Managerial dynamics influencing doctor–nurse conflicts in two Nigerian hospitals

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ABSTRACT

Background: In the hospital, authority does not usually comes from a single person nor is it exercised in a single chain of command as is obtainable in most formal organizations. Doctors exercise substantial authority within the organizational structure of the hospital and therefore enjoy high autonomy in the hospital setting. This nature of autonomy within the medical and its allied professions has the propensity to incite conflicts within the hospital settings. The study thus sought to examine how the relationship of authority and influence between doctors and nurses within the hospital organization generates conflicts and to evaluate the effectiveness of managerial procedures utilized to resolve doctor–nurse conflict in the selected hospitals. **Methods:** Semi-structured questionnaires were self-administered to 323 health workers who were sampled from one secondary and the only one tertiary hospital in the state at the time. Focus group discussions (FGDs) were conducted with three groups each of doctors and nurses in the selected hospitals. The organograms of both organizations were also reviewed to evaluate structural relationships of authority between doctors and nurses. Data were analyzed using unadjusted odd ratios at 95% level of significance. **Results:** Respondents were also twice likely to attest that the command structure and its ability to resolve conflicts was below average in assessment (odds ratio [OR] – 2.05; 95% confidence interval [CI] – 1.27–3.29). Undue advantage (partisan approach) for a particular group by management to conflict resolution was thrice likely to be practiced in both hospitals but more in state hospital compared to the federal medical center (OR – 2.93; 95% CI – 1.54–5.58). Some findings from respondents in the FGDs revealed lackadaisical approach by the management in tackling conflicts among health workers. **Conclusion:** Doctor–nurse conflict is caused by several organizational and managerial factors. Hospital management must understand the interplay of these factors and institute appropriate managerial policies to tackle the problem appropriately.

Keywords: Conflict, doctor, hospital, managerial dynamics, nurse

Introduction

The primary objective of a hospital is to provide individualized care to patients within the limits imposed by current technical–medical knowledge, human resources availability, and dynamics.[1] Thus, the organizational structure of the hospital has an identifiable social structure formally established for the purpose of achieving specific objectives and goals. The achievement of the set goals depends on an effective and efficient management of all resources, which includes the maintenance of a conducive environment for constructive interaction within the health team.[2] The health team which consists of a broad and diverse group of professionals and nonprofessionals alike is saddled with the achievement of the hospital objectives.[2] A subset of the health team is the medical team which is the team directly involved in the functional line (as team directly involved with the care of patients which is one of the primary goals of a health facility). The medical team consists of groups of professionals, which includes doctors, nurses, pharmacists, radiographers, and laboratory scientists/technologists whose work is mutually supportive and interdependent.[3]

However, it is an established fact that the clinical team is the driving force of the hospital because the major services of the hospital as

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an organization is delivered by the clinicians.[4] Clinicians possess an in-depth knowledge of the needs of the patient thus skewing the thrust of decision-making and leadership of the team more with the doctors. In the process, doctors are unassertively saddled with both managerial and technical responsibilities toward the medical team along with clinical expertise for the patients. The members of the team have to interact extensively resulting in learning, success, and development of patient-oriented systems to avoid conflict in all its various ramifications. Relationships between health-care professionals and health managers have increasingly been viewed as problematic and characterized as oppositional in nature.[5] This has been proposed to occur as a result of self-reliant and independent nature of doctors by tradition that emphasizes expertise, autonomy, and responsibility more than interdependence, deliberation, and dialogue.[6]

Even though conflict is inevitable in most human interactions and organizations,[5,7] it needs to be curtailed to limit its negative consequences in the work environment. Conflicts in the workplace have been proven to result in better understanding and adoption of effective teamwork when managed properly in work settings or enable diverse environment that fosters growth and interactions when joint resolutions and cooperation are encouraged.[8] Unmanaged/mismanaged conflict with deleterious consequences arise when little or no cooperation exists among social groups or entities and where the involved entities function in disservice to one another.[9] In this context, conflict would only hinder the coordination and teamwork crucial in accomplishing the organization's goals. It is thus imperative that health systems are frequently assessed bearing in mind the dynamics that exist between the members of the health team to continuously address issues that promote conflicts or hinder efficiency in hospital settings and consequently patient-oriented care.

Therefore, the aim of this article is to examine how the relationship of authority and influence between doctors and nurses within the hospital organization generates conflicts and to evaluate the perceived effectiveness of managerial procedures utilized to resolve doctor–nurse conflict in some selected hospitals of Southwestern Nigeria.

Methods

The study was a mixed methods one, utilizing sequential explanatory approach[10] for its data collection and recruitment of doctors and nurses. The study was conducted in Ekiti State, a Southwestern state in Nigeria. The state, carved out of the territory of old Ondo State, covers the former 12 local government areas (LGAs) that made up the Ekiti Zone of old Ondo State. On creation, it had 16 LGAs, having had an additional four carved out of the old ones. Ekiti State is one of the 36 states that constitute Nigeria. It spans a total area of over 6353 km² with an estimated population of 2,737,186 inhabitants whose principal inhabitants are the Yoruba, with clusters of Igbos and Hausas living in several areas.[11]

The respondents were recruited from the Federal Medical Centre (FMC) and the State Specialist Hospital (SSH). The FMC is a tertiary health facility located in Ido-Osi, Ekiti State. The SSH is a secondary health-care delivery facility situated in the heart of state capital. It has 12 departments and a staff strength of 306 including 58 nurses and 11 doctors; headed by a chief medical director. The medical center on the other hand has 14 departments, 54 beds, and is headed by a chief medical director. Details of the study site and sampling procedures are discussed elsewhere.[5]

Data were collected using pretested semi-structured questionnaires. The questionnaire was pretested on doctors and nurses at the SSH, Akure, Ondo State, before its administration in the main study. Content validity was certified through consultation of relevant literature on managerial dynamics and presented to a group of experts with a wealth of experience for content and structure. Results of pretest were used to improve and produce a revised guide for the field study adjusted to allow for other objectives of the study. Internal consistency was validated with Cronbach's α estimated as 0.87. The pretest was used to correct for ambiguities in the understanding of the questions by respondents. Readability of questionnaire was further ensured by subjecting it to Flesch reading ease score that yielded a score of 73.9 demonstrating a fairly easy tool to read and understand.[12] Furthermore, before the administration of the questionnaire, written informed consents were obtained from each participant subsequent to a detailed description of the study procedure. Privacy of participants and confidentiality of information was ensured during fieldwork by ensuring that no identifiers such as names or contact details were sought during the interviews. Sample size was determined using the Leslie Kish formula for determining single proportion for descriptive studies.[13]

For the quantitative data, information was collected on sociodemographic characteristics, causes of conflict with respect to command structure, communication, desire for power, desire for influence, procedural changes, effectiveness of hospital management in resolving conflicts, and other important domains pertaining to structural command in the hospital. After the quantitative data was completed, focus group discussions (FGDs) were also conducted with groups of doctors and nurses in both the study areas. This involved three groups of doctors and three groups of nurses each in the two facilities. Each group had five discussants and thus a total of six groups and thirty people altogether. Data from the FGDs were later analyzed using the schematic approach. In addition, the organograms of both organizations were also reviewed to evaluate the structural relationship between doctors and nurses. Data were analyzed with the Statistical Package for the Social Sciences (SPSS) Version 22, USA[14] using frequencies and percentages. Association between demographic variables was sought by means of odd ratios and set at 95% confidence intervals. Respondents' perceptions of the cause of conflict between doctors and nurses were analyzed using logistic regression and their confidence intervals. Level of significance was also set conventionally at 95%.

Permission to carry out the study was sought and obtained from the Chief Medical Directors of the FMC, Ido-Ekiti, and the SSH, Ado-Ekiti, through letters of introduction from the Department of Community Medicine, College of Medicine, University of Ibadan. In addition, Ethical approval was obtained from review committee of Ekiti State Ministry of Health. Written informed consents were obtained and obtained from respective doctors and nurses at both hospitals after thorough briefing on the objectives of the study.

Results

A total of 335 respondents were targeted with the questionnaires, being the total staff strength of the two hospitals: The SSH, Ado-Ekiti, and the FMC, Ido-Ekiti, comprising doctors and nurses. A total of 323 respondents completed and returned the questionnaire (response rate = 96.4%). Participants were more of females (81.7%); married (75.9%); nurses (84.5%); below 40 years (53.0%); with majority of respondents with <15 years of professional experience (50.3%). Details of sociodemographic characteristics of respondents are described elsewhere.[5] More nurses (80.6%) compared to doctors (19.4%) were almost thrice likely to agree to the existence of conflicts in the hospital environment (odds ratio [OR] – 2.94; 95% confidence interval [CI] – 1.33–6.49). The nurses were 15 times more likely to disagree with the notion that they demanded influence and recognition in the hospital workplace (OR – 14.98; 95% CI – 7.05–32.24) [Table 1].

Comparison of respondents' perception of managerial approaches

With respect to the perception of respondents of capacity of the hospital management to discharge its statutory functions to minimize conflicts in the hospitals, respondents were almost twice likely to agree that the performance of the hospital against this index was below average (OR – 1.79; 95% CI – 1.10–2.90) [Table 2]. Respondents equally were almost twice likely to agree that the hospital structure was below average in its facilitation of interdependence of work activities among all the members of the health team (OR – 1.71; 95% CI – 1.01–2.88) [Table 2]. With respect to the command structure and how clear it was in delineating responsibilities among health team members, respondents were also twice likely to attest that the command structure and its ability to resolve conflicts was below average (OR – 2.05; 95% CI – 1.27–3.29) [Table 2].

Conflict management and resolution techniques

Of the total 323 respondents, only 217 (67.2%) believed that strategies were employed in their facilities to address conflicts when it arose. Among those that attested to use of strategies, utilization of tact and diplomacy was more likely a strategy used in resolving conflicts at the state hospital compared to the federal center though not with a significant difference (OR – 1.07; 95% CI – 0.57–1.99) [Table 3]. Undue advantage (partisan approach) for a particular group by management to conflict resolution was thrice likely to be practiced in the both hospitals but more in state hospital compared to the FMC (OR – 2.93; 95% CI – 1.54–5.58) [Table 3]. More participants disagreed with the idea that concessions had ever been reached by parties involved in conflicts before (OR – 0.36; 95% CI – 0.18–0.72). Collective negotiation as a strategy for resolving conflicts according to respondents was less practiced in both hospitals (OR – 0.74; 95% CI – 0.37–1.48) [Table 3].

Procedural changes

Only 35 of the respondents reported that management has had to change a procedure as a result of doctor–nurse conflict (OR – 0.74; 95% CI – 0.37–1.48) [Table 3], and 68.5% of those that reported that a change in procedure had been effected reported that the change was effective. More health workers (70.8%) from the state hospitals reported this positive procedural change (OR – 0.91; 95% CI – 0.20–4.21) [Table 3].

Reports/findings from the focus group discussions

In some important excerpts from the FGDs with doctors, it was reported that:

"Nurses do not accept their limitations and want to play a prominent role like that of the doctors, which is not possible because the trainings of the two groups are different"

-FGD D2.

Table 1: Perception of causes of conflict among health workers					
	Health worker		*P*	OR	95% CI
	Doctors, *n* (%)	Nurses, *n* (%)			
Conflict exists (*n*=323)					
Agree	42 (19.4)	175 (80.6)	0.006	2.94	1.33-6.49*
Disagree	8 (7.6)	98 (92.4)			
Respondent's perception on doctor's demand for power (*n*=323)					
Agree	8 (3.6)	214 (96.4)	<0.001	0.05	0.02-0.12*
Disagree	42 (41.6)	59 (58.4)			
Respondent's perception on nurse's demand for influence (*n*=323)					
Agree	36 (47.4)	40 (52.6)	<0.001	14.98	7.05-32.24*
Disagree	14 (5.7)	233 (94.3)			

*Significant associations (*P*<0.05). OR: Odds ratio; CI: Confidence interval

Table 2: Comparison of respondent's perception of managerial approaches

	Performance indices and managerial approaches		P	Unadjusted OR	95% CI
	Below average	Above average			
Capacity of hospital management to perform its functions (n=289)#					
Agree	101 (55.5)	81 (44.5)	0.018	1.79	1.10-2.90*
Disagree	44 (41.1)	63 (58.9)			
Training (n=323)					
Agree	98 (45.2)	119 (54.8)	0.146	0.71	0.45-1.13
Disagree	57 (53.8)	49 (46.2)			
Interdependence of work activities (n=254)#					
Agree	86 (51.8)	80 (48.2)	0.045	1.71	1.01-2.88*
Disagree	34 (38.6)	54 (61.4)			
Command structure (n=323)					
Agree	118 (54.4)	99 (45.6)	0.003	2.05	1.27-3.29*
Disagree	39 (36.8)	67 (63.2)			

#Numbers do not add to 323 due to missing values, *Significant associations (P<0.05). OR: Odds ratio; CI: Confidence interval

Table 3: Conflict management/resolution techniques

	Hospital type		P	Unadjusted OR	95% CI
	SSH	FMC			
Utilization of tact and diplomacy (n=217)#					
Agree	84 (77.1)	25 (22.9)	0.843	1.07	0.57-1.99
Disagree	82 (75.9)	26 (24.1)			
Undue advantage (n=217)#					
Agree	120 (83.3)	24 (16.7)	0.001	2.93	1.54-5.58*
Disagree	46 (63.0)	27 (37.0)			
Concession (n=217)#					
Agree	27 (60.0)	18 (40.0)	0.003	0.36	0.18-0.72*
Disagree	139 (80.8)	33 (19.2)			
Collective negotiation (n=217)#					
Agree	39 (72.2)	15 (27.8)	0.731	0.74	0.37-1.48
Disagree	127 (77.9)	36 (22.1)			
View on procedural changes (n=323)#					
Agree	25 (71.4)	10 (28.6)	0.248	0.63	0.29-1.37
Disagree	230 (79.9)	58 (20.1)			
Effectiveness of procedural changes (n=35)^					
Agree	17 (70.8)	7 (29.2)	0.908	0.91	0.20-4.21
Disagree	8 (72.7)	3 (27.3)			

#Numbers do not add to 323 due to missing values, *Significant associations (P<0.05), ^: Values are a subset of "view on procedural changes. OR: Odds ratio; CI: Confidence interval; SSH: State Specialist Hospital; FMC: Federal Medical Centre

"*Doctors are trained to head the health team anywhere in the world. The training of doctors is definitely more demanding than those of nurses and as such both professional groups cannot be placed on the same pedestal*"

-FGD D1.

"*There has been very little effort on the part of hospital administration to address the conflict and in some cases they actually take decisions that aggravate the situation*"

-FGD D3.

"*To manage the conflict, each group of professionals should be told right from training schools to recognize their role and responsibilities. The nurses should know their limits and confine themselves to those limits. When every professional group especially the nurses, recognizes its limitations then the tension will reduce*"

-FGD D2.

In the FGDs with the nurses' group, it was reported that:

"*Medicine is truly a tedious and comprehensive course while nursing on the other hand is not for dullards. One can earn a PhD in nursing so the doctors should stop acting like they are the only ones that went to school*"

-FGD N1.

"*There are indeed lots of problem between doctors and nurses. The doctors don't respect the nurses and they act like they can do all the work alone*"

-FGD N3.

"*The younger doctors are arrogant and they can be very rude. The doctors need to recognize nursing as a specialty on its own*"

-FGD N3.

"No major effort has been made to resolve the conflict; everyone is just going about his or her work pretending that the conflict does not exist"

-FGD N2.

"The doctors are usually arrogant and tactless and usually want to use their influence to block the nurses while we also try to counter them. It is the doctors that need to shift ground"

-FGD N1.

Discussion

Several factors have been identified in the study as corroborated in literature[15] to be responsible for or facilitate doctors/nurses conflict. It was largely agreed by respondents that doctors seek for too much power in the system, while nurses were also reported to seek for too much influence within the same system. Although the response was highly skewed with regard to the respondents' profession, it is nonetheless instructive to note that a high percentage of the respondent agreed with this assertion. The FGDs also elicited responses that seem to suggest that each group saw the other as trying to violate its autonomy or unduly increase its influence.

These same reasons reported in the study as the causes of doctor–nurse conflict had been documented in the literature as the cause of conflict.[16] Long-standing rivalry between the two professions as proposed may be as a result of in-group ethnocentrism that promotes the belief of one group as superior to the other.[17] The organogram of the SSH and the FMC [Appendices I and II] reveals that the chain of command from nursing officers flows upward through a line of superior nursing officers. These structures do not formally accommodate the matrix linkages that may be required for a smooth doctor–nurse interaction, while the structure also parades an inherent limitation in the career prospects of a nurse and thus can facilitate conflict as had been previously asserted.[6] This was generally agreed on in the FGDs where both groups believed that a fair and practical system of subordination that is possible also with a single chain of command can significantly reduce conflicts.

Various authors had posited that a group was prone to conflict when its manager or leadership does not understand or exhibit the necessary traits required to achieve the corporate goal and objectives.[18,19] This was corroborated in our study by the fact that majority of our participants scored below average with respect to the capacity of hospital management and command structure to perform its statutory functions. Although the responses from the FGDs did not out rightly condemn the professional leadership, they, however, highlighted that they could be part of the problem while the hospital management was clearly scored very low. Application and a heightened realization of the need for emotional intelligence[20] are required to address the arrogance of young doctors as described by nurses in the FGDs. Scholars have described various approaches with respect to the management of conflict.[21,22] This is corroborated in our study as most participants reported a need to change a procedure/standing rules or organizational structure as a result of doctor–nurse conflict. This position was validated by FGDs where most changes mentioned were those that reduced interaction to the barest minimum further confirming the effect of direct working relationship.

Certainly, the major causes of conflicts, as depicted in this study, are as a result of communication gaps; those among peers and those that exist between the workforce and the management. The communication lapses that exist between workforce and management would benefit from policy reforms that involve the use of boundary spanners and external communication specialists.[23] They are important in the flow and transmission of information from lower ranks and disseminate it upward, thereby enhancing communication between channels and preventing the dichotomy of "voice or exit" from setting in. Asides from the use of defined information pathways, notable in the reform of managerial dynamics in any hospital is the choice of its leadership. A paradigm shift in literature now emphasizes the importance and advantages of transformational style of leadership over the conventional transactional approach of leadership. Unlike the transformational approach of leadership, a transactional leader has a strong sense of direction and comes to an agreement with subordinates about what each will do to make a reality of a given vision. A transformational leader, on the other hand, is at the center of a network, allowing a vision to emerge from the dialogue thus encourages a group participation in decision-making[6] that offers every team member a sense of ownership and belonging to the overall aims and objectives of the organization.

The study ought to be compared in view of some limitations. The disparity in terms of hospital class and services rendered per facility were not accounted for in this study. Furthermore, the study being a cross-sectional study can only establish associations but cannot determine causality. In addition, the presence of confounders that could bias our estimates were not factored into our analysis plan. This includes for instance, the effect of the activities of other specialists in the health sector or aberrant circumstances that are common with any workplace. Comparison of findings with other settings in other parts of the country should also be applied cautiously bearing in mind that the sociocultural interactions with health team and health systems vary significantly from place to place. Nevertheless, the study provides significant results that portray the need for improved managerial innovations to minimize crises and conflicts among health workers.

Finally, it may be possible that the lesser professionalization of the nursing profession in Nigeria as yet may be contributing to the seemingly high level of conflict between nurses and medical doctors in Nigeria.[24] This should come from the nursing professionals themselves, to make clear their duties to the patient,

the health-care system and their profession; as these roles and functions do not clash. As soon as they are clarified, nurses should be able to contain any arrogance or other ethico-social erring from the doctors. Similarly, the medical profession in the locality and other places will do well to improve on the areas of emotional intelligence, ethics, and other managerial training and administration or practice enforcement, especially for their younger doctors. It would seem to us that these ethical issues are the ones where the hospital administration should enhance their rules of application to be able to assist in reducing these conflicts. Substantiated arrogance or abuse of other professionals by any health worker should be administratively sanctioned.

Conclusion

Conflict is inevitable in any human organization. However, the eventual outcome/consequence would depend on how the conflict is managed. Several authors have proffered various causes/sources of conflict, while this study of conflict between doctors and nurses include but are not limited to, "interdependence of work activities," "unclear line of authority," and "poor leadership and ineffective managerial strategies."

The study revealed a perceived inaction on the part of management with respect to doctor–nurse conflict. This therefore emphasizes the imperative need to bring the hospital management to appreciate the inevitability of conflict and also to comprehend the modern view as regards conflict. In addition, efforts must be geared toward incorporating an active matrix within the organogram or organizational structure of the hospital, which will place responsibility at par with authority. More importantly, there is the need to enhance the administrative and managerial competence of the hospital leadership and administrative officers, particularly with respect to the peculiarities of the hospital as an organization. It is necessary that management should take firm steps on reported cases of conflict as at when due so as to encourage employees to report the future occurrences through formal reports in a timely manner. The two professions would do well to determine the clear relationships of their professions in actual field practice, improve the professionalization of nursing as well as the ethical and emotional intelligence training of the doctors.

Finally, further studies should be carried out to identify other factors that promote effective managerial strategies and procedures that can mitigate such conflict in health settings.

Conflicts of interest

There are no conflicts of interest.

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## Appendix I: A Sketch of the State Specialist Hospital, Ado-Ekiti
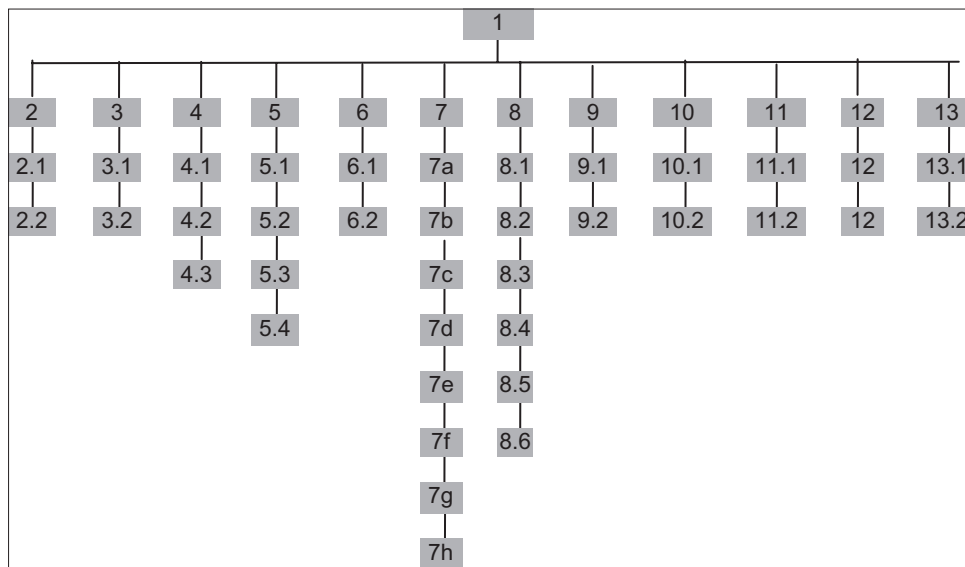
Key to Appendix 1: Organogram for SSH

1. Chief Medical Director
2. Head, Pharmacy Department/Chief Pharmacist
   2.1 Pharmacists
   2.2 Pharmacy Intern
3. Head, Accident and Emergency Department
   3.1 Medical Officers
   3.2 House officers
4. Head, Medical Records Department.
   4.1 Higher Medical Records Officer
   4.2 Senior Medical Records Officer
   4.3 Medical Records Officer
5. Head, Medical Laboratory Scientist
   5.1 Medical Laboratory Scientist
   5.2 Laboratory Technicians
   5.3 Laboratory Assistants
   5.4 Laboratory Attendants
6. Head, Pediatrics Department
   6.1 Medical Officer
   6.2 House Officers

7. Hospital Secretary
    7a. Administration Section
    7b. Accounts section
    7c. Maintenance Section
    7d. Security Section
    7e. Labour Section
    7f. Electrical Section
    7g. Drivers Unit
8. Chief Nursing Officer
    8.1. Assistant Chief Nursing Officer
    8.2. Principal Nursing Officer
    8.3. Senior Nursing Officer
    8.4. Nursing Officer 1
    8.5. Nursing Officer 11
    8.6. Ward Orderlies
9. Head Radiology
    9.1. Radiology Technicians
    9.2. Radiology Attendants
10. Head Physiotherapy Dept.
    10.1. Physiotherapist
11. Head Surgery
    11.1. Medical Officers
    11.2. House Officers
12. Head Medicine
    12.1   Medical Officers
    12.2   House Officers
13. Head Obstetrics and Gynaecology
    13.1. Medical Officers
    13.2. House Officers

Appendix II: A Sketch of the Federal Medical Centre Ido-Ekiti
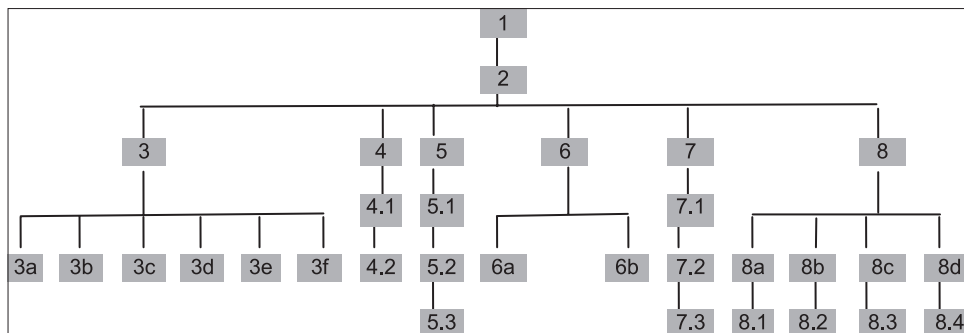
Organogram for FMC Ido Ekiti

1. Chief Medical Director
2. Chairman Medical Advisory Committee
3. Director of Administration
    3a Head Security Unit
    3b Head work Unit
    3c Head Administration Unit
    3d Head Medical Records
    3e Head Laundry Unit
    3f Head Catering Unit
4. Head Radiology Department
    4.1 Radiology Technicians
    4.2 Radiology Attendant

5. Head Laboratory Department
    5.1 Laboratory Scientists
    5.2 Laboratory Technicians
    5.3 Laboratory Attendants
6. Director of Finance and Supply
    6a. Audit Unit
    6b. Accounts Unit
7. Nursing Services Department
    7.1.Nursing Officers
    7.2.Ward Attendants
8. Clinical Services Department
    8a Head Internal Medicine
    8b Head Surgery
    8c Head Pediatrics
    8d Head Obstetrics and Gynaecology
    8.1 Medical Officers