

A narrative study on work place based conflicts in Obstetrics and Gynaecology Department

Khadija Waheed¹, Mohamed Al-Eraky², Noor-i-kiran Naeem³, Sara Ejaz⁴, Amna Khanum⁵

Abstract

Objective: To explore the patterns in research and underlying factors of conflicts in obstetrics and gynaecology and its effect on restricting the quality of education and training of residents.

Methods: The narrative study was conducted at the Obstetrics and Gynaecology Department, Lady Aitchison Hospital, King Edward Medical University, Lahore, Pakistan, from October 2018 to January 2019, and comprised narrative essays by residents associated with the department. Data was subjected to thematic analysis.

Results: Of the 27 residents, 26(96.3%) were females and 1(3.7%) was male. Overall, 19(70.3%) were aged 25-30 years and 8(29.6%) were aged 30-35 years. Three levels of conflict were identified: organisational, interpersonal and individual. Causes of organisational conflict included inadequate facilities, poor security and unclear duty appointments. Interpersonal factors included lack of communication, lack of patient autonomy, non-cooperative co-workers, illiteracy of attendants and unprofessional behaviour. Individual factors were overburdening duty hours and duty negligence.

Conclusion: There was found to be a need to design education programmes, like workshops, that may enable post-graduate residents in obstetrics and gynaecology to handle conflicts at workplace.

Keywords: Conflict, Work, Hospital, Gynaecology, Residents, Patients, Doctors. (JPMA 71: 514; 2021)

DOI: <https://doi.org/10.47391/JPMA.797>

Introduction

Inter-personal conflicts exist in every organisation, including challenges of minor and major degrees.¹ These challenges commonly lead to conflicts between patients and hospital staff, and this situation is observed increasingly now-a-days.²

Conflicts can occur due to difference in interests, needs, desires, responsibilities, perceptions, values, ideas and objectives.³⁻⁴ There can be positive and negative aspects to conflict or in technical terms, conflict can be destructive or constructive.⁵ Conflicts at workplace are defined as disagreements, differences or incompatibility between an individual and his/her superiors, subordinates, patients, administrative staff or peers. Conflict can be task conflicts, emotional conflicts and process conflicts.⁶ Conflicts are quite common at workplace, especially in hospitals, as it involves interactions of many individuals with varying backgrounds during time of stress, pain and anxiety.⁷ Doctors have long duty hours and they spend long time with their seniors, colleagues, peers, subordinates, patients and administrative staff, and have more chances of interpersonal conflicts. Workplace conflicts can occur in labour room, outpatient department (OPD), intensive care units (ICUs), and wards and even in duty rooms, and may

lead to compromising patient safety.⁸

Previously studies have been conducted on inter-personal conflicts among residents, but no study has completely focussed on scope and varieties of conflicts which hospital staff encounters on a daily basis⁹ which has been cited as an important area of concern.¹⁰

The current study was planned to explore the range and varieties of conflicts which arise during daily working in a gynaecology and obstetrics department.

Materials and Methods

The qualitative narrative study was conducted at the Lady Aitchison Hospital, Lahore, Pakistan, from October 2018 to January 2019. After approval from the institutional ethics review board, residents at the Department of Obstetrics and Gynaecology (OB-GYN) were enrolled using purposive sampling method. All the post-graduate (PG) residents were included and written informed consent was obtained from all of them. Data was collected using narrative essays as the instrument of choice because it allows participants to tell their experiences, which, in turn, allows researchers to make meaning out of reflective essays.¹¹ First-hand data about conflicts arising in the daily working of the department was observed and narrated by the participants in the form of reflective essays. The tool was selected because of ease of collecting data as working in the department as consultant for several years makes residents hesitant to talk in face-to-face interviews about conflicts, while direct observation could have made them

^{1,5}King Edward Medical University, Lahore, Pakistan; ²University of Damam, Saudia Arabia; ³Aziz Fatima Medical University, Faisalabad, Pakistan; ⁴Crescent Medical College, Lahore, Pakistan.

Correspondence: Khadija Waheed. e-mail: khadijaw@yahoo.com

Questions participants were asked to answer	
1.	What Happened?
2.	How did you feel about it?
3.	What did you feel?
4.	Why you think this happened?
5.	What did you learn from the event?
6.	What do you plan to do for the future?

Figure: List of Questions.

uncomfortable. Presentations were made for all the subjects and they were assured about confidentiality and anonymity. They were explained what was expected of them. To make it easy for them, templates were provided to them according to which they could describe their story (Figure). In the morning, questions were asked about conflicts in the preceding 24 hours from the batch on duty, and if there was any conflict, the resident concerned used to present that conflict in detail after which the narrative was done by the resident. Confirmation about the episode was subsequently got done from the senior registrar on call. The essays were obtained till data saturation as the analysis was being done manually simultaneously.

Data was subjected to thematic analysis done by manual analysis. Codes were identified through open coding process which means “working intensively with data line by line, identifying themes and categories that seem to be of interest”, and then explicated themes from the interconnection of these categories, which is selective coding. Finally, by the merger of the open and axial codes, sub-categories were made and arranged under a core category/theme.

Results

There were 49 narrative essays contributed by 27 residents;

Table-1: Participants’ Characteristics.

Characteristic	n
Gender	
Female	26
Male	01
Age Group	
25-30 years	19
30-35 years	08
Year of Residency	
First year	06
Second year	09
Third year	06 +1
Fourth year	05
Type of post graduate qualification	
FCPS trainee	21
MS trainee	06+1
Location	
Living in the same city of residency	23
Not living in same city of residency	4

Table-2: List of themes and subthemes found in the study (n=56).

Themes	Subthemes	n
Conflict on an Organizational level	Inadequate facilities	22
	Poor Security System	
	Unclear duty appointments	
	Gap between administration and clinical department	
	Lack of coordination between different specialties	
Conflict on an interpersonal level	Doctor-Doctor conflict	28
	Doctor-Patient Conflict	
	Doctor-Attendant Conflict	
	Doctor-Staff/Administrator Conflict	
Conflict on an individual level	Burnout/exhaustion	6
	Duty Negligence	

26(96.3%) females and 1(3.7%) male. Overall, 19(70.3%) subjects were aged 25-30 years and 8(29.6%) were aged 30-35 years (Table 1).

Themes identified in the study categorised conflict into organisational, interpersonal and individual levels (Table 2). The themes were coded according to sub-themes (Table 3) and residents’ year-wise pattern of conflict (Table 4)

Discussion

The study revolved around three main areas of research which were conflicts on an organisational level and what caused them; conflicts on an interpersonal level and what caused them; And conflicts on an individual level and what caused them.

One interesting finding was that organisational conflicts were more common in senior residents so there was a need to bridge the gap between administration and clinical departments by capacity-building. On the other hand, interpersonal conflicts were more common among junior residents so there was a need to improve professionalism and communication skills at that level.

The immediate manifestations of these conflicts included delay in patient treatment, verbal exchanges in case of interpersonal conflict, threats, punishments and confrontation, involvement of media and defaming of the organisation by angered patients and their attendants, and mistakes while giving treatment leading to increased chances of patient mortality.

Lack of adequate facilities has proven to be a major problem for workplace efficiency in all fields of work, not just healthcare, including business professionals who admitted to a correlation between workplace conflict and lack of tools and resources available to them.¹²⁻¹⁴ CEO of a hospital in Zimbabwe mentioned in a report that lack of

Table-3: Distribution of codes among themes and subthemes identified.

	Subthemes	Codes	
Conflict on an Organizational level (n=22)	Inadequate facilities	Lack of operation theatre	7
		Lack of laboratory investigations	4
		Unavailability of Blood units	3
	Poor security system	Lack of security personal	2
		lack of watchman	1
	Unclear duty appointment	Lack of communication regarding duty	2
Gap between administration and clinical department	Lack of understanding	1	
Lack of coordination between different specialties	Lack of coordination	2	
Conflict at inter-personal level (n=28)	Doctor-Doctor conflict	Lack of communication	5
		Distrust of co-worker	4
		Lack of cooperation with co-workers	6
	Doctor-patient conflict	Lack of patient autonomy	2
		lack of compliance	3
	Doctor- Attendant conflict	Illiteracy of attendants	2
		Incorrect duty perceptions	4
	Doctor-Staff/Admin/Paramedics conflict	Lack of cooperation	1
Unprofessional behaviour		1	
Over-burdening duty hours		3	
Conflict at Individual level (n=6)	Burnout of doctors	Lack of commitment	1
		Dissatisfaction from job	1
	Duty negligence	Lack of incentives	1

Table-4: Resident's year-wise pattern of conflict (n=56).

Themes	n	1st year	2nd year	3rd year	4th year
Conflict on an Organizational level	22	4	3	8	7
Conflict on an interpersonal level	28	8	9	6	5
Conflict on an individual level	6	0	1	3	2

drugs and essential medical equipment was a major contributing factor to the workers' accelerating frustration with their jobs.¹⁵ This sentiment was shared by a healthcare assistant working at a health facility in New Zealand who said it was 'soul-destroying' to see the lack of funding compromising patient health.¹⁶

A study aimed at discovering the conditions of public hospitals in Africa concluded that poor infrastructure and lack of resources further aggravated the already skyrocketing workload due to flooding of hospital with patients of human immunodeficiency virus (HIV) / acquired immunodeficiency syndrome (AIDS).¹⁷

Organisational deficit was also seen to result from a poor security system. A case of security breach at Jinnah Hospital, Lahore, was reported in January 2016 when an assailant opened fire in the emergency department (ED), injuring patients. Working doctors were interviewed and they mentioned that the highly unpleasant security situation of the hospital included absolutely no guards or walkthroughs. Cases of harassment of female doctors were also reported due to the same cause.¹⁸

Research suggests that both doctors and nurses were in

many cases seen to be misinformed of their own as well as the other party's duties, leading to occurrence of conflicts.¹⁹ Similar outcomes appeared in a hospital as alarming conflict, the worst being delay in patient treatment because unclear professional roles contribute to work-related stress and consequent poor performance.²⁰

On the interpersonal level, the study revealed involvement of doctors, nurses, patients, attendants, administrative staff and paramedics in such conflict arising due

to factors like work overload, poorly set priorities and lack of communication amongst team members.²¹

Duties of the doctor also include maintaining a healthy doctor-patient relationship.²² The third theme focussed on conflict that occurred due to individual factors. Participants mentioned working excessively without any clearly-defined duty hours, and that too on bare minimum wages. In one incident reported from Newham General Hospital, London, an anaesthetist accidentally gave a three-year-old patient nitrous oxide instead of oxygen, leading to her death. The cause for this blunder was the stressful and busy hospital environment the physician was coping with.²³ Physician 'burnout' was seen to target around 40% of doctors in the developed country, ultimately interfering with patient wellbeing.²⁴ This proved to be a vital contributor to conflict on an individual level in the shape of stress and burnout, and on an interpersonal level as strained relationships due to burnout.

Further strengthening the findings of the current study, one study suggested that health care workers are more particularly susceptible to work-induced stress.²⁵ According to a survey, the data was alarming when they were asked to answer questions regarding their levels of burnout: 45.8% doctors displayed at least one sign of work-induced burnout; 37.9% had high levels of mental exhaustion; 29.4% displayed excessive existentialism; and 12.4% had poor self-appreciation.²⁶

Some narratives further explained how individual factors contributed to interpersonal conflict. Some of the temper outbursts of the doctor on duty were either due to workload or other reasons like personal differences. A disruptive physician exacerbates the stress in the work environment which affects the morale of other workers around him.²⁷

The current study has limitations as sampling was limited to one department and one specialty in a single centre. This limits the scope of the study. A larger sample size involving all medical specialties in various medical schools is recommended.

Conclusion

The conflicts were mainly categorised into three types: organisational, interpersonal and individual. Contributing factors included lack of security, lack of communication, inadequate facilities, unclear duty appointments and lack of awareness regarding maternal healthcare.

Disclaimer: None.

Conflict of Interest: None.

Source of Funding: None.

References

- Burke WW, Noumair DA. Organization development: A process of learning and changing. 3rd ed. USA: Pearson Education; 2015.
- Yu H, Hu Z, Zhang X, Li B, Zhou S. How to overcome violence against Healthcare professionals, reduce medical disputes and ensure patient safety. *Pak J Med Sci* 2015; 31: 4-8.
- Bradley BH, Anderson HJ, Baur JE, Klotz AC. When conflict helps: Integrating evidence for beneficial conflict in groups and teams under three perspectives. *Group Dynamics: Theory, Research, and Practice* 2015; 19: 243-72
- Chasnow N. Why Are So Many Patients Noncompliant? [Online] 2014 [Cited 2018 Oct 30]. Available from: URL: <https://www.medscape.com/viewarticle/818850>.
- Claramita M, Utarini A, Soebono H, Van Dalen J, Van der Vleuten C. Doctor-patient communication in a Southeast Asian setting: The conflict between ideal and reality. *Adv Health Sci Edu* 2011; 16: 69-80.
- Finn D, Creswel J. Qualitative, Quantitative, and Mixed methods Approaches. Thousand Oaks. California: Sage Publications; 2000.
- Ridder HG. Case Study Research. Design and Methods 4th ed. JSTOR; 2012.
- Denzin NK, Lincoln YS. The landscape of qualitative research. UK: SAGE Publications; 2008.
- Duffy FD, Gordon GH, Whelan G, Cole-Kelly K, Frankel R. Assessing competence in communication and interpersonal skills: the Kalamazoo II report. *Academic Med* 2004; 79: 495-507.
- Elsous A, Radwan M, Mohsen S. Nurses and physicians attitudes toward nurse-physician collaboration: a survey from Gaza Strip, Palestine. *Nurs Res Pract* 2017; 2017: 7406278.
- Entwistle VA, Carter SM, Cribb A, McCaffery K. Supporting patient autonomy: the importance of clinician-patient relationships. *J General Int Med* 2010; 25: 741-5.
- Esterberg KG. Qualitative Methods in Social Research. British Library Social Science Collection Guides. [Online] 2003 [Cited 2018 Oct 30]. Available from: URL: <https://www.bl.uk/britishlibrary/~media/bl/global/business-and-management/pdfs/non-secure/q/u/a/qualitative-research-methods-bibliography.pdf>.
- Altheide DL, Johnson JM. Reflections on interpretive adequacy in qualitative research. In: *The SAGE handbook of qualitative research*. UK: SAGE Publications; 2011, 581-94.
- Anderson K. Ethnographic research: A key to strategy. *Harvard Business Review*. [Online] 2014 [Cited 2019 Nov 1]. Available from: URL: <https://hbr.org/2009/03/ethnographic-research-a-key-to-strategy>.
- Milic MM, Puntillo K, Turner K, Joseph D, Peters N, Ryan R, et al. Communicating with patients' families and physicians about prognosis and goals of care. *Am J Critical Care* 2015; 24: e56-e64.
- Miller PA. Nurse-physician collaboration in an intensive care unit. *Am J Crit Care* 2001; 10: 341-50.
- Muchetu R. Lack of resources lowers morale in hospitals' - Sunday News. [Online] 2018 [Cited 2019 Nov 1]. Available from: URL: <https://www.sundaynews.co.zw/lack-of-resources-lowers-morale-in-hospitals>
- Blomberg J, Giagomi J, Mosher A, Swenton-Wall P. Ethnographic Field Methods and Their Relation to Design. In: *Participatory Design: Principles and Practices*. UK: Lawrence Erlbaum Associates; 1993.
- Bogdan RC, Biklen SK. Research for education: An introduction to theories and methods. Boston, MA: Allen and Bacon. 2007.
- Crowe S, Clarke N, Brugha R. 'You do not cross them': Hierarchy and emotion in doctors' narratives of power relations in specialist training. *Soc Sci Med* 2017; 186: 70-7.
- Nelson HW, Cox DM. The causes and consequences of conflict and violence in nursing homes: working toward a collaborative work culture. *Health Care Manager* 2003; 22: 349-60
- Unicef. Managing conflict with patients. *Med Economics*. [Online] [Cited 2019 Jan 18]. Available from: URL: <https://www.medicaleconomics.com/modern-medicine-feature-articles/managing-conflict-patients>.
- Forbat L, Sayer C, McNamee P, Menson E, Barclay S. Conflict in a paediatric hospital: a prospective mixed-method study. *Arch Dis Child-hood* 2016; 101: 23-7
- Peckham C. Medscape physician lifestyle report 2015. *Medscape* [Online] [Cited 2019 Jan 18]. Available from: URL: <http://www.medscape.com/features/slideshow/lifestyle/2015/public/overview>.
- Freimann T, Merisalu E. Work-related psychosocial risk factors and mental health problems amongst nurses at a university hospital in Estonia: a cross-sectional study. *Scandinavian J Pub Health* 2015; 43: 447-5.
- Sifferlin A. Is your doctor burned out? Nearly half of US physicians say they're exhausted. *Time*. August 21, 2012 [Online] [Cited 2019 Jan 20] Available from: URL: <https://healthland.time.com/2012/08/21/is-your-doctor-burned-out-nearly-half-of-u-s-physicians-say-theyre-exhausted/>.
- Birhanu M, Gebrekidan B, Tesefa G, Tareke M. Workload Determines Workplace Stress among Health Professionals Working in Felege-Hiwot Referral Hospital, Bahir Dar, Northwest Ethiopia. *J Environment Pub Health* 2018; 2018: 1-8.