

Conflict and Conflict Resolution among the Medical and Nursing Personnel of Selected Hospitals in Hail City

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Abstract: The study determined the different types of conflict experienced by medical and nursing personnel of King Khaled Hospital (KKH), Hail General Hospital (HGH) and Maternity and Children's Hospital (MCH) in Hail City and compared the conflict resolution strategies they utilized. A researcher-made instrument that included respondent demographics, frequency of types of conflict encountered by the respondents at the workplace and the Conflict Self-Assessment test by Hurst that determined conflict resolution strategies was used for data-gathering. The presence of a statistically significant difference was observed in: (1) the means at which types of conflict were experienced by the respondents in each hospital; (2) the conflict resolution strategies utilized by the respondents within KKH and HGH when grouped according to gender; (3) the conflict resolution strategies utilized by the respondents within HGH when grouped according to profession and age; and (4) the conflict resolution strategies the respondents between the selected hospitals utilized when grouped according to their demographic profile. Hospital administrators need to implement specific interventions in medical and nursing personnel supervision and management geared toward enhancing conflict resolution and foster teamwork in the workplace at the individual, departmental and organizational levels.

Key Words: Conflict, Conflict Resolution Strategies, Supervision, Management, Teamwork

I. Introduction

Conflict refers to the aggressive striving for a preferred outcome which, if attained, hinders the achievement by others of their own favored outcome [1]. It is likewise a process in which one individual perceives that its interests are being disputed or negatively affected by another individual [2]. Conflict is an extremely complex phenomenon. It can exist at different levels – intrapersonal, interpersonal, intra-group or inter group. Intrapersonal conflict occurs within the person and takes place where an individual must choose between alternatives while interpersonal conflict materializes between people [3]. Similarly, intra-group conflict develops within a single group of people while intergroup conflict transpires between at least two groups of people [4]. The CPP Global Human Capital Report revealed that an overwhelming majority, equivalent to approximately 85%, of employees at all levels experience conflict to some degree [5].

The evolution of views on organizational conflict has been described in various literature [6,7]. The traditionalist view that emerged during the 1930s saw conflict as purely negative and considers it as a disruptive and destructive force within the organization. From the late 1940s to the mid-1970s, conflict was viewed by behaviorists as an important and inevitable part of the organization that should not be eliminated, but rather accepted to possibly make it work positively for the organization. From the mid-70s, the interactionalists subscribed to the viewpoint that conflict is a creative force within the organization and that its absence renders it to become static, non-responsive, inflexible and non-adaptable. As such, the present day view provides the following understanding of conflict: (1) it is an indigenous part of life; (2) it undoubtedly happens in all work settings; (3) it does not mean that a working relationship is going poorly as it could be a positive experience; (4) it is a highly emotional process that triggers the development of new ideas [8]. Furthermore, another prevailing view of conflict is that it is a warning to management that something is amiss and it should stimulate a search for new solutions through problem solving, classification of objectives, the establishment of group norms and the determination of group boundaries [9].

Health care organizations are very complex, characterized by numerous intricate interdependent relationships and job ambiguity, which create stress and produces macro-level conflict [10]. Health care complexities related to time pressure, critical life and death decisions, unmet expectation from peers, and enormous workloads contribute to conflict [10, 11,12,13,14,15]. The common causes of conflict in healthcare organizations are: (1) competition between professionals; (2) disparities in economic and professional values among members of the healthcare team; (3) limited resources; (4) change; (5) lack of clearly defined roles and expectations; (6) capacity to function as a team; (7) interpersonal communication skills; and (8) varied expectations related to level of performance of the different roles of a nurse [16,17, 18].

Conflict in health care organizations appears in a variety of forms. Some of the potential types of conflict prevalent in hospitals include: (1) Role conflict – a type of conflict that occurs when roles are identified

with two people with different statuses and delineation of duties is unclear [19]; (2) Communication Conflict – a form of conflict that happens when individuals' failure to discuss their differences lead to problems with communication, where communication is viewed as a collaborative or collective activity that occurs between two people in agreement [20]; (3) Goal Conflict – a category of conflict which arises when two opposing goals have different levels of relevance to an individual or several individuals [21]; (4) Personality Conflict – a variety of conflict that exists when incompatible or opposing personalities present in the workplace clash [22]; and (5) Value Conflict – a kind of conflict that develops when action from an individual belonging to one moral order (i.e., set of practices, patterns of belief, language patterns) is regarded as unacceptable by another from a different moral order [23].

Physicians, nurses and other frontline health care providers operate under stressful conditions that are prone to conflict. While it is viewed that some of this conflict may generate positive outcomes, much of these conflicts will have antagonistic effects. The negative effects of conflict between physicians and nurses are the following: (1) interference to successful clinical outcomes [10, 14, 24]; (2) decreased job satisfaction among nurses resulting into decreased commitment, absenteeism, increased incidence of grievances, increased turnover rates, continuous orientation of nursing staff, and even increased occurrence of thoughts to leave the profession [25,26, 27]; (3) sustained stress that leads to memory lapses, psychosomatic illnesses, fear, irritability, decreased self-esteem and isolation [14, 24, 26, 28, 29, 30]; (4) poor or absence of collaboration leading to decreased productivity, decreased efficiency and an increase in the frequency of medical errors [14, 26]; (5) increased costs for lost time spent in dealing with conflict in the workplace [31], replacement of nurses due to turnover [32] and for litigation [10].

II. Background Of The Study

Studies conducted in the Arab region have likewise highlighted conflict occurrence in healthcare settings. A quantitative correlational study conducted among 128 nurses hailing from private and government hospitals in Jordan revealed that moderate levels of conflict are experienced by nurses, mostly in the form of intra-group conflict and disruptions from physicians [33]. These findings have been supported by a study that utilized the nursing conflict scale (NCS) to assess the types and level of conflict experienced by nurses in Ain Sham University Hospital in Cairo, Egypt [34]. An investigation to determine the major conflict management styles applied by nurse managers and staff nurses and its effect on turnover intent of nurses at Menoufiya University Hospital and Shebin El-Kom Teaching Hospital in Egypt revealed that avoiding and competing were the most and least utilized conflict management style by the respondents, respectively. More importantly, the study showed that there was a statistically significant positive correlation between turnover intent and the conflict management styles of collaboration, compromise and avoiding, while there was a statistically significant negative correlation between turnover intent and the conflict management style of competing [35].

A journal article highlighted the fact that approximately two-thirds of the total number of nurses currently working in the Kingdom of Saudi Arabia is composed of foreigners. Given this multicultural hospital environment, the expatriate nurses' lack of knowledge of the local Saudi culture can give rise to cultural conflicts and some other form of misunderstanding of behaviors and practices of Saudi nationals [36]. A conflict-related study in the Kingdom of Saudi Arabia has shown that the nature of administration, cultural understanding, and incompatible requests from different sources including educational background and occupation had a significant influence on igniting misunderstandings between and among healthcare providers [37]. In another research investigation conducted in the Kingdom of Saudi Arabia, conflict had been proven to be existent between doctors and nurses with the latter commonly using the conflict resolution strategy of avoidance of physicians [38].

As members of the public health and nursing academe, the research investigators realize the inevitable buildup of conflict in healthcare settings, specifically between and among nurses and physicians. Furthermore, the stark reality that unresolved or repressed, conflict, particularly the dysfunctional type, hinders organizational performance [2] and may potentially cause a negative impact on employee job satisfaction, employee well-being and the quality of patient care behooves both nursing administrators and academicians to assess the nature of conflict in specific healthcare settings and design specific interventions geared toward conflict resolution and management as well as foster teamwork.

III. Objectives

The purpose of the study was to determine the types of conflict encountered by medical and nursing personnel of selected hospitals in Hail City and compare the conflict resolution strategies they adopt. More specifically, it aimed to determine the following:

- 1) The demographic profile of the medical and nursing personnel at King Khaled Hospital (KKH), Hail General Hospital (HGH) and Maternity and Children's Hospital (MCH) in Hail City.

- 2) The means at which different types of conflict were experienced by medical and nursing personnel at these selected hospitals.
- 3) The presence of a significant difference in the means at which different types of conflict were experienced by medical and nursing personnel at the selected hospitals.
- 4) The conflict resolution strategies medical and nursing personnel at these selected hospitals utilized.
- 5) The presence of a significant difference in the conflict resolution strategies medical and nursing personnel within each of the selected hospitals utilized when they were grouped according to their demographic profile.
- 6) The presence of a significant difference in the conflict resolution strategies medical and nursing personnel between the selected hospitals utilized when they were grouped according to their demographic profile.
- 7) Specific interventions in medical and nursing personnel supervision and management that will enhance conflict resolution and foster teamwork in the workplace based on the results of the study.

IV. Methodology

Research Design

This study utilized a descriptive comparative research design. More specifically, it described the demographic profile of the study respondents and the type of conflict they encountered in the workplace. Furthermore, the investigation compared the conflict resolution strategies utilized by the study respondents when they were grouped according to their demographic profile. The study was likewise normative in nature as it aimed toward identifying specific interventions in medical and nursing personnel supervision and management that will improve conflict resolution in the workplace.

Population

The population of study respondents utilized was composed of all the medical and nursing personnel in the three selected hospitals in Hail City, namely: (1) King Khaled Hospital; (2) Hail General Hospital; and (2) Maternity and Children's Hospital.

Distribution of Pre-Surveyed Respondents

Hospital	Number of Medical Personnel	Number of Nursing Personnel	Total (Percentage)
King Khaled Hospital (KKH)	200	480	680 (46.67%)
Hail General Hospital (HGH)	118	343	461 (31.64%)
Maternity and Children's Hospital (MCH)	46	270	316 (21.69%)
Total	364	1093	1457

The table above presents the distribution of pre-surveyed study respondents in the selected hospitals in Hail City. It shows that from a total population of 1457 potential study respondents, 680 or 46.67% of originate from KKH, 461 of 31.64% come from HGH and 316 or 21.69% originate from MCH.

Sampling

Purposive sampling was used to generate the sample of study respondents from the pre-surveyed population. The inclusion criteria for the study respondents to be included in the sampling frame are: (1) Saudi and non-Saudi medical and nursing personnel; (2) with a minimum of two years of experience; and (3) willing to participate in the study.

Research Instrument

The study made use of a three-part researcher-made questionnaire, developed from literature review from human behavior at work, nursing leadership and management as well as researches and studies of various authors, in order to gather the necessary data. The first part of the researcher-made questionnaire provided information on the demographic profile of the study respondents. More specifically, it generated information on the study respondents' profession, gender, age, and length of years in service. The second part of the researcher-made questionnaire determined the different types of conflict encountered by the study respondents in the workplace. It identified and defined five (5) types of conflict rated using a five-point Likert scale. The rating of each type of conflict encountered was as follows: 5 with a verbal interpretation of always; 4 with a verbal interpretation of often; 3 with a verbal interpretation of sometimes; 2 with a verbal interpretation of seldom; and 1 with a verbal interpretation of never.

The third part of the researcher-made questionnaire determined the conflict resolution strategies utilized by the study respondents. It was composed of thirty (30) indicators rated using a five-point Likert scale.

More specifically, the indicators represent behaviors in conflict situations taken from the Conflict Self-Assessment test by Hurst, which was subdivided into five (5) most commonly used conflict resolution strategies [39], namely: (1) collaborating (indicator numbers 1 – 6); (2) competing (indicator numbers 7 – 12); (3) compromising (indicator numbers 13 – 18); (4) accommodating (indicator numbers 19 – 24); and (5) avoiding (indicator numbers 25 – 30) [40]. The rating of how typical the study respondent behaves when encountering conflict was as follows: 5 with a verbal interpretation of very typical; 4 with a verbal interpretation of frequently typical; 3 with a verbal interpretation of occasionally typical; 2 with a verbal interpretation of seldom typical; and 1 with a verbal interpretation of least typical. The highest score for each set of indicators representing a conflict resolution strategy is the one adopted by the study respondent when facing conflict in the workplace. The content of the researcher-made instrument was validated via Delphi technique through a team of experts. Furthermore, the researcher-made questionnaire was pilot tested to a group of twenty hospital staff who were excluded in the actual study. This was done by the investigators to ensure the validity and reliability of the researcher-made questionnaire, as well as to evaluate if the reader can easily understand its content. The computed Cronbach-Alpha coefficient of reliability of the researcher-made instrument was 0.82.

Ethical Consideration

Prior to actual data-gathering, the purpose of the study and its voluntary nature was explained to all the participants. Participants were assured of confidentiality throughout the research process and their freedom to withdraw from the study at any time in the absence of any consequences. They were likewise guaranteed that there will be no anticipated risks or discomforts in participating in this study. Written consent was obtained from each study respondent. Various measures were taken to protect the anonymity and identity of the study respondents. The accomplished researcher-made questionnaires were kept in a locked cabinet in the College of Public Health at the University of Hail and only the research investigators and one assistant (sworn to confidentiality) had access to them. Accomplished researcher-made questionnaires will be destroyed after two years’ time.

Data Gathering Procedure

An approval letter from the respective hospital directors requesting permission to conduct the study was delivered personally by the investigators. After the permit to gather data was granted, it was forwarded to the area manager of the study respondents. To ensure participation of the respondents, permission and proper channeling of the communication letter was sought from all the concerned middle managers of the hospital units and wards. The investigators then distributed the researcher-made questionnaire with its accompanying cover letter and oriented the study respondents on the conduct of the data-gathering. Accomplished researcher-made questionnaires were retrieved personally by the research investigators. Encoding and tabulation of the gathered data in a Microsoft Excel program subsequently followed.

Statistical Analysis

Data was coded for analysis through the use of SPSS version 22. The study respondents’ demographic characteristics, types of conflict encountered in the workplace, as well as the conflict resolution strategies they utilized was analyzed and presented using descriptive statistics in the form of frequencies, percentages, means and standard deviations. One-way analysis of variance (ANOVA) was utilized to determine the presence of a significant difference in the types of conflict encountered by the medical and nursing personnel respondents between the selected hospitals. T-test and one-way analysis of variance were used to determine the presence of a significant difference in the conflict resolution strategies utilized by the medical and nursing personnel respondents, within and between the selected hospitals, when they are grouped according to their demographic profile.

V. Results

Table 1: Demographic Profile of Medical and Nursing Personnel Respondents at Selected Hospitals in Hail City

Name of Hospital	King Khaled Hospital (KKH)		Hail General Hospital (HGH)		Maternity and Children’s Hospital (MCH)	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Physician	109	27%	100	35%	40	18%
Nurse	291	73%	186	65%	179	82%
Total	400	100%	286	100%	219	100%
Gender						
Male	102	26%	81	28%	18	8%
Female	298	74%	205	72%	201	92%
Total	400	100%	286	100%	219	100%
Age						
30 years and below	211	53%	132	46%	126	57%

31 – 40 years	105	26%	85	30%	54	25%
41 years and above	84	21%	69	24%	39	18%
Total	400	100%	286	100%	219	100%
Years in Service						
5 years and below	233	58%	140	49%	121	55%
6 – 10 years	95	24%	87	30%	57	26%
11 years and above	72	18%	59	21%	41	19%
Total	400	100%	286	100%	219	100%

Table 1 shows the demographic profile of medical and nursing personnel respondents at selected hospitals in Hail City. KKH had 109 physicians and 291 nurses representing 27% and 73% of its combined medical and nursing respondents, respectively. With reference to gender, KKH's combined medical and nursing respondents was composed of 102 males, representing 26% and 298 females, representing 74%. Relative to age, there were 211 professionals aged below 30, 105 aged from 31 to 40 and 84 aged 41 years representing 53%, 26% and 21% in KKH's combined medical and nursing respondents, respectively. In terms of years of service, KKH had 233 professionals who have rendered service for 5 years and below, 95 professionals who have served for 6 – 10 years, and 72 professionals who are 11 years and above in service, representing 58%, 24% and 18% of its combined medical and nursing respondents, respectively. On the other hand, HGH had 100 physicians and 186 nurses representing 35% and 65% of its combined medical and nursing respondents, respectively. With reference to gender, HGH's combined medical and nursing respondents was composed of 81 males, representing 28% and 205 females, representing 72%. Relative to age, there were 132 professionals aged below 30, 85 aged from 31 to 40 and 69 aged 41 years representing 46%, 30% and 24% in HGH's combined medical and nursing respondents, respectively. In terms of years of service, HGH had 140 professionals who have rendered service for 5 years and below, 87 professionals who have served for 6 – 10 years, and 59 professionals who are 11 years and above in service, representing 49%, 30% and 21% of its combined medical and nursing respondents, respectively. Lastly, in the case of MCH, it had 40 physicians and 179 nurses representing 18% and 82% of its combined medical and nursing respondents, respectively. With reference to gender, MCH's combined medical and nursing respondents was composed of 18 males, representing 8% and 201 females, representing 92%. Relative to age, there were 126 professionals aged below 30, 54 aged from 31 to 40 and 39 aged 41 years representing 57%, 25% and 18% in MCH's combined medical and nursing respondents, respectively. In terms of years of service, MCH had 121 professionals who have rendered service for 5 years and below, 57 professionals who have served for 6 – 10 years, and 41 professionals who are 11 years and above in service, representing 55%, 26% and 19% of its combined medical and nursing respondents, respectively.

Table 2: Types of Conflict Experienced by Medical and Nursing Personnel Respondents at King Khaled Hospital

Type of Conflict	Never (1)	Seldom (2)	Sometimes (3)	Often (4)	Always (5)	Mean	SD
1) Role Conflict	0	88	41	0	271	4.14	1.28
2) Communication Conflict	0	17	16	0	367	4.79	0.71
3) Goal Conflict	2	159	37	7	195	3.59	1.43
4) Personality Conflict	12	192	99	8	89	2.93	1.23
5) Ethics/Values Conflict	112	149	47	22	70	2.47	1.41

Table 2 shows the different types of conflict experienced by medical and nursing personnel respondents at KKH. Physicians and nurses at KKH reported that communication conflict ($m = 4.79$, $SD = 0.71$) and role conflict ($m = 4.14$, $SD = 1.28$) are the two types of conflict they experience most in the workplace. On the other hand, they indicated that ethics/values conflict ($m = 2.47$, $SD = 1.41$) is the type of conflict they experience least in their workplace.

Table 3: Types of Conflict Experienced by Medical and Nursing Personnel Respondents at Hail General Hospital

Type of Conflict	Never (1)	Seldom (2)	Sometimes (3)	Often (4)	Always (5)	Mean	SD
1) Role Conflict	27	47	80	48	84	3.40	1.31
2) Communication Conflict	10	23	68	63	122	3.92	1.14
3) Goal Conflict	28	77	66	48	67	3.17	1.32
4) Personality Conflict	23	66	88	47	62	3.21	1.24
5) Ethics/Values Conflict	60	77	60	42	47	2.79	1.37

Table 3 shows the different types of conflict experienced by medical and nursing personnel respondents at HGH. Physicians and nurses at HGH reported that communication conflict ($m = 3.92$, $SD = 1.14$) and role conflict ($m = 3.40$, $SD = 1.31$) are the two types of conflict they experience most in the workplace. On the other hand, they indicated that ethics/values conflict ($m = 2.79$, $SD = 1.37$) is the type of conflict they experience least in their workplace.

Table 4: Types of Conflict Experienced by Medical and Nursing Personnel Respondents at Maternity and Children’s Hospital

Type of Conflict	Never (1)	Seldom (2)	Sometimes (3)	Often (4)	Always (5)	Mean	SD
1) Role Conflict	28	41	73	39	38	3.08	1.25
2) Communication Conflict	8	29	77	54	51	3.51	1.10
3) Goal Conflict	24	49	88	33	25	2.94	1.13
4) Personality Conflict	21	51	81	33	33	3.03	1.17
5) Ethics/Values Conflict	43	65	69	25	17	2.58	1.16

Table 4 shows the different types of conflict experienced by medical and nursing personnel respondents at MCH. Physicians and nurses at MCH reported that communication conflict ($m = 3.51$, $SD = 1.10$) and role conflict ($m = 3.08$, $SD = 1.25$) are the two types of conflict they experience most in the workplace. On the other hand, they indicated that ethics/values conflict ($m = 2.58$, $SD = 1.16$) is the type of conflict they experience least in their workplace.

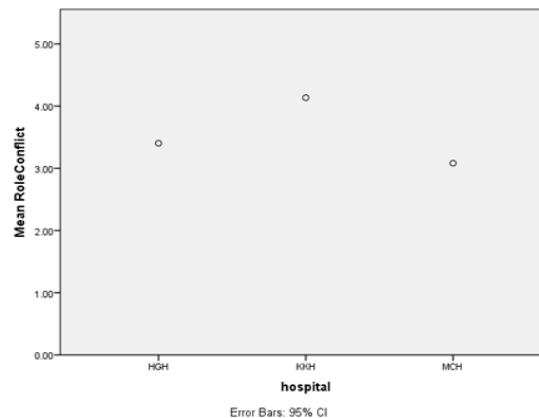


Figure 1: Means Plot for Role Conflict Experienced by Medical and Nursing Personnel Respondents at KKH, HGH and MCH

Fig. 1 shows the means plot for role conflict experienced by medical and nursing personnel respondents at KKH, HGH and MCH. A one-way analysis of variance was conducted to evaluate the presence of a significant difference in the means of role conflict experienced by medical and nursing personnel respondents in the selected hospitals, namely: (1) KKH ($M = 4.14$, $SD = 1.28$, $n = 400$); (2) HGH ($M = 3.40$, $SD = 1.31$, $n = 286$); and (3) MCH ($M = 3.08$, $SD = 1.25$, $n = 219$). The ANOVA was significant $F(2, 902) = 55.10$, $p = 0.000$. Thus, there is a significant difference in the means of role conflict experienced by medical and nursing personnel respondents in KKH, HGH and MCH.

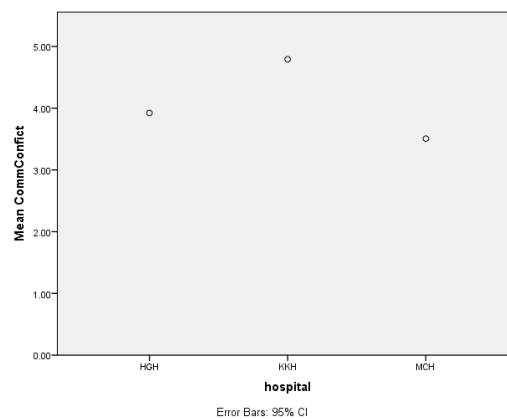


Figure 2: Means Plot for Communication Conflict Experienced by Medical and Nursing Personnel Respondents at KKH, HGH and MCH

Fig. 2 shows the means plot for communication conflict experienced by medical and nursing personnel respondents at KKH, HGH and MCH. A one-way analysis of variance was conducted to evaluate the presence of a significant difference in the means of communication conflict experienced by medical and nursing personnel respondents in the selected hospitals, namely: (1) KKH (M = 4.79, SD = 0.71, n = 400); (2) HGH (M = 3.92, SD = 1.14, n = 286); and (3) MCH (M = 3.51, SD = 1.10, n = 219). The ANOVA was significant $F(2, 902) = 144.88, p = 0.000$. Thus, there is a significant difference in the means of communication conflict experienced by medical and nursing personnel respondents in KKH, HGH and MCH.

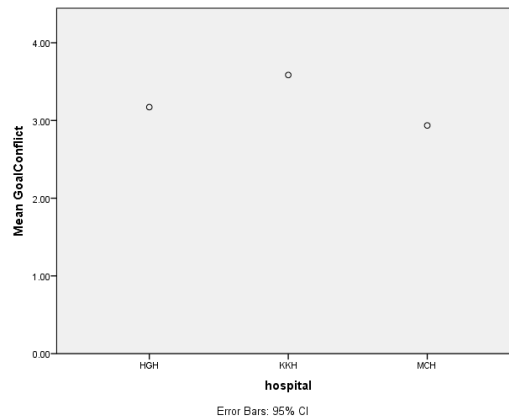


Figure 3: Means Plot for Goal Conflict Experienced by Medical and Nursing Personnel Respondents at KKH, HGH and MCH

Fig. 3 shows the means plot for goal conflict experienced by medical and nursing personnel respondents at KKH, HGH and MCH. A one-way analysis of variance was conducted to evaluate the presence of a significant difference in the means of goal conflict experienced by medical and nursing personnel respondents in the selected hospitals, namely: (1) KKH (M = 3.59, SD = 1.43, n = 400); (2) HGH (M = 3.17, SD = 1.32, n = 286); and (3) MCH (M = 2.94, SD = 1.13, n = 219). The ANOVA was significant $F(2, 902) = 18.77, p = 0.000$. Thus, there is a significant difference in the means of goal conflict experienced by medical and nursing personnel respondents in KKH, HGH and MCH.

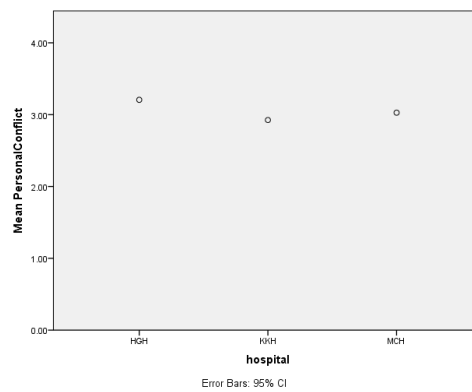


Figure 4: Means Plot for Personality Conflict Experienced by Medical and Nursing Personnel Respondents at KKH, HGH and MCH

Fig. 4 shows the means plot for personality conflict experienced by medical and nursing personnel respondents at KKH, HGH and MCH. A one-way analysis of variance was conducted to evaluate the presence of a significant difference in the means of personality conflict experienced by medical and nursing personnel respondents in the selected hospitals, namely: (1) KKH (M = 2.93, SD = 1.23, n = 400); (2) HGH (M = 3.21, SD = 1.24, n = 286); and (3) MCH (M = 3.03, SD = 1.17, n = 219). The ANOVA was significant $F(2, 902) = 4.44, p = 0.01$. Thus, there is a significant difference in the means of personality conflict experienced by medical and nursing personnel respondents in KKH, HGH and MCH.

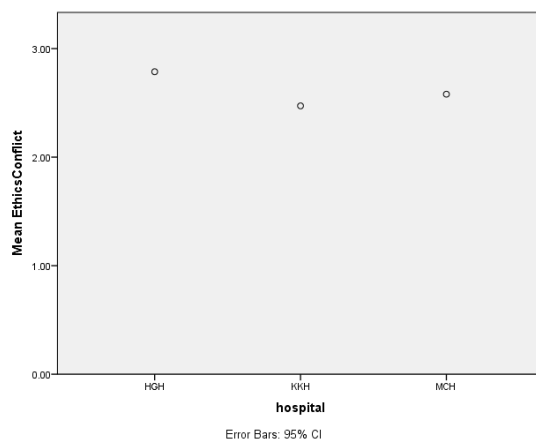


Figure 5: Means Plot for Ethics/Values Conflict Experienced by Medical and Nursing Personnel Respondents at KKH, HGH and MCH

Fig. 5 shows the means plot for ethics/values conflict experienced by medical and nursing personnel respondents at KKH, HGH and MCH. A one-way analysis of variance was conducted to evaluate the presence of a significant difference in the means of ethics/values conflict experienced by medical and nursing personnel respondents in the selected hospitals, namely: (1) KKH (M = 2.47, SD = 1.41, n = 400); (2) HGH (M = 2.79, SD = 1.37, n = 286); and (3) MCH (M = 2.58, SD = 1.16, n = 219). The ANOVA was significant $F(2, 902) = 4.63$, $p = 0.009$. Thus, there is a significant difference in the means of ethics/values conflict experienced by medical and nursing personnel respondents in KKH, HGH and MCH.

Table 5: Conflict Resolution Strategies Medical and Nursing Personnel Respondents at King Khaled Hospital Utilized

Conflict Resolution Strategy	Medical Personnel		Nursing Personnel	
	Mean	SD	Mean	SD
1) Collaborating	3.11	1.28	2.98	1.35
2) Competing	3.89	1.04	3.75	1.23
3) Compromising	4.33	0.89	4.08	1.17
4) Accommodating	2.89	1.31	3.26	1.35
5) Avoiding	4.79	0.55	4.73	0.71

Table 5 shows the conflict resolution strategies medical and nursing personnel respondents at KKH utilized. The conflict resolution strategy of avoiding was most utilized among physicians (M = 4.79, SD = 0.55), while accommodating was least utilized by them (M = 2.89, SD = 1.31). On the other hand, the conflict resolution strategy of avoiding was most utilized among nurses (M = 4.73, SD = 0.71), while collaborating was least utilized by them (M = 2.98, SD = 1.35).

Table 6: Conflict Resolution Strategies Medical and Nursing Personnel Respondents at Hail General Hospital Utilized

Conflict Resolution Strategy	Medical Personnel		Nursing Personnel	
	Mean	SD	Mean	SD
1) Collaborating	3.01	1.32	3.80	1.04
2) Competing	3.81	1.12	3.12	1.19
3) Compromising	4.21	0.99	3.39	1.11
4) Accommodating	2.80	1.33	3.35	1.05
5) Avoiding	4.69	0.82	3.07	1.21

Table 6 shows the conflict resolution strategies medical and nursing personnel respondents at HGH utilized. The conflict resolution strategy of avoiding was most utilized among physicians (M = 4.69, SD = 0.82), while accommodating was least utilized by them (M = 2.80, SD = 1.33). On the other hand, the conflict resolution strategy of collaborating was most utilized among nurses (M = 3.80, SD = 1.04), while avoiding was least utilized by them (M = 3.07, SD = 1.21).

Table 7: Conflict Resolution Strategies Medical and Nursing Personnel Respondents at Maternity and Children’s Hospital Utilized

Conflict Resolution Strategy	Medical Personnel		Nursing Personnel	
	Mean	SD	Mean	SD
1) Collaborating	2.67	1.36	3.63	1.12
2) Competing	3.33	1.47	3.08	1.19
3) Compromising	3.78	1.30	3.22	1.07
4) Accommodating	2.25	1.30	3.15	1.13
5) Avoiding	4.50	1.11	2.98	1.21

Table 7 shows the conflict resolution strategies medical and nursing personnel respondents at MCH utilized. The conflict resolution strategy of avoiding was most utilized among physicians (M = 4.50, SD = 1.11), while accommodating was least utilized by them (M = 2.25, SD = 1.30). On the other hand, the conflict resolution strategy of collaborating was most utilized among nurses (M = 3.63, SD = 1.12), while avoiding was least utilized by them (M = 2.98, SD = 1.21).

Independent t-tests were conducted to determine the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents within KKH utilized when they were grouped according to gender and profession. In terms of gender, there is a statistically significant difference in the conflict resolution strategies utilized by male medical and nursing personnel respondents (M = 3.83, SD = 0.20, n = 102) and the female medical and nursing personnel respondents (M = 3.75, SD = 0.29, n = 298), $t(398) = -2.86$, $p = 0.005$ in KKH. With reference to profession, there is no statistically significant difference in the conflict resolutions strategies utilized by medical (M = 3.80, SD = 0.21, n = 109) and nursing personnel respondents (M = 3.76, SD = 0.29, n = 291), $t(398) = 1.41$, $p = 0.159$ in KKH. A one-way analysis of variance was conducted to evaluate the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents within KKH utilized when they were grouped according to age. The independent variable, age, included three groups: (1) 30 years-old and below (M = 3.80, SD = 0.27, n = 211); (2) 31 – 40-years old (M = 3.75, SD = 0.27, n = 105); and (3) 41-years old and above (M = 3.73, SD = 0.28, n = 84). The ANOVA was not significant $F(2, 397) = 1.94$, $p = 0.145$. Thus, there is no significant difference in the conflict resolution strategies medical and nursing personnel respondents within KKH utilized when they were grouped according to age. Similarly, a one-way analysis of variance was conducted to evaluate the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents within KKH utilized when they were grouped according to years of experience. The independent variable, years of experience, included three groups: (1) 5 years and below (M = 3.78, SD = 1.94, n = 233); (2) 6 – 10 years (M = 3.77, SD = 1.94, n = 95); and (3) 11 years and above (M = 3.74, SD = 1.94, n = 72). The ANOVA was not significant $F(2, 397) = 0.45$, $p = 0.635$. Thus, there is no significant difference in the conflict resolution strategies medical and nursing personnel respondents within KKH utilized when they were grouped according to years of experience.

Independent t-tests were conducted to determine the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents within HGH utilized when they were grouped according to gender and profession. In terms of gender, there is a statistically significant difference in the conflict resolution strategies utilized by male medical and nursing personnel respondents (M = 3.69, SD = 0.31, n = 81) and the female medical and nursing personnel respondents (M = 3.39, SD = 0.69, n = 205), $t(284) = -5.08$, $p = 0.000$ in HGH. With reference to profession, there is a statistically significant difference in the conflict resolutions strategies utilized by medical (M = 3.67, SD = 0.33, n = 108) and nursing personnel respondents (M = 3.35, SD = 0.72, n = 178), $t(284) = 5.10$, $p = 0.000$ in HGH. A one-way analysis of variance was conducted to evaluate the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents within HGH utilized when they were grouped according to age. The independent variable, age, included three groups: (1) 30 years-old and below (M = 3.34, SD = 0.73, n = 132); (2) 31 – 40-years old (M = 3.52, SD = 0.55, n = 85); and (3) 41-years old and above (M = 3.65, SD = 0.40, n = 69). The ANOVA was significant $F(2, 283) = 6.11$, $p = 0.003$. Thus, there is a significant difference in the conflict resolution strategies medical and nursing personnel respondents within HGH utilized when they were grouped according to age. Similarly, a one-way analysis of variance was conducted to evaluate the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents within HGH utilized when they were grouped according to years of experience. The independent variable, years of experience, included three groups: (1) 5 years and below (M = 3.40, SD = 0.66, n = 140); (2) 6 – 10 years (M = 3.49, SD = 0.63, n = 87); and (3) 11 years and above (M = 3.60, SD = 0.48, n = 59). The ANOVA was not significant $F(2, 283) = 2.08$, $p = 0.127$. Thus, there is no significant difference in the conflict resolution strategies medical and nursing personnel respondents within HGH utilized when they were grouped according to years of experience.

Independent t-tests were conducted to determine the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents within MCH utilized when they were grouped according to gender and profession. In terms of gender, there was no statistically significant difference in the conflict resolution strategies utilized by male medical and nursing personnel respondents ($M = 3.33$, $SD = 0.27$, $n = 18$) and the female medical and nursing personnel respondents ($M = 3.22$, $SD = 0.70$, $n = 201$), $t(217) = -1.34$, $p = 0.187$ in MCH. With reference to profession, there was no statistically significant difference in the conflict resolutions strategies utilized by medical ($M = 3.31$, $SD = 0.26$, $n = 40$) and nursing personnel respondents ($M = 3.21$, $SD = 0.74$, $n = 179$), $t(217) = 1.38$, $p = 0.170$ in MCH. A one-way analysis of variance was conducted to evaluate the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents within MCH utilized when they were grouped according to age. The independent variable, age, included three groups: (1) 30 years-old and below ($M = 3.30$, $SD = 0.74$, $n = 126$); (2) 31 – 40-years old ($M = 3.12$, $SD = 0.58$, $n = 55$); and (3) 41-years old and above ($M = 3.13$, $SD = 0.57$, $n = 38$). The ANOVA was not significant $F(2, 216) = 1.91$, $p = 0.151$. Thus, there is no significant difference in the conflict resolution strategies medical and nursing personnel respondents within MCH utilized when they were grouped according to age. Similarly, a one-way analysis of variance was conducted to evaluate the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents within MCH utilized when they were grouped according to years of experience. The independent variable, years of experience, included three groups: (1) 5 years and below ($M = 3.31$, $SD = 0.73$, $n = 121$); (2) 6 – 10 years ($M = 3.12$, $SD = 0.62$, $n = 57$); and (3) 11 years and above ($M = 3.14$, $SD = 0.58$, $n = 41$). The ANOVA was not significant $F(2, 216) = 1.92$, $p = 0.149$. Thus, there is no significant difference in the conflict resolution strategies medical and nursing personnel respondents within MCH utilized when they are grouped according to years of experience.

One-way analyses of variance were conducted to evaluate the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents between the selected hospitals utilized when they are grouped according to gender. In terms of male medical and nursing personnel respondents, the three groups compared were from KKH ($M = 3.83$, $SD = 0.20$, $n = 102$), HGH ($M = 3.69$, $SD = 0.31$, $n = 81$) and MCH ($M = 3.33$, $SD = 0.27$, $n = 18$). The ANOVA was significant $F(2, 198) = 30.13$, $p = 0.000$. Thus, there is a significant difference in the conflict resolution strategies male medical and nursing personnel respondents from the three selected hospitals utilized. With reference to female medical and nursing personnel respondents, the three groups compared were from KKH ($M = 3.75$, $SD = 0.29$, $n = 298$), HGH ($M = 3.39$, $SD = 0.69$, $n = 205$) and MCH ($M = 3.22$, $SD = 0.70$, $n = 201$). The ANOVA was significant $F(2, 701) = 59.14$, $p = 0.000$. Thus, there is a significant difference in the conflict resolution strategies female medical and nursing personnel respondents from the three selected hospitals utilized.

One-way analyses of variance were conducted to evaluate the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents between the selected hospitals utilized when they were grouped according to profession. In terms of medical personnel respondents, the three groups compared were from KKH ($M = 3.80$, $SD = 0.21$, $n = 109$), HGH ($M = 3.67$, $SD = 0.33$, $n = 108$) and MCH ($M = 3.31$, $SD = 0.26$, $n = 39$). The ANOVA was significant $F(2, 253) = 45.93$, $p = 0.000$. Thus, there is a significant difference in the conflict resolution strategies medical personnel respondents from the three selected hospitals utilized. With reference to nursing personnel respondents, the three groups compared were from KKH ($M = 3.76$, $SD = 0.29$, $n = 291$), HGH ($M = 3.35$, $SD = 0.72$, $n = 178$) and MCH ($M = 3.21$, $SD = 0.74$, $n = 180$). The ANOVA was significant $F(2, 646) = 58.43$, $p = 0.000$. Thus, there is a significant difference in the conflict resolution strategies nursing personnel respondents from the three selected hospitals utilized.

One-way analyses of variance were conducted to evaluate the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents between the selected hospitals utilized when they were grouped according to age. In terms of the age bracket 30 years-old and below, the three groups compared were from KKH ($M = 3.80$, $SD = 0.27$, $n = 211$), HGH ($M = 3.35$, $SD = 0.73$, $n = 132$) and MCH ($M = 3.31$, $SD = 0.74$, $n = 126$). The ANOVA was significant $F(2, 466) = 39.09$, $p = 0.000$. Thus, there is a significant difference in the conflict resolution strategies medical and nursing personnel respondents in the age bracket 30 years-old and below from the three selected hospitals utilized. With respect to the age bracket 31 – 40 years old, the three groups compared were from KKH ($M = 3.75$, $SD = 0.27$, $n = 105$), HGH ($M = 3.52$, $SD = 0.55$, $n = 85$) and MCH ($M = 3.12$, $SD = 0.58$, $n = 55$). The ANOVA was significant $F(2, 242) = 34.26$, $p = 0.000$. Thus, there is a significant difference in the conflict resolution strategies medical and nursing personnel respondents in the age bracket 31 – 40 years old from the three selected hospitals utilized. With reference to the age bracket 41 years-old and above, the three groups compared were from KKH ($M = 3.73$, $SD = 0.27$, $n = 84$), HGH ($M = 3.65$, $SD = 0.55$, $n = 69$) and MCH ($M = 3.13$, $SD = 0.58$, $n = 38$). The ANOVA was significant $F(2, 188) = 31.89$, $p = 0.000$. Thus, there is a significant difference in the conflict resolution strategies medical and nursing personnel respondents in the age bracket 41 years old and above from the three selected hospitals utilized.

One-way analyses of variance were conducted to evaluate the presence of a significant difference in the conflict resolution strategies medical and nursing personnel respondents between the selected hospitals utilized when they were grouped according to years of experience. In terms of the experience bracket of 5 years and below, the three groups compared were from KKH (M = 3.78, SD = 0.26, n = 233), HGH (M = 3.41, SD = 0.66, n = 140) and MCH (M = 3.31, SD = 0.73, n = 121). The ANOVA was significant $F(2, 491) = 38.45, p = 0.000$. Thus, there is a significant difference in the conflict resolution strategies medical and nursing personnel respondents in the experience bracket 5 years and below from the three selected hospitals utilized. With respect to the experience bracket 6 – 10 years, the three groups compared were from KKH (M = 3.77, SD = 0.28, n = 95), HGH (M = 3.49, SD = 0.63, n = 87) and MCH (M = 3.12, SD = 0.62, n = 57). The ANOVA was significant $F(2, 236) = 28.58, p = 0.000$. Thus, there is a significant difference in the conflict resolution strategies medical and nursing personnel respondents in the experience bracket 6 – 10 years from the three selected hospitals utilized. With reference to the experience bracket 11 years and above, the three groups compared were from KKH (M = 3.74, SD = 0.29, n = 72), HGH (M = 3.60, SD = 0.48, n = 59) and MCH (M = 3.14, SD = 0.58, n = 41). The ANOVA was significant $F(2, 169) = 24.71, p = 0.000$. Thus, there is a significant difference in the conflict resolution strategies medical and nursing personnel respondents in the experience bracket 11 years and above from the three selected hospitals utilized.

Based on the results of the study, hospital management should undertake the following steps to enhance conflict resolution and foster teamwork in the workplace:

For the individual level:

- 1) Conduct a training needs assessment to identify specific concerns of both medical and nursing personnel related to conflict in the workplace.
- 2) Conduct training needs analyses to determine training needs specific to conflict management at the individual, departmental and organizational levels.
- 3) Conduct trainings in the form of seminars and workshops on conflict prevention and management/mitigation. Training has been shown to be a massively important tool towards high quality outcomes in conflict [5]. Topics may include, but are not limited to:
 - 3.1) Developing the skill of being able to slow down as health care professionals in highly stressful situations tend to move and make hasty decisions without the benefit of gathering sufficient relevant information to systematically mitigate the conflict [41].
 - 3.2) Developing self-awareness through exploration of verbal, non-verbal behaviors, emotional behaviors and underlying intentions that influence behaviors as conflict in the workplace may be lessened or could be made productive when employees inherently have an increased level of self-awareness [42].
 - 3.3) Mental reframing and behavioral changes that will focus on cessation of conflicting parties' attempts to make each other wrong as this is a crucial initial step toward conflict resolution [10];
 - 3.4) Maintenance of individual balance and increase in individual performance levels as a crucial key toward the resolution of conflict through the following: (a) listening to the meaning of words of others with critical focus centered on non-verbal cues; (b) resolving differences constructively; and (c) constructive self-talk about mistakes with the goal of learning objectively how to do better the next time so that making the same mistake again could be avoided [43];
 - 3.5) The use of the rational-intuitive method for resolving conflict that involves utilizing one's own reasons and intuition to make choices about how to react in conflict situations with a view toward recognizing conflict and managing it skillfully toward producing the best result [44];
 - 3.6) Personal discipline, a consideration of people's life stages and communication that includes active listening [3];
 - 3.7) Development of self-assertiveness skills to be heard and merit the respect of peers where transactional analysis can be used as a suitable model for understanding of the self, understanding of others and to facilitate effective communication [45].

For the departmental level:

- 1) Medical and nursing departments can conduct quality circles aimed at broadening, understanding problems, creating more alternative solutions and achieving a workable consensus on decisions coupled with genuine commitment to decisions made [3].
- 2) Nurses should be educated on the significance of cooperation, collaboration and effective ways of resolving conflict. This should include collaboration with higher education institutions of nursing to include conflict resolution and relationship building as part of the nursing curriculum [27]. Such inter-departmental collaboration with the nursing department and inter-institutional collaboration with colleges of Medicine to do the same with the medical curriculum would likewise do well with the medical department to promote conflict prevention and management.

- 3) Both medical and nursing departments must have clear cut mechanisms in place for conflict resolution that includes: (1) individual initiative; (2) informal or assisted negotiation; (3) negotiation; (4) mediation; and (5) involvement of higher authority [46].

For the organizational level:

- 1) Hospital management should maintain high levels of motivation among medical and nursing personnel through sharing of information, conducting informal discussions, and provision of clear job descriptions that could contribute toward controlling role conflict in the workplace [47].
- 2) Hospitals should provide various educational programs that would increase conflict resolution that focus on the relationship between preferred modes of resolution and job satisfaction [48].
- 3) The Registered Nurses' Association of Ontario had formulated a set of guidelines for managing and mitigating conflict at the organizational level [49] that may be adopted by other health care institutions and it includes:
 - 3.1) identification of factors that lead to conflict and implementation of action to mitigate them;
 - 3.2) patronizing systems and procedures that reduce conflict to a minimum, encouraging teamwork, placing a high premium on diversity and instilling a culture of belongingness;
 - 3.3) carrying out periodic assessment to determine types of conflict existing among nurses, physicians and other health care providers and their subsequent results;
 - 3.4) undertaking and maintaining evidence-based strategies that empower leaders to develop self-awareness, emotional intelligence competencies and apply principles of conflict management;
 - 3.5) making certain that nurses, physicians and other support staff possess the knowledge and competencies for management of conflict through the provision of a continuous series of compulsory skills-based education that focuses on transparent communication, team building facilitated by transformational leadership and development of emotional intelligence skills;
 - 3.6) making available third party intervention that renders productive support, common decision-making and alleviation of conflict;
 - 3.7) committing to perpetual utilization of collaborative and active conflict resolution strategies through mechanisms related to recruitment and application of mentorship programs for managers;
 - 3.8) appraising the appropriateness and effectivity of operant conflict management strategies, standards and policies;
 - 3.9) assuring the presence of multi-dimensional, all-encompassing and exhaustive structures and policies on conflict management;
 - 3.10) inculcating a culture of conflict management and promoting positive outcomes through mechanisms that encourage effective intra- and interpersonal collaborative relationships; and
 - 3.11) providing support to handle conflict constructively in inter-professional collaborative practice.

VI. Discussion

The study determined the types of conflict encountered by medical and nursing personnel of King Khaled Hospital (KKH), Hail General Hospital (HGH) and Maternity and Children's Hospital (MCH) in Hail City and compared the conflict resolution strategies they adopt.

The sheer number of medical and nursing personnel currently working in each of these three hospitals indicates the complexity of these healthcare institutions and the potential for the occurrence of conflict in these complex workplaces [10, 13]. Similar to other hospitals, the existence of intra-group conflict involving members of two professions that closely collaborate to deliver patient care is evident in these three hospitals [3, 30, 33, 34, 38]. Other antecedents to conflict present in these three hospitals include the fact that their medical and nursing personnel are diversely distributed in terms of gender [50, 51, 52], age [53] and years of experience [12, 37, 50].

Results of the study had shown that role conflict is the second most frequent type of conflict experienced by the medical and nursing personnel respondents from the three hospitals surveyed. Various studies have identified different reasons for the presence of role conflict in the hospital. A study among health care personnel in the Kingdom of Saudi Arabia revealed that role conflicts arise due to the presence of incompatible requests from different sources and the nature of the administration [47]. The notion that physicians always are the dominating profession in the hospital recognized as leaders responsible for patients and that they must handle all situations creates a misunderstanding of roles leading to identity conflict between nurses and physicians [54]. Other reasons for the presence of role conflict among nurses and physicians include the fact that present-day nurses are holders of academic qualifications that equal or even exceed physicians and that the fast-paced advancement of the field of nursing has left some health care professionals unwilling to accept this reality [55]. As such, boundaries between doctors who provide medical diagnoses and prescribe medical treatment and nurses as healthcare professionals who carry out orders and implement interventions ordered by doctors are becoming less clear [56]. Blurred boundaries between nurses and physicians leading to

role conflict have been attributed to senior-level nurses, considered as experts in their specialties, who fail to operate within the boundaries of nursing practice [57]. Furthermore, an exploratory study conducted among anesthesiologists and certified registered nurse anesthetists (CRNAs) revealed that conflict among these highly-interdependent members of the health care team results from divergent views as to who has the responsibility to perform a certain role [25]. More importantly, role conflict was identified as a factor that positively contributes to emotional exhaustion among Hungarian health care staff [58] and the high level of burnout experienced by nurses relative to physicians at a university hospital in Turkey [59].

Communication conflict ranked as the most common type of conflict experienced by the study respondents from the three hospitals surveyed. Numerous studies conducted on the subject of conflict reveal that interpersonal or professional communication difficulties are the cause of a majority of conflict in the healthcare setting [60]. Interpersonal conflict among physicians and nurses in eight departments in Ramban Hospital in Boston revealed that miscommunication was one of the root causes [30]. Various studies have revealed that occurrence of communication conflict in the form of verbal abuse dished out by nurse managers to staff nurses [12], by an attending physician to a nurse [24] and how nurses who experienced receiving verbal abuse committed errors in the administration of care to patients [14]. More specifically, conflict-creating dysfunctional communication in extremely stressful hospital environments may occur in the form of harsh language, negative criticism, derogatory comments and even bullying [13].

Goal conflict was identified as the third most frequent type of conflict experienced by medical and nursing personnel respondents from KKH and fourth most frequent type experienced in HGH and MCH. Common goals among healthcare professionals may be perceived or experienced differently by nurses and physicians resulting into conflict [16]. On the contrary, conflict between groups in the some organization may be caused by their differences in goals [61]. Disagreements among parties with respect to the approach they opt to pursue in trying to accomplish a common goal are regarded as procedural conflicts while forms of conflict wherein individuals or groups disagree on the substance of the goal itself or exactly what the goal should be are classified as substantive conflict [62]. Procedural conflict was existent between line and staff employees at a teaching hospital in Nigeria in relation to the accomplishment of organizational goals [63]. Substantive conflict was evident among nurses working in an Iranian hospital [64].

Personality conflict was the third most common type of conflict experienced by medical and nursing personnel respondents from HGH and MCH and the fourth most frequent type experienced in KKH. Uniqueness of attitudes, opinions, beliefs, emotional stability, maturity, education, gender and language among others accounts for personality differences that result into conflict situations [65]. An investigation in Canada to determine antecedents of intra-group conflict among nurses revealed that dispositional characteristics and that incompatibility among nurses give rise to personality clashes [11]. Interpersonal conflicts among resident physicians and nurses were identified to be caused by incompatibility of personalities among the conflicting parties [30].

Ethics/values conflict had been shown to be the least frequent type of conflict experienced by medical and nursing personnel respondents in the three hospitals surveyed. Conflict between groups in organizations may be brought about by differences in values [61]. Value based disagreements occur between nurses and physicians when one party attempt to force own set of values on another [54]. Such type of conflict occurs especially when there is incompatibility of values between the physician and the nurse [3]. Conflict of values was reported as the least source of work-related conflict among nurses working in a tertiary hospital located in South-south Nigeria [66].

The presence of a significant difference in the means at which all the five different types of conflict (i.e., role conflict, communication conflict, goal conflict, personality conflict, and ethics/values conflict) are experienced by medical and nursing personnel respondents belonging to the three hospitals can be attributed to the uniqueness of situations present in each hospital that result into conflict. This uniqueness of situations resulting into conflict, in turn, is brought about by varying complexities existent in each of these hospitals. Health care institutions' complexity as a cause for the existence of different types of conflict is well supported by various literature [10, 11, 13, 14]. Although the study did not delve on the complexity of the three hospitals surveyed and how the differences in their complexities have resulted into different types of conflict, the sheer number of medical and nursing personnel interacting in each of the three hospitals, let alone the diverse demographic profile of the medical and nursing personnel respondents in terms of gender, profession, age and years of experience in each of these hospitals contribute to unique complexities that result into them experiencing various types of conflicts in differing means that are statistically significant. Differences in the profile of health workers had been suggested to contribute to varying conflict types or situations [65].

The finding that medical and nursing personnel respondents utilized various conflict resolution strategies in their respective work places is supported by literature and various studies. It was posited that conflict among nurses can likewise be a reason for nurses to adopt passive avoidance, to reduce their working hours and even consider leaving the profession [26]. Increased job turnover, eroding job commitment,

absenteeism, an increase in the frequency of grievances and increased occurrence of thoughts to leave the profession were common among nurses undergoing conflict with physicians and that passive avoidance was a conflict resolution strategy commonly adopted by nurses in such a conflict-laden and stressful environment [27]. With respect to conflict among nurses and physicians, the conflict resolution strategies of avoidance and compromise are commonly used to remedy conflict on an interim basis [2]. A study conducted among 78 nurse respondents in a selected tertiary hospital in the Kingdom of Saudi Arabia revealed that they most often utilized competing in conflict situations with physicians while accommodating was the least used conflict resolution strategy with doctors [38]. Among nurse managers and staff nurses at Menoufiya University Hospital and Shebin El-Kom Teaching Hospital in Egypt, avoiding and competing were the most and least utilized conflict management style by the respondents, respectively [35].

The presence of a significant difference in the conflict resolution strategies utilized by medical and nursing personnel respondents within KKH and HGH when they were grouped according to gender is supported by the fact that females have a natural propensity for peaceful coexistence in the workplace while the males are more prone to be involved in confrontational behavior in the face of conflict [67, 68].

The observed significant difference in the conflict resolution strategies utilized by medical and nursing personnel respondents within HGH when they were grouped according to profession is supported by various literature showing different conflict resolution strategies physicians and nurses tend to employ. Most physicians utilize power and the conflict resolution strategy of competing [54, 69] due to the still existing notion that doctors take the lead role and that nurses in the team must follow their orders [70]. Despite the presence of many nurses who are holders of equal or even higher academic qualifications relative to physicians [55], such trends in nurse advancement has been more prominent in the United States and Canada [71]. On the part of nurses, passive avoidance was commonly adopted as a conflict resolution strategy in stressful environments involving conflicts with physicians [27] as the view that nursing is a low-status profession in the healthcare system is still existent [72].

The presence of a significant difference in the conflict resolution strategies utilized by medical and nursing personnel respondents within HGH when they were grouped according to age is similar to the findings by Havenga (2008) who posited that various age groups tended to utilize different conflict resolution strategies such that younger people (less than 36 years of age) commonly utilized the dominating or competing conflict resolution strategy relative to the older ones (45 years of age and above) [73].

The observed significant difference in the conflict resolution strategies medical and nursing personnel respondents between the selected hospitals tend to utilize when they were grouped according to their demographic profile can likewise be attributed to the uniqueness of antecedent situations present in each hospital that result into conflict and the differences in complexities inherent in each of the hospitals. As mentioned earlier, the diverse demographic profile of the medical and nursing personnel respondents in terms of gender, profession, age and years of experience in each of these hospitals provide each hospital with a different set of complexities. These findings are supported by Berman-Kishony (2011) who posited that no one conflict resolution approach will be effective for each work environment, let alone different work setting [30]. Such leads to the need for condition-specific conflict resolution strategies particularly for different work environments. Various specific interventions in medical and nursing personnel supervision and management on the individual level [3, 10, 41, 42, 43, 44, 45]; the departmental level [3, 27, 46] and the organizational level [47, 48, 49] have been enumerated to be included trainings and mechanisms geared toward enhancing conflict resolution and fostering teamwork in the hospital.

VII. Conclusions And Recommendations

The findings of this research investigation indicated that the types of conflict experienced by the medical and nursing personnel respondents in each of the three hospitals differed significantly. Likewise, the conflict resolution strategies utilized by the medical and nursing personnel respondents within KKH and HGH differed significantly when they were grouped according to gender. Moreover, it was shown that the conflict resolution styles utilized by the medical and nursing personnel respondents within HGH differed significantly when they were grouped according to profession and age. Most importantly, the study revealed that the conflict resolution styles utilized by the medical and nursing personnel respondents in each of the three hospitals differed significantly when they were grouped according to their demographic profile. These findings put together lead to the conclusion that hospital administrators need to implement specific interventions in medical and nursing personnel supervision and management geared toward enhancing conflict resolution and foster teamwork in the workplace at the individual, departmental and organizational levels. The study was limited toward exploring the different types of conflict experienced by medical and nursing personnel and the conflict resolution strategies they subsequently utilized in three selected hospitals. It did not delve into the antecedents of the different types of conflict existent in the three hospitals nor did it attempt to assess the cost of conflict in these health care institutions. Considering the limitations of the current investigation, it is recommended that

further research regarding antecedents of the different types of conflict and an assessment of the cost of conflict in these three hospitals be conducted to generate new solutions that can be evaluated to make conflict work positively for these health care institutions.

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