpose of this study is to analyze the formal structure of the Nursing Service in a healthcare organization.

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LITERATURE REVIEW

Historically, intervening variables in the structure of a company do not comply with the rigid principles of Management, but with factors present in its culture, size and technical system, demand dynamics, technological complexity employed, as well as with power, which are factors that influence decisions. The interdependence and the balance between the organizational structure and its context must achieve the organization purposes properly[3].

The analysis of the environment of the studied hospital institution caused the need for a more specific study about the organizational power and culture and their *relations with Nursing*. The formal and informal structure of the organization is presented considering the influences it receives from culture and power.

Organizational Culture

Some authors[1-2,4] have considered the differentiation among the concepts of organizational culture and atmosphere. However, contradictions have appeared in this differentiation attempt.

One of these concepts state that the organizational atmosphere results from the involvement of different factors, perceived in different ways, by different individuals. As an example, the author mentions the components related to formal and informal aspects of the organization. *Every people has its own culture, and every organization has its own culture as well*[1]. Therefore, the character of different organizational cultures may be either frequently renovated, by keeping the personality of the organization, or kept with old standards.

From another point of view[4], the organizational atmosphere, similar to the culture, is constituted from its values or from explicit and implicit precepts, from its *know-how* or technology, and from its character, understood as people's feelings and reactions. Here, the organizational atmosphere is perceived as less permanent than culture, which is materialized as time goes by, through habits, manners and knowledge. Organizational atmosphere may be understood as how the organization is perceived by its employees, which may be different from its culture[2].

Two experts[5], who are considered responsible for the execution of the General Theory of Systems in the organizations, point out that the organizational culture reflects the rules and values of the formal system, as a reinterpretation of the informal system. Following this logic, they state that, just like society, the organizations have a *cultural heritage* that is transmitted to its new members.

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In the health area, the influence of culture in the hospital organization is highlighted. In a study developed with nurses from a teaching hospital[6], the nursing culture is reflected, since its three main motivational factors are identified: 70% of the nurses consider the importance of *doing*, categorized as the need for execution; 7%, the importance of influencing people, categorized as the need for power, and other 7% value the communion with the group, considering the need for connection. The quality of the nurse's work, as a factor that depends on the performance of a group of people, was a highlighting characteristic of the nursing culture in the studied place.

Power relations

There are several definitions for power:

power is the potential that people have to influence the behavior of others. It is the capability to change, channel and persuade other people to do something they would not necessarily do, if they were not influenced towards it[7].

Opposed to this definition, there is a philosophical current that defends the non-existence of power, because what really exists are practices of power relations, as something that is practiced, executed, that is in action, in a dispute to win or lose[8].

Power allows the individual to achieve goals and authority, and it is a synonym of a legitimate right to command[2]. The distinction between power and authority can be perceived by defining the concept of power as the potential to influence, since this influence is not mandatorily made. On the other hand, the identification of authority is more controversial, because it represents the legal and institutionalized power. Authority is always filled with power, but power is not always associated to the institutionalized authority[1].

Power has its roots in the daily practice of the organization. The ideology and operational devices such as interviews, mediations and evaluations, to which employees are subject and which integrate the organization procedures, are intimately connected to the policy of human resources. Under the advantages granted by the organization, the mediation uses abstraction as a means of subordination, such as abstract logics in the pursuit of money; objectivation, demanding the use of everyone; unterritorialization, separating people from their roots to better receive organizational codes; and channeling energy into work power, aimed at the career[9]. Therefore, the practice of power allows the manifestation of relations that are not revealed in organization charts and functionalist speeches about the organization. Regulation is an efficient instrument of power, defining organizational behavior standards and trying to divide the work guaranteed by hierarchy[10].

In the professional practice, the management functions demanded by hierarchical superiors bring nurses closer to decision levels, in a co-management situation, in which they have more responsibility at work, but do not participate effectively in the formulation of goals and institutional purposes[9].

The management of the Nursing Service is not a simple task, but the greatest difficulty of the managers stands in their relation with the hospital management team, which generally leaves the needs of the nursing service in second place[12].

METHOD

This study presents an experience report about the organizational structure of the Nursing Service in a teaching hospital with extra capacity, in the interior of the state of São Paulo, which has different sceneries of medical and healthcare specialties, as well as teaching and researching activities. The organization is used as an internship field for Nursing and Medicine students.

The study here described was elaborated in six months, in 2001, according to twenty-five meetings that lasted for about one hour. The participants were: the Nursing Service chief and the assistant nurse, two nurses from the Continuing Education Center (CEC) and three Management professors from the Nursing course.

Process

Based on the request for standardization of the nursing procedures by the hospital management, the Continuing Education Center (CEC) articulated a meeting among the nursing service chiefs, the hospital superintendent and executive director, the external consultant working in the institution and a Management professor from the nursing course of the nursing educational institution associated to the hospital.

The program planning considered not only meeting the needs pointed out by the hospital management, but also elaborating a standardization program for nursing procedures based on the Japanese model[13] in order to add value to the practice. Associated to the standardization group, the nursing supervisors of the hospitalization unit were trained, which originated the second group, aimed at work routine management training and later, a third group, denominated the structuring group.

Group 1 – Standardization of nursing procedures

The group consisted of nursing practitioners indicated by the nursing chiefs, a nursing from the CEC and professors from the Nursing Graduation Course, who aimed at guiding and monitoring the execution of the procedures standardization.

The CEC worked as a documentation center of the Standard Operational Procedures (SOP), describing the architecture of the SOP regarding their purpose, creation (*de-*

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sign), application, publication, issuance, review, approval, extinction and history.

Right in the beginning of the meetings, the group of nurses of the institution raised questions about the informality of the nursing service organization; the ambiguity and duplicity in the decisions; the lack of explicitness of authority limits and, consequently of the decision issue, since the Nursing Service did not have any regulation or description of the attributions of each position, which considerably complicated the orientation of the actions of the Nursing Service. Due to these issues, it was fundamental to know who would be the task executant and who would supervise the standardization.

The group questioning was caused because their role was to elaborate a procedure guide that is the systematization of all Standard Operational Procedures (SOP), and, for each of these, they were supposed to answer: What does it do? Who does it? When is it done? Where is it done? How is it done? Which resources does it need? Yet, the determination of who performs each procedure depends on the attributions assigned by the Nursing Service for each function performed in the studied institution. In this context, the need for a third work group (structuring group) emerged, in order to elaborate the organizational structure. The group built the most critical SOP and presented them to the nursing chiefs, the executive director and the superintendent in a meeting, within the established schedule.

Group 2 – Training in work routine management

The following themes were approached in the program: participative management (4h) and, daily work routine management, with a survey of the main problems of the units (12h).

A total of sixteen working hours were developed in weekly meetings in the period from September to October/2001. The participants consisted of nurses (96) who worked in the studied institution (morning, afternoon and night shifts) and who were coordinated by the Management professors of the nursing course and nurses from the CEC.

Practical activities, problematization, and oral and dialogue expositions were used as strategies. Each meeting reviewed the most relevant aspects approached in the previous meeting and the management application in the unit of each nurse. Audiovisual resources, such as an overhead projector, multimedia and a flip chart were used with the nurses. This program, developed in association with the nursing graduation course, happened due to the complementary needs existing in the teaching-learning and health care processes. Consequently, it brought nurses and professors closer, reinforcing the relationship between the two institutions.

Group 3 – Structuring

This group, which consisted of nurses from the CEC, nursing chiefs and assistants, and Management professors of the Nursing Course, aimed at elaborating the organizational structure of the Nursing Service.

Before the study, it was believed that the Nursing Service comprehended the following positions, since the nursing direction had no records of the institution, except for Personnel Department data: nursing chief, nursing supervisors, nursing practitioners, nursing assistants and nursing technicians.

The studied hospital had extra capacity, and the nursing chief answered for all the management and technical activities developed by the nursing department at the hospital, which generated work overload. In this context, the decision process was centralized in the nursing chief and obstructed the communication flow, delaying the decision-making process and distorting information, thus jeopardizing the operationalization and speed of the work process.

Over the last decade, the hospital increased, mainly, its physical, technological and care complexity areas, becoming a reference center for the city and region. However, there was not a simultaneous investment in the quanti-qualitative dimensioning of nursing human resources. Therefore, it is possible that this proposal will meet not only the improvement of healthcare, but also the management needs.

Reinforcing this fact, a study about knowledge and power in a hospital explains that modern hospitals have grown in technological and physical terms, which has demanded important changes in their hierarchical structure and current power[14]. Despite the technological progress, health organizations have not followed the evolution of the modern organizations in terms of management proposals[15].

Positions have been renamed for the redesign of the organizational structure, since the attributions of each level had been equally re-discussed. Moreover, the required profiles were elaborated for each position and function.

The designed proposal consisted of: nursing chief, sector managers, healthcare coordinators, healthcare supervisors, nursing practitioners and assistants. In other words, one hierarchical level was added - sector managers. The addition of this level became necessary in face of the vertiginous growth of the institution, offering new services and, consequently, increasing the amplitude of the nursing actions. The new level had a management focus in order to intensify the collateral communication and, mainly, to decentralize the technical activities from the nursing chief.

This explicitness in the hierarchical relationships is essential in the management of people, and is generally influenced by the organizational culture and policies. The decision power was then decentralized, and the communication flow was increased, speeding the working process and reducing the overload of the nursing chief. The proposed formal structure contemplated the displacement of

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power lines, which were strongly centered in the earlier operational level, towards the strategic level, allowing the strengthening and visibility of the Nursing Service.

The proposals of the three groups (standardization, training and structuring) were incorporated into a single project and submitted to the appreciation of the General Management. Two successful negotiations then occurred, one of them regarding the approval of the organization chart, attributions of the hierarchical levels and profiles, and the other about the sector managers.

During the development of this project, the nurses who participated in the structuring group admitted it was not possible to take on new responsibilities without a salary review. The group studied the local and regional market and then presented a salary proposal that was later attached to the project. Nevertheless, this salary negotiation did not succeed, mainly due to the hospital management's indefiniteness, which ceased the other proposals of the project.

After three months, the Hospital Management hired an external consultancy service aimed at organizing the provision of service to the users of the recently-released healthcare plan of the institution. After a situational diagnostic, this consultancy identified the need to work on the organization of the departments before other activities could be performed. Therefore, the regulation of the Nursing Service was built and implemented in two months.

This position of the Hospital Management and nurses/professors motivated the present study about the influence of the organizational power and culture over the organizational structure proposal for the Nursing Service of a school hospital.

RESULTS AND DISCUSSION

The health case analysis was carried out from two aspects: 1. Conflict – operational × strategic interests; and, 2. Negotiation process – type and style.

Conflict

The standardization of the nursing procedures was important for both the requesting part, the hospital management that pointed out that need, and the requested part, the nursing team to organize the work of this Service. Even though the procedures were not described, these were internalized by the nursing employees of the studied institution.

Nevertheless, the interests were divergent, since there was an economical intention involved by the hospital management part, due to the high demand of nursing procedures in the hospital environment. The high consumption of resources in these procedures generates opportunities of management actions for cost reduction, optimization of procedure resources, as well as educational actions of eco-

nomical interest. Even though the economical intention had not been verbalized, it was *understood* as the purpose of the members that represented the interests of the institution. Therefore, their interests were limited to the operational matter of the efficiency of nursing procedures, which made them believe that, for the organization, the value of the nursing service was in *doing*, the reflection of their culture, background, internalized by everyone. Allied to this question, there was the institutional request for the training of nurses in the daily routine management. This fact reinforced the interests and the organizational culture as this training drove the performance of the professionals towards the operational level. On the other hand, by doing it, the nurse reproduced and reinforced the same model, without noticing it. Literature reports that trainings are usually elaborated in an alienating way, without noticing that subjacent to their decisions, there is the conformation of behaviors desired by other decision levels[16].

On the other hand, the interest of the nurses who represented the Nursing Service was related to the organization of work. In other words, towards the division of tasks (among nurses, nurses and technical levels, nurses and other health professionals) and towards the responsibilities, the dispute for power and control. These nurses saw this opportunity to work in the strategic level, elaborating a proposal of decentralization of the direction power, including new management divisions; this meant the need to widen the area of influence and control, i.e., to widen their power as a group. Therefore, a relational conflict began to exist between the organization representatives (hospital management) and the group of nurses representing the Nursing Service.

Conflicts are manifestations of the power configurations in the organization. Thus, they must be understood in both their declared and silent ways. Yet, the comprehension of the way conflicts are handled or denied reveals the real power relations existing in the organization[17].

The inexistence of a description of attributions and profiles for each hierarchical level complicates the management and action of the nurses, which often generates conflicts and ambiguity in the decisions, as well as it compromises the quality of the healthcare provided to the client. This situation leads to the idea that if these questions are not worked out, the standardization of the procedures will be applied only to a level of records (it would only meet the management's explicit interests), without any application in the healthcare practice (it would not meet the implicit interests). Studies previously developed in this same hospital, in the 1990s, had already shown the lack of explicitness of the attributions for each position and function performed by the nurses. Consequently it complicated the development of actions by these professionals[18] and the possible correlation between the indefiniteness of the nurse's role and the lack of value of the nursing service[19]. It was observed that even after the identification of the problem, it remained without a solution, revealing a culture of indefiniteness.

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Several conflict-generating situations are observed in the daily life, such as those related to daily, monthly and vacation schedules, mainly associated to holidays, weekends and months declared as vacation. A study developed[20] in medical and surgical clinics, and an emergency unit showed that conflicts result from the lack of explicitness of the mission, the institution's view and values, the depreciation of the physical work environment, different types of contracts, the bad organization of the nursing service, conflicting group and personal relationships, as well as poorly developed communication and leadership dimensions. Another study in a Sterilization and Material Center and Surgical Clinic Unit identified the lack of described rules and material as frequent causes for conflict and disagreements[21]. Yet, literature also mentions the lack of a clear definition of roles, invasion of space by other professionals, high turnover, insufficient staff, problems outside work, feelings of depreciation, difficulties with patients and families, lack of confidence, organizational atmosphere and age differences[22].

A nurse spends 20% of his time handling conflicts and presents a passive attitude in its resolution, an incompatible attitude to the purposes of the contemporaneous management[23].

In order to handle the conflict[24], the nurse and his team must: 1 – identify the problem; 2 – analyze its cause; 3 – employ efforts to eliminate it; and, 4 – prevent future occurrences.

Regarding the resolution of conflicts, one study[20] points out that the nurse's behavior is based on previous experiences or values, attenuating the conflict, since it happens repeatedly. Sometimes the conflict is either ignored or facts are not even known, and the institutional punishment system is used in the most serious cases. Another study[25] observed inadequacy in the handling of interpersonal conflicts, with communication rupture among group elements, a less productive environment, unfavorable organizational atmosphere and entropy, causing personal suffering and collective tension. Nursing managers do not usually give up on negotiations in conflict situations. They establish confrontation, demonstrating incapability in dealing with such situations[26].

The techniques for dealing with conflicts[27] suggest assertive communication, negotiation, adaptation, commitment, competition and collaboration. The most common way of solving a conflict is through the negotiation process. Successful negotiation skills solve conflicts and encourage collaboration, thus generating a positive work environment[22].

Negotiation

The power in health organizations is shared by several professional centers, which reinforces the need for im-

> The power in health organizations is shared by several professional centers, which reinforces the need for improving communication and the managers' ability of negotiation.

proving communication and the managers' ability of negotiation. Therefore, negotiation is cooperative when the interests are different, but the purpose is the same, leading professionals to a positive dispute. However, when interests are contradictory, negotiation is conflicting and has a null result. The third type of negotiation is a mixed deal, when it is based on opposite interests combined, with mixed results as well[28].

In the first stage of the experienced situation, the group followed the architecture of the negotiation process with the elaboration of the proposal for designing the organizational structure of the Nursing Service. It was presented to the hospital management, at the negotiation table, with the description of the required profiles and attributions for the hierarchical levels, closing the deal when the proposal was approved. Therefore, the authors understand that this negotiation was cooperative, presenting different interests, but a similar purpose, which leaded to a positive result.

Nevertheless, another negotiation was generated, since the hospital management stated that they could not provide that amount of sector managers, and requested the group to review the number designated in the proposal. Therefore, the analysis of the board of employees and the redistribution of nurses became essential for the feasibility of the proposal, in order to meet this request. Several difficulties appeared then, mainly regarding the legal aspects, which demanded changes in contracts and salaries, since the working hours were not similar for all nurses.

At the second stage, the group returned to the negotiation table with the hospital management for the quantitative matter of sector managers, aimed at reducing the initial proposal. They understood the concession as an important strategy at that moment and also as a demonstration of flexibility, closing the deal with five nurses. This negotiation was a mixed-deal type, with opposed interests, however combined, in which both parts made concessions.

The third stage was guided by the need for financial recognition in order to take on new responsibilities. As the salary proposal was presented at the negotiation table, the hospital management stated they would need to analyze the question and that a new date would be scheduled for the decision. This stage resulted in the issue being delayed.

The fourth stage was filled with questions by the group to the hospital management, about the new date previously agreed. However, the silence from the hospital management in reviewing the salary issue demonstrated their disinterest in negotiating the proposal. An implicit evacuation from the negotiation table was observed, and the process was stuck with a null result, which was evidenced by the conflictive-implicit type of negotiation.

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Formal and informal spaces of negotiation are used to give transparence to the facts, to dispute interests and negotiate power, constituting tense moments of conflict that end with minimum agreement or by breaking the group into factions. It is possible to say that there is always a resetting of internal strengths, in face of situations of conflict[29].

Knowing how to deal with different styles of the interlocutor in a negotiation may represent a differential in the professional practice. Negotiators may be grouped in four basic styles[30], according to their controlling and condescending, formal and informal behavior in: catalyst, controlling, supportive and analytic.

Thus, the group of nurses demonstrated a catalyst style, identified through the innovation, creativity and change evidenced by the proposal (sector manager, visibility, power decentralization and strengthening). A study[31] shows the prevalence of the catalyst style among nursing undergraduate students. On the other hand, the good idea was lost due to the incapability during the negotiation process, since the deal is not the end of the negotiation, but its fulfillment. In other words, the negotiated achievements should have been implemented. A study about the conduction of the negotiation process by nursing managers[26] shows that institutional characteristics interfere in the negotiation process and that managers from private institutions have more diplomatic attitudes when compared to those from public institutions. They are concerned about conciliating divergent interests; they collect complementary information and evaluate the range of their objectives.

The results of a negotiation may be explained by the characteristics of the negotiators, the situation in which it takes place and the negotiation process itself, since these are three categories of variables influenced by culture[32].

The evolution of the negotiation process leads to the reflection that, after the first and second stages of negotiation, the situation required the consolidation of power extension, favorable to the nursing service and accepted by the hospital management. As the group started to deal with the salary issue, the diversion from the nurses/professors' initial purposes was evident, which initially was to formally implement the organizational structure in the Nursing Service. The results reflect the culture where the aspiration for power in the nursing area does not yet constitute a priority. These findings coincide with those from a study developed about nursing culture[6], in which the need for power was identified by only 7% of the nurses from a school hospital.

The style demonstrated by the hospital management was controlling, outlined by the pursuit of results, cost reduction, minor receptivity and authoritarianism, as they requested the quantitative reduction of sector managers regarding the salary matter. The management hegemony of the medical power inside hospitals that comply with a dominant logic over the medical work was demonstrated with the ceasing of the negotiation process (providing *si-lence* as the last word) and the authorization of the external consultancy service to implement the nursing regulation, according to the current traditional practice. This style does not consider other people, only seeing them as resources for the performance of tasks and tries to achieve goals regardless of the means[32]. In 1998, the perceptions of nursing managers were studied regarding the management style of the executive director of the studied hospital, using the Managerial Grid. It was observed that this person worked to accomplish tasks, without straying from the standard routine, being considered centralizing, impersonal and aimed at productivity.

FINAL CONSIDERATIONS

The reflections made about the organizational structure proposal for the Nursing Service at the studied institution allowed some considerations for better understanding the situation experienced.

The occurrence of events in this study showed that the organizational culture has determined the indefiniteness of the organizational structure, and it also made the conflict of interests evident between the operational and strategic parts.

The negotiation process at the general management happened in four stages: the first was the cooperative type; the second was a mixed-deal type; the third was a dependent type; and the fourth was a conflictive-implicit type.

The critical point that blocked the continuation of the negotiation was the request for a salary review at that moment. The nurses' demands regarding the scheduling of the fourth stage at the negotiation table resulted in the silence of the other part, and this negative result generated the annulment of progresses from the previous negotiations.

On the other hand, the diversion by nurses/professors from the objective, which was to formally implement the organizational structure in the Nursing Service, was evident. This reinforced the negotiation disability in terms of procurement of objectives. The demand for a differentiated remuneration would come naturally.

The external consultancy service, in a short period of time, guided the construction and implementation of a regulation in the Nursing Service, general and specific hospitalization units in the way it was practiced, reinforcing the instituted power and culture.

Therefore, the strength of culture and power in health organizations determine the work relations, and the medical management hegemony nurtures traditional dynamics, authoritatively implicit. In this perspective, it is fundamental for the nursing managers to develop skills to handle conflicts and negotiations, in order to create a new culture.

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