CONFLICT AND CONFLICT RESOLUTIONS EXPERIENCED BY EARLY CAREER DOCTORS IN THE NIGERIAN HEALTH SECTOR: A QUALITATIVE REPORT

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Abstract

Background. Conflicts across professional workgroup and hierarchies inundate the clinical workplace. Early Career Doctors (ECDs) are also affected either as victims or as a provocateur/perpetrator. The effects of conflict at their workplaces have both significant positive and negative dimensions and impacts on ECDs. Little has been reported about conflict among ECDs in Nigeria.

Thus, this study explored the issue of conflict and conflict resolution among ECDs in Nigeria, in a bid to elicit information on the causes, consequences, perpetrators and victims.

Method. This was a qualitative study, using Focus Group Discussions (FGD) to explore information on conflict and conflict management among purposively selected key respondents (n = 14) from seven tertiary hospitals in Nigeria. The respondents are ECDs who were leaders and representatives of other ECDs in their various hospitals. Two FGDs were conducted.

Results. The result showed that conflict is inescapable in clinical settings and occurred at different levels. The perpetrators are varieties of health workers, and most are task-related conflicts, although there are relational ones. The conflicts with the government on labour-related issues are also frequent. The lack of job description and specification and power struggle among others were highlighted as the drivers of conflicts between ECDs and other health-workers.

Conclusion. The findings of the study were discussed, and suggestions were made to reduce its effect, which would require structural solutions to mitigate at different levels and the diverse players in the health sectors.

Keywords

conflicts • early career doctors• Nigeria • doctors • workplace • clinical • hospital

Introduction

The concept of conflict has different definitions by different scholars depending on disciplines [1, 2]. One of such defined conflict as a process in which various factors, likely but not necessarily including, conflicting interests, adverse effects, such as anger and dislike, negative cognition such as stereotypes, real or imagined wrongs, and actual or anticipated thwarting, result in an individual or group taking actions that are incompatible with the interest of other individuals or groups [3]. Conflict is a complex phenomenon, which exists in all aspects of human interactions; hence, health organizations and institutions are inclusive [1, 2, 4]. This phenomenon occurs amongst doctors, across hierarchies, the intra-professional and interprofessional group within hospitals [2]. The Nigerian health sector is plagued by problems that lead to conflicts among human resources for health/health workforce, with their employers or government [1].

The consequences of conflicts may be positive or negative in the outcome [1]. Consequences are negative when conflicts are not adequately managed and are allowed to degenerate to a dysfunctional status which is evident from reduced turnover among employees, reduced productivity, mental health problems, and outright violence [1]. While potential positive consequences are social change, decision-making,
reconciliation, group unity, group cooperation, the inspiration of creativity, shared and respect of opinions, and improved future communication, among others.

The occurrence of conflict among healthcare workers hinders the quality of services rendered [1]. Therefore, conflict resolution is essential to avoid the breakdown of teams, especially management teams in healthcare and promote peace and harmony among its workers.

There is a paucity of data as regards to conflict among ECDs in Nigeria. Thus, the study explored the issue of conflict and conflict resolution among ECDs in Nigeria, in a bid to elicit information on the causes, consequences, perpetrators and victims. Analysis of these problems will improve workplace issues and give the insight to help reduce the poor indices and outcomes of healthcare catastrophes affecting low-and medium-income countries such as Nigeria.

This article reports the results of the qualitative exploration among ECDs on the conflict at the clinical workplace. The study is part of the Challenges of residency training and early career doctors in Nigeria (CHARTING) study, which is a mixed study design to explore themes among Early Career Doctors (ECDs) in Nigeria [5-7]. One of the significant themes includes workplace issues.

**Methods**

**Study area**

The study was conducted during two official gatherings of the Nigerian Association of Resident Doctors (NARD), where leaders/delegates of each branch converge for the meeting. The first was during the South West regional caucus meeting held at LAUTECH Teaching Hospital, Ogbomosho while the second was an ordinary general meeting of NARD held at Yenagoa, Bayelsa State. Statutorily the National Executive Committee (NEC), National Executive Council and Expanded National Executive Council attend these meetings although other delegates who are members but non-NEC members may attend [8].

**Study design**

The study used Focus Group Discussion (FGD), which is a qualitative method to unravel the conflict and conflict resolution experienced among early-career doctors in the Nigerian health sector. Purposive sampling was used to recruit participants for the FGD.

**Study population**

Two FGD sessions were conducted among fourteen consenting respondents from seven residency-training institutions in Nigeria. The sample size was limited to only two geo-political zones (8 from South-west and six from South-south) in Nigeria due to accessibility and availability of participants. However, the study population has a more in-depth knowledge of the subject matter as they are mostly involved in conflict resolution being mainly leaders of their centres.

**Data collection**

A semi-structured FGD guide was designed to address specific aspects of conflict and conflict resolution issues experienced by respondents. FGD was used to elicit responses from participants. The guide was carefully designed and tested to ensure that the questions are simple, clear and short. Also, questions were constructed in an open-ended format, ensuring that probe, follow up and exit questions are embedded, which helped elicit correct responses without leaving any stone unturned.

Two sessions were conducted until data saturation was achieved, and each session lasted between 60-90 minutes. A trained moderator guided each session while trained research assistants managed note takings and recordings and other roles. The participants were informed before the sessions. All participants gave oral and written consent to participate in the study. Discussions were digitally recorded with participant consent to ensure that the details of the conversations are adequately captured. Previous qualitative reports on other themes have been published from the qualitative aspect of this project [10, 11].

**Sample Description**

The distribution of the respondents based on professional cadre, gender, geo-political zones and training institutions are shown in Table 1. All participants were ECDs who are medical practitioners with a degree in medicine or dentistry and are undergoing internship, residency training or are medical officers and equivalent below the rank of a Principal Medical/Dental Officer (PMO/PDO) [5, 8].

**Analysis**

Audio-recordings were correctly transcribed verbatim by research assistants. Transcripts were analysed and thematically coded according to the research themes that emerged from the discussion. Coding was done using the NVivo 12 program. Open coding was also used to identify specific themes that emerged from the discussions. Themes and subthemes were generated and supported with illustrative quotations from the discussion.

**Ethical considerations**

Ethical approval was obtained from the National Ethics Review Committee, Federal Ministry of Health before fieldwork
commenced (NHREC Approval Number NHREC/01/01/2007-26/06/2019). Written and verbal consent was received from the participants before conducting the sessions and before audio-recording. All information obtained from each participant, including personal details, was treated with the utmost confidentiality.

### Results

The result of our analysis showed that conflict is a common occurrence in clinical settings, and, it is inevitable. Four themes were identified, which represents perpetrators, causes, consequences of conflict and conflict resolution strategies. These themes were presented with supportive quotes to buttress respondents' views further.

#### Perpetrators of conflict

The study participants identified the perpetrators of conflict as all health workers within the hospital:

"Starting from the ward, nurses you are definitely going to have conflict with them" "You are going to have problems with the cleaner" "You are going to be having problems with the lab technicians" "You are going to have problem with the hospital administrator" "So in summary working in a teaching hospital as a resident doctor you are going to have conflict with everyone" (R6 SW).

"Some pharmacist that disregards doctor’s prescription of some drugs” (R2 SW).

"Rift between we and other personnel in the workplace span across the nurses up to the cleaners" (R6 SS).

"There is also conflict between patients" (R4 SS).

"Also, there is this communication gap between health care workers and patients" (R3 SS).

#### Causes of conflict

As reflected in the below verbatim expressions, drivers of conflict within the hospitals vary from lack of job description and specification to power struggle to lack of respect to poverty to mention a few:

"Well, in a system where nothing works, and you are a doctor in that system you are going to have a conflict with everybody (definitely)” (R6 SW).

"Like us in surgery, you see us sometimes roll the patient into the suite because the patient needs emergency craniotomy, and the health attendant cannot be found and all that. So you keep on doing somebody else’s job, and that is what causes conflict so you can have a backlash between a doctor, health attendant and all that” “So I think that is just the bane of our problem in the health sector. No job description and no job specification” (R4 SW).

"A lot of people don’t know what they are supposed to do, when they are supposed to do it and how they are supposed to do it” (R4 SS).

"At every available opportunity, they want to rub shoulders with the doctor, want to have whatever the doctor gets in the system. As you all know there is a hierarchy duties assigned that doctor is the head of the medical team, but the strategic roles the doctors play is not really appreciated by other workers in the health system, and this has really caused interpersonal conflict and has really affected service delivery” (R6 SS).

"If I don’t give respect to my colleague no other person will give respect to my colleague” "There is no respect first amongst ourselves (it’s been lost), and we have to find a way to go back because if we don’t have respect for ourselves nobody will have respect for you” “For instance, where a junior doctor is slapped because a nurse said something (you understand) because you are having issues with a nurse or a cleaner and you are not corrected away from the presence of other personnel’s, but you are brought down in front of them” (R4 SS).

"Poverty is the one major issue in this our environment. A patient comes in poor, comes in bad and you cannot do anything for the patient because the patient came in without nothing and you cannot access anything you now become the culprit, you become the evil person and then that is where another issue comes in like doctor battering, or doctors abuse comes to play, so that is another factor for conflict in our hospitals” (R4 SS).

#### Consequences/effect of conflict

Generated transcripts revealed that in most cases, patients are the victims of conflict.

"The consequence is that most of the time the patient suffers because when you do people’s job, you will get to the point that you cannot continue” “It is the patient that bears the brunt of the conflict” (R3 SW).

"Generally, the patient will bear the brunt but generally most times it extends to the populace when you have conflict, rivalry, strike action, lockdown you know the whole country and populace bear the whole brunt” (R5 SW).

"There is an African proverb that says when two elephant fights the grass suffers” “You can imagine when you tell a nurse that sister give that patient IM injection and she is like why can’t you do it? Don’t you have hands? And at the end of the day, the patient ends up not getting the injection, and you might end up losing that patient” (R1 SS).

"When the health workers are fighting the care, we give to the patient is very poor” “There is decay in the health system because of this conflict” (R1 SS).
Assessment of conflict resolution (interventions/strategies)
Factors that can be used to resolve conflict are attractive remuneration, professional laws, mutual respect to mention a few. As opined by some of the participants:

“There should be reward system in place” (R7 SW).
“Government is responsible, and they do what is expected of them; they pay salaries as at when due, you increase salary as at when due then people will not go on strike and if there is need to have conflict there are options that people will consider before any association go on strike” (R3 SW).

“Then also the rights of doctors or health care worker should also be respected because conflict does not only come from the workers. It also comes from management and workers, so this staff-management relationship has to be good too because in this setting we always see management like ok they are the ones that are at the helm of affairs so whatever they do is right. For instance, in our society also there is this issue of no work no pay, but there is no pay no work” “Then provision of facilities if facilities are provided, and the environment is made in a good manner I believe that workers or staffs we have the necessary equipment’s to work, and there would be no conflict of any sort” (R3 SS).

“I think we should have laws backing each and every profession; we should have laws backing them that if you come to my field, you will pay a penalty, if I go to your field or if I do what you are supposed to do there’s a penalty it will help us know our boundaries” (R1 SS).

“And I think also the pay sometimes as doctor we should not just look at…when we go for pay increment, we should just think of ourselves, but we should think of carrying the ally health workers along because if our pay is very good and their pay is poor the zeal to work will not be there on their part, and we can’t do everything so we should also carry them along when we are going for pay increment or negotiating our salaries scale we should also think of them because we can’t do all the works ourselves” (R5 SS).

“People should know their job and stay in their area of calling. Doctor should not do porter’s job carrying blood. Pharmacist should not treat patients. You know your calling so stay in your area of calling” (R5 SW).

“Mutual respect is also very important, what makes you think you are the most important person. I think we should all respect one another no matter the category of the worker that you are working because all of us at the end of the day are humans. Some of these persons that we feel we are better than they also have people they control and so we should be able to understand that and appreciate these facts and give each other respect” (R3 SS).

Discussion

The themes that emerged from the study indicated that conflict occurs commonly between ECDs and other health care professionals. The conflict appears to be unavoidable due to regular human interactions that take place in the clinical workplace, just like any other workplace [3, 12]. A quantitative study conducted amongst doctors and nurses in two public hospitals in Ido-Ekiti, Nigeria revealed that healthcare workers agree to the existence of conflict at the workplace [1, 13]. Such conflicts involve many of the categories of the health workforce and not limited to doctors, especially ECDs, and this is similar to the finding of other studies on the conflict between doctors and other health workers [14, 15]. Conflict can occur between residents, with their consultants or hospital management, and other healthcare workers within hospitals and even patients [16, 17].

While there are mixed results regarding the usual provocateur of conflicts in hospital settings, the respondents agreed on the increased likelihood of conflict with all categories of the health workforce [16]. However, the study did not explore the reasons for this diversity in such conflict against the ECDs or doctors. The clinical workplace where doctors and other health workers work is however frosted, with stressful conditions, which most likely predispose them to conflict [1, 13]. These stressful conditions are further worsen in Nigeria due to infrastructural deficiencies and inadequacies and organizational failure, which the respondents pointed out. These deficiencies and inadequacies imposed stress may explain to a large extent the precipitation in such setting rather than mere power play which may exist between a doctor or other health workers or even between a doctor and patients [18]. Furthermore, many of the conflicts with other health workers are task-related as opined by respondents; some can be inferred to be relational related. The later serves as a potential source of unfavourable outcome and dysfunction in the health system while the former may be a great source of improved efficiency to the system [19, 20].

The respondents also highlighted the recurrent role of the Government as a provocateur of conflicts in the public health system in the way she handles labour issues, especially as it relates to wages and welfares of doctors in the Nigerian healthcare system [14]. This highlight is not unusual, considering the respondents are representative of their various unions. While many studies have elucidated why doctors as a group may readily confront the Government when the doctor group interest is threatened is inherent in being a powerful and privileged group (18). This capacity may further be buttressed by the fact that they have historically succeeded in pursuing their interests.
as a professional group [21]. Most of the benefits that have accrued to the group from Government such as salary review and other welfare issues in Nigeria have been as a result of the very virulent strikes and other labour forms of labour agitations [3].

Generally, the precipitation of conflict appears to be human resources management variable of staff relationship unlike another study which has pointed out another staff-related factor; staff shortage which may arise from inadequate supply and attrition/migration [16, 22]. While that study was questionnaire-based, this study design is qualitative and by nature allows hidden themes to be explored. Although, our respondents are from tertiary centres which are relatively better staffed than other levels of care in Nigeria notwithstanding the general doctor-patient ratio in Nigeria and may not be bothered with a staff-patient ratio in respect to the conflict in the workplace [23].

Conflict in health workplace poses a negative effect on the health system and the quality of services, particularly the patients whether in conflicts between the health worker and the doctor or cases of an industrial dispute with the ECDs. All these undermine the effective functioning of the clinical workplace and the output of the workers [13].

Furthermore, the respondents highlighted the significant causes of conflict in clinical settings as lack of job description and specification, power struggle, lack of respect, poverty to mention a few, which supports previous studies findings [1]. These views are slightly different from another quantitative study, which showed that healthcare workers agree to differing aetiologic factors of conflicts. The causes among them were hegemony, poor interpersonal communication, inadequate opportunities for staff interaction, sexual harassment, stress, personality differences, dysfunctional teams, favouritism, warring egos, heavy workloads, and poor job descriptions.

It is imperative for the managers in the Nigerian Health system while realizing that conflicts are unavoidable since there is regular human interaction in the clinical workplace; to institute institutional conflict resolution mechanism. Furthermore, sufficient conflict resolution may help to prevent the attrition of the insufficient health workforce in Nigeria [23, 24].

Strategies that can be used to minimize conflict are attractive remuneration, professional laws, mutual respect, among others. Majority of these solutions focus on what can only be resolved at the managerial level.

It is, therefore, necessary for hospital administrators and the Government; who are the major employers of doctors in Nigeria to consider conflict management by strategically imbibing a proactive mindset in addressing conflict and its impact in the Nigeria health sector [25].

There is a need to conduct In-depth Interviews (IDI) on how healthcare professionals cope with conflicts within their collaboration as most physicians choose between ignoring the conflict and/or engaging in it [6]. Moreover, this will help design effective conflict management strategies. The study is limited because all respondents are from training centres in only two geo-political zones of Nigeria. However, the results of this study would make a valuable contribution to the knowledge of conflict and ECDs in Nigeria.

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Conflict of Interest Statement

All authors are ECDs except the third and last authors.

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### Table 1. Participants’ socio-demographic characteristics (N=14)

| Variables | Nr | %  |
|-----------|----|----|
| **A** Status |    |    |
| House officer | 1  | 7.1|
| Senior Medical Officer | 1  | 7.1|
| Registrar | 4  | 28.6|
| Senior Registrar | 8  | 57.2|
| **B** Sex |    |    |
| Male | 12 | 85.7|
| Female | 2  | 14.3|
| **C** Zones |    |    |
| South-west | 8  | 57.1|
| South-south | 6  | 42.9|
| **D** Centre |    |    |
| University College Hospital (UCH), Ibadan | 2  | 14.3|
| Obafemi Awolowo University Teaching Hospital Complex (OAUTHC)Ile-Ife | 2  | 14.3|
| Lagos University Teaching Hospital (LUTH) Lagos | 2  | 14.3|
| LAUTECH Teaching Hospital (LTH), Ogbomoso | 2  | 14.3|
| River State University Teaching Hospital (RSUTH), Port-Harcourt | 2  | 14.3|
| Federal Medical Centre (FMC), Yenagoa | 3  | 21.4|
| Niger Delta University Teaching Hospital (NDUTH), Okolobiri | 1  | 7.1|