Experiences of Conflicts and Conflict Management Styles among Healthcare Professionals: Do Conflict’s Perception and Attitude Matter?

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ABSTRACT

The healthcare industry is complex, heterogeneous in terms of staff composition, but few studies exist on how these complexities influence the perceptions and vulnerability of the healthcare team to conflict. This study examined healthcare professionals’ perceptions and attitude to conflict, as well as their experiences of conflict in their day-to-day interaction within the context of teamwork environment. The study adopted a concurrent mixed method design that consisted of structured questionnaire and face-to-face interviews. The study was conducted among six categories of health workers (nurses, doctors, pharmacists, physiotherapists, laboratory scientists, and medical records officers) at the Obafemi Awolowo University Teaching Hospitals Complex (OAUTHC), Ile-Ife. A multi-stage sampling technique was employed to select 150 health professionals for the survey. Six in-depth interviews were also conducted with senior health professionals currently occupying administrative positions at the hospital. The quantitative results showed that certain health occupations/professions are more conflict prone than others. Analysis of the health professionals’ responses to statements assessing attitude to conflict showed that a majority (77.3%) had positive attitude. There was a significant relationship between occupation/specialty and frequency of occurrence of conflict among the healthcare professionals (F = 3.54; P < 0.05). No significant relationship was found between gender and the occurrence of conflict among the professionals (F = 0.66; P > 0.05). However, the qualitative findings inter alia linked conflicts with high handedness, unhealthy rivalry, overzealousness and stepping out of job descriptions by some individuals. In conclusion, the study noted that conflict is a regular occurrence among healthcare professionals. Concerted efforts are therefore required to improve team cohesion and maximize the gains of multidisciplinary health team in the Nigerian health sector.

Introduction

The healthcare sector is complex, heterogeneous in terms of staff composition and conflict prone. Healthcare service provision is inherently interdisciplinary; it requires physicians, nurses, pharmacists, and other health professionals with different specialties to work in teams (Manser, 2009). Gittell, Fairfield, Bierbaum, Head, Jackson, Kelly, Laskin, et al. (2000) observed that multidisciplinary collaboration of scholars will optimize quality of care, lowers cost and subsequently results in improved patient’s outcomes. Collaboration among health care providers
continues to remain an essential ingredient in the healthcare service delivery today. Findings by Rafferty, Ball, and Aiken (2001) equally reinforced the value of teamwork and its association with a range of positive occupational and organizational attributes such as job satisfaction, satisfaction with being a nurse, plans to remain in post, and lower levels of reported burnout.

Beyond being a highly heterogeneous team, the pressures of clinical work that increases within an ever-limited staffing supply and the inadequate resources in many developing countries among others have all combined to increase the complexities of the vulnerability of the healthcare team to conflict (Kelly, 2006; Saulo and Wegener, 2000). In addition, differing background, interest, training, specialization, values, and professional allegiance can make conflict become inevitable (Suppiah, Uli and Othman, 2006). Behfar, Peterson, Mannix, and Trochim (2008) specifically identified ambiguity and conflict over roles; and conflict and confusion over leadership as particularly contributory to conflict among team members. Consistent with this is Todorova and Mihaylova-Alakidi (2009) submission that conflicts represent inevitable part of organizational everyday life in healthcare structures. The net result is increased propensity of the healthcare team members who are expected to work together as a strong cohesive team to conflict (Gerardi, 2003).

While conflict is regarded as a natural phenomenon in every human relationship (Kelly, 2006), concerns have however existed as to whether conflict plays a constructive or destructive role in society (Hill, 2001). De Dreu and Weingart (2003) in their study established strong and negative correlations between relationship conflict, task conflict, team performance, and team member satisfaction. In a related study, Wilson (2004) reported that conflict within the nursing profession drains energy, reduces focus, and causes discomfort and hostility. Hall and Weaver (2001) threading a path of caution, also posit that conflict, when mishandled, could make the team ineffective and dysfunctional. Brinkert (2010) noted that unmanaged conflict is costly not only in monetary terms and not only for the healthcare personnel but can extend to affect the users.

The negative impact of conflict though may be indisputable, conflict can as well be constructive; providing personal gain; acting as incentive for creativity; and serving as a powerful motivator (Marriner-Tomey, 1996). Kapusuzoglu (2010) added it can even provide opportunity for learning anew as well as growth. Brinkert (2010) equally noted that the impact of conflict on an interdisciplinary team can result in the patient benefitting more from treatment decisions that are a product of careful deliberation and combined expertise. To Todorova and Mihaylova-Alakidi (2009), conflicts are preferable because they indicate systemic
problems, give opportunity for hidden negative processes to occur, and are generator of ideas and alternatives. Wilmot and Hocker (2007) have also emphasized on the positive dimensions of conflict such as its role in helping to: solve important problems (e.g. getting individuals to address power and relationship issues); clarify individual and shared goals; overcome resentments; and come to mutual understanding. Similarly, Siders and Aschenbrener (1999) have long ago asserted that a well-managed conflict enhances self-confidence and self-esteem of the parties; builds relationships; and engenders creative solutions beyond expectations. The lesson then as Mayer (2008) puts it is that it is the manner of handling workplace conflicts that determines the eventual outcome at the individual, professional, group and organizational levels.

This as a matter of fact explains why perception and attitude matters in workplace conflicts. Taking a cue from Ajzen and Fishbein (1980) Theory of Reasoned Action and its extension, the Theory of Planned Behaviour, the best predictor of human behaviour is Behavioural intention which is in turn determined by attitude towards the behaviour and the social normative perceptions regarding it. It follows then that when a people have a positive attitude and satisfactory perception of conflict situation especially when working together in a team, it becomes easier to manage frictions and help to nip in the bud conflict situations or turn such around for greater good of the greater majority.

In Nigeria, anecdotal evidence reveals the existence of incessant rancour among healthcare professionals with a number of such rancour degenerating into full-blown conflicts and sometimes industrial dispute following poor resolution. It is somewhat paradoxical that despite the vulnerability of the Nigerian health sector to conflict situations, only very few studies have examined the conflict phenomenon in our complex, high pressured, and fragile health sector. Moreover, experience is not finite but fluid, it is thus necessary for a re-evaluation over time. This study therefore explores the healthcare professionals’ attitude to conflict, their perception of conflict, and their general experiences of conflict in a Teaching Hospital in Nigeria.

**Methods**

This study employed a cross-sectional research design and a complimentary quantitative and qualitative data collection approach, to investigate the attitude and perception of healthcare professionals to conflict as well as their experiences of conflict in their day-to-day interaction within the context of co-existence teamwork environment. The study was carried out among healthcare workers of Obafemi Awolowo University Teaching Hospitals Complex (OAUTHC). OAUTHC is a conglomerate of six (6) health facilities namely: Dental Hospital,
Obafemi Awolowo University, Ile-Ife; Urban Comprehensive Health Centre, Eleyele, Ile-Ife; Ife Hospital Unit along Ilesha road, Ile-Ife; the Wesley Guild Hospital, Ilesha; the Rural Comprehensive Health Centre, Imesi-Ile; and the Multipurpose Health Centre, Ijebu-jesa road, Ilesa. The hospital, established in September 1975, to date has the Ife Hospital Unit (this study setting) as the biggest of the facilities and the administrative head of the conglomerate. The hospital complex is a federal teaching hospital that offers primary, secondary, and tertiary care and serves as a training ground for all cadres of healthcare workers. This multiplicity of roles performance and the ready availability of a hub of healthcare professionals within its establishment makes it particularly suitable for the study.

The study population comprised six categories of health workers (nurses, doctors, pharmacists, physiotherapists, laboratory scientists, and medical records officers) who are plying their trade in the Ife Hospital Unit of the OAUTHC, Ile-Ife. By taking the official list of all health professionals working in the hospital as the sampling frame, multi-stage sampling technique was employed to select one hundred and fifty (150) professionals who completed the questionnaire for this study. In addition, six in-depth interviews were conducted with health professionals who have been working in OAUTHC for not less than five years, and who at the same are very senior health professional holding administrative positions.

The key instruments used for data collection were: a structured questionnaire, comprising a researcher developed demographic section and three other sections adapted from Thomas-Kilmann Conflict Mode Questionnaire (1974) and Johnson's (1990) 'What's your Conflict Management Style?'; and an interview schedule which consisted of nine open-ended questions that allowed for further probing as desirable. The structured questionnaire consisted of four sections: sections A to D. Section A explored the respondents' socio-demographics and other background information. Section B contained seven items, two of which sought information on frequency of occurrence of conflict and the remaining five items assessed respondents' perception of conflict. Responses were coded on a three point Likert scale: "Agree", "Don't Know" and "Disagree". The "Agreed" response is rated 3, "Don't Know" 1, and the "Disagree" response zero (0). Two of the items were however scored in reverse order. A score of "0 - 6" is adjudged 'Unsatisfactory', "7 - 9" as 'Satisfactory', while "10 - 12" is considered as 'Very Satisfactory'. Section C made up of 8 items explored respondents' attitude to conflict on a four point Likert scale ranging from "always", "occasionally", "rarely" to "never" that is scored from 3 to 0. Maximum score obtainable is 24 and minimum score is zero. A score of "0 - 11" is considered as negative attitude while a score of "12 - 24" is taken as positive attitude. Section
D is a 35 item scale that sought conflict handling-styles employed by the health professionals. Items 1, 6, 11, 16, 21, 26, and 31 were reminiscent of "withdrawing"; items 2, 7, 12, 17, 22, 27, and 32 indicative of "forcing"; items 3, 8, 13, 18, 23, 28, and 33 suggestive of "smoothing"; items 4, 9, 14, 19, 24, 29, and 34 "compromising"; while items 5, 10, 15, 20, 25, 30, and 35 expressive of "confronting". Responses were coded as: 1 - never do this; 2 - seldom do this; 3 - sometimes do this; 4 - frequently do this; and 5 - usually do this. The higher the total score for each strategy, the more frequently the respondent tend to use the approach.

The in-depth interview explored among others the health professionals' experiences about previous conflict situations, the mode of resolution, and the relationship between the different professionals. The validity of the adapted questionnaire was established through construct validity technique and the reliability by test-retest method among health professionals drawn from Ladoke Akintola University of Technology Teaching Hospital, Osogbo. A reliability coefficient of 0.84 was obtained from comparing the responses on first and second administration on the health professionals.

Prior to data collection, a formal application seeking for permission to conduct the study was made to the authority of OAUTHC, Ile-Ife. This was followed by submission of proposal of the study and other requirements to the Ethical Review Board of the institution to obtain ethical clearance. In addition, informed consents of participants were also sought after the participants were informed about the nature of the study and how confidentiality and anonymity of participants will be guaranteed.

Data collection commenced with daily distribution and retrieval of the self-administered questionnaire from one unit of the hospital to the other until all the selected units were covered. This was followed by the in-depth interviews that were carried out in the respondents' offices following booked appointments. Participation in the interview was voluntary and each session was audio-recorded with participants' permission. The quantitative data generated from questionnaire administration was analyzed with the aid of Statistical Package for Social Sciences Version 19 (SPSS 19) while transcripts of the field interviews were transcribed verbatim and subjected to thematic analysis. Statistical techniques used include: frequency, percentages, means, and standard deviation for descriptive statistics while relationships between the independent variables (Health professionals' specialty; and gender) and the dependent/outcome variable (occurrence of conflicts) were tested with One Way Analysis of Variance (ANOVA). The independent variables are categorical variables and mutually exclusive while the outcome variable is continuous and are as such in keeping with the assumptions of
ANOVA. In terms of suitability of statistical technique, Munro (1997) advanced that ANOVA has been found to be 'robust'; meaning that even if the researchers do not rigidly adhere to the assumptions guiding its application, the results may still be close to the truth. An alpha level of 0.05 was used throughout.

Results

The participants' ages range from 20 to 59 years with a mean age of 32.8 ± 10.3 years. A majority (62.3%) of the respondents were females. More than half (59.9%) were nurses; 20 were physicians (13.3%), and ten (6.7%) were Pharmacists, Physiotherapists, Medical Laboratory Scientists, and Medical Record Officers respectively. A majority (86.7%) were Christians, 12% were Muslims while only 1.3% had no religion. More than half (58%) were married, 40.7% were single, one each was divorced or widowed. The educational profile of the participants showed that 50.7% possessed diploma qualifications in Nursing, 38.7% were first-degree holders, 8.7% had Master's degree and 3% had doctoral degree (PhD). As regards the employment status of the respondents, the largest majority (86.7%) were permanent staff of the institution while the rest were on short term appointments. The respondents' years of service range from 1 year to 25 years with a mean of 6.6 years. Findings showed that conflict is fairly rampant among healthcare professionals in the study setting (Table 1). All respondents expressed that they had at one point or the other been involved in conflict situation in the course of delivering health service.

<table>
<thead>
<tr>
<th>Occurrence of Conflict</th>
<th>Frequency</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently</td>
<td>21</td>
<td>14.0</td>
</tr>
<tr>
<td>Occasionally</td>
<td>93</td>
<td>62.0</td>
</tr>
<tr>
<td>Rarely</td>
<td>23</td>
<td>15.3</td>
</tr>
<tr>
<td>Never</td>
<td>13</td>
<td>8.7</td>
</tr>
<tr>
<td>Total</td>
<td>150</td>
<td>100</td>
</tr>
</tbody>
</table>

Figure 1 below presents the views/opinions of respondents about what they consider as conflict. Their responses were coalesce into three major groups viz: fight/clash/scuffle/skirmish/brawl; disagreement/intensive discussion; and mere argument.
Fig 1: Healthcare Professionals' views of conflict

Respondents attributed the immediate and remote causes of conflict among healthcare professionals to high handedness on the part of some individuals, unhealthy rivalry, competition for leadership, incursion into somebody else professional role, and unsolicited interference in another man's duty. Virtually all the key informants were of the opinion that working together as a team would have been splendid but for the incessant rivalry, mostly revolving around issues of power and control, differential in pay packages, marginalization, solidarity with professional colleagues, and status symbol. A chief pharmacist for instance stated that:

The heterogeneous nature of the health team gives room for conflict to abound especially as related to work schedule, treatment of patients, decision-making, seeking of opinions.....

The comment of a nursing officer suggests that the perceived monopoly of knowledge and supremacy of idea held by certain members of the health team may be contributory to the incessant conflict among the healthcare team. In her words:

Every aspect of care contributes to the total wellbeing of the patient and nobody can lay claim to monopoly of knowledge. On a daily basis, we all contribute our quota. As such due recognition must be given and no one should be looked down upon as inferior contributor..... The truth is that nobody can claim to know a profession more than the person trained to give service in that profession.

While also acknowledging the value and complexity of teamwork, a consultant medical practitioner argued that:
In a team, naturally, there has to be a leader and everyone has different leadership style and when this is understood and others not only cooperate but also contribute their own quota, there shall be less friction and less conflict. Analysis of the responses of the healthcare professionals to the Likert scale statements assessing participants' perception of conflict situations showed that 81 (54%) had very satisfactory perception of conflict; 52 (34.7%) had satisfactory perception while 17 (11.3%) had unsatisfactory perception. Analysis of their responses to the 8 statements assessing attitude to conflict similarly showed that 77.3% had positive attitude while 22.7% exhibited negative attitude (Table 2). During one of the interview sessions, a very senior medical record officer stated that:

Conflict should really not be heard of among health care professionals as we are all working towards the same goal of optimal health for the patients but what we are witnessing is the contrary…….

Table 2: Perception and Attitude of Healthcare Professionals to Conflict

<table>
<thead>
<tr>
<th>Conflict's Perception</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsatisfactory</td>
<td>17</td>
<td>11.3</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>52</td>
<td>34.7</td>
</tr>
<tr>
<td>Very Satisfactory</td>
<td>81</td>
<td>54.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attitude towards Conflict</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>34</td>
<td>77.3</td>
</tr>
<tr>
<td>Positive</td>
<td>116</td>
<td>22.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Further analysis revealed a significant relationship between occupation/specialty and frequency of occurrence of conflict among the healthcare professionals (F = 3.54; P < 0.05) but no significant relationship was found between gender and the occurrence of conflict among the professionals (F = 0.66; P > 0.05) as reflected on Tables 3 and 4 respectively.
Table 3: Occupation/Specialty and Occurrence of Conflicts among Healthcare Professionals

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Records Officer</td>
<td>-</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>2</td>
<td>6</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Medical Laboratory Sciences</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Physician</td>
<td>3</td>
<td>16</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Nurse/Midwifery</td>
<td>12</td>
<td>54</td>
<td>14</td>
<td>80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
<td><strong>93</strong></td>
<td><strong>23</strong></td>
<td><strong>137</strong></td>
</tr>
</tbody>
</table>

F = 3.54  SS = 629.5  MS = 209.8  P < 0.05

Table 4: Gender and Occurrence of Conflict among Healthcare Professionals

<table>
<thead>
<tr>
<th>Sex</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
<td>32</td>
<td>5</td>
<td>47</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>61</td>
<td>18</td>
<td>90</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
<td><strong>93</strong></td>
<td><strong>23</strong></td>
<td><strong>137</strong></td>
</tr>
</tbody>
</table>

F = 0.66  SS = 308.1  MS = 308.1  P > 0.05

Further analysis of the quantitative data revealed that healthcare professionals in the study setting employ diverse strategies to resolve conflict. Dominant approaches found are collaborating or confronting style (identifying conflicts as a problem to be solved and seeking solutions that satisfy everyone’s goals i.e. working with the other party to find a solution that mutually satisfies the concerns of both party, producing a win/win situation); compromising (finding an expedient, mutually acceptable solution or a middle ground that partially satisfies both parties); smoothing/accommodating (tolerating the situation and giving up ones goal for the sake of harmonious relationship and continuity of work); forcing/dominating/competing (pursuing owns interest with vigour no matter whose ox is gored); withdrawing/avoiding (beautifully captioned by Thomas and Kilmann (1978) as diplomatic sidestepping on issue, postponing an issue until a better time, or simply withdrawing from a threatening situation). Although results revealed little shades of variation in conflict management styles along professional line, no specific pattern of conflict handling styles was established across disciplines. As obvious from Fig 2, healthcare professionals in the study setting employ a multiplicity of conflict handling styles. One of the key informants reported that she often employ avoidance/withdrawal style while two others claimed that they usually adopt collaborating/integrating and accommodating style. In the words of a chief nursing officer:
The ability to swallow personal pride, tame one’s personal feelings and emotions, and the consciousness that at one point in time or the other one may have to work with individuals who are sharp-tongued and confrontational helps in working things out.

Likewise, a chief physiotherapist explained that:

Teamwork will definitely give room for divergence of opinions, so when one’s opinion is not taken that should not give rise to disagreement. However, when one is sure that his/her opinion is not only scientific and evidenced-based but also in the right direction, one should insist on getting it done the right way so that the overall objective of optimal patients’ health can be achieved.

Majority of the key informants recalled that they had mediated in conflicts among their colleagues. The consultant medical practitioner recounted how she intervened in some volatile conflicting situations among co-workers when she was the head of her unit. As regards the issue of possible conflict with the management of the hospital, the consensus was that when such situation arises, it is pure wisdom for professional associations to dialogue with the management of the organization until a mutually acceptable solution is reached.

![Conflict Handling Styles](image-url)
Discussion

As stated inter alia, multidisciplinary teamwork, though an efficient and productive way of achieving goals and results, it’s affected by several barriers that hinder its potential from becoming fully exploited (Xyrichis and Lowton, 2008). One of such is the vulnerability of teams especially the multi-disciplinary teams to conflict. Yet to maximize the potential benefits inherent in teamwork and harness it for the overall success of the healthcare delivery system, there is a need for a smooth working relationship among team members (Igbimi and Adebamowo, 2006).

Our study recorded a high proportion of nurses (59%) compare with those of the other healthcare professionals. This though symbolic, is neither peculiar to the study setting nor the Nigerian environment, but rather a global pattern. The nature of nursing job that requires nurses to provide an uninterrupted twenty four seven coverage through shift duties modality seems to be a major contributor to this. Gerein, Green, and Pearson (2006) have earlier noted that nurses/midwives are the major providers of health care services in sub-Saharan Africa, particularly in the area of maternal and child health. The more females than males (male 32.7%, female 62.3%) recorded in the study is not equally not unexpected. Nursing is a feminine dominated profession the world over and since nurses formed a large chunk of our study population, that must have impacted on the sex distribution of the study population.

We found that all our participants were adults except for a few middle-aged folks. This is not heroic as the 9-3-4 system of education called the Universal Basic Education and the immediate past 6-3-3-4 system of the country requires that an individual spends a minimum of 16 years of formal education in order to qualify as a professional. Related to this is the retirement age that has been officially pegged at 60 years for the Nigerian government employees. The preponderance of Christian over those of the Islamic faith and other religious groups as observed in this study may however not be peculiar to healthcare professionals in Nigeria, but rather a reflection of the religious affiliation of the Ile-Ife community. The same goes for the preponderance of the Yoruba as Ile-Ife, the town where the Teaching Hospital is situated is historically regarded as the cradle of the Yoruba race. Although it is a general belief that work attitudes and dispositions towards conflicts and its resolution are context and culture driven, the littleness of other ethnic groups in the study population makes it difficult to test that assumption.

What however appears to be the high point of the study is the high occurrence of conflicts established among the healthcare professionals. This supports findings from earlier studies (Fagin, 1992; McMahan, Hoffman, and McGee, 1994; and Blickensderfer, 1996) that
indicated that the relationship between physicians and nurses is often less than optimal, even adversarial. It also gives handle to Pearson (2001) submission that researches on team interactions indicate that interdisciplinary teams often fall short of the expectations of their members, clinical leaders, and managers. In a more recent study, Todorova and Mihaylova-Alakidi (2009) declared that mutual activity between colleagues with different specialties and status and patients is prerequisite for occurrence of conflicts. The net result is a practice environment that too often exhibits a lack of cooperation, with professionals struggling to defend their disciplines and protect their authority at the expense of the overall well-being of the system, occasioning high inclination to conflict and undue suffering to the patients (Larson, 1999; Institute of Medicine, 2001).

While previous studies had identified value differences and differing goals among team members; difference in social perceptions, roles, motives of the team members; tensions around status relations, scarcity of resources for giving quality healthcare; dependence and asymmetry of different parts of the mutual medical activity, different specializations and differentiation; difficulties in communication on different levels; differences in skills, abilities, individual and psychological qualities of the professionals; and dissatisfaction from the fulfilled professional roles (Scott, 1990; Mariano, 1999; Hall and Weaver, 2001; Marinova, 2002; Todorova and Mihaylova-Alakidi, 2009; Brinkert, 2010) as factors contributing to conflict among members of work team, this study had established a few other factors that are prevalent in the study setting and Nigeria health industry. These factors are: high handedness on the part of some individuals, unhealthy rivalry, and overzealousness resulting in individuals stepping out of their job description and trying to take over the job of others. This discovery will not only help to better understand the phenomenon of conflict but will also assist concerted effort at reducing the occurrence of conflict and its negative consequences in the Nigerian health sector.

Also noteworthy is the generally satisfactory perception of conflict and the generally positive attitude to conflict established among the healthcare professionals in the study setting. This might explain why they could still work together in spite of the obvious differences in their background, training, professional culture, values, skills, discipline, and professional affiliation. Yet important is the observed relationship between occupation and the frequency of conflict among the healthcare professionals (F = 3.5385; P < 0.05). That suggests that members of certain occupation/profession are more conflict prone than members of the other occupational/professional groups. What makes this to be so could be the concern of future investigation.
Contrary to contemporary notion that women are more reluctant than men to engage in conflict for fear of being dismissed as emotional women (Marquid and Huston, 2000), this study found no significant relationship between gender and the occurrence of conflict among the healthcare professionals ($F = 0.6561; P > 0.05$). Consistent with our finding is Sportsman and Hamilton (2007) submission that women and men had similar preferences. Although the findings may not readily lend itself to generalization because of our relatively small sample size and the fact that contextual differential in work settings could be confounding, it nonetheless arouses a consciousness of a changing world and the need not to passively accept the traditional dogma of women as gentle and peace loving individuals but to begin to actively develop proactive measures to prevent and manage conflict among healthcare professionals.

Lastly, the study established no definite pattern in conflict management styles adopted by healthcare professionals. The only submission that could be safely made is that the use of these conflict handling styles rather than being stereotypical or discipline-specific is influenced by quite a number of other factors including the conflict situation itself. This is akin to Sportsman and Hamilton (2007) finding that there was no significant difference between the prevalent conflict management styles chosen by graduate and undergraduate nursing students and those in allied health.

**Conclusion and Recommendation**

This study has established that conflict is rampant among healthcare professionals. Results have also provided empirical data on the healthcare professionals' attitude, perception, and experiences of conflict in a Nigerian Teaching Hospital. Efforts should however be made to address issues identified as contributing to conflict in the healthcare sector, in order to improve team cohesion and maximize the gains of multidisciplinary teamwork. In addition, further studies may need to be conducted to unveil what makes certain health occupation/profession more conflict prone than others.
References


