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RESEARCH ARTICLE

Three insights, two programs, one theory: Transformative practices as opportunities for moral growth in the healthcare workplace

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Abstract

Increasing demands on healthcare systems and complex pressures within healthcare settings create the conditions for workplace conflict; this inevitably has a detrimental impact on patient care and worker morale. We present two case studies illustrating how training and conflict coaching premised on the transformative model reduced organizational costs, increased employee engagement, and restored healthcare workers' ability to care for patients. Transformative theory and insights, which center on increasing awareness and development of one's moral identity, prove to be especially well-suited to the healthcare workplace where caring for others is of primary concern.

1 | CONTEXT

Healthcare is a highly challenging environment with healthcare workers reporting more than any other employee group that their jobs are highly stressful (Wilkins, 2007). Every day, individuals working in this environment are expected to deal with the differing stresses of caring for others with acute injuries and conditions as well as chronic and terminal illnesses. The constant exposure to the suffering of others and the sometimes inability to eliminate or reduce it can result in empathic distress, which has implications for standards of patient care as well as negative impacts on a worker's mental and physical well-being (Cocker & Joss, 2016). Like policing and aviation, healthcare is a high stakes workplace, where decisions made in error could worsen a person's health status or even result in their untimely death.

In both the United Kingdom and Canada, the social safety net that provides healthcare to all citizens is challenged on multiple fronts. Both countries are struggling to care for an aging population as well as increasing numbers of patients with chronic multiple morbidities (Sambamoorthi, Tan, & Deb, 2015; Vogeli et al., 2007), whose predictably higher demand for healthcare services is being

met with decreasing resources. The pressures on these healthcare systems are further intensified by the vagaries of politics, not the least of which in the United Kingdom is currently represented by Brexit. This has already had an impact on retention and recruitment and comes at a time of serious staff shortages and a heavy reliance on European migration. With the loss of EU funding, collaborative research and development will be compromised and both will necessarily compound workforce pressures (McKenna, 2017).

This potent combination of workplace and system stressors negatively impacts employee health and also sets the stage for more conflict in the healthcare workplace. The human resources aphorism that observes that "people don't leave jobs, they leave people," recognizes this fact and points to why conflict is so costly. While the direct costs per grievance or lawsuit for an organization have been estimated at approximately US$100,000, unresolved, unproductive conflict frequently results in higher rates of absenteeism, decreased engagement and productivity, and loss of expertise as people transfer to other work areas or leave the organization altogether. When these indirect costs are included in the calculation, an organization may face a cost of US$600,000 (Dana, 2012).

A particularly troubling aspect of conflict in the healthcare workplace is that its reach may extend to the sick and dying. An environmental scan conducted at Nova Scotia Health Authority (NSHA) by LeBlanc (2010) revealed that unresolved, unproductive conflict resulted in delays in providing medical treatment and administering medication as well as medication errors. These results comport with extant empirical evidence that finds that healthcare workers who are preoccupied by workplace conflict are more prone to making clinical errors (Rosenstein & O'Daniel, 2002).

To respond to these outcomes, increasing numbers of healthcare organizations are offering conflict training and conflict coaching services (Brinkert, 2016; Zweibel, Goldstein, Manwaring, & Marks, 2008). Research conducted by Gilin Oore, LeBlanc, Brownlow, and Solarz (2017) examined workplace conflict resolution programs (CRPs) in two organizations in Nova Scotia, Canada, namely Saint Mary's University and NSHA, both of which use Bush and Folger's (1993, 2005) transformative theoretical framework as the basis of their work.

In an unpublished report detailing the findings of the NSHA data, Gilin Oore (2017, p. 3) concluded that participants in the organization's workplace CRP:

- spent on average 188 fewer work hours dealing with and worrying about their conflicts than did employees who sought formal action (grievances and complaints);
- were better able to counteract the natural and harmful tendency to make the fundamental attribution error, that is, the tendency for individuals to blame others more than themselves for negative events;
- were significantly more satisfied with the CRP process than were those who used formal adversarial means;
- reported significantly greater satisfaction with the state of the relationship with the other party post-conflict-resolution than those who engaged in formal action.

In this article, we provide a brief overview of Bush and Folger's transformative theory. We then present two case studies to illustrate how conflict coaching and conflict training, based on three insights drawn from the transformative model, are likely to minimize organizational costs, increase employee engagement, and improve the quality of patient care. We conclude with a discussion about the particular relevance of the transformative model for the healthcare workplace on both the program and organizational levels.

2 | TRANSFORMATIVE THEORY AND INSIGHTS

The Institute for the Study of Conflict Transformation (ISCT) was created in 1999 to support transformative intervention work in the United States and abroad, with the stated aim of linking practice to underlying theory.

First articulated in *The Promise of Mediation* (Bush & Folger, 1993), the transformative theory of conflict starts by defining what conflict means to the people involved in a conflictual situation. "What people find most significant in conflict is that it leads them to behave, toward themselves and others, in ways that they find uncomfortable and even repellant. It alienates them from their own sense of strength and sense of connection to others and disrupts and undermines the interaction between them as human beings" (Bush & Folger, 2005, p. 45). This interactional crisis is the most affecting and significant aspect of the experience of conflict. Insights from the fields of psychology and communication support this view of the meaning that conflict holds for individuals and groups (Bush, Folger, & Della Noce, 2010).

First, conflict generates a sense of relative weakness and incapacity for people: a loss of control over their situation accompanied by confusion, doubt and indecisiveness. Second, conflict generates a sense of relative self-absorption, where the person becomes more self-protective, more suspicious, hostile, closed, and impervious to the perspective of the other person. The experience of the two effects reinforces each other in a feedback loop leading to conflict escalation and an interactional degeneration or a crisis in human interaction. This crisis distresses people because it compromises their essential human moral identity. However, transformative theory also posits that people have an inherent capacity for strength (agency or autonomy) and responsiveness (understanding and empathy) and an inherent social or moral impulse that activates these capacities when people are challenged by negative conflict. When that impulse is activated, the negative cycle can be reversed and interaction regenerated, even without the presence of a mediator or intervenor. When people move out of "weakness" and return to their innate strength they become clearer, calmer, and more confident. When people move from self-absorption to responsiveness they become more understanding, open, and attentive to the other person. They regain their human moral grounding becoming less reactive, more responsive, and therefore better able to interact with the other person without escalating a negative dynamic. Sometimes, as one person regains their innate resourcefulness, the other person remains weak and self-absorbed; nonetheless, choosing to act with strength and responsiveness even when it is difficult to do—especially when it is difficult to do—proves to be valuable and meaningful. Balancing concern for self with concern for the other is at the heart of moral development; it is the opportunity embedded in each of our conflicts.

Several insights emerge from this understanding of conflict:

1. Awareness of the incapacitating effects of weakness and self-absorption is the first step to responding, rather than reacting, to conflict;
2. We can choose to respond to conflict by drawing from our innate strength and connection to others—our moral grounding or best self;
3. Achieving a balance of strength and responsiveness is success, no matter what the outcome may be.

The transformative model and in particular, the three insights derived from this model, serve as the foundation of the conflict training and conflict coaching programs introduced in healthcare systems in London, England, and Nova Scotia, Canada, respectively.

We begin by detailing the need for conflict training among managers and other supervisory staff working in a National Health Service (NHS) Trust in the United Kingdom. Then, we describe how a training premised on the transformative model satisfies this need.

3 | RESPONDING EFFECTIVELY TO CONFLICT: TRAINING FOR CLINICIANS WHO MANAGE PEOPLE IN HEALTHCARE IN A UK NHS TRUST

3.1 | The learning need

Gaspar is Head of the Staff Counseling, Stress Management and Conflict Resolution Service in a large National Health Services (NHS) Trust in the United Kingdom with 11,500 staff across three major hospital sites. The service provides comprehensive staff support including: time-limited therapy, stress management, responses to traumatic incidents, customized training, supervision, a bullying and harassment helpline, and conflict resolution interventions, including mediation.

One of the biggest stressors identified by clients coming to the counseling service are interpersonal difficulties amounting to 60% of clients using the service. It therefore makes sense to offer a range of services to the workforce so that they can achieve the overall goal of the organization, that is, to offer first class healthcare to patients. In post-service evaluations administered internally, staff have said that using the service has improved their capacity to offer quality services to patients by 87%.

Gaspar has observed that healthcare professionals in our NHS Trust have a wealth of communication skills that they use frequently in the course of their working lives, including breaking bad news, performance management, patient and staff complaints, medical and nursing errors, and moral and ethical issues. The workforce of our NHS Trust does not lack the essential skills in their daily working lives but rather the ability to use those skills in difficult conflictual moments, particularly if it involves their manager, a peer or a member of the multi-disciplinary team (MDT) as opposed to a patient or their family members.

Although managers and others in supervisory roles in the Trust were able to access training to develop their leadership capacity, none of the six management programs on the Trust offered training on conflict management despite the clear need for such training. Managers and supervisors were looking for ways to bring their communications skills into play when it mattered the most. Responding Effectively to Conflict (REC), a program based on the transformative model, was the program that met this need.

3.2 | REC training

In 2014, Joe Folger first developed "Self-Managed Conflict" training, partly in response to hearing transformative mediators share how they had successfully applied the transformative model to their own personal and professional conflicts (Bush & Folger, 2016). A team of scholar/trainer/practitioners within ISCT worked on applying the core concepts and practices of transformative mediation to develop a new training "Responding Effectively to Conflict" and it is essentially conflict management training from a transformative perspective. It enables people to identify the conflict behaviors that arise from their relative weakness and self-absorption when faced with a conflictual situation. It supports them to choose to respond rather than react in these difficult moments. The training enables people to "self-manage" their own responses so that they have greater capacity to connect with those they disagree with, or hold differing opinions from. This approach,

premised on a relational worldview, is therefore likely to stop a difference of perception spiraling into a conflictual situation, so that disagreements can be worked with as they occur. ISCT "strongly believes that the concepts and practices of the transformative approach can bring new resources to individuals and organizations involved in conflicts of all kinds, even when there is no third party to assist them … with the potential for much greater impact on our society as a whole, and its culture of conflict" (Bush & Folger, 2016, p. 2).

REC introduces the theoretical basis of the transformative model experientially, through participants' listening to each other's experiences of conflict and the emotional, physiological, and behavioral impact. As we discovered when we offered this training to managers, supervisors, clinicians and physicians in our Trust, this kind of reflective practice (Schön, 1983) is an intrinsic driver of the development of good practice for the many professionals in healthcare: medical staff, nurses, and allied health professionals.

During the REC training in our NHS Trust, participants were introduced to three insights from the transformative model. The first insight was introduced when participants were invited to reflect on their own incapacity in dealing with conflict when they are weak and self-absorbed and therefore trapped, to some degree, within a limited way of thinking, perception, and understanding about the situation and the other person with whom they are in conflict with. By becoming aware of their incapacity, participants began to have choice: Do they stay weakened and likely to react or do they choose relational and responsive ways to engage with the other person so that the conflict does not escalate and they regain their moral grounding and stay connected to themselves and the other person?

Participants explored the second insight as they considered the value of acting from their best self. By discussing the moral value of acting from "our best self" participants made choices about how they want to behave differently in conflictual situations; but more importantly, how they want to "be" with themselves to keep the connection open with people who hold different views and ways of seeing a situation. In transformative theory, the "best self" integrates strength of self with compassion for other, and this is a matter of basic human moral identity. This broad construct is particularly valuable from a multi-cultural perspective as we have over 100 different nationalities working in the Trust. It also has value because different members of the MDT will have different perspectives as they see dilemmas from a medical, nursing, or allied health professional prospective. From a leadership perspective it enables managers to serve as role models for their staff, who are likely to struggle with the same communication challenges. Slowing or stopping the destructive cycle of conflict interaction creates value: personally, interpersonally, and organizationally.

The third insight of achieving a balance of strength and responsiveness was introduced through role-plays that reflected their workplace experiences of conflictual situations. As each role-play was debriefed and processed, participants developed personal strategies and skills in the following areas:

- creating for themselves a space to deliberate and decide how to respond;
- breaking limited or restricted thinking and questioning their own assumptions about the other person;
- communication skills such as active listening, reflection, the ability to share their perspective, and being able to clarify areas of disagreement.

The initial pilot of the REC training with 90 participants from our Trust was qualitatively evaluated by participants at the end of each course. A total of 98% of participants reported that the training was highly relevant to both their work and personal development.

Participants were asked to comment on the structure of the course and how this facilitated their learning and integration of theory into practice. They reported that the role-plays were crucial in

highlighting the importance of their own feelings, beliefs, and behaviors in conflictual situations. It gave them opportunities to challenge their approach and question their assumptions about the other person. Participants reported "putting on the pause button" in order to listen to and understand the other person so that they could respond rather than react and see the impact on the conflict dynamic in action through their own and observer reflections.

Participants appreciated facilitated discussions, telling us that these enabled open and honest discussions and opportunities for self-reflection in a safe and nonjudgmental environment.

When asked about their understanding of the transformative model, participants' comments reflected that they had integrated the model and were able to link it to their own experience of being in conflict and how this would affect their future behaviors and conversations in conflictual situations. Participants were highly reflective about their own reactions and how these might impact on another person and escalate a conflict dynamic. This ownership of "self" in relation to "other" featured highly in comments telling us that most participants embraced the relational ideology of the transformative model and saw value in trying to be their "best self" in order to meet the other person and keep open to their own and the other's experiencing. Some participants linked this to three of our four trust values: kind, collaborative, and aspirational.

An "open response" section elicited comments and suggestions that have helped us to further develop the course and have given us ideas to develop conflict services.

- We have expanded the one-day stand-alone session to include a half-day follow-up session. This has allowed us to evaluate the extent to which participants were able to apply and integrate the insights and related skills and strategies. In the future, we will conduct an evaluation 3 months posttraining.
- We will consider having drop-in practice groups with a transformative facilitator/coach for participants who have completed the course and want to develop responses to current conflicts, either personal or team.
- Extend the REC training throughout the medical education program to include residents as well as physicians and surgeons of varying levels.
- REC continues be a valued program in the Trust. In order to "join up" conflict services, the service plans to integrate REC as a module in all management training programs. Additionally, it will be important to work with the Human Resources Advisory service so that the Trust works toward an integrated conflict management system; as have other large public-sector organizations (Brubaker, Noble, Fincher, Park, & Press, 2014).

From this report of a conflict training program offered in a London healthcare NHS Trust, we turn our attention to another application of the three insights derived from transformative theory in another healthcare setting in Nova Scotia, Canada. The narrative case study of conflict coaching that follows offers another example of the value of the transformative model for those working in healthcare.

4 | TRANSFORMATIVE CONFLICT COACHING IN THE HEALTHCARE WORKPLACE

4.1 | The NSHA workplace CRP

The Capital District Health Authority (CDHA) in Halifax, Nova Scotia, established the workplace Conflict Resolution Program (CRP) in response to the findings of an employee survey, which

suggested that employees had been struggling with long-standing unresolved, unproductive conflict with impacts to staff well-being and the quality of patient care. Since 2009, this program has offered transformative mediation, conflict coaching, and education and training services.

To our best knowledge, the workplace CRP is the only one of its kind among Canadian healthcare organizations. Though CDHA was later merged into a new provincial health system, the Nova Scotia Health Authority (NSHA), the best and strategic practices remain in place. The program is intentionally located outside of the Human Resources Department to remove any barriers, real or perceived, to accessing program services. Coaching and mediation services are strictly voluntary, confidential, and may not be used as part of the disciplinary process. Through these principles and practices, the program offers alternative dispute resolution services and thus, informal approaches, to staff who want to resolve workplace conflicts. The informal approaches complement formal approaches such as formal complaints and union grievances.

When Solarz's role as the Consultant for Communication and Conflict Competence was first imagined, many expected that mediation would be a large part of the work. It became apparent early on that conflict coaching would be the most sought after service because beyond resolving a specific conflict they faced, most employees wanted to be better at handling conflict altogether. More than one client has shared that of all the things they were taught in school, "conflict was not one of them," adding that if they were going to work in healthcare it certainly should have been. Conflict coaching seems to meet this need. The demand for conflict coaching led the author to pursue graduate studies and further training in coaching and conflict coaching in particular.

Over the last decade, Solarz has integrated transformative theory into the practice of conflict coaching. To illustrate how this can been be done, we offer the case of an individual coaching client, Ann.[1]

5 | A NURSE LEADER DISCOVERS HER BEST SELF

While attending nursing school, Ann aspired to become a leader in her field. Once she graduated and started working as a registered nurse, she did indeed have a leadership role, but the reality of this position fell miserably short of how she imagined it would be. Like many other healthcare workers, Ann and her colleagues struggled to do important work despite understaffing, a lack of resources, and an overwhelming workload. Because she was in a leadership position, Ann felt obligated to take on tasks outside of her scope of practice to address deficits or urgent needs on the unit. Many conflicts in her unit remained unresolved and the resulting frustration and irritation she experienced on a daily basis left her with insomnia.

What brought her to conflict coaching, however, was how all of this turned her into someone she no longer recognized or even respected. This young nurse, once so full of passion and zeal for her profession, found that irritability and negativity were her "new normal." Rather than inspiring others through her nursing leadership, she was joining in the complaining and griping. In her own words, "I am participating in the very thing I hate." From the point of view of transformative theory, Ann was losing her moral grounding, her sense of strength of self, and concern for others.

While confident in her nursing abilities, Ann was confounded by workplace conflict. She knew how to handle conflicts with patients and families, "But when it comes to staff—I don't know what it is—it's a lot different." She explained that the situation was unsustainable, that she would never make it in healthcare if she could not find a way to turn this around for herself and others. When presented with a depiction of the transformative model, Ann could easily identify that her thoughts, feelings and behaviors' were "weak and self-absorbed" and that this was the cause of her distress. Resonating

with the first insight from the transformative model, Ann agreed that she wanted to be more responsive and less reactive in her conflicts. She wanted to regain her moral center.

When we first met, we discussed the outcomes she wanted from coaching. One goal she identified was to become a role model for others. Consistent with co-active coaching, I asked her "powerful questions" to create a space where she could give voice to her value about being a role model, what it offered her and others when she acted as an example to others, and the personal cost of not being able to do so. "Who is someone who you feel handles conflict really well? Who's your role model?" Ann easily named a physician colleague and shared that what she admired most about him was his assertiveness. He would not go to an authority to get things sorted out; instead, he would go to people directly to have a conversation in a respectful way. If she were to learn how to be more assertive, she predicted, "I would have a more positive outlook, complain less and not have all the physical symptoms that go with it. I'd be more proactive, a problem-solver. I'd be more focused on dealing with things rather than complaining about them."

The most meaningful outcome from coaching, however, would be to reconnect with the passion that inspired her to go into nursing in the first place and restore her ability to offer her patients and colleagues the best of what she had to offer:

> I feel I lost my passion for nursing because I've been so bogged down with all the other stuff that comes with working with other people … I'd like to make the workplace better for other people because it's a pretty good group and we get along quite well in most respects … You know, I think about leaving all the time but I know I'll have the same issues elsewhere, so I'd really like to fix them where I am now.

Ann took the second insight about choosing to be her best self to heart, striving to find ways to act that were both strong and caring. Her coaching journey included reading, reflection, and journaling; developing assertive ways to engage with others in times of conflict; practicing these during her coaching sessions; and debriefing about the outcomes from her growing assertiveness on herself, others, and the situation overall. Indeed, Ann said in one session that a work friend was curious about what she was doing because she was "different" now, prompting Ann to share what she was learning in conflict coaching. She realized that she was actually becoming the role model she had wanted to be.

Over time, Ann's confidence and capacity grew to make it possible for her to use her assertiveness to effectively offer feedback to her own supervisor. The third insight became especially salient in this situation. Ann had no guarantees that offering feedback to her own supervisor would go well; however, the third insight enabled her to redefine success in a conflict. Putting the transformative theory into practice, her priority was to hold on to her moral grounding rather than achieve a specific outcome. Thus, she approached the conversation focusing her attention on remaining internally resourceful and at the same time, responsive to her supervisor. Ann later reported that this was both empowering and gratifying; the fact that her supervisor took the feedback in the spirit with which it was given was a "bonus."

This conflict coaching practice was examined in a quantitative research study conducted by Gilin Oore et al. (2017). The authors observed that:

> This is the first evidence that conflict coaching may have the potential to improve relationship quality and acceptance (Bush & Folger, 2005), and subsequently increase employee on-task focus and job performance. It is fairly common for mediation to stall because the other party is unwilling or unable to approach a joint conflict resolution

process together. It is an empowering possibility that conflict coaching can allow individuals with unresponsive conflict counterparts to nonetheless move ahead with reframing the relationship involved.

Transformative conflict coaches have the benefit of a theory to guide their practice and thus engage in reflective practice. Having specific insights to offer clients makes it possible for the transformative conflict coach to offer them the theory in a succinct and accessible way. Moreover, the transformative model's optimistic premises as well as its nondirective yet supportive practices are congruent with coaching principles and best practices (see Table 1).

The arc of coaching for Ann was shifting the conversation from "What's the matter with me?" to the more morally grounded question, "What matters to me?" This trajectory follows the pattern Bush and Folger first identified in their transformative theory. In the conflict coaching practice presented here, clients have discovered that conflict is a valuable entry point for contacting and developing their best self, their moral self, an activity that Lange and Solarz (2017) have called *restorative learning*. This activity "enables learners to reconnect with their moral-ethical ideals and provides the internal stability and resourcefulness necessary for genuine and meaningful transformation on both personal and societal levels" (p. 191). For many of these clients, transformative conflict coaching provided an opportunity to restore a connection and deepen their commitment to the values of caring, healing, and service that initially informed their decision to pursue a career in healthcare.

6 | LESSONS LEARNED

We have illustrated through our case studies as well as quantitative and qualitative research that training and coaching based on transformative theory add value for individuals, workplace relationships, and healthcare organizations in a number of ways.

First, for healthcare workers like Ann and the REC training participants, being one's best self at work holds particular meaning. They are well aware that a treatment or procedure may or may not work but being able to offer presence and care to patients and families is healing. Research suggests that restoring a connection to one's moral self also promotes the well-being of the provider. Drach-Zahavy (2009) found that the mental health of nurses with a high caring orientation is negatively impacted when they are unable to offer patient-centered care and suggests that "caring orientation

TABLE 1 Comparison between the transformative model and coaching principles and practices

Transformative premises and practices	Coaching principles and practices
People have both the motivation and capacity to act with strength and connection	Every client is creative, resourceful and whole.
Transformative practitioners honor people's self-determination by supporting opportunities for decision-making about such things as content, process, and pace.	Coaches see clients as capable, responsible, and accountable and the expert of their life; clients "design the alliance" with the coach, making decisions about goals, action steps (content), how the coach and client will work together (process, pace).
Outcomes include feeling heard; increased clarity; perspective-taking; identification of next steps; and/or making decisions; reconnecting with personal strength and responsiveness.	Outcomes include feeling heard; increased clarity; perspective-taking; identification of next steps; and/or making decisions; reconnecting with innate creativity, resourcefulness, wholeness.

programs focusing on the nurse's personal meaning of being a nurse, identification of caring values and assimilating caring values into their professional identity should be developed" (p. 1471). In other words, restoring a connection to one's moral grounding has concrete practical value for all healthcare workers–and for all of us.

Second, both anecdotal and empirical evidence suggest that conflict training and conflict coaching premised on the three transformative insights could also counteract the ill effects of emotion labor in the healthcare environment. Emotion labor is the psychological burden that results from workers being required to display positive emotions as a condition of employment, no matter what their genuine emotional state may be (Beatty, 2011; Bierema, 2008; Hochschild, 1983). Standards of practice in the various health disciplines emphasize the importance of professional communication and interactions with patients and families regardless of circumstances, including workplace conflict; thus, emotion labor is a well-recognized source of stress in this context (Riley & Weiss, 2016). We have observed that teaching healthcare workers about transformative theory and concepts fosters the development of emotional intelligence or emotion learning (Cherniss & Goleman, 2001; Goleman, Boyatizis, & McKee, 2002) and allows them to satisfy both personal and professional expectations about their interactions with patients and families. Gilin Oore et al. (2017) found that those who sought services from the transformative-based NSHA workplace CRP felt better about themselves, the outcome of the conflict, and the organization where they worked:

> The group who sought alternative conflict resolution services ($n = 137$) had less self-serving attributions for the conflict, greater satisfaction with subjective outcomes of the conflict (self/process/relationship), fewer weekly work hours lost to the conflict, and greater self-rated job performance, up to one year after the focal conflict, than did the group who pursued formal action ($n = 36$). Further, the conflict services versus formal action group difference in lost work time was fully mediated by attributions and satisfaction in the conflict. Qualitative analysis also suggested well-being benefits for conflict resolution participants, in terms of lower negative affect and greater insight.

Although this analysis and supporting anecdotal evidence suggest a financial savings to the organization, an area for future research would be to focus on capturing higher-level training and coaching impacts to the bottom-line.

Related to these first two lessons about the benefits of the transformative model on the individual level is the impact of restorative learning on broader levels. In terms of the underlying transformative theory, relationships can be ended relationally, because success lies in maintaining moral balance, whether or not the relationship continues. Some healthcare employees feel that they simply cannot maintain a moral balance if they continue working within a particular service or in a stressful, under-resourced system where they feel incapable of providing quality patient care. The restorative learning healthcare employees experience through transformative training and coaching makes it possible for them to terminate a relationship from a more morally grounded position, which allows for greater satisfaction in both the short- and long term.

That said, we have noticed that many REC participants and coaching clients experience Ann's shift in perspective, coming to believe that they are operationalizing their best self by staying and working to improve their service or system from within. Whether confronting interpersonal conflicts or broader systemic stressors, the transformative model offers rehumanizing benefits to the individual, team, and organization by reinvigorating people's passion for their work and equipping them to see opportunities for constructive individual and collective action.

Finally, by giving people an opportunity to reconnect with and further develop their moral self, transformative conflict training and coaching give healthcare workers time and space for reflection-on-action (Schön, 1983), that element of reflective practice that enables people to explore their motivations and identify new ways to engage in an event.

We concur with Thompson and Pascal (2012) that many practitioners hold an anemic understanding of reflective practice, believing it simply means "having paused for thought from time to time—with no indication of analysis, no links to an underlying professional knowledge base and no hint of being able to draw out learning or new knowledge from the experience" (p. 311). As a corrective to this literal interpretation, they suggest that practitioners be more rigorous about including theory in their reflection to better inform practice. The transformative model offers not only a credible and research-based theoretical foundation from which to operate, but also establishes a point of reference for evaluating whether or not a skill or strategy can make a difference early on in conflictual situations and will conform with one's ethical-moral sensibilities.

In conclusion, conflict training and coaching based on transformative theory are uniquely well-suited to the healthcare environment. They provide a theory, language, and concepts that support healthcare workers to intentionally restore a connection to the values that inspired them to choose a career in a caring profession, to engage in emotion learning as a way to counteract emotion labor, and to take part in reflective practice. This kind of workplace learning helps people to recognize and act from their "best selves" on multiple levels. Healthcare workers who learn to "transform conflict from the inside out," are able to offer more whole-hearted engagement in their work, provide moral-ethical leadership within multi-disciplinary teams, and navigate the increasingly complex environment that is healthcare.

ENDNOTE

[1] Name changed to protect client privacy.

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