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# DOCTOR-NURSE CONFLICTS AND THE WELL-BEING OF PATIENTS IN SELECTED PUBLIC HOSPITALS IN KOGI STATE, NIGERIA

**Dr. Edime YUNUSA**[1*]

[1*] Department of Sociology, Faculty of Social Sciences, Prince Abubakar Audu University, Anyigba, Kogi State – Nigeria.

*** Correspondence:** Dr. Edime YUNUSA

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**ABSTRACT:** Doctor-nurse conflict remains a persistent challenge in public hospitals, threatening healthcare quality, patient outcomes, and the effectiveness of healthcare delivery. This study examined doctor-nurse conflict and its implications for patients' well-being in selected public hospitals in Kogi State, Nigeria. Specifically, it assessed the prevalence and dynamics of such conflicts, identified their major causes, examined their effects on patients' well-being, and analyzed strategies for conflict reduction. The study was anchored on Social Conflict Theory, Functionalist Theory, and Symbolic Interactionist Theory. A cross-sectional descriptive survey design was adopted. Using quota sampling, respondents were selected from a population of 444 healthcare workers across 59 public hospitals in Kogi State. Data were collected through questionnaires and in-depth interviews. Reliability testing using Cronbach alpha yielded coefficients ranging from 0.71 to 0.91, confirming instrument reliability. Hypotheses were tested using Multiple Linear Regression. Findings revealed that doctor-nurse conflict is prevalent in public hospitals, the respondents acknowledged the existence of no cordial professional relationships, which were generally weak. Major sources of conflict included lack of mutual respect, wage

disparities, the quest for professional recognition, and disagreements over treatment approaches. The study further established that doctor-nurse conflict significantly affects patients' well-being, with the regression model explaining 52.4% of the variance in patient outcomes ($R^2 = .524$). Conflict level was the strongest predictor ($\beta = .386$), followed by anxiety/depression ($\beta = .298$) and stress/trauma ($\beta = .276$), with all variables showing significant relationships ($p < .001$). The study concluded that doctor-nurse conflict has serious implications for patient care, healthcare policy, and practice. It recommended, among others effective conflict resolution mechanisms, improved communication and collaboration, recognition of both professions' contributions, and clear communication protocols to reduce disagreements and enhance healthcare delivery.

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background to the Study

The issue of conflict is as old as human existence, and as individuals with different socio-cultural backgrounds, educational training and qualifications, value orientation and upbringings interact on daily basis, conflict is inevitable. The concept of conflict literally means a state of disagreement, opposition or antagonism caused by differences in ideas, opinions, interest or principles over a particular cause of action (Yunusa et al., 2025).

Professional conflict is prevalent in every organisation around the world especially where two or more professionals interact to achieve common goals. Specifically, a conflict between doctors and nurses is a common phenomenon in the hospitals and it affects the quality of healthcare service delivery to patients. In order to achieve the objective for which healthcare system is set up, disagreements between doctors and nurses must be managed in such a way that patients will not be at the receiving end. Because when it occurs, it would be like where two elephants fight, it is the grass that suffer (Yunusa et al., 2025).

Doctor-nurse conflict is a prevalent issue in healthcare settings worldwide, and Nigerian public hospitals are no exception. For instance, Institute of Medicine, IOM (2023) reported that there was an inter professional conflict between doctors and nurses in Lagos State University Teaching Hospital (LASUTH) over roles and responsibilities where nurses

accused doctors of encroaching on their duties leading to a brief work stoppage. Following the same trend of thought, Ogunsiji et al., (2022) reported also that there was a disagreement between healthcare professionals over patient management protocols at the University of Abuja Teaching Hospital and which resulted in tension between nursing and medical staff. In the same vein at Prince Abubakar Audu University Teaching Hospital in Anyigba, there was an unreported rift between a medical doctor and nurses on duty over battle for supremacy where the nurses insisted that they should be saluted by the doctors and the doctors insisted that they should be respected and saluted by nurses leading to vehement exchange of words as witnessed by the researcher (Yunusa et al., 2025). Likewise in India, there were reported cases of disagreements between healthcare professionals over hierarchy and decision-making processes, which led to protests and work slowdowns at a Government Hospital in 2022 among other myriads of unreported cases (Yunusa et al., 2025).

These conflicts, most times arise due to various factors, such as power dynamics, communication barriers, and differences in professional roles and responsibilities (Ogbonnaya et al., 2019). The impact of doctor-nurse conflict extends beyond the healthcare professionals involved, as it can significantly affect patients' well-being. Patients who are exposed to a hostile or tense healthcare environment may experience increased stress, anxiety, and dissatisfaction with the quality of care they receive (Asuquo et al., 2017). In Nigerian public hospitals, the effects of doctor-nurse conflict on patients' well-being are particularly concerning. These hospitals often face challenges such as overcrowding, inadequate resources, and understaffing, which can exacerbate the existing tensions between healthcare professionals (Oyelade et al., 2020). When doctors and nurses are unable to work collaboratively and effectively, patients may perceive a lack of cohesion and trust in the healthcare team, leading to feelings of uncertainty and vulnerability (Omisore et al., 2017).

Moreover, doctor-nurse conflict can hinder effective communication and coordination of patient care. When healthcare professionals are not working together harmoniously, there is an increased risk of miscommunication, delayed treatment, and medical errors (Akinbobola & Adeleke, 2020). These factors can contribute to patients' psychological distress, as they may feel that their health and well-being are compromised due to the conflict within the healthcare team. The well-being of patients is a crucial aspect of their overall health and

recovery process. Patients who experience high levels of stress, anxiety, and dissatisfaction are more likely to have poorer health outcomes, longer hospital stays, and reduced adherence to treatment plans (Olajide et al., 2019). Therefore, addressing doctor-nurse conflict and its impact on patients' well-being is essential for improving the quality of care in Nigerian public hospitals.

The frequent conflict between healthcare professionals might take the form of mild or confrontational patterns, which leaves possibilities for ineffective patients' healthcare management. On healthcare teams, inter-professional conflict is frequent and may stems from misconceptions and other conflicts about patients' treatments. At public hospitals, disagreements between nurses and doctors occur invariably as they carry out their tasks especially on patients' healthcare. As a result of these struggles over dominance, relevance and power, patients suffer. Interprofessional conflicts arise when nurses and doctors, who collaborate and communicate regularly to achieve a shared goal, disagree within the healthcare institution (Mohammed et al., 2022).

Medical professionals with varying areas of specialization ought to collaborate as a team in order to provide high-quality healthcare services. These professionals include doctors, pharmacists, nurses, medical laboratory scientists, and other healthcare workers (Mohammed et al., 2022). Multidisciplinary collaboration among these various healthcare workforces has the potential to improve patients' outcomes and quality of care, but it also has the potential to be harmful to patients' health management and the healthcare system (Mohammed et al., 2022). These authors assert that doctors and nurses clash or obstruct one another while attempting to accomplish the common objectives, which causes this conflict. Conflict implicitly implies actions that might hinder other people's productivity.

When achieving corporate goals, it may cause any of the groups to be less productive and even spark competition between them (Chiekezie et al., 2016). These authors further stated that, given that they have the power to save or terminate people's lives while attending to their medical conditions, the competition between the two is regarded as being extremely unhealthy for patients. Patients' healthy outcomes are highly dependent on the doctors' skills in diagnosis and treatment, as well as nurses' capacity to continuously monitor patients and relay the necessary information to the doctors (Zaimova-Tsaneva and Hadjieva, 2018). Conflict, however, inevitably arises since people are social animals by

nature and must engage with one another (Chiekezie et. al, 2016). Relationships between doctors and nurses are among the most challenging in the world, despite the fact that their professions are among the most noble and humane (Zaimova-Tsaneva & Hadjieva, 2018). Conflicts between the two are common. A successful healthcare facility must have a positive working connection between nurses and doctors and as demonstrated by Ogbimi and Adebamowo (2019), smooth working relationships between doctors and nurses are prerequisites for efficient delivery of healthcare.

The importance of efficient doctor-nurse teamwork to patient care cannot be overemphasized. The conflict has created numerous issues in healthcare systems around the world, particularly in developing and underdeveloped nations. Nonetheless, there has been serious fallout from the two parties' failure to address this issue. A study conducted in one of the tertiary hospitals in Abia State demonstrated a high prevalence of workplace violence amongst healthcare workers in which, "patients and their relations were the main perpetrators of physical assault and threats while senior colleagues were the main workplace bullies" (Ogbonnaya, et al., 2022). Thus, an analysis of the nature of the doctor-nurse interaction as well as the rationale behind and effects of the conflict between the two groups becomes important.

Interestingly, most scholars such as Olajide et al. (2015), Omisore et al., (2017), Emelda (2020), Luke et al., (2022), Akinbobola and Adeleke, (2020), Ogbonnaya et al., (2019), Oyelade et al., (2020) and Olajide et al., (2019) among others have only concentrated on the causes, mode of expressions of doctors-nurses conflict, the interpersonal relationships and disputes between healthcare professionals. Little or no research have been carried out on the adverse effects of the conflict on patients' psycho-social wellbeing and on the overall aim/objectives behind establishing healthcare systems. Hence, this study bridged this gap in the body of literature by examining doctor-nurses conflict and the well-being of patients in Kogi State.

### 1.2 Statement of the Problem

The relationship between doctors and nurses is a critical component of providing high-quality patient care in hospital settings. However, conflicts and breakdowns in communication between these two groups of healthcare professionals can have significant negative impacts on patient outcomes and general well-being. Inter professional conflicts

arising from factors like hierarchical power dynamics, differing care philosophies, and poor teamwork can create a tense and stressful environment on hospital units. This toxic milieu has the potential to adversely affect the general wellness of patients admitted to these facilities (Olajide et al., 2022).

Interprofessional conflict between doctors and nurses remains a persistent challenge in healthcare systems globally, with Nigerian public hospitals down to Kogi State frequently experiencing such tensions. These conflicts often arise from ambiguities in professional roles, overlapping responsibilities, and power dynamics within the healthcare team. For instance, Nigerian Health Watch (2023) documented a conflict at Lagos State University Teaching Hospital (LASUTH), where disputes over role boundaries led to a temporary work stoppage. Similarly, Ogunsiji et al. (2022) highlighted professional disagreements regarding patient management protocols at the University of Abuja Teaching Hospital, resulting in strained relations between nursing and medical staff. Anecdotal evidence also suggests unresolved tensions as witnessed by the researcher at the Prince Abubakar Audu University Teaching Hospital, one of the public hospitals in Anyigba, where interpersonal disputes 'unreportedly' escalated due to contested expectations around hierarchical respect. These incidents underscore a broader, systemic issue in Nigerian healthcare institutions that warrants empirical investigation into the causes, dynamics, and consequences of doctor-nurse conflicts on patients wellbeing.

When doctors and nurses are embroiled in overt conflicts or poor collaboration, patients may experience increased anxiety, fear, and feelings of being unsupported or caught in the middle of disputes, depression, stress, trauma, grief and loss, social isolation, stigma and discrimination, lack of control and autonomy, uncertainty and unpredictability, delayed recovery, nonresponsive to medications, doubt in prescription, body image issues, pain and discomfort, sleep disturbances, family conflicts and dynamics, financial stress and burden, cultural and language barriers, lack of social support, history of abuse or trauma, mental health conditions like bipolar disorder, schizophrenia, etc., substance abuse and addiction, cognitive impairment and dementia (Ogunsiji et al., 2022).

These problems can impact patients' physical health, mental well-being, and overall hospital experience, making it essential for healthcare providers to address them appropriately, because the stress of perceiving chaos and lack of cohesion among care

providers could exacerbate psychological, social and physical distress in patients already made vulnerable by their medical conditions. Strained doctor-nurse relationships also disrupt the flow of care and vital information sharing, raising risks of medical errors, sub-optimal treatment plans, and failure to fully address patients' psychological and social needs beyond just their physical health issues. Patients who perceive poor teamwork and lack of integrated, holistic care are more likely to experience loss of trust in the healthcare system, and adverse general health outcomes (Ridley, 2023).

Despite the wealth of research on the impact of doctor-nurse relationships on the quality of healthcare, a significant knowledge gap persists. For instance, existing studies (Olajide et al., 2015; Olaopa et al., 2020; Ogbonnaya et al., 2022; Sabir et al., 2023; Rodriguez, 2023) have primarily focused on how communication breakdown, collaboration, and workplace bullying affect patient care, overlooking the profound consequences of these interpersonal dynamics on patients' overall well-being and care experience. This study therefore sought to address this critical omission by investigating the intricate links between doctor-nurse conflict and patients' well-being in selected public hospitals in Kogi State, Nigeria.

### 1.3 Research Questions

This research work provided answers to the following questions:

a. What is the prevalence of doctor-nurse conflict in Kogi State public hospitals?
b. What are the dynamics of doctor-nurse conflict in public hospitals in Kogi State?
c. What are the major sources of conflicts between doctors and nurses in public hospitals in Kogi State?
d. What are the effects of doctor-nurse conflicts on the well-being of patients in public hospitals in Kogi State?
e. What are the strategies for doctor-nurse conflicts reduction in public hospitals in Kogi State?

### 1.4 Aim and Objectives of the Study

The aim of this study was to assess doctor-nurse conflict and general well-being of patients in selected public hospitals in Kogi State. The specific objectives were to:

a) Ascertain the prevalence of doctor-nurse conflicts in public hospitals in Kogi State.

b) Examine the dynamics of doctor-nurse conflicts in public hospitals in Kogi State.

c) Identify the major sources of conflicts between doctors and nurses in public hospitals in Kogi State.

d) Determine the effects of doctor-nurse conflict on the well-being of patients in public hospitals in Kogi State.

e) Examine the strategies for doctor-nurse conflicts reduction in public hospitals in Kogi State.

## 1.5 Research Hypotheses

The following formulated null hypotheses were tested at 0.05 level of significance to guide the study:

**$Ho_1$:** The prevalence of doctor-nurse conflicts has no significant effects on patients stress/trauma, anxiety /depression in Kogi State public hospitals.

**$Ho_2$:** Differences in wages/salaries, lack of mutual respect, pride and the quest for professional relevance do not significantly lead to doctor-nurse conflict in public hospitals in Kogi State.

**$Ho_3$:** Doctor-nurse conflict resolution strategies do not significantly reduce patients' general well-being in public hospitals in Kogi State.

## 1.6 Scope of the Study

This study explored the effects of doctor-nurse conflict on patients' well-being in Nigerian public hospitals using Kogi State as a point of reference. Although, many factors are associated with the issue of conflict but this study was limited to only healthcare related conflict, especially between doctors and nurses. Specifically, it examined the prevalence, the dynamics, causes, and the effects of this conflict on the well-being of patients. The contextual scope of the study covers all categories of patients, nurses and only medical doctors because they are the healthcare professionals that directly and generally interact with patients' well-being in public hospitals in Kogi State. All other Healthcare workers like the Pharmacists, Laboratory Technicians, Medical Records Keepers among others

don’t directly manage patients' healthcare like the nurses and doctors. The study also covers both the in-patients and out-patients within the age of 18 years and above in the selected public hospitals within the time frame from December 2024 – February 2025.

Geographically, the Study covered 21 Local Government Areas (LGAs) in Kogi State, with data collected from 59 state-owned public hospitals. Methodologically, the research adopted a pragmatic approach usin descriptive cross-sectional survey design, combining quantitative and qualitative methods. The sample included 409 healthcare professionals (doctors and nurses) selected through census sampling, supplemented by purposively sampled in-depth interviews with 35 patients and 3 Chief Medical Directors. Data collection tools included questionnaires and interviews, with analysis performed using descriptive statistics, inferential statistics and thematic methods.

### 1.7 Significance of the Study

The significance of this study lies in the following theoretical and practical relevance:

From the practical point of view, studies have shown that conflicts between doctors and nurses are common in healthcare settings in Nigeria due to differences in roles, responsibilities, power dynamics, and communication issues. Therefore, investigating the prevalence and effects of these conflicts in public hospitals in Kogi State is crucial for understanding their potential impact on patient care and general well-being.

Still on the practical relevance, doctor-nurse conflicts can have detrimental effects on the quality of patient care. When healthcare professionals are not working collaboratively or effectively communicating, it can lead to errors and delays in treatment, and suboptimal care delivery. Therefore, examining how these conflicts affect patients' well-being in public hospitals in Kogi State is essential for identifying areas for improvement.

On the policy relevance, patients’ general wellbeing encompasses their emotional, social, physical and psychological health, hence, exposure to doctor-nurse conflicts can potentially increase patients' stress levels, anxiety, and dissatisfaction with their care experience. Therefore, it is important to understand through this study how these conflicts may affect patients' trust in healthcare providers especially doctors and nurses as it relates to patients' ability to cope with illness, and their overall recovery process. By

understanding doctor-nurse conflicts and patients' wellbeing, the study will inform healthcare policy makers about the development of targeted interventions and policies to mitigate these negative impacts. This may include training programmes for healthcare professionals to enhance collaboration and communication skills, as well as strategies to create a more patient-centered care environment.

Furthermre, while some studies have been conducted on doctor-nurse conflicts in various healthcare settings across different continents of the world, there is still limited research specifically focusing on the Nigerian context. Nigerian public hospitals face unique challenges, such as resource constraints, high patient volumes, and cultural factors that may influence inter professional dynamics. Therefore, conducting a study in this setting will practically provide valuable insights tailored towards the Nigerian healthcare system.

Again, by conducting a study on doctor-nurse conflict and patients' well-being in public hospitals in Kogi State, the researcher shed more light on an important issue that has the potential to impact patient care and outcomes. Moreover, the study's findings will inform efforts to improve inter professional collaboration, enhance patient-centered care, and ultimately promote better healthcare delivery in Nigeria and Kogi State. The research highlights the need for policy interventions that address wage disparities, role clarity, and collaborative frameworks, issues central to Industrial Sociology's focus on equitable labour practices.

On the theoretical relevance, the study's findings will no doubt contribute to the existing body of knowledge and serves also as a reference material for future researchers in this area who would be interested in studying inter professional conflicts in healthcare system and their effects on patient outcomes. In this way, it will provide empirical evidence specific to the Nigerian context, which can be compared and contrasted with findings from other settings, as this knowledge will help in advancing the understanding of doctor-nurse dynamics and their implications for patients' care.

This study holds significant implications for Industrial Sociology, a field deeply rooted in the examination of workplace dynamics, professional hierarchies, and institutional conflict. By investigating doctor-nurse conflicts within public hospitals, the research advances understanding of how occupational power structures, role ambiguity, and institutional

policies shape inter-professional relations in bureaucratic settings. The findings contribute to broader sociological debates on labour relations, workplace stratification, and organizational dysfunction, particularly in highly professionalized environments like the hospitals where asymmetrical authority and competing interests prevail.

The study underscores the consequences of hierarchical tensions on both worker morale and service delivery, reinforcing Industrial Sociology's concern with how structural inequalities perpetuate workplace discord. By applying Social Conflict Theory, it extends theoretical discourse on power struggles, resistance, and negotiation within institutional labor systems, offering empirical insights into how professional dominance (doctors) and subordinate agency (nurses) manifest in healthcare.

The findings not only enrich academic discourse but also provide practical recommendations for improving organizational cohesion, conflict resolution, and workforce management in healthcare and analogous professional sectors. Thus, this study bridges empirical healthcare research with foundational Industrial Sociology themes, reinforcing the field's relevance in analyzing contemporary workplace challenges.

### 1.8 Operational Definition of Terms

The key terms used in this study are defined as follows:

**Doctor** refers to a physician, medical practitioner, medical doctor, or simply doctor is a health professional who practices medicine, which is concerned with promoting, maintaining or restoring health through the study, diagnosis, prognosis and treatment of disease, injury, and other physical and mental impairments.

**Nurse** is a healthcare professional who is responsible for preparing care plans for patients, administering medications and treatments, monitoring vital signs and maintaining medical records. They can work with patients in hospitals and clinics or provide in-home care.

**Conflict** has to do with any form of friction, disagreement, or discord occurring within a group when the beliefs or actions of one or more members of the group are either resisted by or unacceptable to one or more members of another group.

**Inter-professional conflict** refers to differences in interests, values, and ethics arising in healthcare settings where each health care professional have a different educational background, code of ethics, value system, and perspective on patient care as well as rivalry.

**Patients:** The word patient originally refers 'one who suffers', who has the "patience" to suffer and who is ill or injured and in need of receiving medical attention, care, or treatment from a doctor or other medically educated person.

**Well-being** refers to a person's overall state of physical, psychological, emotional, mental, and social health. It encompasses various aspects of an individual's life, including their physical health, emotional resilience, mental clarity, and social connections.

**Public hospital:** A public hospital, or government hospital (both tertiary, secondary or general) refers to one which is government owned and is fully funded by the government and operates solely off the money that is collected from taxpayers to fund healthcare initiatives.

**Healthcare:** Health care, or healthcare, refers to the improvement of health via the prevention, diagnosis, treatment, amelioration or cure of disease, illness, injury, and other physical and mental impairments in people. Health care is delivered by health professionals and allied health fields.

# CHAPTER TWO

## LITERATURE REVIEW

This chapter is devoted to the review of relevant and related literature with theoretical orientation of findings. It therefore involves the analysis of books, reports, publications, academic journal articles, archival materials and internet based documented source materials among others that are germane to the subject matter of this study. Therefore, based on the aim and objectives of this study, the review of relevant and related literature was done under the following subheadings:

## 2.1 Conceptual Review

The key concepts in this study are clarified as follows:

### 2.1.1 Conflict

Although, it is commonly accepted that disagreements over beliefs cause conflict, conflict is not always simple to define. Many scholars have come up with different definitions, concepts, views or school of thoughts about conflicts from a more intellectual platform all over the world. Wright as cited in Oyelade et al., (2020) for instance defines conflict as opposition among social entities directed against one another. He distinguished competition and defined it as opposition among social entities independently striving for something of which the resources are inadequate to satisfy all.

Whereas in the sociological sense, which is of ordinary usage, Kriesberg and Dayton (2017) simply defines conflict as a relationship between two or more parties who believe they have incompatible goals. Luke et al., (2022) emphasized that if disadvantaged groups and individuals refuse to consider open conflict, they deny themselves what sometimes is their most effective means for bringing about needed change. These authors therefore saw nothing wrong in conflict; he saw it as a natural and inevitable human experience and as a critical mechanism by which goals and aspirations of individual and groups are articulated; it is a channel for the definition of creative solutions to human problems and a means to the development of a collective identity. What these authors are trying to infer is that without conflict we cannot have change.

Orjiako et al., (2022) see conflict as the forms of friction, disagreement, or discord occurring within a group when the beliefs or actions of one or more members of the group are either resisted by or unacceptable to one or more members of another group. Conflict as a complex phenomenon exist at different levels: intrapersonal, interpersonal, intra-group, inter-group. Intrapersonal conflict occurs within the person and takes place when a person must choose between alternatives while interpersonal conflict occurs between people (Orjiako et al., 2022). These authors further noted that conflicts can also arise between members of the same profession, known as intra-professional conflict, or it can occur between members of two or more profession, known as inter-professional conflict.

Reflecting the above scholarly definitions, the concept of conflict in the context of this study refers to a disagreement, rivalry, competitive or opposing action of incompatibles, antagonistic state or action (as of divergent ideas, interests, or persons) in decision making and mode of operations between doctors and nurses on matters relating to patients' health management processes in the healthcare system.

#### 2.1.1.1 Types of Conflict

According to Hashish (2022), there are several types of conflicts that are grouped into different categories. They include for instance, conflicts based on one's position and functions in the organizational structure can arise due to various factors, such as power dynamics, role ambiguity, and competing interests. This review will explore the types of conflicts that can occur based on an individual's position and functions within an organization, drawing on relevant research and literature as follows:

**i. Vertical conflicts**

Vertical conflicts occur between individuals at different hierarchical levels within an organization. These conflicts can arise due to power imbalances, differences in authority, and communication barriers. A study by Adler et al. (2015) found that vertical conflicts between supervisors and subordinates can negatively impact job satisfaction, organizational commitment, and job performance. Similarly, a qualitative study by Stahl et al. (2017) identified power struggles and hierarchical tensions as sources of conflict in matrix organizations.

**ii. Horizontal conflicts**

Horizontal conflicts occur between individuals at the same hierarchical level within an organization, such as colleagues or team members. These conflicts can arise due to competition for resources, differences in working styles, or interpersonal tensions. A study by Jain (2023) found that task-related conflicts among team members can have both positive and negative effects on team performance, depending on how they are managed. A meta-analysis by de Jong et al. (2016) also found that relationship conflicts among team members are generally detrimental to team performance and satisfaction.

**iii. Role-based conflicts**

Role-based conflicts occur when there is a lack of clarity or compatibility between an individual's position, functions, and expectations within an organization. These conflicts can take the form of role ambiguity, role overlap, or role incompatibility. A study by Djukic et al. (2017) found that role ambiguity and role conflict among nurses were associated with lower job satisfaction and higher turnover intentions. A qualitative study by Konlan et al., (2023) also identified role conflicts as a major source of tension in interdisciplinary teams, particularly when professionals have overlapping or competing responsibilities.

**iv. Interdepartmental conflicts**

Interdepartmental conflicts occur between different departments or functions within an organization. These conflicts can arise due to competing goals, resource allocation issues, or differences in organizational subcultures. A study by Luo et al. (2016) found that interdepartmental conflicts can negatively impact organizational performance and innovation, particularly when there is a lack of integration and collaboration between departments. A case study by Amarneh and Nobani (2022) also highlighted the challenges of managing interdepartmental conflicts in a matrix organization, where individuals may have multiple reporting lines and competing loyalties.

**v. Stakeholder conflicts**

Stakeholder conflicts occur when there are competing interests or expectations among different stakeholders within an organization, such as employees, managers, shareholders, or customers. These conflicts can arise due to differences in values, priorities, or perceptions of organizational goals. A study by Afulani et al., (2021) found that stakeholder conflicts can impact firm performance and value creation, depending on how managers prioritize and balance different stakeholder interests. A qualitative study by Amoah et al., (2021) also identified stakeholder conflicts as a major challenge for corporate social responsibility initiatives, particularly when there are tensions between economic, social, and environmental objectives.

**vi. Inner conflict**

This is a conflict that occurs in the heart, and mind, in the soul of a character. So, it is a conflict experienced by the humans with themselves. This conflict is more of an internal

problem of a human being. For example, it occurs due to a conflict between two desires, beliefs, and different choices, hopes, or other problems (Boloya et al., 2021).

**vii. Role ambiguity and overlap**

Conflicts can arise when there is a lack of clarity regarding the roles and responsibilities of doctors and nurses. A study by Beach (2023) found that role ambiguity and overlap led to tensions between the two professions, particularly in areas such as decision-making and patient care planning. A qualitative study by Black (2023) also identified role boundary issues as a source of conflict in the ICU, with doctors and nurses struggling to define their respective areas of authority.

The issue of conflicts based on one's position and functions in the organizational structure can take various forms, including vertical conflicts, horizontal conflicts, role-based conflicts, interdepartmental conflicts, and stakeholder conflicts. These conflicts can arise due to factors such as power dynamics, role ambiguity, competing interests, and differences in goals and values. Managing these conflicts effectively requires a combination of clear communication, role clarification, collaborative problem-solving, and stakeholder engagement. By understanding the types of conflicts that can occur based on organizational structure and functions, managers and leaders can develop targeted strategies to prevent, mitigate, and resolve these conflicts, ultimately promoting a more productive and harmonious work environment.

**Types of Conflicts between Nurses and Doctors**

Conflicts between doctors and nurses are common in healthcare settings and can significantly impact patient care and workplace satisfaction. Here's an overview of the main types of conflicts between these professionals:

**i. Hierarchical Conflicts**

These conflicts arise from traditional power dynamics in healthcare settings, where doctors have historically been seen as superior to nurses. For instance, a study by Braithwaite et al. (2022) found that in Australian hospitals, nurses often felt their input was undervalued in decision-making processes, leading to frustration and reduced job satisfaction.

ii. **Communication Breakdowns**

Poor communication can lead to misunderstandings, errors, and conflicts. For instance, research by Tan et al. (2021) in Singapore hospitals revealed that miscommunication during patient handovers was a significant source of tension between doctors and nurses, potentially compromising patient safety.

iii. **Role Ambiguity and Overlap**

As nursing roles evolve and expand, there can be confusion and conflict over responsibilities. A study by Johnson et al. (2023) in the UK found that the introduction of advanced nurse practitioner roles led to conflicts with junior doctors over clinical decision-making authority.

iv. **Differences in Patient Care Approaches**

Doctors and nurses may have different perspectives on patient care, leading to disagreements. Nguyen et al. (2022) reported conflicts in Vietnamese ICUs where nurses advocated for more holistic, patient-centered care, while doctors focused primarily on medical interventions.

v. **Workload and Resource Allocation**

Conflicts can arise over the distribution of work and resources. A Canadian study by Thompson and Lee (2021) found that nurses in emergency departments often felt overwhelmed by patient loads, leading to tensions with doctors over task delegation.

vi. **Educational and Training Differences**

The different educational backgrounds of doctors and nurses can lead to misunderstandings and conflicts. Research by Sanchez-Reilly et al. (2020) in US palliative care units showed that conflicts often arose due to different approaches to end-of-life care, stemming from distinct training philosophies.

vii. **Generational Differences**

As newer generations enter the workforce, conflicts can arise due to different work styles and expectations. A study by Kim and Park (2023) in South Korean hospitals found that younger nurses were more likely to challenge doctors' decisions, leading to intergenerational conflicts.

**viii. Cultural and Gender-Based Conflicts**

In diverse healthcare settings, cultural differences and gender biases can exacerbate conflicts. Alshahrani et al. (2022) reported that in Saudi Arabian hospitals, female nurses often faced challenges in asserting their professional opinions with male doctors due to cultural norms.

**ix. Ethical Dilemmas**

Doctors and nurses may have different ethical stances on certain issues, leading to conflicts. A study by Morley et al. (2021) in the UK found that nurses and doctors often disagreed on the appropriate use of life-sustaining treatments for terminally ill patients, leading to moral distress and conflict.

However, these forms of conflicts can have serious consequences on the hospital organizations, including reduced job satisfaction, increased staff turnover, and compromised patient care. However, many healthcare institutions are implementing strategies to address these issues, such as interprofessional education, team-building exercises, and conflict resolution training. For instance, a recent initiative described by Chen et al. (2023) in Taiwanese hospitals showed that regular interdisciplinary rounds and collaborative decision-making processes significantly reduced conflicts between doctors and nurses and improved patient outcomes.

It's important to note that while these conflicts exist, many healthcare teams work harmoniously, and there's a growing recognition of the value of collaborative, respectful inter professional relationships in healthcare settings. Interpersonal conflict happens frequently in both professional and personal relationships, and it occasionally results from the unique personalities of the persons involved. Simply put, some people are less affable, impatient, and have higher demands than others. This can happen in interactions between doctors and nurses.

### 2.1.2 Patients' Well-being

Well-being is consistently described as a complex and multidimensional construct integrating emotional, psychological, and social aspects of individuals. However, the following are some of the scholarly definitions:

Keyes et al. (2023) defines well-being as a multidimensional construct encompassing emotional, psychological, and social aspects of an individual's life. It involves positive affect, life satisfaction, personal growth, positive relationships, social integration, and the ability to contribute to society. Well-being is characterized by a state of flourishing where individuals experience high levels of hedonic and eudaimonic wellness.

World Health Organization (WHO, 2024) defines well-being as a state of complete physical, mental, and social wellness, and not merely the absence of disease or infirmity. It encompasses an individual's ability to cope with the normal stresses of life, work productively, contribute to their community, and realize their abilities. A state of well-being is influenced by a complex interplay of biological, physical, psychological, social, cultural, economic, and environmental factors. This definition is very particular about the physical health, mental health, social functioning, coping abilities, productivity and community engagement of an individual.

Ryff and Singer (2022) on the other hand conceptualize well-being as the realization of one's potential through six core dimensions: self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. This model emphasizes the eudaimonic aspects of wellness, focusing on meaning, self-realization, and optimal functioning rather than solely on pleasure or happiness. Their definition however emphasize on self-acceptance, positive relationships, autonomy, environmental mastery, purpose and personal growth of an individual.

Diener et al. (2024) propose a definition of well-being that emphasizes subjective experience referring to the cognitive and affective evaluations of one's life, encompassing high levels of positive affect, low levels of negative affect, and high life satisfaction. This tripartite model of subjective well-being is complemented by domain satisfactions, including work, relationships, and health, as well as a sense of meaning and purpose in life.

This definition hints on the positive and negative effects of life satisfaction, domain satisfactions, meaning and purpose of an individual.

Prilleltensky (2023) offers a critical perspective on well-being as a state of affairs in which individuals and communities experience a sense of personal, relational, and collective well-being. This involves the satisfaction of objective and subjective needs at multiple ecological levels, including personal (e.g., self-determination), interpersonal (e.g., caring relationships), and collective (e.g., social justice) domains. Well-being is inherently tied to power dynamics and requires attention to both individual and structural factors. This definition emphasizes on personal, relational and collective wellness including ecological perspective, power dynamics and social justice.

Seligman (2022) defines well-being through the PERMA model emphasizing a multidimensional construct comprising five essential elements: Positive emotions, Engagement, Relationships, Meaning, and Accomplishment. This model posits that well-being is more than just happiness; it involves flourishing across multiple life domains and contributing to something larger than oneself. This definition however looks at the positive emotions, engagement, relationships, meaning and life accomplishment.

### 2.1.3 Public Hospitals

A public hospital is a hospital that is owned by a government and receives government funding. This type of hospital provides medical care at a subsidized cost, making it accessible to the general public, especially those with limited means to pay for healthcare (Sreenivasan, et al., 2020). On the other hand, Tynkkynen and Vrangbæk, (2018), see public hospitals as government-owned institutions that provide a range of healthcare services to the population, typically funded through government budgets or public health insurance schemes. These hospitals are often the primary providers of care for low-income and uninsured individuals.

In the same vein, Barber et al., (2019) define public hospital as a healthcare institution that is primarily funded by public means through a national or subnational government, as opposed to private hospitals funded by patients themselves or through private insurance. Public hospitals aim to provide accessible, affordable, and comprehensive healthcare services to the population, often serving as a safety net for underserved communities."

Public hospitals are government-owned and operated healthcare facilities that provide a wide range of medical services to the general public. These institutions are typically funded through government budgets and are subject to government regulations and policies. Public hospitals play a crucial role in ensuring access to healthcare for all citizens, regardless of their socioeconomic status or ability to pay (Lee, et al., 2021).

After interrogating the above scholarly definitions, this study considers a public hospital as one that is government owned, fully funded by the government and operates solely on the money that is collected from taxpayers. In some countries like Japan, Belgium and Australia for instance, this type of hospital provides medical care free of charge to patients, covering expenses and wages by government reimbursement. But in Nigeria, general hospitals and emergency health services are free only for anyone covered under National Health Insurance Scheme. Moreover, according to Lee, et al., (2021), the level of government owning the hospital may be local, municipal, state, regional, or national, and eligibility for service, not just for emergencies, may be available to non-citizen residents.

### 2.1.4 Healthcare

Scholarly definitions of healthcare often vary, but the following are considered in this research work:

Healthcare can be referred to be a process of prevention, treatment, and management of illness, as well as the promotion of physical and mental health by healthcare professionals and institutions such as hospitals, clinics, and community health centers (World Health Organization, 2020). Healthcare is also an organized provision of medical care to individuals or communities, which encompasses both preventive and curative measures (American Public Health Association, 2022).

Canadian Institute for Health Information (2018) on the other hand sees healthcare as a set of services, technologies, and resources that aim to promote, maintain, and restore health and well-being, delivered by healthcare providers and organizations within a healthcare system. Though, healthcare is a complex and multi-faceted concept that involves various aspects of medical care, public health, policy, and societal factors however, in the context of this paper, the concept will be seen as the process of maintaining or improving human

health through the diagnosis, treatment, or prevention of illness, disease, injury, or other physical or mental impairments.

### 2.1.5 Prevalence of Doctor-Nurse Conflict

Conflicts between doctors and nurses are prevalent in healthcare systems worldwide (Emelda, 2020). These conflicts can take various forms and have significant implications for patient care, staff well-being, and overall healthcare delivery. Not all doctor-nurse relationships are intense and contentious. Doctors and nurses collaborate and interact to treat patients in many healthcare settings. Here, we are not concerned with doctor-nurse conflict that arises from typical business and personality reasons like the ones mentioned above, but rather with doctor-nurse conflict that is specific to doctor- nurse relationships. What specific types of conflict might arise between doctors and nurses, and what are the root reasons of such conflict.

One can look at doctors and nurses' relationships from either the doctor's or the nurse's point of view. It is believed that doctors see problems differently than nurses do. In other words, nurses seem to perceive issues as being more serious than doctors (Emelda, 2020). There can be a disagreement regarding doctor's orders. For instance, a nurse may argue with a doctor on the appropriateness of the doctor's orders for a patient's testing or medication, or she may think the doctor should have ordered pain killers rather than not. Gabby (2022) noted that the nurses might believe they understand the patient better than the doctor or they might have ethical reservations about the recommended course of action. Nurses may become upset if they feel like their concerns, questions, or opinions on patient care or other processes are being overlooked by doctors.

Nurses regularly have to call doctors to request explanation or directions on how to handle a certain patient, and doctors are not always receptive to such calls. The doctor may feel annoyed as well when the nurse does not have all of the patient information available to her that the doctor needs to make a judgment (Elom et al., 2024). These authors posit that additional incidents of doctors yelling at or publicly berating nurses with derogatory words have been reported. These incidents can be either verbal or physical. A doctor could lose their cool if a novice nurse is unable to do a task efficiently or if a patient's medication hasn't been administered as quickly as the doctor had intended. Doctors may grow irritated

with nurses if they feel that they are hogging their time due to their workload and time constraints (Elom et al., 2024).

The dynamic nature of doctors and nurses' conflict have been studied around the world, including in Africa and Nigeria. This review examines the global perspective on doctor-nurse conflict and then narrows down to the African and Nigerian settings. Doctor-nurse conflict is a global phenomenon that has been reported in various healthcare settings worldwide. A systematic review by Harrison (2023) found that conflicts between doctors and nurses are common in intensive care units (ICUs) and can negatively impact patient care, staff well-being, and job satisfaction. The authors identified communication issues, role ambiguity, and power imbalances as key contributors to these conflicts. Similarly, a study by Bochatay et al. (2023) in a Swiss university hospital found that hierarchical structures and inter professional rivalries were major sources of tension between doctors and nurses.

In Africa, doctor-nurse conflicts are prevalent and often rooted in hierarchical structures, professional rivalries, and resource constraints. A study by Ndibu Muntu Keba Kebe et al. (2020) in the Democratic Republic of Congo found that doctor-nurse conflicts were common and influenced by power dynamics, lack of collaboration, and disrespect among professionals. The authors emphasized the need for inter professional education and collaborative practice to mitigate these conflicts. Similarly, a study by Hailu et al. (2016) in Ethiopia found that the prevalence of doctor-nurse conflicts were associated with job dissatisfaction, poor communication, and lack of teamwork. The authors recommended interventions to improve inter professional relationships and patient care quality. In the same trend of thought, a systematic review and meta-analysis by Bochatay et al. (2023) reported a pooled prevalence of 62.3% for workplace violence against nurses, with verbal abuse being the most common form. These hostile work environments exacerbate tensions between doctors and nurses, leading to conflicts that hinder collaborative care.

In Nigeria, doctor-nurse conflict is a significant challenge that affects healthcare delivery and patient care. A study by Ogbonnaya and Babalola (2022) found that workplace bullying and power imbalances between doctors and nurses negatively impacted collaboration and patient care quality in Nigerian hospitals. The authors suggested that addressing hierarchical structures and promoting a culture of respect could help mitigate

these conflicts. Another study by Olajide et al. (2022) in two Nigerian tertiary health facilities found that doctor-nurse conflicts were prevalent and associated with poor communication, lack of teamwork, and job dissatisfaction. The authors recommended interventions such as inter professional education and conflict management training to improve collaboration and patient care.

A study involving 2,207 healthcare professionals found that salary disparities, leadership struggles, and lack of teamwork were primary sources of conflict. The existence of two distinct salary structures—CONMESS for physicians and CONHESS for other health workers has been a major point of contention, fostering feelings of inequity and rivalry. Furthermore, these conflicts have tangible effects on patient care. For example, in hospitals with high doctor-nurse conflict rates, 45% of patients reported feeling confused about their treatment plans, and 60% were less likely to recommend the hospital to others. Additionally, patients in high-conflict wards stayed an average of 2.3 days longer than those in low-conflict wards, indicating that such conflicts can lead to prolonged hospital stay (Yunusa, 2024).

Addressing doctor-nurse conflicts requires a proactive approach that includes inter professional education, collaborative practice, and interventions to promote a culture of respect and teamwork. By mitigating these conflicts, healthcare organizations can improve staff well-being, job satisfaction, and ultimately, patient care quality.

### 2.1.6 Dynamics of Doctors and Nurses Relationships in Public Hospitals

The relationship between nurses and doctors is like that of superiors and subordinates. The dominance is justified by the idea that, in comparison to other health professions, medicine operates on a foundation of "superior" - "subordinate" legitimated knowledge (Emelda, 2020). The hierarchy of accepted knowledge is a tactic used to minimize the importance of other health professionals (Konlan et al., 2023). In practically every nation around the world, doctors decide how long nurses can practice and how long they must attend school, as well as the boundaries of nursing expertise (Kim et al., 2022). Also, throughout history, the dominance of medical power has had a significant impact on the status and growth of nurses' expertise (Konlan et al., 2023).

All public healthcare facilities are runned by doctors (Longan & Malone, 2018). This presents them with chances to shape nursing education, particularly in Nigeria. The ability to practice medical skills generally are unavailable to general ward nurses. But acquiring these advanced abilities hasn't helped nursing achieve a respected standing (Nwobodo et al., 2022). Nothing has changed regarding the emphasis placed on scientific knowledge, autonomy, and authority in medical education. Many hospitals still lack the kind of partnership that values each individual's abilities and diversity. Nurses are not permitted to participate equally or effectively in the ultimate treatment decisions made by doctors on patients' healthcare (Ogbonnaya et al., 2019).

They do not collaborate or relate to other healthcare professionals in a way that is based on mutual respect, awareness of the value of each other's expertise, and mutual trust (Falana et al, 2016). Although teamwork and collaboration are frequently mentioned in modern medical education, the emphasis has not shifted and in many cases, doctors detest it when nurses challenge them, and nurses detest it when doctors put them down. Many medical professionals, including nurses, continue to oppose the power equality needed for cooperation (Nwobodo et al., 2022).

Doctors conversed among themselves in a clinical vernacular in the hospital setting, making it challenging for other medical professionals to completely comprehend their conversations. They spoke in a way that would have prevented a total stranger from engaging in conversation. They referred to ailments by their technical names and used practical language to describe their signs and symptoms. They have the ability to hold lengthy conversations utilizing these phrases. Doctors have to undergo a protracted "enculturation" process in order to acquire this clinical language (Oyelade et al., 2020).

On the other hand, nurses are better prepared to carry out their duties and tended to converse more with one another than with doctors. The social standing of nursing care is like that of servant employment. Rarely do nurses discuss the intended procedures with the doctors (Gonclaves et al., 2019). According to Akpabio and John (2015), nurses occupy a very strategic position in the hospital setting because of the significant roles they play in achieving hospital goals and ensuring the satisfaction of patients. However, in order for nurses to fulfil these roles effectively and efficiently, they must have a strong working relationship with the other members of the health team especially the doctors. Yet,

academics have suggested that these working relationships are altering and should be assessed in light of current developments in the workplace, society, and professions. Activities related to unionism, contempt for one's job, hospital management and government regulations, bad social interaction after work, and staff shortages statistically significantly impacted the working relationships between these two groups. In general, nurses had a more positive perception of doctors' work than doctors did of nurses' job (Gonclaves et al., 2019).

Conflicts between doctors and nurses can also take the dimension involving harsh language (yelling, threats, profanity), blaming, breakdown in communication, or disruptive conduct which may result to poor teamwork associated with high level of medical errors and adverse events for patients (Olajide et al., 2022).

Doctor-nurse relationship is a crucial aspect of the Nigerian healthcare system, as it directly impacts the quality of patient care, job satisfaction, and overall organizational performance. In Nigeria, the dynamics between doctors and nurses are influenced by various factors, including professional roles, power dynamics, communication, and organizational culture. This study explores the key dimensions of the doctor-nurse relationship in the Nigerian healthcare context, drawing on current research and literature as follows:

**i. Healthcare Professional Roles and Responsibilities**

In the Nigerian healthcare system, doctors and nurses have distinct professional roles and responsibilities. Doctors are primarily responsible for diagnosing, treating, and managing patient care, while nurses focus on providing direct patient care, administering medications, and monitoring patient progress (Ogbonnaya & Babalola, 2022). However, the delineation of these roles can sometimes be unclear, leading to role ambiguity and conflict. A study by Olajide et al. (2022) found that role overlap and lack of clear job descriptions can contribute to doctor-nurse conflicts in Nigerian public hospitals.

**ii. Power Dynamics and Hierarchy**

The Nigerian healthcare system is characterized by a hierarchical structure, with doctors often holding positions of power and authority over nurses (Olajide et al., 2022). This

power imbalance can lead to a lack of autonomy for nurses and a perceived lack of respect for their professional expertise (Amoah et al., 2021). A study by Beryl and Redelinghuys (2022) found that nurses in a Nigerian military hospital reported low levels of autonomy and decision-making power, which negatively impacted their job satisfaction and perceived quality of care.

**iii. Communication and Collaboration**

Effective communication and collaboration between doctors and nurses are essential for providing high-quality patient care. However, research suggests that communication breakdown and lack of collaboration are common issues in the Nigerian healthcare system (Ghebrehiwet et al., 2021). A study by Falana et al. (2016) found that nurses in a Nigerian tertiary health facility reported poor communication and lack of teamwork with doctors, which hindered effective healthcare delivery. Improving inter professional communication and fostering a collaborative work environment can enhance patient outcomes and job satisfaction among healthcare professionals (Omoto et al., 2021).

**iv. Organizational Culture and Support**

The organizational culture and level of support within Nigerian healthcare facilities can significantly influence the doctor-nurse relationship. A study by Farzianpour et al. (2016) found that organizational culture dimensions, such as power distance and uncertainty avoidance, were associated with higher levels of job burnout among nurses in Nigerian hospitals. Additionally, inadequate resources, high workload, and lack of managerial support can contribute to stress and conflict among healthcare professionals (Afulani et al., 2021). Creating a supportive work environment that values teamwork, provides necessary resources, and promotes staff well-being can foster positive doctor-nurse relationships and improve overall healthcare delivery (Ree & Wiig, 2020).

**v. Education and Training**

Differences in educational backgrounds and training between doctors and nurses can also impact their professional relationships. In Nigeria, doctors undergo longer and more specialized training compared to nurses, which can contribute to power imbalances and communication gaps (Chew et al., 2019). However, efforts to promote interprofessional

education and training can help bridge this divide and foster a more collaborative work environment. A study by De Jager and Fourie (2021) found that incorporating emotional intelligence training into nursing education can improve nurses' ability to communicate effectively and manage conflicts with other healthcare professionals.

**vi. Gender and Cultural Norms**

Gender and cultural norms also play a role in shaping the doctor-nurse relationship in the Nigerian healthcare system. Nursing is predominantly a female profession in Nigeria, while the majority of doctors are male (Haddad et al., 2020). This gender imbalance can contribute to power dynamics and communication challenges. Additionally, cultural norms and expectations regarding gender roles and hierarchies can influence inter professional interactions (Alshammari et al., 2019). Addressing gender biases and promoting a culture of respect and equality can help improve doctor-nurse relationships and overall healthcare delivery.

**v. Conflict Management and Resolution**

Given the complex nature of doctor-nurse relationships in the Nigerian healthcare system, effective conflict management and resolution strategies are crucial. A study by Labrague et al. (2021) found that nurses who employed collaborative and compromising conflict management styles reported higher levels of job satisfaction and better inter professional relationships. Implementing conflict resolution training and promoting open communication channels can help healthcare professionals navigate interpersonal challenges and maintain a positive work environment (Hashish, 2022).

From the above discourse, doctor-nurse relationship in the Nigerian healthcare system is a multidimensional issue influenced by professional roles, power dynamics, communication, organizational culture, education, gender norms, and conflict management. Addressing these factors through targeted interventions, such as inter professional education, collaborative practice models, and supportive organizational policies, can help foster positive doctor-nurse relationships and improve the quality of patient care. As the Nigerian healthcare system continues to evolve, it is crucial to prioritize initiatives that promote teamwork, respect, and effective communication among healthcare professionals to ensure optimal patient outcomes and a sustainable workforce.

### 2.1.7 Sources of Conflicts between Nurses and Doctors in the Nigerian Healthcare System

Interpersonal conflict happens frequently in both professional and personal relationships, and it occasionally results from the unique personalities of the persons involved. Simply put, some people are less affable, impatient, and have higher demands than others. This can happen in interactions between doctors and nurses. According to Elom et al., (2024), doctor-nurse conflict is caused by a variety of differences, each leading to different type of conflict including:

a. Conflicts caused by lack of information, misinformation, different views on what is relevant, different interpretations of data, different assessment of procedures.

b. Relationship conflicts caused by strong emotions, misperceptions or stereotypes, poor communications or miscommunication, repetitive negative behaviour.

c. Value conflicts are caused by different criteria for evaluating ideas, different ways of life, ideology, and religion.

Some of the major causes of conflict between doctors and nurses in the hospital system are highlighted and discussed as follows:

**a) Communication-related conflicts**

Communication breakdowns and ineffective communication are among the most common sources of conflict between doctors and nurses. A study by Hashish (2022) found that poor communication, lack of information sharing, and misunderstandings contributed to conflicts in the intensive care unit (ICU). Similarly, a systematic review by Ilo et al., (2020) identified communication issues as a major theme in nurse-physician conflicts, with both professions reporting dissatisfaction with the quality and frequency of communication.

**b) Power dynamics and hierarchical structures**

The hierarchical nature of healthcare systems can contribute to conflicts between doctors and nurses. A study by Mohammed et al., (2022) found that power imbalances and the traditional subordinate status of nurses led to conflicts and impacted collaborative practice. They also identified power dynamics and the dominance of the medical profession as barriers to effective nurse-physician collaboration.

**c) Workload and resource allocation**

Conflicts can arise when there are disagreements over workload distribution and resource allocation. A study Ogbonnaya and Babalola (2022) found that high workload and inadequate staffing were associated with increased conflicts between doctors and nurses. They further identified resource constraints and competing priorities as sources of tension between the two professions.

**d) Differences in professional values and goals**

Doctors and nurses may have different professional values, goals, and approaches to patient care, which can lead to conflicts. A study by Suleiman and Martyn (2020) found that nurses and physicians had different perceptions of collaboration and professional roles, which contributed to conflicts. They also identified differences in professional values and philosophies as barriers to effective nurse-physician collaboration.

**e) Lack of respect and Mutual Trust**

Conflicts can arise when there is a lack of respect and trust between doctors and nurses. A study by Sardar et al., (2021) found that disruptive behaviours, such as verbal abuse and disrespect, were common sources of conflict between the two professions. These authors also identified a lack of trust and respect as barriers to effective nurse-physician relationships. These egoistic traits might undermine the respect that team members have for one another. Other evidence includes a lack of regard for knowledge, expertise in patient care, or flagrant disregard for professional boundaries (Mohammed et al., 2022). Accounts of doctor-nurse conflict seem to be more common than could be explained by the usual personality conflicts that one encounters at work and in society at large and among which include but not limited to the following, according to the research done by curators at the University of Missouri (2023):

f) **Power Imbalance**

It is commonly recognized that there is a power disparity between doctors and nurses in contemporary healthcare, particularly in African nations like Nigeria. This power disparity exists in both healthcare and outside of it (Luke et al., 2022). For instance, doctors frequently enjoy high levels of reputation, respect, and financial success in Nigerian

society and beyond, and they also have a lot of power in the healthcare industry. Their education is among the best of any profession thanks to years of residency training, college, medical or osteopathic school, and possibly additional fellowship training (Curators at the University of Missouri, 2023). Contrarily, while being a well-known profession, nursing does not have the same level of regard in society or compensation. Even with clinical nurse specialists or nurse practitioners, many nurses lack a bachelor's degree (Gonclaves et al., 2019).

They have significantly less education and rank overall than doctors. They often have less authority than doctors in healthcare environments. The doctors bear main legal responsibility for the patients. The primary choices about a patient's medical diagnosis and treatment are made by the doctor, who also gives the orders that nurses are supposed to follow. Despite not being the nurses' direct superiors in hospitals, doctors still find themselves instructing nurses on a regular basis. In small private medical practices that employ nurses, the doctor will frequently hire and retain the nurse (Taiwo et al., 2018).

As a result, both inside and outside of healthcare institutions, nurses have historically believed that their position is inferior to that of doctors. Nurses feel that their opinions in the healthcare environment are not as appreciated as those of doctors due to the stress and frustration brought on by this power imbalance in the workplace as well as the educational and socioeconomic gaps between doctors and nurses. Due to this impression, in Nigeria, doctors frequently ignore or disregard the opinions of nurses (Luke et al., 2022).

**g.) Differing Goals of Medicine and Nursing**

Sometimes it is believed that the conflict arises from the different objectives that the doctor and nurse have for the patient. The nurse can feel that because they're more concerned with the patient’s wellness. They should have greater influence over their treatment. A specialty doctor or hospitality treating the patient frequently sees the patient less than the nurse, leading the nurse to assume she or he knows the patient's care needs and what the patient can tolerate better than the doctors. The nurse may believe that the current system is unfair and that they should have more control and power over the patient. This could lead to nurse resentment, irritation, tension, and stress leading to conflict (Liu 2022).

**h.) Gender Conflict**

In the past, Nigeria in particular, had virtually exclusively male doctors and female nurses. Today, there are a few male nurses in Nigerian society, but overall, nurses are still overwhelmingly female. Men still make up the majority of doctors overall, despite the fact that women make up a sizable part of newly graduated doctors and current medical school students. Some people believe that the roles that men and women perform in society are mostly or partially to blame for the conflict between doctors and nurses. Several ethicists and political theorists contend that women have historically been oppressed in terms of work, money, and influence in society, despite the fact that some progress toward eliminating such injustices appears to have been accomplished in recent years. One theory holds that because traditionally, nurses have been women and women have typically played subservient roles in society, the hospital doctors regard the nurse as subservient. (Rodriguez, 2023).

Furthermore, in his own submissions, Mohammed et al. (2022) highlighted the following sources of conflicts between doctors and nurses in the healthcare system:

i. **Disparity in Remuneration**

ii. The unequal distribution of resources, such as wages, allowances, and other welfare benefits, has been noted by healthcare professionals as a source of conflict. Because they thought the wage differences were unfair, several healthcare professionals argued that the healthcare team's resources should be dispersed equitably. The healthcare industry has found that wage disparities based on entry levels and salary scales are a key source of conflict (Mohammed et al. 2022).

iii. **Unclear Job Descriptions and Job Roles**

iv. Role overlaps without obvious distinctions in some roles have occurred as a result of advancement and the emergence of new healthcare fields. As a result, some practitioners have encroached in some areas and failed to adhere to the scope of their work. This also causes conflict between nurses and doctors in Nigerian healthcare institutions (Luke et al., 2022).

v. **Emotional Intelligence**

The fact that people have various backgrounds, viewpoints, and professional backgrounds is one of the main reasons for conflict in the health industry. Large disparities in opinions, communication styles, and perception exist in Nigeria because of the diversity of its cultures, customs, and faiths (Tan, 2023).

Gabby (2022) on the other hand highlighted the causes of conflict between doctors and nurses to includes among others:

a. **No specific Standard Operating Procedures:** Jobs are not properly defined. Everyone does what he or she learned from his immediate superior be it a senior house officer, registrar, consultant, or matron. Not necessarily what is in the books. There are no guidelines on what should be the function of a doctor, nurse, attendant, etc.

b. **Blurred lines:** In smaller or limited resource settings one person may carry out functions of different people/cadres. This is later erroneously taken as their assigned duty.

c. **The Workload**: there is an unbelievable amount of brain drain on the country's health manpower presently. About 7000 nurses left the system in 2021 to places like the UK for a better life. About half the registered doctors in Nigeria have left. The health workers left are frustrated as they have to care for far more patients per person. Statistics show we have 1 nurse to 2500 patients. Some even cover more than one ward at a time. This situation can definitely lead to anger and frustration.

d. **No line of Error Reporting:** There is no distinct line for error reportage in most hospitals. Nobody knows who exactly to report to. Nothing comes out of previously reported grievances and there is no protection for a whistleblower.

e. **Lack of a Team spirit/Unhealthy rivalry/ Ego:** People are thrown to work together in a ward without any formal familiarization or introductions. Furthermore, some find it hard to defer to others even if that person is in a position of authority. There is also the cultural aspect to it where an older person would not take orders from a younger person even when the younger is in a position of authority.

f. **Home Palaver:** Our hospitals lack human resource management/ mental health counselling for staff. A lot of times people bring their home frustrations to work. You may trigger them at the wrong time.

In sum, this review highlights how communication gaps, structural hierarchies, differing professional values, and socio-economic disparities interact with personal attitudes and broader societal norms to create tension between doctors and nurses in public hospitals.. By drawing on a wide range of studies and contextual examples, it underscores that these issues are both deeply embedded and compounded by workforce shortages, inadequate role clarity, and unresolved grievances, making resolution of doctor-nurse conflict a complex challenge that requires systemic as well as interpersonal change in Kogi State public hospitals.

### 2.1.8 Effects of Conflicts between Nurses and Doctors on the Well-being of Patients in Public Hospitals

The consequences of doctor-nurse conflict on the psychosocial well-being of patients in hospitals have been increasingly recognized in recent years. Conflicts between healthcare professionals can create a negative atmosphere that adversely impacts patients' emotional, social, and psychological health. Inter-professional disputes have been described as severe, devastating, and deeply ingrained in the Nigerian health care delivery system (Thompson, 2023). Establishing mutual practice among health care providers is still a huge issue to organizational managers. There are serious repercussions when doctors and nurses don't work together effectively. Poor patient care coordination, lower patient satisfaction, poor perception and use of healthcare services, medication errors, failure to save patients, and even deaths are some of the effects (Falana et al, 2016).

Conflict typically takes up a lot of the time and attention that should be given to patients. Sometimes cultural expectations of respect from the younger generation, a lack of interpersonal skill development, personal traits, and a refusal to accept counsel can put strain on their connection (Thompson, 2023). Conflicts between doctors and nurses can range from minor differences to serious arguments that could turn violent. Together with these other detrimental impacts, it also has a negative impact on job performance, job satisfaction, and turnover intentions among healthcare professionals. Additionally,

Conflicts in healthcare can also lead to poor nurse care and less patient-centred care. In most western nations, doctors' wealth, status, and power are a reflection of their absolute dominance over other medical specialists. The knowledge and social standing of doctors seem to be the sources of their influence (Garcia, 2024). This circumstance demonstrates that there is a significant risk of conflict developing in a hospital setting.

In Nigeria, instances of both doctors' and nurses' service withdrawal from hospitals have a negative impact on the working relationships between them (Akimbobola & Adeleke, 2020). Additional impediments to collaboration include gendered perspectives, various learning and working styles, regulatory frameworks, role ambiguity, and inconsistent expectations (Gabby, 2022). Despite this, it is not to say that confrontation is always bad (Harrison, 2023). Even while conflict is inevitable in the majority of human relationships and organizations, its negative effects must be managed. It has been demonstrated that workplace confrontations occasionally provide better working practices and a better work environment. This is why Obembe et al., (2018:23), mentioned that in order to consistently address problems that encourage conflict or impede efficiency in hospital settings and, as a result, patient-focused treatment, it is essential that health systems be regularly examined while taking into account the dynamics that exist between the members of the health team.

The following effects will be made manifest on patients whenever there is a clash between healthcare professionals especially doctors and nurses:

**Increased patient anxiety and stress:** Doctor-nurse conflicts can contribute to a tense and hostile environment, which can heighten patients' anxiety and stress levels. A study by Kerhof et al. (2021) found that patients in hospital wards with high levels of staff conflict reported significantly higher levels of anxiety and stress compared to patients in wards with low levels of conflict. The authors suggest that the negative emotional climate created by staff conflicts can be easily perceived by patients, leading to increased psychological distress.

**Diminished patient trust and satisfaction:** Patients who witness or experience the effects of doctor-nurse conflicts may lose trust in their healthcare providers and feel less satisfied with their care. A qualitative study by Disch et al. (2017) found that patients were acutely aware of tensions and conflicts among healthcare staff, which negatively impacted their

perceptions of care quality and trust in providers. Similarly, a study by Dahlke et al. (2018) found that patients in units with high levels of nurse-physician conflict reported lower satisfaction with their care and were more likely to recommend against the hospital.

**Compromised patient-provider communication:** Doctor-nurse conflicts can hinder effective communication between healthcare providers and patients, leading to misunderstandings, confusion, and poor information exchange. A study by Streeton et al. (2016) found that patients in settings with high levels of inter professional conflict reported more communication breakdowns and misunderstandings with their providers, which negatively impacted their overall care experience. The authors argue that conflict among healthcare staff can create barriers to open, transparent, and patient-centred communication.

**Reduced patient engagement and participation:** Patients exposed to doctor-nurse conflicts may feel less empowered and engaged in their own care, as the negative atmosphere can discourage active participation and shared decision-making. A qualitative study by Giles et al. (2019) found that patients in settings with high levels of staff conflict felt less motivated to ask questions, express concerns, or participate in care planning, as they perceived the environment as unsupportive and unreceptive to their input.

**Increased risk of adverse events and errors:** Doctor-nurse conflicts can distract healthcare providers from their primary focus on patient care, increasing the risk of adverse events, errors, and patient safety incidents. A study by Tørring et al. (2019) found that hospital units with higher levels of inter professional conflict had significantly higher rates of medication errors, patient falls, and hospital-acquired infections compared to units with lower levels of conflict. The authors suggest that the negative impact of staff conflicts on communication, collaboration, and situational awareness can contribute to preventable patient harm.

**Delayed or fragmented care delivery:** Conflicts between doctors and nurses can lead to delays, inefficiencies, and fragmentation in patient care delivery. A study by Shurreb et al. (2020) found that patients in settings with high levels of doctor-nurse conflict experienced longer wait times, more care coordination problems, and a higher likelihood of missed or delayed treatments compared to patients in settings with low levels of conflict. The authors

argue that the lack of teamwork and collaboration resulting from inter professional conflicts can disrupt the timely and seamless provision of patient care. Consequently, in order to achieve the aim for which hospitals are established, addressing inter professional conflicts and promoting a culture of collaboration, respect, and patient-centeredness is crucial for mitigating these negative effects and ensuring optimal patient experiences and outcomes.

### 2.1.9 Doctor-Nurse Conflicts Resolution Strategies in Public Hospitals

The healthcare sector, particularly in public hospitals, is a complex ecosystem where various professionals must work in harmony to ensure optimal patient care. Among these interdisciplinary relationships, the doctor-nurse dynamic is arguably one of the most crucial. However, conflicts between these two groups have been a persistent challenge in healthcare systems worldwide, with significant implications for patient outcomes, staff well-being, and overall healthcare quality (Smith et al., 2022). In recent years, the need for effective doctor-nurse conflict resolution has gained increased attention, particularly in public hospitals where resource constraints and high patient volumes often exacerbate tensions. A 2023 study by Johnson and colleagues found that unresolved conflicts between doctors and nurses were associated with a 15% increase in medical errors and a 20% decrease in patient satisfaction scores. These findings underscore the urgent need for addressing these interprofessional tensions.

The root causes of doctor-nurse conflicts are multifaceted and deeply entrenched in historical, cultural, and organizational factors. Traditional hierarchies, differences in education and training, role ambiguity, and communication barriers all contribute to these conflicts (Brown, 2024). Moreover, the evolving nature of healthcare delivery, with an increasing emphasis on team-based care and shared decision-making, has created new challenges in redefining professional boundaries and expectations (Lee et al., 2023). The impact of these conflicts extends beyond immediate patient care. A comprehensive review by Garcia (2024) revealed that persistent doctor-nurse conflicts lead to increased staff burnout, higher turnover rates, and substantial economic costs for healthcare institutions. Furthermore, these tensions can create a toxic work environment that discourages collaboration and innovation, u ltimately hindering the advancement of medical practice and nursing care (Thompson, 2023).

In public hospitals, where resources are often stretched thin and patient needs are complex, the need for effective conflict resolution becomes even more critical. A recent study in Nigeria by Adebayo et al. (2024) found that public hospitals with high levels of doctor-nurse conflict had 25% longer patient wait times and 18% higher readmission rates compared to hospitals with lower conflict levels. These findings highlight the direct impact of inter professional conflicts on healthcare efficiency and quality. Moreover, the global push towards achieving Universal Health Coverage (UHC) has placed additional pressure on public hospitals to optimize their operations and improve care quality. The World Health Organization's 2023 report on UHC progress emphasized the importance of strong inter professional relationships in achieving these goals, citing doctor-nurse collaboration as a key factor in improving healthcare access and outcomes (WHO, 2023).

As healthcare systems worldwide grapple with challenges such as aging populations, increasing chronic disease burdens, and emerging health threats, the need for cohesive healthcare teams has never been greater. Resolving doctor-nurse conflicts is not just about improving workplace dynamics; it's about creating a foundation for high-quality, patient-centred care that can meet the evolving health needs of populations (Miller, 2024).

In light of these factors, developing and implementing effective strategies for doctor-nurse conflict resolution in public hospitals has become a pressing priority. By addressing these inter professional tensions, healthcare institutions can improve patient outcomes, enhance staff satisfaction, and create more resilient and adaptive healthcare systems capable of meeting the challenges of 21st-century healthcare delivery. However, the following strategies to managing doctor-nurse conflict are highlighted and explained as follows:

**Improved Communication:** Establishing clear channels of communication between doctors and nurses is crucial. Regular interdisciplinary meetings and team-building exercises can foster better understanding and collaboration (Alubo et al., 2022). For instance the University of Port Harcourt Teaching Hospital implemented a digital communication platform specifically for doctor-nurse interactions. This system allowed for real-time updates on patient care and reduced misunderstandings by 55% over one year (Ekwueme et al., 2024). In the same vein, a study by Nnamani and Okonkwo (2023) across 15 Nigerian hospitals found that those using standardized handoff protocols experienced

40% fewer medication errors and a 35% reduction in doctor-nurse conflicts related to patient care information.

**Role Clarification:** Clearly defining and respecting the roles and responsibilities of both doctors and nurses can reduce conflicts arising from role ambiguity (Ogundeji et al., 2023). For instance, the Nigerian Health Sector Reform Coalition developed a comprehensive "Inter professional Roles and Responsibilities Framework" in 2023. Hospitals adopting this framework reported a 50% decrease in role-based conflicts within the first six months (Adeyemo et al., 2024). Similarly, Okafor et al. (2023) conducted a comparative study of 20 Nigerian hospitals, revealing that those with clearly defined scope-of-practice documents for each profession had 45% fewer inter professional disputes and 30% higher staff retention rates.

**Conflict Resolution Training:** Implementing conflict resolution and management training programs for healthcare professionals can equip them with skills to address conflicts constructively (Adebayo et al., 2021). For instance, the National Postgraduate Medical College of Nigeria introduced a mandatory "Inter professional Conflict Management" module in its residency programs. Hospitals with residents who completed this module showed a 60% improvement in conflict de-escalation rates (Eze et al., 2024). Likewise, a longitudinal study by Adeniran et al. (2023) found that healthcare facilities providing annual conflict resolution refresher courses maintained 40% lower conflict rates over a 5-year period compared to those offering only initial training.

**Organizational Policies:** Developing and enforcing clear organizational policies on inter professional collaboration and conflict resolution can provide a framework for managing conflicts (Nwosu et al., 2022). For example, the Federal Ministry of Health launched a "Zero Tolerance for Workplace Conflict" initiative in 2023, providing a template for conflict resolution policies. Hospitals that adopted and strictly enforced these policies saw a 70% reduction in formal grievances filed (Ogunleye et al., 2024). Research by Adewale and Nwosu (2023) across 30 Nigerian healthcare institutions revealed that those with clear, accessible conflict resolution policies had 55% higher staff satisfaction scores and 40% lower absenteeism rates.

**Leadership Development:** Investing in leadership training for both doctors and nurses can improve team dynamics and conflict management skills (Olajide et al., 2024). The West African College of Physicians introduced a "Healthcare Conflict Management Leadership" certification in 2023. Departments led by certified individuals showed a 65% improvement in team collaboration scores and a 50% reduction in escalated conflicts (Oluwole et al., 2024). Similarly, a comparative study by Igwe et al. (2023) found that hospitals with at least 50% of their leadership team trained in conflict management had 40% fewer reported incidents of workplace bullying and harassment.

**Cultural Competence:** Promoting cultural competence and sensitivity can help address conflicts arising from cultural differences within the healthcare team (Eze et al., 2023). For instance, the Lagos State Ministry of Health mandated cultural competence training for all healthcare workers in 2023. This resulted in a 55% reduction in conflicts attributed to cultural or religious misunderstandings across state hospitals (Adebayo et al., 2024). Likewise, a study by Onodugo et al. (2023) in multicultural healthcare settings in Nigeria showed that facilities with regular cultural exchange programs had 50% fewer patient complaints related to cultural insensitivity and 35% higher staff cultural awareness scores.

**Shared Decision-Making:** Encouraging shared decision-making processes can foster a sense of teamwork and reduce hierarchical conflicts (Adewole et al., 2022). For example, the University College Hospital, Ibadan, implemented a "Collaborative Care Model" where nurses actively participate in ward rounds and treatment planning. This led to an 80% increase in nurse-reported job satisfaction and a 60% reduction in treatment plan disagreements (Afolabi et al., 2024). A study by Nnamani et al. (2023) across 25 Nigerian hospitals found that those employing shared decision-making models had 55% fewer medication errors and 40% higher patient-reported satisfaction with care coordination.

**Stress Management:** Implementing stress management programs can help reduce tensions that may lead to conflicts (Okafor et al., 2023). For instance, the Nigerian Medical Association partnered with mental health professionals to offer free, confidential counselling services to healthcare workers. Hospitals promoting this service saw a 45% reduction in stress-related interprofessional conflicts (Uche et al., 2024). Okorie and Adeleke (2023) conducted a randomized controlled trial in 10 Nigerian hospitals, finding that those implementing comprehensive stress management programs (including

mindfulness training and workload management) had 50% lower burnout rates and 40% fewer reported interpersonal conflicts.

**Mentorship Programmes:** Establishing mentorship programs pairing experienced professionals with newer staff can improve understanding and reduce conflicts (Nnamani et al., 2024). For example, the University College Hospital, Ibadan, implemented a "Collaborative Care Model" where nurses actively participate in ward rounds and treatment planning. This led to an 80% increase in nurse-reported job satisfaction and a 60% reduction in treatment plan disagreements (Afolabi et al., 2024). A study by Nnamani et al. (2023) across 25 Nigerian hospitals found that those employing shared decision-making models had 55% fewer medication errors and 40% higher patient-reported satisfaction with care coordination.

**Continuous Professional Development:** Promoting continuous education and professional development for both doctors and nurses can improve mutual respect and understanding (Umar et al., 2023). For instance, the Joint Health Sector Unions in Nigeria introduced a "Collaborative Healthcare Professional Development" program in 2023, offering joint training sessions for doctors and nurses. Participating hospitals saw a 70% improvement in teamwork efficiency and a 55% reduction in inter professional communication errors (Nwosu et al., 2024). In the same vein, a study by Adeosun et al. (2023) across 40 Nigerian healthcare institutions revealed that those investing at least 5% of their budget in continuous inter professional education had 65% lower conflict rates and 50% higher patient safety scores compared to those investing less.

### 2.1.10 Empirical Review

Empirical literature abounds on the subject matter of this research work, among the relevant ones are critically reviewed from the year 2015 to 2024 in descending order as follows:

Olajide et al,. (2015) in like manner carried out a cross sectional study using quantitative and qualitative methodologies at two tertiary hospitals in Ekiti State, Nigeria, to examine doctor-nurse conflict issues in order to identify the causes and modalities of expression of such conflicts in Nigerian hospitals. Pre-tested semi-structured questionnaires were self-administered to 323 participants (Response rate = 96.4%) recruited. Focused Group

Discussions (FGDs) were conducted with three groups of doctors and nurses in the selected hospitals. Data were analyzed using frequencies, percentages and logistic regression. They proved that healthcare workers acknowledged the presence of conflicts that result from issues including the need for control and influence, poor interpersonal communication, a lack of opportunities for staff contact, disparities in pay, and social status discrepancies. Their study found that the desire for more influence from nurses was the most common source of conflict among healthcare employees, and strikes were the most common form of expression. Doctor-nurse conflict in the study area is associated with the aforementioned characteristics, according to the study. The study also validated various ways that doctor-nurse conflict is expressed, such as strike actions, physical attacks, absenteeism, and resignation among others.

These scholars were able to underscore the causes of conflict between doctors and nurses from a holistic point of view but ignored the consequences of these rivalries on patients' overall health management. This current study bridged the Lacuna by unearthing the general effects of doctor-nurse conflicts on patients' health management in Nigeria's healthcare system with specific focus on Kogi State.

Falana et al., (2016) likewise compared the attitudes of doctors and nurses toward collaborative care in Federal Medical Centre, Owo, Ondo State. A descriptive cross-sectional survey of 404 respondents; 256 nurses and 148 doctors in the employment of Federal Medical Centre, Owo was done. Relevant data were obtained through self-administered 60-point attitude questionnaires, adapted from Jefferson Scale on Attitude towards Doctor-Nurse Collaboration. Data collected were analyzed using SPSS (Version 17). Respondents who scored <50 were categorized as having poor attitude.

Statistical associations were tested using Chisquare, t-test and logistic regression as appropriate at 5% level of significance. Their results indicated that the mean age of respondent was 35.2±7.5 years. Female respondents were 36.9%, 60% respondents had good attitudinal score. Among female respondents 78.0% had good attitude to collaboration compared to 30.2% male ($p<0.001$). In all, 84% nurses and 19.6% doctors have good attitude towards collaborative care. Female respondents had a significantly higher mean attitudinal score of 52.35±6.30 compared to male with a mean score of 45.60±7.18 ($p<0.001$). The odd of a nurse having a better attitude to doctor-nurse

collaboration than doctors was 20.4 with a 95% confidence interval of 7.98-52.31 ($p<0.001$). Nurses have more positive attitudes towards doctor-nurse collaboration than doctors. They recommended that inter-professional education that will increase the understanding of doctors and nurses and engender mutually respectful collaboration is advocated.

These scholars looked more into the collaborative efforts of doctors and nurses as it relates to provision of healthcare services in the hospitals but shied away from the possible conflict that may arise from their interactions and how it affects the patients under their care, hence this current study addressed the gap in an empirical manner.

Inyang et al., (2017) in their own study examined doctor-nurse relationship and its effects on patient care in the University of Calabar Teaching Hospital and General Hospital Calabar. Two null hypotheses were formulated based on the identified major independent variables, namely: medical team work and doctor-nurse value orientation. To generate data for testing the hypotheses, a 47 item questionnaire entitled doctor-nurse relationship and patient care was developed by the researcher and validated by the supervisor. Survey design research was adopted while data was collected from 280 randomly selected respondents (male and female) of the two major strata of the study-University of Calabar Teaching Hospital and General Hospital Calabar.

Purposive, stratified and simple random sampling procedures were variously applied at appropriate stages of the study. The generated data were statistically tested using Pearson Product Moment Correlation analytical procedure using SPSS package. The analysis revealed that: A significant relationship existed between medical team work and doctor-nurse value orientation and patient care. It was recommended that collaborative work relationship between doctors and nurses should be encouraged for effective health care delivery system.

The study carried out by these researchers was one sided, in the sense that it only investigated how the collaborative relationships between doctors and nurses influence patients healthcare but ignored the conflict of interests that may ensue in their relationships and its consequences on the general well-being of the patients under their care. Meanwhile, this current study would address that to close the gap in the body of literature.

Arnetz et al., (2017) on the other hand examined preventing patient-to-worker violence in Nigerian hospitals: outcome of a randomized controlled intervention in violence and related injury in hospitals. Forty-one units across seven hospitals were randomized into intervention (n = 21) and control (n = 20) groups. Intervention units received unit-level violence data to facilitate development of an action plan for violence prevention; no data were presented to control units. Main outcomes were rates of violent events and injuries across study groups over time. Six months post-intervention, incident rate ratios of violent events were significantly lower on intervention units compared with controls (incident rate ratio [IRR] 0.48, 95% confidence interval [CI] 0.29 to 0.80). At 24 months, the risk for violence-related injury was lower on intervention units, compared with controls (IRR 0.37, 95% CI 0.17 to 0.83). This data-driven, worksite-based intervention was effective in decreasing risks of patient-to-worker violence and related injury.

These scholars pitched the tent of their own study to examine patients to worker violence in the hospital but failed to critically and empirically investigate the causes as to why patients behave in a riotous manner towards their care givers as well as the implications of such violence on the quick recovery of such patients. Hence, this current study succinctly brings to light the major sources of the conflict between the care givers and how it disturbs the psychosocial well-being of patients under their care.

Young and Ki-Kyong (2018) in their own research examined the relationship between types of conflict management style, role conflict, professional autonomy and organizational commitment of hospital nurses, and identified factors influencing organizational commitment. Participants of the study were 165 conveniently selected nurses from one general hospital in Gangwon province. Data were collected from March 28 to April 6, 2018 using self-report questionnaires. The results of their investigation showed that there was a significant difference in the level of professional autonomy and organizational commitment depending on the nurses' styles of conflict management. A statistically significant positive correlation between professional autonomy and organizational commitment was found, and a negative correlation between environmental barriers in role conflict and organizational commitment. Participants' professional autonomy and environmental barriers in role conflict explained 17.9% of organizational commitment. These findings indicate that professional autonomy and environmental

barriers were both very important factors influencing organizational commitment. Accordingly, it is necessary to improve nurses' organizational commitment, enhance autonomy and reduce environmental barriers for nurses performing nursing roles.

This study however, was able to establish the significant relationships between organizational autonomy and commitment and was also able to bring to light the different types of conflict management styles among nurses but failed to establish how conflict between nurses and other healthcare professionals especially doctors can be managed so that the adverse effect of it will not be on the general well- being of patients. Interestingly, this current study covered the gap.

Amiri, (2018) investigated the effects of nurse empowerment program on patient safety culture in a randomized controlled trial. A randomized controlled trial was conducted during April–September 2015 in 6 adult ICUs at Namazi Hospital, Shiraz, Iran. A total of 60 nurses and 20 supervisors were selected through proportional stratified sampling and census, respectively, and randomly assigned to the experimental and control groups. The intervention consisted of a two-day workshop, hanging posters, and distributing pamphlets that covered topics such as patient safety, patient safety culture, speak up about safety issues, and the skills of team strategies and tools to enhance performance and patient safety. Data were collected through a hospital survey on patient safety culture. Eventually, 61 participants completed the study. Data were analyzed using descriptive statistics, independent-samples t-test, paired-samples t-test, and Chi-square test. $P < 0.05$ was considered statistically significant. In the experimental group, the total post-test mean scores of the patient safety culture ($3.46 \pm 0.26$) was significantly higher than that of the control group ($2.84 \pm 0.37$, $P < 0.001$). It was also higher than that of the pre-test ($2.91 \pm 0.4$, $P < 0.001$). Additionally, significant improvements were observed in 5 out of 12 dimensions in the experimental group. However, dimensions such as non-punitive response to errors and the events reported did not improve significantly. Empowering nurses and supervisors could improve the overall patient safety culture. Nonetheless, additional actions are required to improve areas such as reporting the events and non-punitive response to errors.

The authors of this study examined how nurses' empowerment can lead to patients' safety. Apart from been biased for limiting their research to only nurses instead of adding the

doctors, the study failed to bring to light how nurses' collaboration with doctors can lead to more safety and they by improving the psychosocial well-being of patients. This current study addressed the gap.

Taiwo et al., (2018) examined 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 in Ekiti State. 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. 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 centre (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. 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.

Taiwo et al., in their study only investigated the fundamental causes of conflict between doctors and nurses but failed to look at the consequences of the rift on the well-being of the patients under their watch. Hence, this current study bridged the knowledge gap in the body of literature.

Logan and Malone (2018) explored the association between nurses' perceptions and attitudes of teamwork and workplace bullying. A total of 128 nurses in two hospitals in the northeast USA completed three surveys: Attitudes about teamwork survey, Team characteristics survey, and Negative intention questionnaire. A majority of nurses believed that teamwork was an important vehicle for providing quality patient care. Two thirds of

the nurses reported the presence of important variables such as leadership, trust and communication on their teams. Despite these positive perceptions, one third of the nurses reported being bullied and half observed others being bullied. A number of effective team skills were associated with fewer occurrences of workplace bullying.

These two authors examined bullying of nurses and how it affects teamwork with other healthcare providers but ignored how bulling in a complex organization like the hospital could disturb the psychosocial well-being of the patients at the hospital wards but interestingly, this current study looked at that direction to bridge the knowledge gap.

Attia et al., (2019) explored the relationship between conflict and perception of professionalism among nurses working at Kafr Sakr General Hospital. Descriptive correlational design was utilized in their study. A convenience sample of nurses (n=184) was chosen. Two tools used for collect data namely: nursing conflict scale and valiga concept of nursing scale. Findings revealed that the most common types of conflict was intrapersonal followed by disruptive and the lowest type was intergroup (86.9%, 82.2%& 69% respectively). The highest percentage of nurses had high level of conflict (79.6%). Also, the highest percentage of nurses had a higher perception of professionalism (81.5%). Their study concluded that there were statistically significance relation between nurse's perception toward professionalism and level of all conflict types (p=0.01). Therefore, efforts should be made by the nurse managers to occasionally stimulate conflict by promoting different views and motivating staff and unit/department through rewards for their outstanding performance. The subject of professional nursing should be included in the curriculum of nursing education.

Attia et al., limited their study to only nurses' conflict and the perception of professionalism, even as they ignored nurses rivalry with other healthcare providers, they failed to examined the effects of their disagreements on the patients' general well-being in the public hospitals. But this current study bridged the knowledge gap.

Amoah et al., (2019) examined the perceived barriers to effective therapeutic communication among patients and nurses at Komfo Anokye Teaching Hospital, Kumasi. An exploratory study design was employed using a qualitative approach. A purposive sampling technique was used to select 13 nurses and patients who were interviewed using

an unstructured interview guide. Interviews were audio-taped, transcribed verbatim and analyzed using thematic content analysis. Patient-related characteristics that were identified as barriers to effective therapeutic communication included socio-demographic characteristics, patient-nurse relationship, language, misconception, as well as pain. Nurse-related characteristics such as lack of knowledge, all-knowing attitude, work overload and dissatisfaction were also identified as barriers to effective therapeutic and environmental-related issues such as noisy environment, new to the hospital environment as well as unconducive environment were identified as barriers to effective therapeutic communication among patients and nurses at Komfo Anokye Teaching Hospital, Kumasi. The study concluded that nurse-patient communication is an inseparable part of the patients' care in every health setting; it is one of the factors that determine the quality of care. Several patient-related characteristics, nurse- related characteristics and environmental-related issues pose as barriers to effective therapeutic communication at Komfo Anokye Teaching Hospital, Kumasi and have ultimately; resulted in reducing effective communication at the wards. Therefore, all the barriers must be eradicated to promote effective therapeutic communication.

These scholars looked at the communication problems as it relates to prescription between nurses and doctors on patients' ill health while this current study intends to examine doctor-nurse conflict and how it affects the general well-being of patients. This means that this current study filled the gap not covered by these scholars in the body of knowledge.

Tosanloo et al., (2019) carried out a study to identify the causes of conflicts experienced by clinical and administrative staff in hospitals. A cross-sectional study was carried out in 2018. The sample included 320 clinical and administrative staff from six hospitals affiliated to Ardabil University of Medical Sciences that were selected using two-step clustering sampling method. Data collection was accomplished by self-administered questionnaires. Descriptive statistics, t-test, and ANOVA were used for data analysis. Total conflict score revealed that clinical staff had higher levels of perceived conflict than administrative staff. In terms of organizational position, the study results showed a significant difference in the reported conflict between nurse groups and other groups (physicians and paramedical, administrative, financial, and logistic staff).

The most important causes of conflict in the viewpoint of clinical staff were organizational and job characteristics (3.54 ± 1.28), poor management (3.51 ± 1.12), and inefficient communication system (3.42 ± 1.33). For administrative staff, on the other hand, poor management (3.18 ± 1.33), inefficient communication system (3.17 ± 1.36), and attitudes and perceptions (3.06 ± 1.41) were shown to be paramount factors. Clinical and administrative staff of hospitals are like parts of a train track. The irrational relationship between them will result in distortion and lower quality of services. Therefore, effective strategies to decrease staffs' experience of conflict need to be developed. This might create a healthier and more productive work environment which positively affects the care quality.

The authors of this study investigated only the causes of conflict between clinical and administrative staff of hospitals but did not go further to look at the sources of conflict between doctors and nurses and how the rift affects the general well-being of patients under their watch. Hence, this current study bridged the lacuna in the body of knowledge.

Chew et al., (2019) examined the collaboration of nurses and physicians and their perceived barriers to inter professional bedside rounds in Singapore,. A cross-sectional survey was conducted on 371 medical ward-based nurses and physicians from an acute care tertiary hospital in Singapore, using a 27-item Nurse-Physician Collaboration Scale and a 21-item Perceived Barriers to Inter professional Bedside Rounds questionnaire. The overall Nurse-Physician Collaboration scores indicated positive attitudes toward nurse-physician collaboration in bedside rounds, with no significant difference found between nurses and physicians. While the sharing of information was reported to be the most frequent collaborative activity, the cooperative relationship was rated to be the least frequent behaviour. The highest ranked barriers were related to time-related issues. The nurses reported a significantly greater perceived barrier in attending bedside round than the physicians. To optimize nurse-physician collaboration, the study advocates healthcare leaders to foster cooperative relationships between nurses and physicians and to reorganize ward routines to provide designated time periods for nurses to attend rounds.

These authors looked at the collaboration of doctors and nurses as relates with the perceived barriers to inter professional bedside rounds in a nutshell but the study abruptly failed to bring to light how these perceived barriers or obstacles affect the recovery

processes and general well-being of patients under their care in the public hospital facilities. However, this current study closed the gap in the body of knowledge.

Ojo et al., (2020) examined critically the cordiality that exists between doctors and Nurses in the work environment and how this impacts patient care at the University of Benin health services, Benin City. The objectives of this study were to examine the relationship that exists between doctors and nurses in the hospital environment; to ascertain if the type of organizational structure contribute to the kind of relationship among doctors and nurses. This was a descriptive study. Data were collected with the aid of a self-structured five (5) point rating Likert scale format questionnaire, and analyzed using statistical package for social science (SPSS) version 20 which was presented on frequency tables, expressed in simple percentages.

It was revealed that (50.0%) of the respondents disagreed that there is no mutual relationship between doctors and nurses on patient care; Also, (40.0%) of the respondents agreed that superiority of doctors over nurses affect their interrelationship between doctors and nurses on patient care. The results of this study showed that was there is no mutual relationship between doctors and nurses on patient care; there is a role conflict among doctors and nurses on client/patient care. Pride is a factor that mar the interrelationship between doctors and nurses. Mutual understanding should be encouraged among doctors and nurses on client/ patient care. Measures should be put in place to combat any factors militating against interpersonal relationship between doctors and nurses.

This study examined the relationship between nurses and doctors and its impacts on patients' care in the University of Benin, but did not critically investigate the possible conflicts that may ensue out of their cordial relationships and how it affects patients care and general well-being. Hence, this current study addressed the knowledge gap in Kogi State public hospitals.

Ilo et al., (2020) in their own study identified specific job characteristics and their influence on work-family conflict among nurses working in the teaching hospitals in Anambra State. Descriptive survey design was adopted for the study, as a proportionate sampling technique was used to select 257 nurses from the two teaching hospitals in Anambra State. The instrument for data collection was work-family conflict instrument,

and Work-design questionnaire which was adopted, modified and revalidated. The data generated was statistically analysed using Kruskal-Wallis and Spearman correlation with the aid of Statistical Package for Social Science (SPSS) version 23. Results stated that high level of work-family conflict was reported by nurses. Average number of patients served per day and workload influenced work-family conflict positively with a p-value of 0.044 and 0.00, respectively. Workload and average number of patient served per shift are the job characteristics that influence work-family conflict. Therefore, workload of nurses should be analyzed critically and the review of nurses workload for further adjustments so as to increase their productivity both at work and home.

These scholars only looked at specific job features and its influence on work-family conflict but did not extend their search to how the job characteristics such as work load affects the overall well-being of the patients under the nurses' care. Interestingly, this current research work covered the gap in the body of knowledge.

Adim et al., (2020) carried out a study to examine conflict management and performance of healthcare professionals in Teaching Hospitals in Rivers State. The study used a cross sectional research design involving medical doctors, nurses, medical laboratory scientists and pharmacists in University of Port Harcourt Teaching Hospital and Rivers State University Teaching Hospital. A Multi-stage sampling was employed to select 165 healthcare professionals from both hospitals. The reliability of the instrument was achieved by the use of the Cronbach Alpha coefficient with all the items scoring above 0.70. The hypotheses were tested using the Spearman's Rank Order Correlation Coefficient with the aid of Statistical Package for Social Sciences version 23.0. The tests were carried out at a 95% confidence interval and a 0.05 level of significance. Results from analysis of data revealed that conflict management significantly predict performance of health care professionals in Teaching Hospitals in Rivers State. The study recommends that health care professionals' collaboration should be adopted in Teaching Hospitals. This includes sharing of patient information, joint participation in the care and in the decision-making process, and degree of cooperation, must be carefully scrutinized and implemented with the added input of nurses, physicians and other paramedics.

While Adim et al., (2020) were able to examine workplace conflict management and performance of healthcare professionals, yet they woefully failed to investigate how

effective conflict management can influence quick recovery of patients' ill health and not only influencing the performance of healthcare professionals bearing in mind the effects of their conflict on the psychosocial well-being of patients in the hospital ward. Albeit, this current study succinctly brings to light how effective doctor-nurse conflict management can improve on the overall well-being of the patients under watch.

Suleiman and Martyn (2020) examined teamwork, professional identities, conflict, and industrial action in Nigerian healthcare. Focus Group Discussions and In-Depth Interviews were conducted with nurses, doctors, and medical laboratory scientists who work in multi professional settings giving a total of 41 participants. Results were analyzed within the framework of the social identity theory. Results and conclusions: The dominant themes that emerged as barriers to teamwork include professional hierarchy, role ambiguity, and poor communication. At the same time, the health sector leadership and remuneration were the main themes concerning industrial actions. The salience of professional identities was also demonstrated, providing a link between inter professional conflict in the workplace and competitive industrial actions by trade unions representing health professionals. The implications for educational and clinical practice and the need for inter professional education are discussed.

This study carried out by Suleiman and Martyn (2020) employed only qualitative methods. Though the findings of their study was elaborate but employing quantitative method or both and covering more participants would have made their findings more generalizable even though they did not care to look at the effects of teamwork and professional conflict among healthcare professionals on the general wellbeing of patients under care.

In the same vein, Emelda (2020) researched into the inter-professional relationships and disputes between nurses and doctors in tertiary health institutions and discovered that the causes of the conflict were inequalities in pay and tasks given to the two groups. This researcher found that the main causes of confrontations between nurses and doctors at work were salary disparities and doctor views about nurses. He went on to say that because they were caught in the middle of the fights between these two groups, the patients experienced abandonment and neglect. Well, this scholar focused on one sided causes of conflicts without looking at other sides of the rivalry such as the quest for relevance and dominance and how patients place more importance on doctors more than nurses among

other innate causes which would be critically looked at in this current study. Moreover, Emelda (2020) ignored to find out how the confrontations between doctors and nurses affect the patients' overall well-being in the hospitals. Hence, this current study filled the knowledge gap in the body of literature.

Olaopa et al., (2020) explored the issue of conflict and conflict resolution among Early Careers Doctors in Nigeria, in a bid to elicit information on the causes, consequences, perpetrators and victims, a qualitative study, using Focus Group Discussions (FGD) was adopted to explore information on conflict and conflict management among purposively selected key respondents (n = 14) from seven tertiary hospitals in Nigeria. The respondents were ECDs who were leaders and representatives of other ECDs in their various hospitals. Two FGDs were conducted. The result showed that conflict is inescapable in clinical settings and occurred at different levels. The perpetrators are varieties of health workers, and most are task-related conflicts, although there are relational ones. The conflicts with the government on labour-related issues are also frequent. The lack of job description and specification and power struggle among others were highlighted as the drivers of conflicts between ECDs and other health-workers. The findings of the study were discussed, and suggestions were made to reduce its effect, which will require structural solutions to mitigate at different levels and the diverse players in the health sectors.

Although, these scholars succeeded in exploring the issue of conflict and conflict resolution among early career doctors, they did not delve into the consequences of conflict among doctors on patients' healthcare and how conflict resolution can influence patients' recovery from ill health. Albeit, this current study took a different dimension in dealing specifically with doctor-nurse conflict and the overall well-being of patients in public hospitals.

Following the same trend of thought, Kuye and Akinwale (2021) investigated the conundrum of bureaucratic processes and healthcare service delivery in government hospitals in Nigeria. The authors surveyed 600 outpatients and attendees visiting tertiary and government hospitals in Nigeria using descriptive design to obtained data from the respondents. The questionnaire instrument was used to gather data. Out of the 600 outpatients visiting the 20 hospitals in government and tertiary hospitals, 494 responses were returned from the attendees. The study employed random sampling strategy to collect

the information. The findings of this study were that service delivery in government hospitals were in adverse position on all the four constructs of bureaucratic dimensions as against quality of service delivery in Nigerian hospitals. It discovered that bureaucratic impersonality cannot impact on the quality of service delivery in government hospitals in Nigeria. Separation and division of labour among health workers have no significant effect on quality service delivery in government hospitals. Formal rules and regulations (administrative procedure, rules, and policies) prevent quality service delivery in government hospitals in Nigeria. Also, patient's waiting time was not significant to the quality of service delivery in government hospitals.

Though Kuye and Akinwale (2021) were able to critically examine the conundrum of bureaucratic process and healthcare service in public hospitals but did not specifically identify the problems of bureaucracy and how it affects effective healthcare delivery to patients bearing in mind the overall well-being of patients under care. Hence, this current study to covered the gap in the body of knowledge.

Jemal et al., (2021) assessed nurse–physician communication in patient care in public hospitals of Harari Regional State and Dire-Dawa city administration, Eastern Ethiopia. Multicenter-mixed methods (a quantitative cross-sectional and phenomenological qualitative) were conducted from March 07 to April 07, 2019 in public Hospitals of Eastern Ethiopia. A total of 440 nurses and physicians working in public hospitals in the Harari Regional State and Dire-Dawa administration were enrolled in the study. Participants were approached through a simple random sampling technique. Data were collected using a pretested, self-administered questionnaire and entered into Epi-Data version 3.1, and exported to STATA software (version SE 14) for further analysis.

Descriptive statistics were carried out using frequency tables, proportions, and summary measures. Multivariable logistic regression analysis was carried out to identify the true effects of the selected predictor variables on the outcome variable after controlling for possible confounders. Statistical significance was declared at p-value <0.05. Qualitative data were collected from 10 key informants using a semi-structured questionnaire and analyzed using statistical software, Open Code (version 4.2) by thematic analysis method. Overall, the magnitude of the level of nurse–physician communication in patient care was found to be 53.2% [95% CI (48.9–58.0)]. In the final model of multivariable analysis,

being in the age group of 31–40 [(AOR=0.42, 95% CI (0.25–0.72)], ever married nurse or physician [(AOR=2.28, 95% CI(1.41–3.69)], being a nurse professional [AOR=2.36, 95% CI (1.23–4.54)], a salary class of 2250–3562ETB [(AOR=0.25, 95% CI (0.08–0.84)], higher score for organizational related factors [(AOR=0.58, 95% CI (0.36–0.92)], and higher score for work-related attitude behaviours [(AOR=0.62, 95% CI(0.39–0.984)] were factors independently associated with the poor level of nurse–physician communication in patient care. In the qualitative findings, unattractive working environments and negative attitudes of professionals were found to be barriers to nurse–physician communication in patient care.

The study concluded that nurse–physician communication in patient care was relatively low because more than half of the level of nurse–physician communication was found to be poor. Increasing in age, getting a lower monthly salary, higher report for work-related attitude, and organizational related factors were the potential predictors that would decrease the good level of nurse–physician communication in patient care. This result provides cue due attention to improving nurse–physician communication in patient care through various techniques.

These scholars were able to look at the trend of doctors-nurse communication as it relates to patient healthcare but did not clearly bring to light how communication breakdown between doctors and nurses affect patients' healthcare and general well-being in the hospitals. Hence, this current study bridged the gap in the body of literature by unearthing how communication breakdown can result in doctor-nurse conflict.

Boloya & Tawari (2021) carried out a study to determine the perceived influence of doctor-patient relationship on effective healthcare delivery in some Health Facilities in Ogbia Local Government Area of Bayelsa State. A descriptive cross-sectional study design was conducted among patients in Federal Medical Center, Otuoke, General Hospital, Kolo and Cottage Hospital, Otuasega, all in Ogbia Local Government Area of Bayelsa state. Data collection was carried out using both self-administered and interview administered questionnaire. 138 patients were selected for the study. An average of 20 interviews was conducted per clinic day. Results of the study showed that majority of patients interviewed agreed that their relationship with the doctor is important in treatment outcome and were involved in making treatment decisions and were satisfied with the services received from

their doctors. Many of the patients were satisfied with the level of doctor patient relationship.

This study only investigated doctor-patient relationship as it relates to effective healthcare service delivery but did not specifically bring to light how the relationship influence patient healthcare and general well-being in the hospital. Albeit, this current study bridged the gap in the body literature.

Alimba and Jafaru (2021) assessed conflict dynamics and management strategies of student nurses in government hospitals in Adamawa State, Nigeria. A descriptive survey design was adopted and a sample of 160 student nurses was selected through random sampling technique. A self-structured questionnaire titled "Student Nursing Conflict Questionnaire" (SNCQ) was used to elicit primary data. Data collected were analysed with frequency counts, percentage and standard deviation. The study discovered that the majority of student nurses frequently encountered conflict (50.6%) in hospitals and they often perceived it as something bad (70.6%). Also, the major types of conflict often experienced by student nurses were "nurse-student nurse conflict" (NSC) (36.9%) and "patient relatives-student nurse conflict" (PRSC) (36.9%). The main causes of these conflicts were lateness to the hospital (=3.375) and unclear definition of responsibilities between student nurses and other auxiliary health workers (=3.338).

Furthermore, the main consequences of conflict on student nurses were lowering their productivity (=3.550) and discouraging effective training of student nurses (=3.569). The conflict management styles often adopted by student nurses were collaborating style (=3.153) and accommodating style (=3.025). Based on these findings, it was recommended that medical peace education should be promoted in all ramifications in health establishments in order to help those that wish to become health practitioners such as student nurses as well as those already practicing in the field to understand conflict behavioural dynamics for constructive mitigation to enhance their productivity and healthcare service delivery.

The study carried out by these scholars only assessed conflict dynamics and management strategies of student nurses in government hospitals and its consequences on the nurses but

did not bring to light the impacts of it on patients' healthcare and general well-being in the hospital. Meanwhile, this current study filled the gap in the body of knowledge.

Sardar et al., (2021) also assessed the reasons for conflicts in tertiary healthcare hospital in Rawalpindi in a cross sectional study comprising of hospital staff, health administrators, clinicians, nurses and paramedics working in tertiary care hospital Rawalpindi were included in the study. These questions were asked to assess the general understanding of the respondents regarding the subject of conflicts to deduct their possible response in conflict situations. As per "Traditional" view conflict was considered as dysfunctional, destructive and irrational. The "Human relations view" describes conflict as natural, suggests tolerating it whereas the latest "inter-actionist view" defines conflict as a means for keeping us viable and creative, and suggests encouraging it. Average 44% of the respondents, mainly administrators and clinicians have fair idea regarding current concept of conflict. Clinical and administrative staffs of hospitals are like parts of a train track. The irrational relationship between them will result in distortion and lower quality of services. Therefore, effective strategies to decrease staffs‟ experience of conflict need to be developed. This might create a healthier and more productive work environment which positively affects the care quality.

Although, these scholars were able to reveal the causes of conflict in tertiary healthcare as well as how it lowers quality of service delivery to patients but left a vacuum of how the conflict affects the psychosocial well-being of patients to be filled by this current study.

Mohammed et al., (2022) carried out a study to provide an in-depth understanding and a clearer insight into the causes of conflict in the Nigerian health sector. A qualitative strategy was employed using a semi-structured interview approach. Data were obtained from health practitioners from diverse backgrounds in various healthcare facilities. The phenomenon of conflict was reported as a long existent and trans-generational strain on inter-professional relationships occurring in all sectors of health practice, primarily between the physicians and other health care professionals. Inter-professional conflict was reported to emanate primarily from lapses in leadership, remuneration structure, role description, communication and emotional intelligence. This has affected the effectiveness of the Nigerian healthcare system and has contributed to hindrance in the provision of high-quality care in the country. Evidence from this study can help in developing

contextual policy in addressing inter-professional conflict in the health sector, and this will consequently improve health care delivery in the country.

It has been established by Muhammed et al., (2022) that conflict among healthcare professionals is inimical to effective quality care in the healthcare system but did not find out how the conflict negatively affect the general well-being of patients under the care of nurses and doctors but however, this current study bridged the gap in the body of literature.

Alshehry (2022) examined nurse–patient relatives' conflict and patient safety competence among nurses in Saudi Arabia. This descriptive and cross-sectional study surveyed 320 nurses in Saudi Arabia using the "Healthcare Conflict Scale" and "Health Professional Education in Patient Safety Survey" from December 2019 to January 2020. The subscale "mistrust of motivations" was perceived to have the greatest conflict, whereas "contradictory communication" was rated as the lowest conflict. A significant difference was observed between the perceived conflict and the different hospital units where nurses worked. Saudi nurses reported higher nurse–patient/family conflicts than Filipino and Indian nurses. The highest PS competence was reported in "communicating effectively," whereas "working in teams with other health professionals" had the poorest safety competence. The nurses' perceived "mistrust of motivations" and "contradictory communication" were associated with poorer self-reported PS competence. Perceived conflicts between nurses and their patients/relatives had negative association with the perceived confidence of nurses in the difference patient safety competencies. The results can become the basis for formulating hospital policies geared toward the elimination of healthcare conflicts to help ensure the patient safety competence of nurses. Policies on mitigating conflicts between healthcare workers and patients/relatives must be created and implemented.

The author of this research actually succeeded in examining nurse–patient relatives' conflict and patient safety competence among nurses but did not investigate how the cordial relationship between nurses and patients can influence patients' healthcare and overall well-being in the hospital. Albeit, this current study carried out this study in that regards to bridge the knowledge gap.

Nwobodos et al., (2022) designed a study to identify if inter professional conflicts existed among healthcare teams in health institutions in South-East Nigeria, and to explore their nature, causes, identify the extant resolution mechanisms as well as feasible mechanisms to mitigate the conflicts. The aim was to enhance the functionality of health teams for an overall better patient care outcome. An online questionnaire survey collected data from 58 health healthcare professionals in four healthcare settings in the South-East of Nigeria. Quantitative and qualitative analyses were conducted resulting in seven central themes of conflict. The paper adopted narrative qualitative survey tools to survey a cohort of healthcare professionals who have practiced for varying periods. This study investigated the existence, or otherwise, and nature of the conflicts within health teams, probes the most at conflict as well as approaches being used in conflict resolution. Many institutional conflicts exist among the healthcare teams. There are several conflict resolutions approaches that are being employed to resolve the conflicts. Most resolutions are simply the avoidance approach. Many of the conflicts potentially affect patient care out comes but these are issues that could be resolved on a permanent to semi-permanent basis at local levels whilst others are broader institutional issues that will require external fixes. There is a need to improve on the team process for healthcare professional early and systematically. Key or essential steps for doing this based on the importance of continued attentions to better patient care approaches are provided in this paper.

It is a fact that Nwobodos et al., (2022) carried out an elaborate study in this regard but a critical look at the dimensions that they took revealed that the effects of healthcare inter professional conflict on patients' healthcare and general well-being is abruptly missing in their study and that as well constitute a gap covered by this current study.

Mutair et al., (2022) examined the quality of nursing work life (QNWL) among nurses working in Saudi Arabia and to determine the association between demographic variables and quality of work life among nurses. Methods: It was a cross-sectional design using Brooks’ quality of nursing work life survey. It was distributed among nurses over the kingdom of Saudi Arabia. There were 860 nurses participating in the study. The mean total score for the participants was 174.5+/− 30.3, indicating moderate to high QNWL. The highest score achieved by the nurses was for the work world context (4.29) while the lowest score was for work design dimension (3.92). The study revealed that nationality,

income, and shift duration, having a dependent person, and having family accompany the nurse as significant factors affecting the quality of work life among the nurses. A contribution of the study was that the demographic characteristics of the participants, including nationality, income, having family accompany the nurse, having an independent child, or spouse or parents, and shift duration, tended to have a statistically significant correlation with QNWL. The comprehensive results of this study have practical implications whereby authority bodies can create regulatory plans for enhancing satisfaction and performance over the sole utilization of job satisfaction measurements and can thereby improve nurses' retention and turnover rates.

This research was limited to studying only the quality of nursing work life but did not find out the relationship between the quality of nursing work life and the quality of patients healthcare. Meanwhile, this current study addressed that and even found out how the quality of nursing work life influences the general well-being of patients in the hospitals.

Adeyemo et al., (2022) examined nurses' perception of patient safety incident and the impact of workload in Ondo State, Nigeria. In this study, perceptions of nurses in Ondo state, Nigeria regarding the patient safety incidents; the need for establishing patient safety incident, the processes of patient safety incident, and factors that can impede successful implementation of patient safety incident were examined. The study was a cross sectional descriptive survey that employed quantitative method. The study population comprised of 260 nurses working in the hospital. The researcher purposely selected 100 nurses as study participants. The questionnaire used was self-explanatory, researcher-developed and divided into nine sections. The instrument was subjected to face and content validity. Internal consistency method was used to determine the reliability of the instrument. The reliability index was calculated using Cronbach's Alpha which yielded reliability coefficient value of 0.798. Descriptive statistics was used to answer the research questions.

The results of the study suggest that nurses perceive the culture in public hospitals of Nigeria to be castigatory and that individuals are not comfortable in reporting errors. Gynaecology and maternity ward was most represented of the nurse respondent with 41%. The highest qualification obtained by the respondents was Master of Science in nursing (5%) while majority of the participants have Bachelor of Science in nursing (61%). The participants perceived that the culture of patient safety in public hospital should be a

priority. Uncomfortable in reporting errors (62%), and that workload interferes with their ability to practice patient safety (62%). The barriers stated by the participants include; too much workload and stress is the top barrier to patient safety incident. Most nurse participants acknowledged the need for patient safety incident. Considering these obstacles to patient safety incident, a pragmatic approach is needed for successful establishment of patient safety incident.

These scholars assessed nurses' perception of patient safety incident and the impact of workload. Apart from the narrowness of the topic, the authors did not specify how nurses' perception of patients' safety can influence patients' healthcare and general well-being in the study area. And moreover, utilizing qualitative methods in addition to the quantitative method used would have made the findings more elaborate and generalizable. However, the current study covered the gap not covered by these current studies.

Park and Kang (2022) investigated the effects of role conflict and professional autonomy on the role performance of patient safety coordinators in small and medium-sized hospitals in Korea. The participants in this cross-sectional study were 121 patient safety coordinators in general hospitals or hospitals with more than 100–300 beds. Data were collected through an online survey for about three weeks in February 2022. The variables were role conflict, professional autonomy, and role performance. In the data analysis, we employed the t-test, ANOVA, correlation, and multiple regression methods. Almost all (99.2%) of the participants were nurses. The lower the role conflict and the higher the professional autonomy, the better the role performance shown. As a result of analyzing the factors affecting role performance, the regression model was found to be significant ($F = 6.988$, $p < 0.001$). The most influential factor in role performance was professional autonomy ($\beta = 0.279$, $p = 0.002$). In conclusion, it is thought that systematic education and legal and institutional arrangements for independent roles and work regulations are needed to strengthen patient safety coordinators' competency in small and medium-sized hospitals in Korea. This will improve the role performance of patient safety coordinators and create a better patient safety culture.

These authors did not find out how role conflict and professional autonomy among healthcare providers in the hospital can influence the general well-being of patients in their

cross sectional survey but meanwhile, this current study bridged the gap in the body of knowledge.

Mohammed (2022) examined the knowledge, causes, and experience of inter professional conflict and rivalry among healthcare professionals in Nigeria. A cross sectional study was undertaken to administer questionnaires to healthcare personnel in various healthcare facilities in Nigeria. Data were analysed using Statistical Package for Social Sciences. A total of 2207 valid responses were received, and male participants were in majority as indicated by 63.7% of the sample. Collectively, doctors and pharmacists represented two-thirds of the sample, and majority of the participants were in the public sector (82.5%). Disparity in salary structure was the highest source of conflict. Whilst almost all the participants indicated that inter-professional rivalry and conflict are prevalent in health sector, about three-quarters of them (73.2%) disagreed that this practice is productive. A considerable number of the respondents had experienced inter-professional conflict and rivalry. Evidence from this study can help policymakers in developing framework that can be utilised in addressing rivalry and conflict in the healthcare sector.

Though, the author was able to examine the knowledge, causes, and experience of inter professional conflict and rivalry among healthcare professionals in Nigeria but did not as well investigate how inter professional conflict will affect or influence patients' healthcare and general well-being, albeit, this current research work bridged the knowledge gap.

Kim et al., (2022) verified the impact of nurse–physician collaboration, moral distress, and professional autonomy on job satisfaction among nurses acting as physician assistants. Descriptive and correlational research was conducted on a convenience sample of 130 nurses from five general hospitals in South Korea. In the final regression model, the adjusted R square was significant, explaining 38.2% of the variance of job satisfaction ($F = 8.303$, $p < 0.001$), where ‘cooperativeness’ ($\beta = 0.469$, $p = 0.001$) from nurse–physician collaboration, ‘institutional and contextual factor’ from moral distress ($\beta = -0.292$, $p = 0.014$), and professional autonomy ($\beta = 0.247$, $p = 0.015$) were included. In hospital environments, a more cooperative inter-professional relationship between nurses and physicians led to less moral distress caused by organisational constraints. A higher level of professional autonomy among nurses acting as physician assistants is required to increase their job satisfaction.

Likewise, as relevant as the study carried out by these scholars are, they unavoidably neglected to find out how doctor-nurse collaboration and moral distress negatively affect patients' healthcare and general well-being. Meanwhile, this current study bridged the knowledge gap.

Amarneh and Nobani (2023) investigated the relationship between physician-nurse collaboration and patient safety culture and compares patient safety culture levels between Jordanian hospitals from different sectors. In addition, examined differences in patient safety culture levels according to the position of health care providers (i.e., nurse managers, RN, and physicians). A descriptive, cross-sectional design using a self-administered questionnaire was used for the current study. Data were collected between February and May of 2019. Four different hospital settings in Jordan (University, not-for-profit, private and governmental hospitals) were selected. In addition, we recruited a convenience sample representing registered nurses, nurse managers, and physicians at the selected hospitals. Measurements Three self-administered questionnaires were used to collect data for the current study: Demographic Data, Collaboration and Satisfaction about Care Decisions (CSACD), and Hospital Survey on Patient Safety Culture version 1.0 (HSOPS). Data were screened for errors in data entry, outliers, or missing values.

Data were normally distributed without extreme outliers. The study used descriptive statistics, the Pearson product-moment correlation, one-way ANOVA, and the Chi-square tests were used in this study.). The level of significance (alpha value) is set at 0.05. Results showed that physician-nurse collaboration had a significant positive relationship with all patient safety culture levels ($P< 0.01$). In addition, the Pearson's product-moment correlation coefficient results indicated that all patient safety culture scores and subscales were positively and significantly correlated with physician-nurse collaboration ($P<0.01$). Furthermore, the results of one-way ANOVA showed a statistically significant difference in the overall perception of patient safety culture according to the position of participants ($P< 0.01$). Moreover, Participants in Not-for-Profit Hospitals were more likely to report an ‘excellent/very good’ patient safety grade ($P <0.001$) than in other hospitals. They concluded that physician-nurse collaboration positively impacts overall patient safety culture grades. Healthcare organization in Jordan has the potential to increase levels of patient safety cultures; however, to achieve this aim, there should be a stronger focus on

building effective inter-professional collaboration and building a blame-free culture among healthcare providers, and these organizations should receive the needed support from health care leaders in the country. To help strengthen the health care system, raise patient safety culture levels, and improve quality.

Meanwhile, this study carried out by Amarneh and Nobani (2023) on the relationship between physician-nurse collaboration and patient safety culture was one sided in scope and they did not attempt to find out the disagreements that may ensue from doctor-nurse collaboration and how it can affect the overall well-being of patients under their watch. Hence, this current study addressed the gap in the body of knowledge.

Adigwe et al., (2023) carried out a study aimed at articulating contextual strategies to mitigate and prevent inter-professional conflict among healthcare workers in Nigeria. A cross sectional study was undertaken in various health facilities in Nigeria. Questionnaires were administered to healthcare professionals. Completed questionnaires were analysed using Statistical Package for Social Sciences. Descriptive and inferential statistical analyses were undertaken. A total of 2207 valid responses were included for analysis. Findings revealed that almost all the respondents (92.9%) indicated that the Ministry of Health has a key role in resolving conflict in the healthcare sector. Close to three quarters (70.4%) of the study participants disagreed that leadership of hospitals and health agencies be limited to a particular profession. Almost all the participants (90.15%) indicated that cognate administrative expertise and experience are critical for leadership. A strong majority of the sample (93.5%) opined that reforms are required in the leadership selection process of hospital and other healthcare agencies. Due to the criticality of this issue to patients' access to healthcare, findings from this study can underpin a proactive evidence based strategy that can comprehensively address inter-professional conflict among healthcare workers in Nigeria.

Although as captivating as the study carried out by these authors are on articulating strategies to mitigate and prevent inter-professional conflict among healthcare workers in Nigeria. They didn't go further to bring to light how mitigating and preventing inter-professional conflict probably among doctors and nurses could influence effective patients' healthcare in the hospital. But interestingly, this current study bridged the gap not covered by these scholars.

Konlan et al., (2023) examined the influence of conflict among clinical care professionals on patient care in the Tamale Teaching Hospital (TTH). This qualitative cross-sectional descriptive study collected data from clinical care professionals through homogenous focus group discussions in the TTH. This tertiary care facility is the only teaching hospital that serves the five regions of the northern sector of Ghana and is in the eastern corridor of the Tamale metropolis. The focus group sessions were audio-recorded and transcribed verbatim. Data analysis was done using thematic analysis that employed three interrelated stages of data reduction, display, and drawing of conclusions, with Nvivo software. Conflict was described as an almost normal occurrence in complicated healthcare settings like the TTH. Personal and family problems, misunderstanding of medical jargon, a sense of being subdued, ambiguity of job descriptions of health workers, and improper dissemination of information were factors that led to conflicts in the hospital. The positive influences were that conflict ensures people comply with institutional rules and policies and promotes creative thinking. The negative consequences of conflict include the frustration of team members, poor patient care, and poor job output. Prompt and pragmatic measures must be instituted to alleviate hospital conflicts and mitigate their negative influence. A conflict alleviation committee that is fair, just, and prompt must be established to reduce the impact of conflict.

Although, Konlan et al., (2023) succeeded in investigating how conflict among healthcare professionals can influence patients' healthcare, however, they left the side of how the conflict can negatively affect the general well-being of patients in the public hospital, and that is the gap that this current study covered in the body of knowledge.

Sabir et al., (2023) measured the impact of nurse's workplace bullying on patient's quality of care with the mediating role of workplace deviance. Data was gathered from nurses in primary healthcare hospitals in Sahiwal and Faisalabad divisions of Punjab, Pakistan. The sample size was taken from a population comprising 1255 nurses through Krejcie and Morgan calculation formula and the final sample size was based on 254 nurses. Statistical analysis was performed through SPSS (v-26) software. Constructs reliability and validity were analyzed through Cronbach's alpha value which was above 0.90. The results confirmed that workplace bullying has a significant positive influence on workplace deviance and workplace deviance has significant negative influence on patient's quality-of-

care. Moreover, workplace bullying has a negative influence on patient's quality-of-care and workplace deviance mediates the relationship between workplace bullying and patient's quality of care.

These were able to establish from their study that workplace bullying has a significant positive influence on workplace deviance and workplace deviance has significant negative influence on patient's quality-of-care but did not take into cognizant the general well-being of the patients during workplace bullying. But notwithstanding, this current study addressed that vacuum in the body of knowledge.

Omole (2023) explored the effects of workplace bullying and burnout on job satisfaction among nurses in Sokoto State. The study employed a descriptive cross-sectional survey design. Self-administered questionnaires were used to collect data from 300 respondents, using a stratified random sampling technique. The choice of this method was to ensure that the sample was representative of the population, with adequate representation from different demographic groups. Participation in the study was voluntary, and all respondents were informed about the purpose of the study, their right to refuse or withdraw at any stage, and the confidentiality of their responses. Informed consent was obtained from all participants. The study sample consisted of 300 nurses, predominantly females (93.67%) aged between 30 and 49 years old (48.00%) with more than ten years of nursing experience (66.33%). The results indicated that a high frequency of bullying behaviours was reported, including intimidation (26.00% always, 53.67% often), malicious rumours (30.67% always, 56.00% often), and unfair treatment (41.66% always, 50.33% often). Reports of burnout were also common with feelings of being drained after work (43.00% always, 51.00% often) and work-life balance skewed towards work (72.33% yes).

A significant proportion of nurses were unsatisfied or very unsatisfied with their jobs (38.00%, 22.67% respectively), particularly regarding recognition for their work and pay and benefits. A majority (69.00%) felt that workplace bullying and burnout negatively impacted their job satisfaction. The findings underscore the urgent need for organizational and policy interventions to mitigate workplace bullying and burnout among nurses in Sokoto State, Nigeria, and their significant impact on job satisfaction. Despite these challenges, an overwhelming majority (91.67%) would still recommend nursing as a profession to others, indicating a resilient commitment to the profession.

Unlike the study carried out by Sabir et al., (2023), Omole (2023) looked at workplace bullying in another dimension by relating it to job satisfaction among nurses. But how can nurses be satisfied if the patients' overall wellness are at stake. So, to balance up the study, this current research work intends to interrogate doctor-nurse confrontations and patients' overall well-being in the public hospitals.

Feyisara (2023) examined service delivery by bureaucrats in accident and emergency units of selected hospitals in Ekiti State. The author employed both primary and secondary sources. The author got its primary data through structured in-depth interview with the medical staff, administrative staff and patients of the selected hospitals on bureaucratic procedures adopted in the management of patients in their Accident and Emergency unit of the hospitals. The secondary data was from government publications, journals and articles. Data from the interview were qualitatively analyzed using content and discursive analysis to understand the trend of bureaucratic procedures and quality of healthcare services in Ekiti State. The study found that bureaucratic tendencies in the healthcare system have been a cog in the wheel of speedy care of patients.

The cost and volume of bureaucratic directives has reduced the confidence of patients in public hospitals. The study therefore recommended that emotional intelligence training should be given to all healthcare employees. This will entail awareness and understanding of emotions and applying them to behaviour and decision making in the hospitals, government partnership and collaboration with foreign organizations should be encouraged in order to improve on the quality of service given in the Accident and Emergency unit of Nigeria Hospitals.

Feyisara (2023) was successful at examining how bureaucracy affects service delivery to patients in public hospital but only revealed to us that bureaucracy has made patients lost confidence in public hospitals but did not specifically find out how bureaucracy occasioned by the psychology of waiting could distort the general well-being of patients in the hospitals but this current study also bridged the knowledge gap.

Okafor (2023) on the other hand assessed the effects of hospital bureaucracy on the effective implementation of National Health Insurance Scheme (NHIS) in FCT, Abuja. The study adopted neo-bureaucratic theory which de-emphasized the harsh effects of the

Weberian bureaucratic theory as theoretical framework. The survey study utilized questionnaire instrument to elicit data from Health workers and NHIS enrolees in nine health institutions spread across four Area Councils in Abuja, namely, AMAC, Gwagwalada, Kuje and Kwali. The data were analyzed using Statistical Package for Social Science (SPSS). The study observed that inefficient bureaucracy affects the effective implementation of NHIS in FCT to a high extent. The study concludes that hospital bureaucracy affects the effective implementation of NHIS in the FCT and the views of NHIS enrollees and health workers vary significantly regarding it. It recommended among other things that NHIS documentation processes in the health facilities should be done prior to falling ill and coming to access care. Though Okafor (2023) looked at bureaucracy and how it affects NHIS, this current study looked at how it affects the general well-being of patients in the public hospitals.

Alharbi et al., (2023) assessed patients' satisfaction with the nursing care quality during their hospitalization in two provinces of Saudi Arabia (Riyadh and Medina). A quantitative cross-sectional descriptive design was employed for the study. A convenience sample of 238 patients were recruited from hospitals in two provinces in Saudi Arabia. Patient satisfaction was measured by the Arabic version of the Patients' Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ-Ar). Significant differences were found between Saudi provinces regarding the overall quality of nursing care ($M=4.65$, $p < 0.001$). The study revealed mean significant variations between patient satisfaction with nursing care and socio-demographic factors, including age ($p=0.002$), education level ($p=0.047$), marital status ($p=0.017$), employment status ($p = 0.038$), urban vs. suburban residence ($p=0.006$), length of hospitalization ($p=0.001$), and accompaniment by a family member ($p=0.014$). The study concluded that improving patients' experience during their hospitalization requires regular examination of the quality of nursing care services.

A critical look at this study carried out by Alharbi et al., (2023) overlooked the factors that could lead to patients' dissatisfaction about the care provided by the nurses and how conflict in between doctors and nurses could affect the general well-being of the patients under their watch. Hence, this current study took that route in order to cover the knowledge gap in the body of literature.

Carvalho et al., (2023) analyzed violence in the nursing professional workplace in the context of primary health care in Brazil. It was a qualitative study with theoretical and methodological reference to institutional analysis. It was carried out in basic health units in Brazil. Nursing professionals (N=11) participated in semi-structured interviews and discussion groups, in addition to a research diary and participant observation. Data collection took place from October to December 2021. The results are presented in five categories: types of violence and aggressors from the perspective of nursing professionals; the causes of violence reported by professionals; strategies for the management of violence; professionals' proposals for preventing violence in health contexts; the consequences of violence in the workplace. Nursing professionals make up a large part of the workforce and have reported verbal, physical, moral, and psychological violence. The main causes are associated with user access to services. For the prevention of violence, professionals do not see themselves as protagonists of change. The consequences are the loss of quality of work and the health of professionals who requested sick leave and transfers. The study's findings can help in the development of public policies and educational and management actions.

Although these scholars confirmed the manifest presence of violence in the nursing profession, they abruptly overlooked how workplace violence in the hospitals could affect patients overall healthcare and general well-being. However, this current study looked in that direction to bridge the knowledge gap.

Balami et al., (2023) carried out a study to identify causes and effects, and proffer ways to salvage the prevailing circumstance that leads to conflicts amongst professionals for smooth delivery of health care services in Borno State. A sample of 393 health care personnel were derived from the total population of 5000 health personnel using sample size electronic calculator. However, a hospital based cross-sectional study which employs interviewer administered structured questionnaire was conducted in University of Maiduguri teaching Hospital, State Specialist Hospital and Umar Shehu Ultra-Modern Hospital Maiduguri, simple random sampling technique was adopted in questioners administered to the target respondents. Data generated were analysed using SPSS version 6, frequency tables were used to describe the findings of the study. Findings revealed that majority of the respondents agreed that personality differences, indistinct job margins,

battle for limited resources, decision-making and interdepartmental competition are major causes of Inter-professional conflict among healthcare workers which impact patient's over all wellbeing and poor outcomes, quality of care and high cost of care delivery. It was recommended that causes of inter-professional conflict among healthcare workers in Maiduguri which is multifactorial require discipline to be inculcated amongst workers, such could be optimized and encourage a work-together attitude toward a shared goal that focuses on the patient's welfare which reflect effective service delivery.

Balami et al., (2023) was able to establish the causes and effects, and way out of conflicts amongst healthcare professionals but did not specifically examined how the conflict between care givers can negatively impact on the general well-being of patients in the public hospitals. But this current study examined the direction in order to bridge the knowledge gap.

Elom et al., (2024). Investigated the prevalence and factors associated with workplace violence in a tertiary healthcare facility in South East Nigeria. Cross-sectional study was conducted at a Teaching Hospital in Abakaliki, Ebonyi State, for 4 weeks in 2020 among 205 employees. The hospital was stratified into Clinical, Nursing Services, Pharmacy, Laboratory, and administrative divisions; proportionate allocation and random sampling were used to select the allocated samples. A structured questionnaire was used to collect data. Descriptive statistics determined the measures of central tendencies and dispersion, while bivariate analysis of the variables was done using Pearson's Chi-Square test. Statistical significance was set at $p < 0.05$ with a confidence level of 95%. The mean age of the participants was 39.1 ± 7.8 years. The prevalence of workplace violence was 70%. The most common reason for non-reporting was complexities and time-consuming reporting procedures (26.5%) followed by fear of reprisal on career (22.4%). The proportion of respondents with good knowledge of workplace violence prevention strategies was high (69.8%). Gender ($p = 0.03$), work setting ($p = 0.006$), previous workplace violence training ($p = 0.005$) and knowledge of workplace violence preventive strategies ($p = 0.04$) had statistically significant associations with experience of workplace violence. The high prevalence of workplace violence suggests a need for a workplace violence prevention program which should include a simple process of reporting and

training. The improved awareness from previous training may account for the significant association with workplace violence.

In as much as Elom et al., (2024) critically looked at the prevalence and factors associated with workplace violence in the tertiary hospitals, they failed to investigate their effects of the violence on the overall well-being of patients and this current study bridged the knowledge gap in the body of literature.

#### 2.1.10.1 Gaps Discovered from the Literature Reviewed

The above empirical reviews provide an in-depth explanation and understanding of the effects of doctor-nurse conflicts on patient healthcare and general well-being, highlighting the importance of effective communication, collaboration, and conflict management strategies in promoting positive patient healthcare outcomes. The studies uncover various aspects of the topic, including the impact of doctor-nurse conflict among other healthcare professionals on patient safety, quality of care, job satisfaction, and organizational culture. Although, the overall findings of the various studies above emphasized on the need for interventions to improve on inter professional relationships and create a supportive work environment for healthcare professionals. But none of all the reviewed empirical literatures specifically examined the general effects of doctor-nurse conflicts on the overall well-being of patients under the care of doctors and nurses in the Kogi State public hospitals and that is the major gap that this current study bridged in the body of knowledge and with particular focus on selected public hospitals in Kogi State.

Most reviewed studies appear cross-sectional, lacking investigation into the long-term impact of doctor-nurse conflict on patients' physical and psychological health over time. While psychosocial well-being is highlighted, there is limited focus on how conflicts directly influence clinical outcomes such as recovery times, readmission rates, mortality, or treatment adherence. Few studies incorporate patients' and families' views on how inter-professional conflicts affect their experience and health outcomes, leaving out critical stakeholder perspectives. There is a lack of studies examining how cultural, regional, or institutional factors unique to different healthcare settings (especially in sub-Saharan Africa) shape the nature and effects of doctor-nurse conflicts.

Although some studies recommend interventions (like conflict management training, empowerment programs), empirical evaluation of specific intervention strategies and their effectiveness in reducing conflicts and improving patient well-being is missing. Economic consequences of doctor-nurse conflicts, such as increased healthcare costs, resource wastage, or financial burden on patients and institutions, are not addressed. The role of health information technologies or communication platforms in mitigating or exacerbating conflicts is largely absent from the reviewed literature.

The review lightly touches on hierarchical and dominance issues but lacks a deeper exploration of how gender, professional status, and power imbalances contribute to conflicts and their impact on patient care. While some mention bureaucracy or leadership issues, comprehensive analyses of how specific organizational policies or leadership styles either contribute to or alleviate doctor-nurse conflicts remain scarce. The focus is heavily on doctor-nurse relationships; however, conflicts involving other healthcare professionals (pharmacists, lab technicians, administrators) and their effect on patient care are underexplored.

There is limited investigation into how conflicts affect the mental health and burnout of healthcare workers themselves, and how that, in turn, influences patient care quality. Few studies critically assess how doctor-nurse conflict affects the culture of safety reporting, incident disclosure, and error management within hospitals. Moreover, it was discovered that only one among the studies reviewed above has theoretical framework to buttress their respective findings from their research. Hence, this current study provided an extensive theoretical foundation and orientation into the various aspects of the research questions and objectives to buttress the findings.

## 2.2 Theoretical Framework

This study reviewed three theories but anchored on one theoretical framework as highlighted and discussed as follows:

i. Social Conflict Theory

ii. Functionalist Theory

iii. Symbolic Interactionist Theory

### 2.2.1 Social Conflict Theory

Conflict theory is a Marxist based theory which argues that individuals and social groups (social classes) within society have differing amounts of material and non-material resources and that the more powerful and influential groups use their power in order to exploit the less powerful groups. The two methods by which this exploitation is done are through brute force usually done by police, the army and economy (Dahrendorf, 1959). Earlier social conflict theorists argue that money is the mechanism that creates social disorder. Conflict theory is associated with radical orientation and left wing political activism. Karl Marx conceptualizes modern society, i.e. capitalist society in terms of class struggle between the owners of the means of production and the workers (Yunusa & Usman, 2022). This struggle which may proceed through different stages depending on the nature of consciousness and organization of the working class ultimately ends in a show down between the two groups and the annihilation of the bourgeoisie. According to Marxist thinking, with the overthrow of the bourgeoisie, the workers will install a socialist society where all conflict will come to an end (Yunusa & Usman, 2022).

The theory argues that the relationship between the powerful and the less powerful groups is unequal and favours the most influential, and it is this type of relationship that the conflict theorist will use to show that social relationships are about power and exploitation. Marxism posits that human history is all about this conflict, a result of the strong-rich exploiting the poor-weak. Thus, the social conflict theory states that groups within the capitalist tend to interact in an exploitative way that allows no mutual benefit or little cooperation because the various institutions of the society such as the legal and political system are instruments of ruling class domination and serve to further its interests. As a result of this injustice and abrupt lack of fairness, the solution Marxism proposes to this problem is that of a workers' revolution to break the political and economic domination of the capitalist class with the aim of reorganizing society along lines of collective ownership and mass democratic control (Yunusa & Usman, 2022).

By application, social conflict theory provides a robust framework for understanding the tensions between doctors and nurses in Kogi State’s public hospitals. Rooted in Marxist thought, the theory posits that societal structures are shaped by power struggles between dominant and subordinate groups competing over limited resources. In the context of this

research, doctors represent the dominant professional class, wielding greater authority, status, and influence within the healthcare hierarchy, while nurses occupy a comparatively subordinate position despite their critical role in patient care. This inherent imbalance creates fertile ground for conflict, as the theory suggests that such disparities inevitably lead to friction between groups with opposing interests.

The study examines how these conflicts arise from structural inequalities embedded in the healthcare system, such as disparities in wages, professional recognition, and decision-making authority. Social conflict theory helps elucidate why nurses, despite their indispensable contributions, often face marginalisation and diminished autonomy, fostering resentment and workplace discord. The theory also explains how doctors, as the more powerful group, may unconsciously or consciously reinforce their dominance through institutional practices, further entrenching professional hierarchies. These dynamics mirror broader societal patterns where dominant groups maintain control over resources and opportunities, while subordinate groups challenge or resist such arrangements.

Moreover, the theory sheds light on the manifestations of conflict, including verbal disputes, resistance to collaboration, and occasional work stoppages, as forms of collective bargaining or protest by nurses against perceived injustices. The study explores whether these conflicts serve as a catalyst for change, prompting institutional reforms, or whether they perpetuate dysfunction, ultimately harming patient care. By framing doctor-nurse tensions through the lens of social conflict theory, the research highlights how systemic inequities in healthcare organisations reflect wider societal struggles over power, recognition, and fair treatment.

The assumptions of this theory contribute to a deeper sociological understanding of how professional hierarchies operate within public institutions, particularly in resource-constrained settings like Nigeria's healthcare system. The theory not only explains the origins and persistence of these conflicts but also underscores the need for structural interventions, such as policy reforms, equitable pay structures, and inclusive leadership models, to mitigate tensions and foster a more collaborative work environment. In doing so, the study aligns with the broader aims of social conflict theory, which seeks not merely to diagnose societal tensions but to advocate for transformative change that reduces exploitation and promotes fairness in institutional relationships.

However, conflict theory has been criticized for being ideologically radical, underdeveloped and unable to deal with order and stability in a society. Critic of Marx have often presented him as a rabble rouser advocating a war of all against all and identifying crisis where there is none (Collins & Sanderson, 2015). Its strength in this study is based upon the view that the fundamental causes of the conflict between doctors and nurses in Nigeria are the quest for professional relevance and dominace operating within the healthcare system, and it includes competition over private accumulation of wealth, differences in remuneration, professional achievement and exploitation among others. Since ideas and mode of training vary, interests also vary and these run contrary to one another then disagreements between nurses and doctors become inevitable.

### 2.2.2 Functionalist Theory

Functionalist analysis of society has a long and chequered history in Sociology; it is prominent in the works of Auguste Comte (1798-1857) and Herbert Spencer (1820-1903). It was developed by Emile Durkheim (1858-1917) and refined by Talcott Parsons. But the most definitive statement about functionalism was made by Alfred Reginald Radcliffe-Brown, who, along with Bronislow Malinowski, could be described as the founders of modern functionalism (Durkheim, 1993). Radcliff-Brown (1959:181), has noted that "the function of a particular social usage is the contribution it makes to the functioning of the total system". Such contribution may be positive or negative. Whenever it is positive, the contribution is said to be functional. For example, Durkheim thought that religion plays a positive role in society by promoting social solidarity. Durkheim gave a holistic view of the society. To him, the society is a whole which comprises many parts, none of which is greater than the whole, meaning therefore that the society is "sui-generis" (all-in-all). He adopted sui-generis just to indicate the importance of the society over the individual members comprising it.

The survival of the parts therefore depends on the effective functioning of these parts. An abnormal state of the society results when the parts fail in the performance of their expected roles. By that token, functional institutions are those that contribute positively to the survival and smooth running of the society. As a corollary, there are other human activities which alter the delicate balance of the social system by their destructive outcomes. These are what Robert Merton calls the dysfunctional elements of human

society. For example, conflicts can have severe destructive consequences on the orderly functioning of society (Durkheim, 1993).

Malinowski (1944) also keyed into the argument about the importance of functionalism by saying that every established social pattern makes its own contribution to satisfying the needs for the functioning of the larger society. This is commonly known in sociological literature as "the postulate of universal functionalism" an idea that has been attacked by Goode (1951) who asserted that some activities in society are of no consequence at all to the overall functioning of the social system.

Talcott Parsons analysis of this comes via his AGIL pattern variable. Where A-Adaptation, G-Goal attainment, I-Integration, and L-Latent pattern maintenance.

Adaptation performs the role of the distribution of scarce resources and this is done by economic institution. Goal attainment is to mobilize both resources and energy needed for the attainment of the societal goal and survival performed by the political institution. Integration focuses on the coordination of all other institutions to ensure peace and this is performed by the legal institutions. Latent pattern maintenance provides the means for the characteristics of the society and it is done by the family, educational and religious institutions. According to Parsons, the four institutions are the prerequisite for equilibrium maintenance within the society.

The strength of Functionalist Theory as applied to the subject of this study is hinged upon the fact that it has been able to point out the role that doctors and nurses should play in maintaining social order by ensuring that patients receive necessary care, reducing the risk of social disruption due to ill health. Functionalism views doctors and nurses as the dominant figures in healthcare system, providing expertise and leadership, while nurses play a vital supporting role, ensuring the smooth functioning of the healthcare system. This division of labour contributes to social order and stability in the society.

The application of functionalist theory to this study offers a complementary perspective by examining how doctor-nurse interactions contribute to the stability and functioning of public hospitals in Kogi State. Unlike conflict theory, which emphasises power struggles, functionalism views society, and by extension, institutions like hospitals, as a system of interdependent parts working cohesively to maintain social order. From this standpoint,

doctors and nurses are seen as specialised roles within a broader healthcare system, each performing distinct but mutually reinforcing functions essential for effective patient care.

Functionalism posits that occupational roles emerge to meet the needs of society, and in this context, the hierarchical division between doctors and nurses can be interpreted as a functional necessity rather than an arbitrary power imbalance. Doctors, with their advanced medical training, assume diagnostic and decision-making responsibilities, while nurses focus on patient monitoring, care coordination, and treatment implementation. This role differentiation ensures efficiency, as each professional group operates within its area of expertise, minimising overlap and maximising institutional productivity. The theory suggests that conflicts, when they arise, may signal a dysfunction in this system, such as unclear role boundaries, inadequate communication channels, or resource shortages, disrupting the equilibrium required for smooth operations.

The study explores whether doctor-nurse conflicts undermine the functional harmony of hospitals, leading to inefficiencies in patient care, or whether such tensions, when managed constructively, can spur organisational adaptations that strengthen the system. For instance, recurring disputes over treatment protocols might prompt hospitals to standardise procedures, thereby reducing ambiguity and improving collaboration. Functionalism also highlights the latent functions of conflict, such as reinforcing professional identities or prompting institutional reforms that enhance long-term stability.

Furthermore, functionalist theory draws attention to the broader societal role of healthcare institutions in maintaining public well-being. If conflicts between doctors and nurses impair service delivery, the hospital's ability to fulfil its societal function, restoring health and preventing disease, is compromised. The study thus assesses how these professional dynamics affect the hospital's capacity to meet its core objectives, aligning with functionalism's emphasis on institutional performance and societal needs.

By applying functionalist theory, the research not only diagnoses sources of institutional strain but also identifies pathways to restore equilibrium, such as clarifying professional roles, improving interdisciplinary training, or optimising resource allocation. This perspective underscores the importance of cohesion and cooperation in achieving the overarching goal of healthcare institutions: the effective delivery of medical services to the

community. In doing so, the study contributes to a balanced understanding of how organisational structures can either facilitate or hinder the smooth functioning of vital public services.

However, functionalism as a sociological theory has been subjected to strident criticisms. Critics accuse functionalist theorists of overemphasizing social cohesion thereby creating the impression that divisive factors are unimportant in human societies. In addition, the notions of functional unity and universal functionalism are highly improbable and misleading.

### 2.2.3 Symbolic Interactionist Theory

Symbolic interactionism was founded by George Herbert Mead, a social psychologist, but popularized by Herbert Blumer and the one famous Chicago school of Sociology. Blumer, 1986). In fact, the term symbolic interactionism was put together by Blumer in 1937. The basic assumption of symbolic interactionism as popularized by Blumer is that man has a unique ability in the use of symbols. Lower animals communicate by gestures and their interaction is non-symbolic. The major characteristic of symbolic interaction is language. Language is a key to symbolic interaction because language is a function of thought, a process facilitated by a prior learning of the symbolic communication of a group.

Blumer (1969) summarized the three principles which characterized symbolic interactionism. The first characteristic is the action of people towards things as a function of the meanings the actors attach to the actions; second, the meanings arise out of social interactions and third, the meanings "handled" and "modified" by those involved in the process of dealing with "things" encountered. These principles determine the views and positions of individuals, their social interaction and the entire social structure. The actor is thus an active agent within his milieu. For Meads (1969), without symbols, there would be no human interaction and no human society. Symbolic interactionism is to him a sine qua non since man has no instincts to direct his behaviour. He is not genetically programmed to react automatically to external stimuli. In order to survive, he must therefore construct and live within a world of meaning. For example, man must classify the natural environment into categories of foods, and non-food in order to meet basic nutritional requirements. Meads further underscored the importance of symbols by noting that via symbols, meaning

is imposed on the world of nature and human interaction with that world is thereby made possible (Blumer, 1986).

The strength of symbolic interactionist theory as applicable to this study lies in the fact that it has been able to explain how the hospitals as a healthcare system in the Kogi State can be enhanced when doctors and nurses understand each other's symbols and languages in the process of attending to patients healthcare or ill health, but the misunderstanding and or misinterpretation of these symbols and languages constitute a conflict of relationships between the healthcare professionals in a pluralistic or multilingual society like Nigeria.

By application, symbolic interactionist theory illuminates how the everyday interactions, perceptions, and symbolic meanings attached to professional roles shape the dynamics between doctors and nurses in Kogi State's public hospitals. This theoretical lens shifts focus from structural hierarchies to the micro-level exchanges and shared (or contested) understandings that define interprofessional relationships. At its core, symbolic interactionism examines how individuals construct meaning through social interaction, and how these meanings influence behaviour. In the hospital setting, the professional identities of doctors and nurses are not merely defined by formal qualifications but are continually reinforced, or challenged, through daily encounters. For instance, the use of medical jargon, deference in communication, or even nonverbal cues like body language can symbolically reinforce the perceived superiority of doctors and the subordination of nurses. These subtle interactions perpetuate a culture where authority is negotiated and contested in routine practices, such as ward rounds or handover meetings.

The study explores how conflicting interpretations of roles and responsibilities arise from these symbolic exchanges. A nurse's suggestion about patient care, if dismissed or overlooked by a doctor, may be interpreted not just as a clinical disagreement but as a denial of professional worth. Conversely, doctors might perceive nurses' assertiveness as overstepping boundaries, reflecting deeper tensions about autonomy and expertise. Such misunderstandings are rooted in the differing symbolic meanings each group attaches to collaboration, respect, and professional boundaries.

Symbolic interactionism also highlights how labels and stereotypes, such as "just a nurse" or "arrogant doctor", shape workplace culture. These labels, once internalised, influence

self-perception and behaviour, potentially entrenching divisions. The theory suggests that conflict resolution requires more than policy changes; it demands a renegotiation of these shared meanings through improved communication, mutual recognition, and reflective practices that challenge ingrained stereotypes.

By applying this framework also, the study reveals how doctor-nurse conflicts are not solely about resource allocation or power (as conflict theory emphasises) or systemic roles (as functionalism examines), but about the lived experiences and symbolic negotiations that define professional relationships. This perspective underscores the need for interventions that address interpersonal dynamics, such as team-building exercises or narrative-based training, to foster a shared understanding of collaborative care. In doing so, the research contributes an interactional dimension to the study of workplace conflict in healthcare settings.

Albeit, symbolic interactionism has been criticized for examining human interaction in a vacuum. It tends to focus on small-scale, face-face interaction with little concern for its historical or social setting. Another criticism flung at symbolic interactionism is the failure of the interactionists to explain the source of the meanings to which they attach so much importance.

### 2.2.4 Appraisal of the Reviewed Theories and Choice of Framework

Haven observed that no single organizational and sociological theory will be adequate in providing an exhaustive explanation to the phenomenon of doctor-nurse conflict in Nigerian public hospitals, it becomes necessary for the researcher to evaluate the relevance of these three classical sociological theories together, in order to provide a meaningful explanation to the issue of doctor-nurse conflict in Nigerian public hospitals.

By adopting social conflict theory, the researcher has been able to explain how Marxism provides a systematic theoretical basis upon which to interrogate social structural arrangements, and the hypothesis that economic power is translated into political power, substantially accounts for the general disempowerment of the minority groups. So the theory becomes importance because in a capitalist society like Nigeria, nurses' exploitation and oppression by doctors are supported by the ruling class or the entire government machinery through their mode of training and the resources involved.

Laws are enacted to protect the capitalist and their property against the workers and the property-less. In this case, Marxist approach sees doctor-nurse conflict as inevitable because as healthcare professionals struggle for economic advantage, competition over scarce resources no doubt would erase the law of decorum collaborative existence, and these scenarios will necessarily bring about conflict between these healthcare professionals in Nigerian public hospitals. Meanwhile, despite its major flaws as being ideologically radical, underdeveloped and unable to deal with order and stability in a society, Marxist approach has been able to provide meaningful explanation on how monopoly capitalism characterized by competition, private accumulation of wealth, achievement, an undue quest for professional relevance, dominance and exploitation will definitely bring about conflicts between the healthcare professionals especially between doctors and nurses in Nigerian public hospitals.

Also, the application of functionalist theory to this study is necessary because functionalism has been able to explain how the distinct structures or institutions shape a society and how each structure has a specific role to play in determining the behaviour of a society. For instance, to maintain a good state of healthcare for the members of a society, it has the hospital system to cater for the members from the threat of sicknesses and diseases, with doctors and nurses to maintain a cordial relationship and keep order and stability of the healthcare system. According to the functionalist theory, parts of the systems are the structures of the society and the functions of the healthcare systems are to ensure wellness and stability of the hospital systems. From the above therefore, despite its inadequacies of overemphasis on social cohesion which create the impression that divisive factors are unimportant in human societies among others, functionalism has been able to explain the need for a cordial relationships between doctors and nurses in maintaining social order and stability while attending to patients in the hospitals.

Likewise, by adopting symbolic interactionist theory, the researcher has been able to explain how the interpretation and or misinterpretation of symbols or languages and meanings during the process of interaction between different individuals from different professional groups (as a result of language differences) result to conflict between doctors and nurses in Nigerian public hospitals. Thus, the theory asserts that language is socially constructed but manifests itself during interaction between different professional groups.

Albeit, symbolic interactionism has been criticized in its explanation of the conflict between doctors and nurses in Nigerian public hospitals. For instance, it has been accused of observing human interaction in a vacuum and focusing on small-scale, face-face interaction, but it has provided a meaningful explanation to the importance of mutual understanding of the interaction between the doctors and nurses in Nigerian public hospitals in Kogi State.

Haven appraised all these sociological theories used in this study, the researcher decided to apply or anchor one of the theories to this research work. That is, Social Conflict Theory. Thus, the Social Conflict Theory sees the fundamental causes of the conflict between doctors and nurses in the quest for professional relevance and dominance operating within the healthcare system, and it includes competition over private accumulation of wealth, differences in wages/salaries, professional achievement and knowledge exploitation among others. Since ideas and mode of training and upbringing vary, interests also vary and these run contrary to one another then disagreements between nurses and doctors become inevitable, because competition over scarce resources no doubt would erase the law of decorum for a peaceful coexistence of doctors and nurses in the society.

## 2.3 Conceptual Framework

A conceptual framework provides a structured way of understanding the relationships among key variables in a study. In this research, the conceptual framework was developed to illustrate the influence of doctor-nurse conflicts on the well-being of patients in public hospitals in Kogi State, Nigeria. The framework integrates elements of Social Conflict Theory**,** Organizational Justice Theory**,** Functionalist Theory**,** and Symbolic Interactionist Theory to explain the phenomenon as displayed in the diagram fig. 1 below:

**Doctor-Nurse Conflict and Patient Well-being Model**

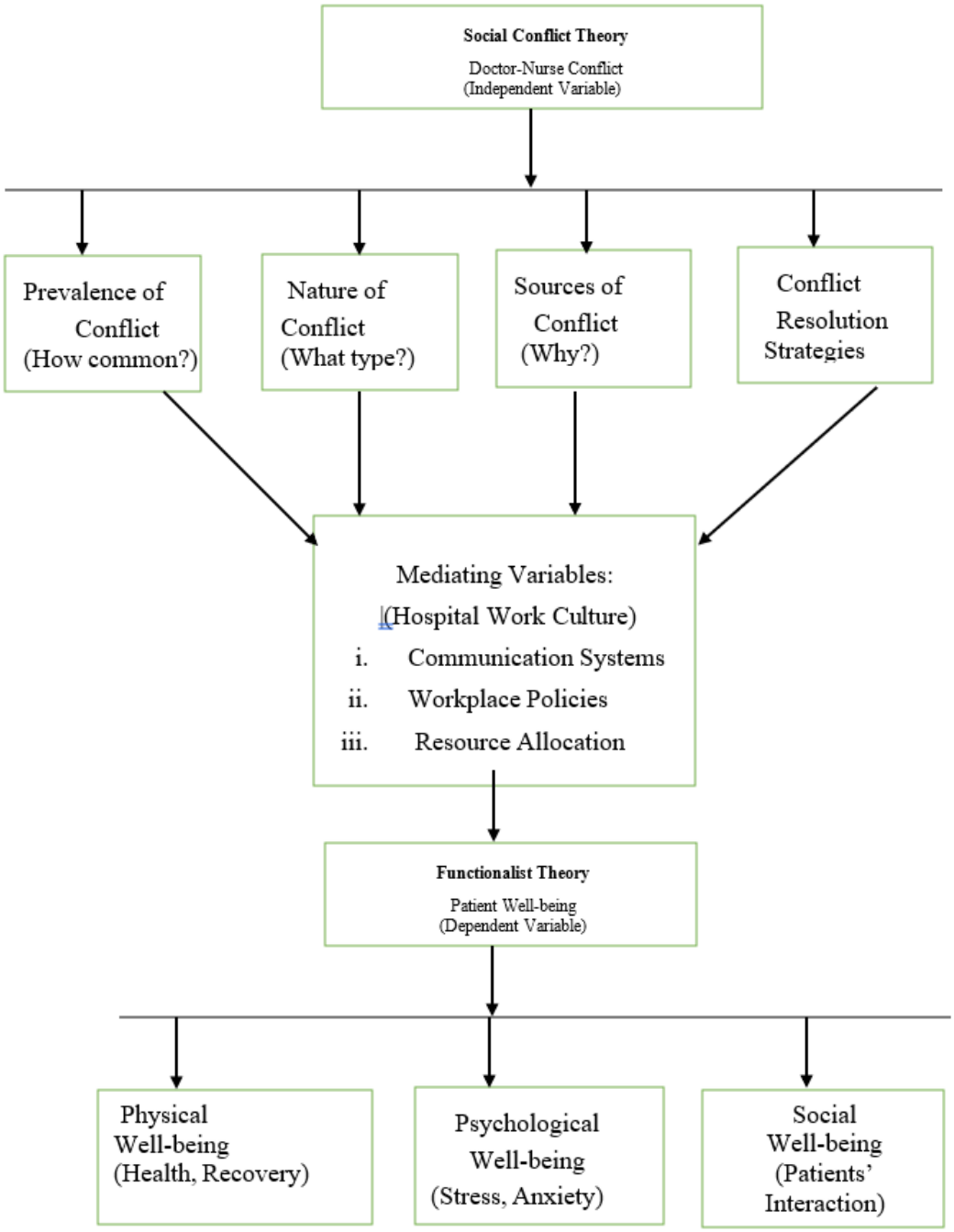



**Fig 1:** Conceptual Framework

**Source:** Yunusa., (2025)

**Key Variables in the Conceptual Framework**

The study revolved around three key categories of variables:

a. Independent Variable: Doctor-Nurse Conflict

This includes:

i. **Prevalence of Doctor-Nurse Conflict**: Frequency and intensity of conflicts between doctors and nurses.

ii. **Nature of Doctor-nurse Conflict**: Power struggles, communication breakdowns, role ambiguity, and hierarchical tensions.

iii. **Sources of Doctor-Nurse Conflict**: Differences in wages, job roles, recognition struggles, and treatment disagreements.

iv. **Doctor-Nurse Conflict Resolution Strategies**: Methods used to mitigate conflicts, such as mediation, teamwork training, and communication improvement.

b. Mediating Variables: Hospital Environment and Work Culture

These variables influence how Doctor-Nurse conflicts affect patient well-being:

i. **Workplace Policies**: Hospital rules, standard operating procedures (SOPs), and leadership structures.

ii. **Communication Systems**: Availability and effectiveness of formal and informal communication channels.

iii. **Resource Allocation**: Availability of medical equipment, staff workload, and hospital funding.

c. Dependent Variable: Patient Well-being

This includes:

i. **Physical Well-being of Patients**: Impact on timely and effective medical care, recovery rates, and mortality.

ii. **Psychological Well-being of Patients**: Effects on patient anxiety, trust in healthcare providers, and overall satisfaction.

iii. **Social Well-being of Patients**: Relationships between patients and healthcare staff, as well as family engagement in patient care.

## 2. Theoretical Framework Underpinning the Conceptual Model

The study was grounded in three major theories:

i. **Social Conflict Theory:** This theory underpins the Independent Variable (Doctor-Nurse Conflict) by explaining the power struggles, hierarchical tensions, and competition for professional recognition that drive conflicts between doctors and nurses. It explains doctor-nurse conflict as a struggle for power, resources, and recognition within healthcare institutions. Hierarchical structures in hospitals create tensions, where doctors (often higher in status) and nurses (subordinate in ranking) engage in conflicts due to unequal roles.

ii. **Functionalist Theory:** This theory relates to the Dependent Variable (Patient Well-being) by showing how unresolved conflicts disrupt the hospital system's stability, affecting patient care, teamwork, and overall healthcare efficiency. It argues that hospitals, like any other system, must maintain stability and function efficiently. Conflicts, if managed properly, can lead to improved hospital structures and better collaboration.

iii. **Symbolic Interactionist Theory:** This theory explains the interpersonal dynamics of doctor-nurse interactions, particularly how miscommunication, stereotypes, and differing professional symbols contribute to tensions that ultimately affect patient outcomes. It focuses on how daily interactions between doctors and nurses shape professional relationships. Poor communication and misinterpretation of roles can escalate tensions, influencing patient outcomes.

# CHAPTER THREE

## RESEARCH METHODS

This chapter discusses the procedures of data collection and techniques of data analysis. It specifically covers the following areas: research design, the study area, population of the study, data collection techniques, sample size, sampling procedures, instrument of data collection, pilot study, validity and reliability of the research instrument, techniques of data analysis, ethical considerations, inclusion and exclusion criteria.

### 3.1 Research Design

This study adopted a descriptive cross-sectional survey research design. Survey research design, a popular social research method involves the administration of questionnaires to a sample of respondents selected appropriately from some population. It is one in which a group of people or items is studied by collecting data from only a few people or items considered to be representative of the entire group (Asika, 2001). Survey research design focuses on the vital facts of people and their beliefs, opinions, attitude, motivations and behaviour on a subject matter.

The reason why this study adopted descriptive cross sectional survey research design in this study is because, it is most helpful in describing the characteristics of a large population that cut across a wide geographical area, studying individuals' attitudes either by interviewing or asking respondents to fill out a questionnaire. It is more flexible and allow for precise comparisons to be made between the responses from respondents.

### 3.2 The Study Setting

Kogi State is located in the North-Central Geopolitical Zone of Nigeria. It is bordered by Kwara, Nasarawa, Benue, Enugu, Anambra, Edo, Ondo and Ekiti States and the Federal Capital Territory. The state was created on August 27, 1991, by the Babangida military administration, carved out of parts of the old Kwara and Benue States (Agba et al., 2019). The history of the area now known as Kogi State can be traced back to the ancient Nok culture, which thrived in the region between 900 BC and 200 AD. The Nok culture is renowned for its terracotta figurines and iron smelting technology (Adepegba, 2021). During the pre-colonial era, the region was home to several ethnic groups, including the

Igala, Ebira, Yoruba, Nupe, and Bassa. These groups had their own distinct cultural traditions and political systems, ranging from centralized kingdoms to decentralized chieftaincies (Okene & Olayemi, 2020). In the late 19th century, the area came under the influence of the Sokoto Caliphate and the British colonial administration. The British eventually established their control over the region through a series of military campaigns and diplomatic negotiations (Adepegba, 2021).

After Nigeria's independence in 1960, the present-day Kogi State remained part of the Northern Region until the creation of the Kwara State in 1967. The area then became part of the Kwara and Benue States until the establishment of Kogi State in 1991 (Agba et al., 2019). Kogi State is rich in natural resources, including coal, limestone, and iron ore. The state's economy is primarily based on agriculture, with cash crops such as cashew nuts, cassava, yam, rice, and maize being the main products (Okene & Olayemi, 2020). The state is home to diverse ethnic groups, including the Igala, Ebira, Yoruba, Nupe, and Bassa, among others. This ethnic diversity has contributed to the state's cultural richness, with various festivals and traditions celebrated throughout the year (Adepegba, 2021).

One of the most notable cultural events in Kogi State is the annual Igala Cultural Festival, which showcases the rich heritage of the Igala people through music, dance, and traditional displays (Agba et al., 2019). There are a number of social amenities such as commercial banks including local, State and Federal public health facilities. However, Kogi State has faced challenges in recent years, including issues related to improved infrastructure development, healthcare, and education (Okene & Olayemi, 2020).

### 3.2.1 Brief Description of the Study Setting

Public hospitals in Kogi State can be traced back to the colonial era, when the British established a few health facilities in the region to cater to the needs of colonial administrators and their families. These early hospitals were predominantly located in urban centres like Lokoja, the state capital (Okene & Olayemi, 2020). After Nigeria's independence in 1960, the government recognized the need for improved healthcare infrastructure and began establishing more public hospitals across the country, including in the present-day Kogi State (Adepegba, 2021).

One of the earliest and most notable public hospitals in Kogi State is the Lokoja General Hospital, which was established in the late 1960s. This hospital has since grown into a major referral center for the state and neighbouring regions (Agba et al., 2019). Over the years, the Kogi State government has made efforts to expand the public healthcare system by establishing more general hospitals, specialist hospitals, reference hopsitals, cottage hospitals and primary healthcare centre across the state's three senatorial districts (Okene & Olayemi, 2020).

The public hospital system in Kogi State is structured into three tiers, namely, primary healthcare, secondary healthcare, and tertiary levels of care.

**Primary Healthcare Centres (PHCs):** These are the entry-level facilities mostly owned and funded by Local Government Authority to provide basic healthcare services such as immunizations, antenatal care, treatment of minor ailments, and health education. Kogi State has over 600 PHCs distributed across its 21 local government areas (Agba et al., 2019).

**Secondary Hospitals:** These are general hospitals mostly owned and funded by State Government Authority to offer a wider range of healthcare services, including outpatient and inpatient care, surgery, laboratory services, and basic diagnostic imaging. Some notable secondary hospitals in Kogi State include the Lokoja General Hospital, Obangede General Hospital, and Grimard Hospital in Anyigba (Okene & Olayemi, 2020).

**Tertiary Hospitals:** These are specialized hospitals mostly owned and funded either by State or Federal Government to provide advanced healthcare services and serve as referral centres for complex cases. The Kogi State Specialist Hospital in Lokoja and the Kogi State University Teaching Hospital in Ayingba are examples of tertiary hospitals in the state (Adepegba, 2021).

Public hospitals in Kogi State are staffed by various healthcare professionals, including doctors, nurses, pharmacists, laboratory technicians, and other support staff. However, the state has faced challenges in retaining and attracting healthcare workers due to issues such as poor remuneration, inadequate infrastructure, and limited career growth opportunities (Agba et al., 2019). The majority of public hospitals in Kogi State are funded through the state government's annual budget allocation for healthcare. However, funding has often

been insufficient, leading to shortages of essential medical supplies, equipment, and infrastructure maintenance (Okene & Olayemi, 2020).

To address these challenges, the Kogi State government has implemented various initiatives, such as the renovation and upgrading of existing hospital facilities, the establishment of public-private partnerships, and the recruitment of healthcare professionals through incentive schemes (Adepegba, 2021). Despite these efforts, public hospitals in Kogi State continue to face significant challenges, including overcrowding, long waiting times, inter-professional conflicts and suboptimal quality of care. Many residents, particularly those from urban areas, often opt for private healthcare facilities or seek medical treatment in neighbouring states or the Federal Capital Territory (Agba et al., 2019) as a result of these challenges which also inform the quest to embark on this research adventure.

### 3.3. Population of the Study

The population for this study were 35 accidentally selected patients, all the doctors and nurses working in the State-owned public hospitals in Kogi State which, according to the information gathered from Kogi State Hospital Management Board (2024) were 103 doctors, 306 nurses, making the total population to be 444 within the 59-state owned public hospitals across the 21 Local Government Areas of the State, respectively.

### 3.4 Sample Size and Sampling Techniques

#### 3.4.1 Sample Size Determination

Considering the relatively small size of the study population, it was not difficult for the researcher to cover the entire respondents. Therefore, the total population of the study which is 409 was considered as the sample size and used for the study.

### 3.5. Sampling Techniques

The researcher adopted census sampling technique to select the study participants randomly from the sample size because it provided accurate and comprehensive information about the entire population, making it ideal for studies that require precise data. Census sampling eliminates sampling errors, allowing for detailed cross-tabulations

and reliable data for small geographic areas or sub-populations. By including every individual respondent in the study, census sampling offered a complete enumeration of the population, enabling researchers to draw definitive conclusions.

Therefore, table 1 below shows the selected public hospitals in each of the selected facilities across the local government areas of Kogi State:

**Table 1:** The LGAs, Doctors and Nurses selected for the Study

| **LGA** | **No. of Doctors selected** | **No. of Nurses selected** | **Total number of respondents** |
|---|---|---|---|
| Adavi | 2 | 10 | 12 |
| Ajaokuta | 6 | 18 | 24 |
| Ankpa | 3 | 24 | 27 |
| Dekina | 17 | 38 | 55 |
| Idah | 5 | 18 | 23 |
| Ijumu | 2 | 15 | 17 |
| Kogi | 3 | 14 | 17 |
| Lokoja | 24 | 50 | 74 |
| Mopa-Muro | 3 | 18 | 21 |
| Ofu | 3 | 16 | 19 |
| Ogorimangogo | 3 | 14 | 17 |
| Okene | 10 | 33 | 43 |
| Olamaboro | 3 | 14 | 17 |
| Omala | 2 | 10 | 12 |
| Yagba East | 3 | 12 | 15 |
| Yagba West | 2 | 14 | 16 |
| **Total** | **91** | **318** | **409** |

**Source:** Researcher's Field Survey, 2025

Meanwhile, the researcher accidentally selected 35 In and Out-patients on different occasions through purposive sampling technique for in-depth interview from across the selected state owned hospitals and 1 Chief Medical Director (CMD) each from State owned public hospitals in the three Senatorial District of Kogi State, namely; Prince Abubakar Audu University Teaching Hospital, Anyigba (Kogi East), Kogi State Specialist

Hospital Lokoja (Kogi West) and Reference Hospital Okene (Kogi Central) in order to have an in-depth view on the issue of doctor-nurse conflict and its effects on the well-being of patients in the State's public hospitals, totalling the figures i.e **409 + 35** amounted to **444** respectively.

### 3.6. Methods of Data Collection

This study employed both primary and secondary sources of data collection. Primary sources involved quantitative method via the use of survey through questionnaire and qualitative method through the use of in-depth interview. While the secondary sources involved the use of text books, journal articles, reports, newspaper/magazines including internet documented sources relevant to the study. The researcher employed the mixed-methods approach (combining both quantitative and qualitative methods) for a comprehensive understanding of the problem and ensured that findings were cross-validated and more reliable. Furthermore, the researcher employed mixed methods approach because it allowed the researcher to propose evidence-based and experience-driven solutions for managing doctor-nurse conflicts in hospitals.

The research instruments were administered by the researcher with the support of 15 trained research assistants, including some of the researcher’s colleagues working across the various public hospitals in Kogi State. Prior to data collection, the research assistants were adequately briefed on the purpose, objectives, and procedures of the study to ensure uniformity and accuracy in the administration of the instruments. Their familiarity with the hospital settings facilitated access to respondents and enhanced the efficiency of the data collection process. This collaborative approach enabled the successful collection of extensive data across the state within a period of five months.

This study adopted pragmatic research paradigm because it focuses on solving practical problems related to doctor-nurse conflicts and their effects on patient well-being. The pragmatic approach allows the researcher to combine both quantitative and qualitative methods to gain a comprehensive understanding of the phenomenon. Pragmatism emphasizes the practical application of research methods that best address the research questions rather than being confined to a single philosophical stance (positivism or interpretivism).

### 3.7. Instruments for Data Collection

For the instruments of data collection, the study employed questionnaire and in-depth interview to elicit information from the respondents and participants. Questionnaire was used because it gives the respondents several alternative options from which they choose the one closest to their views, or requires the respondent to fill in the actual figure(s) related to the question asked. Specifically, the study used closed-ended questions in the questionnaire because of its ability to collect quantitative data that can be easily analyzed and compared, ensuring consistency in respondents' answers, and minimizing the time and effort required for respondents to complete the questionnaire. This structured approach also helped to reduce ambiguity and misinterpretation, making it ideal for large-scale surveys and quantitative research. Additionally, closed-ended questionnaires provided a clear and definitive way to test hypotheses and validated existing theories, allowing for precise and comparable data collection.

While the In-depth interview was used to gather more information on the subject matter and to complement the responses of the study participants. The questionnaire and In-depth interview were categorized into sections consisting of the socio-demographic characteristics of the respondents and the substantive issues of the research in tandem with the aim and objectives of the study. The in-depth interview consisted of open headed questions while the questionnaire consisted of open and closed-ended questions including questions on Likert Scale.

### 3.8 Pilot Study

A pilot study was conducted at six selected public hospitals in Benin City among the population of interest, doctors and nurses, because they share similar ideas, demographic, professional, and institutional characteristics which were considered universal with those in Kogi State public hospitals, the main study area. Benin City was chosen not only for this similarity but also because it provided easier accessibility to participants, reduced travel and logistical costs, and ensured a shorter turnaround time for data collection and analysis. Additionally, the hospitals in Benin City offered a controlled and supportive research environment, which made it easier to obtain administrative approval and coordinate with hospital management.

Thirty copies of the questionnaire were distributed to doctors and nurses, whose responses were used to test the instrument's validity and reliability before the main survey. The pilot test also helped assess the feasibility of the study procedures, determine the adequacy of research instruments, highlight potential respondent fatigue or misunderstanding, and refined the sequence and structure of questions. This process ensured clarity of language, eliminated ambiguities, and allowed the researcher to estimate the time required for completion before deploying the questionnaire in the main research. Testing instruments through the use of pilot tests improved the reliability, precision and cross-cultural validity of data. Data collected were subjected to analysis with the use of Cronbach's Alpha reliability coefficient test and Exploratory Factor Analysis with the reliability results ranging from 0.74 – 0.905 (See Tables 2 and 3).

### 3.9 Reliability and Validity of Research Instrument

#### 3.9. 1 Validity of Research Instrument

To prove that the questionnaire (instrument for data collection) was of acceptable standard constructed for the survey research, the instrument was subjected to face validity by two experts in the field of the study, such as the researcher's supervisors and two other experts from the Department of Educational Administration and Management in the faculty of Education, Prince Abubakar Audu University Anyigba. This aims to ascertain that the instrument is free from errors, ambiguity of instruction or wording, time inadequacy and measurability of construct.

Validity was done with the use of Exploratory Factor Analysis (EFA) where the item communality and item loading of 0.7 is considered acceptable. Cohen (2013) states that if inter-item correlation lies within 0.10 and 0.29, then there is a weak correlation for both positive and negative values, and when inter-item correlation lies within 0.30 and 0.49 a medium correlation, and lastly if inter-item correlation is between 0.50 and 1.00 a strong correlation. Moreover, Robinson et al., (1991) recommends that, in an empirical approach and as a rule of thumb, if the score of the item-total correlations is more than 0.50 and the inter-item correlations exceeds 0.30, the construct validity is satisfied.

**Table 2:** Validity Test Results for the Questionnaire

| **Measure Name** | **Number of Items** | **Item Communality range** | **Construct Validity (*Item total Correlation range*)** | **KMO Measure of Variable Adequacy** |
|---|---|---|---|---|
| The Prevalence of Doctor-Nurse Conflicts in Public Hospitals in Kogi State. | 13 | 0.71 - 0.82 | 0.72 - 0.83 | 0.88 |
| The Dynamics of Conflict Between Doctors and Nurses in Kogi State Public Hospitals. | 2 | 0.75 - 0.87 | 0.71 - 0.81 | 0.86 |
| The Major Sources of Conflicts between Doctors and Nurses in Kogi State Public Hospitals. | 9 | 0.70 - 0.84 | 0.70 - 0.81 | 0.81 |
| Effects of Doctor and Nurse Conflict on the General Well-being of Patients in Kogi State Public Hospitals. | 19 | 0.71 – 0.91 | 0.74 – 0.87 | 0.83 |
| Effective Strategies for Doctor-Nurse Conflict Reduction in Kogi State Public Hospitals. | 6 | 0.69 – 0.78 | 0.74 – 0.82 | 0.87 |

**Source:** Researcher's Computation, 2025

Based on Table 2, five different scales (The Prevalence of Doctor-Nurse Conflicts in Kogi State Public Hospitals, The Dynamics of Doctor-Nurse Conflicts in Kogi State Public Hospitals, The Major Sources of Doctor-Nurses Conflicts in Kogi State Public Hospitals,

The Effects of Doctor-Nurse Conflict on the Wellbeing of Patients in Kogi State Public Hospitals and The Effective Strategies for Doctor-Nurse Conflicts Reduction in Kogi State Public Hospitals) were used to assess various aspects of the topic: Doctor-Nurse Conflict and the Well-being of Patients in Public Hospitals in Kogi State, Nigeria. For each scale, Exploratory Factor Analysis (EFA) was used where item communality loading was obtained at figures between 0.69 to 0.87, which is considered acceptable (El hajjar, 2018); also, inter-item correlation or item total correlation using bivariate analysis was used to determined construct validity and figures obtained ranged between 0.70 to 0.87 which was also considered acceptable (Robinson et al., 1991). Kaiser-Meyer-Olkin (KMO) was used to measure variable adequacy to which figures range of 0.81 to 0.87 obtained were acceptable (Beaves et al., 2013).

In this study, all the scales have good content validity, which means that the items in the construct accurately represent the content domain of Doctor-Nurse Conflict and the Psychosocial Well-being of Patients in Public Hospitals in Kogi State, Nigeria. The instrument also have good construct validity, which means that they accurately measure the underlying constructs or concepts they are intended to measure. Furthermore, the measures have acceptable criterion validity, which means that they are related to external criteria or standards scale for investigating the Doctor-Nurse Conflict and the Psychosocial Well-being of Patients in Public Hospitals in Kogi State, Nigeria.

### 3.9.2 Reliability of the Research Instrument

Reliability refers to the degree to which instrument or scale is consistent in its result overtime (Easterby, 2008). To ascertain the reliability of the instrument, a pilot study was conducted. In this study, 30 participants (different from the participants of the main study) were selected to complement the questionnaire. Cronbach Alpha Co-efficient was used in estimating the reliability. According to Nunnally (1978) the major way to tests internal consistency reliability is Cronbach's alpha. A general accepted rule is that α of 0.6-0.7 indicates an acceptable level of reliability, and 0.8 or greater a very good level (Hulin, Netemeyer, & Cudeck, 2001; Wim et al, 2008). Cronbach Alpha Co-efficient is chosen as it gives a numerical coefficient of the internal consistency of the variables under study.

**Table 3:** Reliability Test Results

| Measure Name | Number of Items | Cronbach's Alpha |
|---|---|---|
| The Prevalence of Doctor-Nurse Conflicts in Kogi State Public Hospitals. | 13 | .714 |
| The Dynamic of Conflict between Doctors and Nurses in Kogi State Public Hospitals. | 2 | .822 |
| The Major Sources of Conflicts between Doctors and Nurses in Kogi State Public Hospitals. | 9 | .905 |
| The Effects of Doctor-Nurse Conflicts on the Psychosocial Wellbeing of Patients in Kogi State Public Hospitals. | 19 | .864 |
| Effective Strategies for Doctor-Nurse Conflicts Reduction in Kogi State Public Hospitals. | 6 | .822 |

**Source:** Researcher's Computation, 2025

Table 3 shows the five different scales (The Prevalence of Doctor-Nurse Conflicts in Kogi State Public Hospitals, The Dynamics of Doctor-Nurse Conflicts in Kogi State Public Hospitals, The Major Sources of Doctor-Nurses Conflicts in Kogi State Public Hospitals, The Effects of Doctor-Nurse Conflict on the wellbeing of Patients in Kogi State Public Hospitals and The Effective Strategies for Doctor-Nurse Conflicts Reduction in Kogi State Public Hospitals) that were used to various aspects of the topic: Doctor-Nurse Conflict and the Psychosocial Well-being of Patients in Public Hospitals in Kogi State, Nigeria. For each measure, the study conducted a reliability test using Cronbach's Alpha as the reliability coefficient. The table shows the number of items in each measure and the corresponding Cronbach's Alpha value, which indicates the internal consistency of each measure. Note that a Cronbach's Alpha value of 0.70 or higher is generally considered acceptable for research purposes. In this study, all the scales have a Cronbach's Alpha value greater than 0.70, which suggests that they are reliable scales for assessing the various aspects Doctor-Nurse Conflict and the Psychosocial Well-being of Patients in Public Hospitals in Kogi State, Nigeria.

### 3.10 Administration of the Research Instruments

The study administered 406 copies of questionnaire to only doctors and nurses across the selected hospitals and conducted In-depth interview with 35 patients (both in-patients and out-patients) of the selected hospitals and one Chief Medical Directors (CMD) each from three tertiary hospitals across the three Senatorial Districts of Kogi State. The researcher, assisted by research assistants and student nurses on practical training, distributed 406 copies of the questionnaire directly to doctors and nurses working in the selected hospitals. At the same time, in-depth interviews were carried out with 35 patients (both in-patients and out-patients) from these hospitals, as well as with one Chief Medical Director from each of the three tertiary hospitals located in the three Senatorial Districts of Kogi State. The copies of the questionnaire were both self-administered and researcher-assisted, while the interviews followed a prepared schedule to guide the conversation and ensured that all relevant theme following the research objectives were covered.

### 3.11 Methods of Data Analysis

The quantitative data generated for the study were presented and analysed in descriptive statistics using tables and percentages to give a clearer understanding, enhances and clarifies the data collected from the field. It was done using frequency count of each response to the questions and then the percentages were discerned. The response to the questionnaire were coded appropriately in order to help in the comparative description, interpretation and general discussion of the study findings. while the responses from the interview schedules were translated, transcribed and content analyzed.

The hypotheses of the study were tested through inferential statistics using Multiple Linear Regression because of the multiple variables involved respectively with the aid of Statistical Packages for Social Sciences (SPSS) IBM v29 as the tool of analysis because it includes relevant and updated statistical test features and equally has scripting procedures necessary for this study. Multiple Linear Regression (MLR) was the appropriate statistical tool for testing the stated hypotheses because it allowed the researcher to examine the simultaneous and combined influence of multiple independent variables on one or more dependent variables while controlling for inter-variable relationships.

In this study, the nature of the hypotheses involves assessing cause-and-effect relationships between several predictors (independent variables) such as differences in wages/salaries, lack of mutual respect, pride, and quest for professional relevance and multiple outcomes (dependent variables) such as patients' stress/trauma, anxiety/depression, and overall well-being. MLR effectively captures the magnitude, direction, and significance of each predictor's contribution to these outcomes within a single statistical model. Specifically, the hypotheses focused on how variations in organizational and interpersonal factors among healthcare professionals (doctors and nurses) collectively affected patient-centered outcomes in Kogi State public hospitals.

Furthermore, Multiple Linear Regression enabled the researcher to determine the extent to which each independent variable predicts or explains variations in patients' psychological and health-related responses (stress, anxiety, depression, and general well-being), to control for the intercorrelations among predictors (e.g., wage disparity and lack of respect), ensuring that the unique effect of each variable is isolated and objectively estimated, to quantify the joint effect of multiple conflict-related factors on patient outcomes, providing a more holistic understanding than bivariate or simple regression analyses and to assess the model fit and predictive accuracy, using statistical indices such as $R^2$ and adjusted $R^2$, which indicate how well the predictors explain the variance in the dependent variables.

### 3.12 Ethical Consideration

In carrying out a systematic study of this nature, ethical consideration is sacrosanct. This is because it is one of the most important points that deserve attention. The researcher was therefore guided by the ethics of conducting research to protect the image of the respondents by treating their responses with strict confidentially and strictly for this academic purpose. The researcher sought for permission from the appropriate authorities in the Kogi State Hospital Management Board before the research activities. The principle of informed consent was also observed in the study appropriately while the ethical clearance was obtained from Prince Abubakar Audu University Teaching Hospital, Anyigba (KSUTH/ETHICS/005/VOL.1/59) (see Appendix V).

### 3.13 Inclusion and Exclusion Criteria

#### 3.13.1 Inclusion Criteria

This study specifically included only medical doctors and nurses working in hospitals owned by the Kogi State government. These healthcare professionals were selected because doctor-nurse conflict are more prevalent in public hospitals than private hospitals and they equally have firsthand experience with the issues been investigated. By focusing on doctors and nurses in state-owned hospitals, the study aimed to ensure consistency in institutional policies, work environments, and administrative structures, which might differ from those in local or federal hospitals.

#### 3.13.2 Exclusion Criteria

The study excluded medical doctors and nurses working in hospitals owned by private individuals, corporate organizations and federal or local governments to maintain a uniform research scope and avoid variations in administrative policies and funding structures that could influence findings. This exclusion was necessary to ensure that the data collected specifically reflected the perspectives and experiences of doctors and nurses in state-owned hospitals across the various local government areas in Kogi State.

## CHAPTER FOUR

## DATA PRESENTATION AND ANALYSIS

This chapter deals mainly with the presentation and analysis of the data collected from the field in tabular form using figures, frequency count and percentages. The presentation and analysis of the data were based on questionnaire administered to doctors and nurses across the Kogi State owned hospitals in the three Senatorial District of Kogi State, Nigeria, in which a total number of four hundred and nine (406) copies of questionnaire were distributed to the respondents by the researcher alongside the research assistants, out of which a total of three hundred and ninety eight (398) copies were filled, returned and used, while eleven copies (11) were not returned due to the respondents forgetfulness while some mishandled the instruments when the researcher returned to retrieve the instruments. Of the

406 questionnaires distributed, 94% were duly completed, returned, and included in the analysis, while 6% were not returned and therefore excluded. This high response rate demonstrates strong participant engagement and enhances the credibility, reliability, and representativeness of the data collected.

**Section A: Presentation and Analysis of Socio-demographic Characteristics of the Respondents**

**Table 4:** Distribution of the Socio-Demographic Characteristics of the Respondents

| Variable | Category | Frequency (N = 398) | Percentage (%) |
|---|---|---|---|
| **Local Government Area** | Adavi | 11 | 2.8 |
| | Ajaokuta | 15 | 3.8 |
| | Ankpa | 75 | 18.8 |
| | Dekina | 98 | 24.6 |
| | Idah | 19 | 4.8 |
| | Ijumu | 16 | 4.0 |
| | Kogi | 11 | 2.8 |
| | Lokoja | 49 | 12.3 |
| | Mopa-Muro | 9 | 2.3 |
| | Ofu | 15 | 3.7 |
| | Ogorimangogo | 10 | 2.5 |
| | Okene | 26 | 6.5 |
| | Olamaboro | 13 | 3.3 |
| | Omala | 17 | 4.3 |
| | Yagba East | 6 | 1.5 |
| | Yagba West | 8 | 2.0 |
| **Sex** | | | |
| | Male | 117 | 29.4 |
| | Female | 281 | 70.6 |
| **Age (years)** | Less than 21 | 33 | 8.3 |
| | 21-25 | 59 | 14.8 |
| | 26-30 | 61 | 15.3 |

| | | | |
|---|---|---|---|
| | 31-35 | 76 | 19.1 |
| | 36-40 | 78 | 19.6 |
| | 41-50 | 80 | 20.1 |
| | 51 and above | 11 | 2.8 |
| **Marital Status** | Single | 104 | 26.1 |
| | Married | 167 | 41.9 |
| | Divorced | 44 | 11.1 |
| | Widowed/Widowered | 54 | 13.6 |
| | Separated | 29 | 7.3 |
| **Highest Qualification** | Consultant | 28 | 7 |
| | M.Sc/Ph.D. | 59 | 14.8 |
| | B.Sc | 138 | 34.7 |
| | RN/RM | 173 | 43.5 |
| **Length of Service (in years)** | 0-5 | 77 | 19.3 |
| | 6-10 | 89 | 22.4 |
| | 11-15 | 91 | 22.9 |
| | 16-20 | 101 | 25.4 |
| | 21-35 | 40 | 10.1 |
| **Job Status** | Medical Doctor | 65 | 16.3 |
| | Nurse | 333 | 83.7 |

**Source:** Researcher's Field Survey, 2025

The Local Government Areas of the respondents as shown on table 4 indicates that 11(2.8%) of the respondents were from Adavi LGA, 15(3.8%) were from Ajaokuta LGA, 75(18.8%) of the respondents indicated Ankpa LGA, 98(24.6%) of the respondents accounted for Dekina LGA, 19(4.8%) of the respondents indicated Idah LGA, 16(4.0%) of the respondents indicated Ijumu LGA, 11(2.8%) of the respondents indicated Kogi LGA, 49(12.3%) of the respondents indicated Lokoja LGA, 9(2.3%) of the respondents indicated Mopa-Muro LGA, 15(3.7%) of the respondents indicated Ofu LGA, 10(2.5%) of the respondents indicated Ogorimangogo LGA, 26(6.5%) of the respondents were from Okene LGA, 13(3.3%) of the respondents were from Olamaboro LGA, 17(4.3%) of the respondents indicated Omala LGA, 6(1.5%) were from Yagba East LGA, 8(2.0%) of the respondents indicated Yagba West LGA.

These findings indicate that the majority of respondents in the study were from Dekina LGA, which could be attributed to the fact that the local government area houses Prince Abubakar Audu University Teaching Hospital which is the largest State-owned health facility in the State. Additionally, the concentration of respondents in Dekina LGA may be linked to the more availability of public hospitals, which, if not evenly distributed across LGAs, could skew the findings. This has implications for policy recommendations, as solutions drawn from data heavily influenced by one area may not fully address the realities of doctor-nurse conflicts and patient well-being in other parts of the state. Moreover, the overrepresentation from Dekina LGA means findings may reflect conflict dynamics specific to a large, centralized hospital, possibly skewing insights into broader systemic issues. Larger hospitals often have more complex hierarchies, role overlap, and interprofessional tensions, which may exacerbate doctor-nurse conflicts compared to smaller, more collaborative settings.

The sex distribution of the respondents as shown in table 4 reveals that 117 (29.4%) of the respondents were male while the remaining 281(70.6%) of the respondents were female. The high figure of female respondents is an indication that we have more females especially nurses in the healthcare institutions particularly in Kogi State public hospitals. This could also be attributed to the fact that women's traditional roles as caregivers and nurturers have led to a natural alignment with the nursing profession, as nursing requires empathy, compassion, and a strong desire to care for others, traits that are often associated with women. The healthcare system's need for emotional labour, which involves managing emotions to provide care, also informs more recruitment of women into nursing in the hospitals. Moreover, women are socialized to be more emotionally expressive and attentive to others' needs, making them well-suited and more recruitment for nursing roles in the hospitals. This gendered composition can influence the power dynamics between doctors (who may be male-dominated) and nurses (female-dominated). Conflicts may stem from gendered assumptions, communication barriers, or hierarchical attitudes, with female nurses potentially experiencing marginalization or undervaluation by male doctors in male-led professional environments.

The age distribution of the respondents as presented in table 4 indicates that 33(8.3%) were within less than 21 years of age, 39(14.8%) of the respondents were within the age of 21-

25 years, 61 representing 15.3% of the respondents were within the age of 26-30 years, 76(19.1%) of the respondents were within the age of 31-35 years, 78(19.6%) of the respondents were within the age of 36-40 years, 80(20.1%) of the respondents were within the age of 41-50 years while the remaining 11(2.8%) of the respondents were within the age of 51 years and above. The high proportion of those whose age ranges between 36-40 and 41-50 years indicates that most of the respondents were in their active working age across the hospitals in Kogi State. This age range suggests that professionals are experienced and assertive, which may intensify conflict when roles or decisions are challenged. Nurses and doctors in this bracket may demand respect and autonomy, creating friction when there is lack of mutual recognition or professional boundaries are blurred

In examining the marital status of the respondents, table 4 further reveals that 104(26.1%) of the respondents account for single nurses and doctors, 167(41.9%) of the respondents account for married, 44(11.1%) of the respondents account for divorced while 54(13.6%) of the respondents loss their spouses to death, whereas the remaining 29(7.3%) of the respondents were separated from their partners. This implies that majority (41.9%) of the respondents were married. This was expected because most of the respondents were adults and matured enough for marriage, hence the high proportion of the married among the nurses and doctors in Kogi State hospitals. Married professionals may have stronger time and emotional management skills, yet they may also be less tolerant of prolonged workplace stress or disrespect. Tensions may arise if either doctors or nurses feel their roles add excessive burdens, impacting work-life balance. Personal values shaped by marriage may also influence conflict resolution approaches.

With regards to the qualifications of the respondents, table 4 also shows that 28(7%) of the respondents indicated that they were Consultants, 59 representing 14.8% admitted that they had M.Sc and Ph.D. degree certificates, 138(34.7%) indicated that they had B.Sc/MBBS degree certificates while 173(43.5%) had admitted that they had Registered Nurses/Midwifery certificates respectively. This signifies that majority of the respondents had BSc and RN/RM certificates in Kogi State public hospitals. And this could be as a result of the shorter duration and more accessible requirements of undergraduate programs.

In contrast, pursuing M.Sc and Ph.D. degrees require significant time, financial investment, and academic rigour, limiting the number of healthcare professionals

especially nurses and doctors who pursue or had advanced degrees for academic endeavours among other professions outside healthcare. Additionally, the healthcare system's need for frontline caregivers is often prioritized over specialized research or academic roles. This results in a larger workforce of nurses and doctors with graduate qualifications more than postgraduate experience. The qualification distribution of healthcare professionals in Kogi State public hospitals also has significant implications for the healthcare system.

For instance, the predominance of professionals with B.Sc/MBBS and RN/RM certificates suggests a workforce primarily composed of practitioners focused on direct patient care rather than specialized or research-based roles. This may enhance the availability of frontline healthcare providers, ensuring that basic medical and nursing services are adequately delivered. The relatively lower number of M.Sc and Ph.D. holders could indicate a potential gap in advanced expertise, medical research, and healthcare policy development within the system. Although, differences in qualifications can lead to perceived status imbalances however, doctors with MBBS may see themselves as more authoritative than nurses with RN, while nurses may feel undervalued despite frontline experience. This educational gap can fuel power struggles, particularly when roles are not clearly delineated or when nurses are excluded from decision-making.

Furthermore, The limited number of specialists may mean over-reliance on basic care roles, with doctors expected to make complex decisions alone and nurses feeling excluded from advanced responsibilities. This mismatch can lead to tension when expectations are high but roles and training do not align accordingly. Additionally, the emphasis on frontline care providers over specialized roles may contribute to an imbalance in the healthcare system, where immediate patient care is prioritized at the expense of long-term healthcare advancements. Addressing this gap might require policies that encourage and support further education, such as scholarships, career incentives, and institutional support for research and specialization. Strengthening postgraduate education among healthcare professionals could lead to improved healthcare service delivery, better patient outcomes, and a more resilient healthcare system in the long run.

Regarding the length of service of the respondents, table 4 shows that 77(19.3%) of the respondents indicated that they had been in the healthcare services within the range of 0-5

years in service, 89(22.4%) of the respondents account for 6-10 years in service, 91(22.9%) of the respondents account for 11-15 years in service, 101(25.4%) of the respondents account for 16-20 years in service, while the remaining 40 representing 10.1% of the respondents account for 21-35 years in service respectively. The implication of these findings is that majority of the respondents have so far spent about 20 years in the healthcare services. This signifies that majority of the respondents had a good knowledge of the research topic considering their length of experience in the service of providing healthcare for patients in the hospitals. Longer service duration suggests deep-rooted professional identities and expectations. Conflicts may arise when experienced nurses challenge younger doctors, or when long-serving professionals feel their contributions are overlooked in clinical decisions. Institutional memory may clash with new practices, fueling misunderstandings and resistance.

On the basis of job category of the respondents, table 4 shows that 65(16.3%) of the respondents were medical doctors while the remaining 333(83.7%) of the respondents were nurses. The high percentage of nurses as against doctors is an indication that they were more nurses than doctors across the public hospitals in Kogi State. The small percentage of medical doctors in hospitals compared to nurses could be as a result of nursing education and training programs which are often more accessible and affordable than medical school. Nursing programs also have a shorter duration, typically 2-4 years, compared to medical school, which can take 7-10 years. Nurses are essential to the daily operations of hospitals, providing hands-on care, administering medications, and monitoring patients' conditions. This requires a larger workforce to ensure adequate staffing.

Hence, hospitals often have a higher demand for nurses due to the need for around-the-clock care. Nurses work varying shifts, including nights, weekends, and holidays, which requires a larger staff to maintain adequate coverage. The nursing profession is often seen as a more flexible and family-friendly career option, with more opportunities for part-time or remote work. This attracts individuals who value work-life balance. The combination of these factors contributes to a larger workforce of nurses compared to medical doctors in Kogi State hospitals. This numerical imbalance can lead to workload disparities and feelings of hierarchical dominance by a smaller doctor population. Nurses may feel overworked and underappreciated, while doctors may feel pressured by being in short

supply. This dynamic can fuel resentment, role confusion, and blame, especially during high-pressure situations.

**Section B: Analysis of Results Based on Research Objectives**

**Research Objective 1**: To ascertain the prevalence of doctor-nurse conflicts in public hospitals in Kogi State.

**Table 5:** Distribution of the Prevalence of Doctor-Nurse Conflict in Kogi State Public Hospitals

| **Items** | **Category** | **Frequency (N = 398)** | **Percentage** |
|---|---|---|---|
| **Conflict between Doctors and Nurses are prevalent in Kogi State hospitals.** | Strongly Agreed | 106 | 26.6 |
| | Agreed | 97 | 24.4 |
| | Neutral | 91 | 22.8 |
| | Strongly Disagreed | 62 | 15.6 |
| | Disagreed | 42 | 10.6 |
| **Prevalence of doctor-nurse conflicts in public hospitals in Kogi State** | Occurs almost everyday | 103 | 25.9 |
| | Occurs several times within a week | 93 | 23.4 |
| | Occurs occasionally within a Month | 87 | 21.9 |
| | Conflict is rarely experienced | 71 | 17.8 |
| | Conflict is not experienced | 44 | 11 |
| **Types of conflict that do occur between Doctors and Nurses in the hospitals** | Ethical Conflict | 56 | 14 |
| | Communication Related Conflict | 21 | 5.3 |
| | Role Conflict | 51 | 12.8 |
| | Gender Based Conflict | 66 | 16.6 |
| | Differences in Treatment Approach | 95 | 23.9 |
| | All of the Above | 109 | 27.4 |
| **Times that conflict usually occur between doctors and nurses in the hospitals** | During and After Bed Rounds | 93 | 23.4 |
| | During Drug Prescription | 82 | 20.6 |
| | During Patients' Admission | 79 | 19.8 |

| | | | |
|---|---|---|---|
| | During Board Meeting | 87 | 21.9 |
| | Others | 57 | 14.3 |
| **The frequency of doctor-nurse conflicts has increased over the past few years** | Strongly Agreed | 101 | 25.4 |
| | Agreed | 90 | 22.7 |
| | Neutral | 73 | 18.3 |
| | Strongly Disagreed | 61 | 15.3 |
| | Disagreed | 73 | 18.3 |
| **Number of doctor-nurse conflicts have you personally witnessed or been involved in** | None | 69 | 17.3 |
| | 1-2 | 88 | 22.1 |
| | 3-5 | 74 | 18.6 |
| | 6-10 | 72 | 18.1 |
| | More than 10 | 95 | 23.9 |

**Source:** Researcher's Field Survey, 2025

Regarding whether conflict between doctors and nurses are common in Kogi State public hospitals, table 5 shows that 106(26.6%) of the respondents strongly agreed that it was common, 97(24.4%) of the respondents just agreed that it was common, while 91(22.8%) were neutral in their responses, 62(16.6%) of the respondents strongly disagreed and the remaining 42(10.6%) of the respondents just disagreed. The implication of these findings, going by the higher proportion of the respondents who strongly agreed signifies that doctor-nurse conflict is common across the different public hospitals in Kogi State, Nigeria. This also implies a systemic issue that affects the overall functioning of healthcare delivery. This perception points to a breakdown in interprofessional collaboration, poor communication, and likely role ambiguity, all of which can negatively impact patient safety and service quality. The presence of such conflict also suggests deficiencies in organizational leadership, lack of structured conflict resolution mechanisms, and possible gaps in policy and training. Furthermore, it reflects a workplace culture where such tensions may be normalized, leading to low staff morale, reduced job satisfaction, and potential increases in turnover, particularly among nurses. The findings call for urgent attention to strengthening teamwork, leadership accountability, and institutional support to foster a more collaborative and efficient healthcare environment.

On the frequency of doctor-nurse conflict in Kogi State public hospitals, table 5 shows that 103(25.9%) of the respondents indicated that the conflict occurred almost everyday, 93(23.4%) of the respondents indicated that the conflict occurred several times within a week, while 87(21.9%) of the respondents were revealed that the conflict occurred occasionally within a Month, 71(17.8%) of the respondents indicated that the conflict is rarely or seldom experienced and the remaining 44(11%) of the respondents indicated that such conflict was not experienced. Going by the majority of the respondents who indicated almost everyday, it implies that doctor-nurse conflict was prevalent in public hospitals across Kogi State, Nigeria.

On the types of conflict that normally occur between doctors and nurses across the public hospitals in Kogi State, table 5 also reveals that 56(14%) of the respondents indicated ethics related conflict, 21 representing 5.3% of the respondents indicated communication related conflict, 51(12.8%) of the respondents indicated role conflict, 66(16.6%) of the respondents indicated gender based conflict, 95 (23.9%) of the respondents indicated differences in treatment approach while the remaining 109( 27.4%) of the respondents indicated all of the above. The implication of these findings is that different conflicts as mentioned above occurred between doctors and nurses and are not limited to just only one type of conflict.

In investigating when does the conflict usually occur between doctors and nurses across the different public hospitals in Kogi State, table 5 further reveals that 93(23.4%) of the respondents indicated during and after ward rounds, 82 representing 20.6% indicated during drugs prescription, 79(19.8%) of the respondents indicated during parents' admission, 87(21.9%) of the respondents indicated during board meeting while the remaining 57(14.3%) of the respondents indicated other times. These findings signifies that most of the conflicts between doctors and nurses across the different facilities occurred usually during or after ward rounds when the two professionals will determine the appropriate diagnosis for a particular patient especially those with complicated health issues.

With regards to whether the frequency of doctor-nurse conflict has increased over the past few years, table 5 equally reveals that 101(25.4%) of the respondents strongly agreed, 90(22.7%) of the respondents disagreed, while 73 representing 18.3% of the respondents

were undecided on the question 61(15.3%) of the respondents strongly disagreed and the remaining 73(18.3%) of the respondents disagreed. This larger proportion of the respondents who indicated strongly disagreed signifies that the frequency of doctor-nurse conflict across the public hospitals in Kogi State has increased over the past few years.

On the number of conflicts personally witnessed or involved in by the respondents, table 5 shows that 69 (17.3%) of the respondents indicated that they didn't witness or involved in any conflict with their healthcare counterparts, 88(22.1%) of the respondents indicated 1- 2 times, 74(18.6%) of the respondents indicated 3 – 5 times, 72(18.1%) of the respondents indicated 6 – 10 times while the remaining 95(23.9%) of the respondents admitted that they have witnessed or involved in conflict with their healthcare counterparts for more than 10 times now. These findings implies that majority of the respondents have witnessed or been involved in doctor-nurse conflicts.

The findings from the In-depth interview with patients on this research objective complement and support the findings of questionnaire as presented below:

One interviewee had the following responses to say thus:

> Yes, I noticed some friction during my week-long stay for malaria treatment. The doctor would give instructions about my medication timing, but the nurses seemed to have their own schedule. I could sense frustration in their voices when they talked to each other about my care. I remember one specific instance where a nurse seemed frustrated because the doctor changed my treatment plan without informing her team. What really struck me was how this affected the flow of information – sometimes I would get different instructions from the nurse and doctor about my dietary restrictions. There was also a particularly memorable incident when a doctor ordered some urgent tests, but the nurse explained they were short-staffed and couldn't process them immediately. Their disagreement escalated into a heated discussion right there in the ward. It definitely impacted my care because my tests were delayed, and

> I felt quite uncomfortable watching them disagree about my treatment plan. **(IDI/1/Female/42years/Out-Patient/2025).**

In support of the above views by one interviewed, other participant expressed his own experience thus:

> During my three visits for antenatal care, I observed a particular incident where a nurse challenged a doctor's prescription. They had a heated discussion in the corridor, though they tried to keep their voices down. It made me feel uncomfortable as I could tell they disagreed about my treatment approach. Then during my maternity stay at this hospital, I noticed friction between doctors and nurses about twice a week. There was this situation where a nurse disagreed with a doctor's decision about my pain management plan. While they maintained professionalism, their body language and curt responses to each other were obvious. The tension affected my care because I received mixed messages about my medication timing**.** What caught my attention during my surgical recovery was how the nurses and doctors rarely spoke directly to each other. They would use patients' files to communicate, which seemed inefficient and created confusion about my post-operative care. **(IDI/1/Female/32 years/Out-Patient/2025).**

In response to this also, a participant revealed that:

> In my experience as a regular outpatient, I've witnessed several instances where nurses and doctors disagreed about patient priorities in the emergency room. Their body language and curt responses to each other were quite telling. I was admitted for a week after a car accident, and I noticed the tension mostly during shift changes. The nurses seemed frustrated when doctors

> modified treatment plans without consulting them first**.** Then as someone who visits quarterly for chronic condition management, I've noticed the tension varies depending on how busy the hospital is. During peak hours, there's more visible friction, especially regarding patient assessment priorities. My month-long stay made me aware of hierarchical issues. Nurses would sometimes delay implementing doctors' orders, seemingly in passive protest when they disagreed with the treatment approach. And to be frank with you sir, I've been here several times this year, and each time I notice how nurses and doctors seem to work in parallel rather than together. They rarely have direct conversations about patient care in my presence **(IDI/1/Male/34 years/Out-Patient/2025).**

Following the same trend of thought, an interviewee had these to say thus:

> After spending ten days in the hospital, I noticed that younger doctors and experienced nurses often had the most noticeable conflicts, particularly regarding patient care decisions. During my treatments, I've witnessed several instances where nurses felt undermined when doctors dismissed their observations about patient conditions, creating a palpable tension in the ward. Moreover, my lengthy stay made me notice that tensions peak during night shifts, when fewer staff are available and decisions about patient care become more contentious. What struck me during my stay was how differently doctors and nurses approached patient care. Their philosophical differences often led to visible disagreement during treatment discussions. Throughout my recovery period, I noticed that emergency situations heightened the existing tensions. The stress seemed to amplify underlying communication issues between the staff ***(*IDI/1/Male/33 years/In-Patient/2025).**

In the same vein, the findings from Chief Medical Director further corroborate that of the patients' stance as the CMD interviewed had the following to say thus:

> Haven served as CMD for the past few years, I observe that interprofessional conflicts between doctors and nurses occur approximately once every two months. Just last month, we had a situation in the emergency department where a senior nurse challenged a medical officer's prescription of high-dose antibiotics for a septic patient. The nurse felt the dosage was unusual. I've found that most conflicts stem from communication breakdowns rather than actual clinical disagreements. After the antibiotics incident, we introduced monthly interprofessional meetings where doctors and nurses discuss challenging cases together. This has fostered mutual respect and understanding of each other's roles. We've also implemented a clinical mentorship program where senior consultants and experienced nurses co-mentor junior staff, helping break down traditional hierarchical barriers. Since these interventions, we've seen a 60% reduction in reported conflicts, and patient satisfaction scores have improved significantly. More importantly, staff retention has increased as both professional groups report feeling more valued and understood **(IDI/1/Male/51years/Chief Medical Director/2025).**

These findings from both patients and the Chief Medical Director (CMD) revealed consistent patterns of doctor-nurse conflict in Kogi State public hospitals, highlighting its impact on patient care, communication, and hospital efficiency. Patients' perspectives emphasize how these conflicts manifest in daily hospital operations, while the CMD's insights provide an administrative viewpoint on their causes and possible solutions. A critical comparison of these perspectives reveals both overlapping concerns and differing interpretations of the problem's severity and resolution. For instance, patients frequently observed visible tension between doctors and nurses, with conflicts arising from differences in medication timing, treatment approaches, and hierarchical disputes. In the first response, a patient noted that conflicts disrupted the flow of information, resulting in

mixed messages about dietary restrictions and delayed test processing. This aligns with the second response, where another patient experienced similar communication breakdowns, particularly through the inefficient use of patient files for indirect communication. This indirect method of coordination suggests a deep-rooted issue in interprofessional collaboration, where the absence of direct dialogue leads to confusion and inefficiencies in patient care. The implication is that patients are left uncertain about their treatments, which can erode trust in healthcare providers and compromise adherence to medical instructions.

Similarly, the third and fourth patients revealed the situational nature of these conflicts. The third patient noted that tension was more pronounced during shift changes and peak hospital hours, suggesting that increased workload and stress exacerbate underlying conflicts. This contrasts with the fourth patient's observation that conflicts were more common between younger doctors and experienced nurses, indicating that power dynamics and perceived professional authority play a role in these disputes. Additionally, this respondent noted that emergency situations heightened tensions, suggesting that high-pressure environments further expose weaknesses in interprofessional relationships. The implication is that hierarchical struggles and stress-related communication failures can directly impact the quality of emergency and critical care, potentially putting patients at risk.

The CMD's response provides an administrative perspective that contextualizes the conflicts as primarily stemming from communication breakdowns rather than fundamental clinical disagreements. Unlike the patients, who focused on the visible manifestations of doctor-nurse conflict, the CMD acknowledged systemic factors contributing to these tensions and detailed structured interventions aimed at mitigating them. The implementation of interprofessional meetings and mentorship programs suggests an institutional effort to address the root causes of these conflicts by fostering collaboration and breaking down hierarchical barriers. The reported 60% reduction in conflicts and improved patient satisfaction scores imply that structured communication and role clarification can significantly alleviate professional tensions. However, the CMD's perspective somewhat contrasts with the patients' observations, particularly in the frequency of conflicts. While patients perceived doctor-nurse friction as a regular occurrence affecting daily hospital interactions, the CMD described conflicts as occurring

once every two months, suggesting that administrators might underestimate the prevalence of these issues.

In all, the juxtaposition of these findings s highlights that doctor-nurse conflicts in Kogi State public hospitals are not isolated incidents but part of a systemic challenge influenced by communication failures, workload pressures, and professional hierarchy. From the patients' viewpoint, these conflicts create an unsettling environment that can lead to inconsistent medical guidance, delays in care, and a lack of confidence in hospital services. From the CMD's perspective, the issue is primarily one of professional misunderstanding and inadequate communication structures, which can be managed through policy interventions. The implication of this findings is that while administrative solutions such as mentorship and interprofessional meetings may be effective, a more patient-centred approach that ensures direct and efficient communication between doctors and nurses during treatment planning is necessary to improve healthcare delivery and overall patient experience.

**Research Objective 2**: To assess the dynamics of doctor-nurse conflict in public hospitals in Kogi State.

**Table 6:** Distribution of the Dynamics of Doctor-Nurse Conflict in Public Hospitals in Kogi State

| **Items** | **Category** | **Frequency** ***(N* = 398*)*** | **Percentage (%)** |
|---|---|---|---|
| Cordial relationship exists between doctors and nurses in Kogi State public hospitals. | Strongly Agreed | 87 | 21.9 |
| | Agreed | 65 | 16.3 |
| | Neutral | 98 | 24.6 |
| | Strongly Disagreed | 45 | 11.3 |
| | Disagreed | 103 | 25.9 |
| Rate the overall working relationship between doctors and nurses in the hospital. | Excellent | 92 | 23.1 |
| | Good | 97 | 24.4 |
| | Fair | 113 | 28.4 |
| | Poor | 61 | 15.3 |
| | Very Poor | 35 | 8.8 |

**Source:** Researcher's Field Survey, 2025

In respect of whether cordial relationship exists between doctors and nurses in public hospitals in Kogi State, table 6 reveals that 87(21.9%) of the respondents indicated strongly agreed, 65(16.3%) of the respondents indicated agreed, while 98(24.6%) of the respondents indicated neutral, 45(11.3%) of the respondents strongly disagreed and the remaining 103(28.4%) indicated disagreed. These findings imply that cordial relationship does not exist between doctors and nurses in Kogi State public hospitals.

Regarding the degree of the working relationship between doctors and nurses in public hospitals, table 6 also reveals that the relationship was excellent, 113(28.4%) of the respondents rated the relationship to be good, 97(24.4%) of the respondents rated the relationship to be fair, while 61(15.3%) rated the relationship to be poor, the remaining 34(8.8%) of the respondents rated the relationship to be very poor.

These findings reveal a contradiction between the perceived lack of cordiality and a generally fair working relationship between doctors and nurses in Kogi State public hospitals. While the majority of respondents either disagreed or remained neutral about the existence of a cordial relationship, suggesting strained interpersonal dynamics, a notable portion still rated the overall working relationship as fair to good. This dichotomy implies that while professional interactions may meet functional expectations, they are likely characterized by underlying tensions, lack of mutual trust, or emotional disconnect, which can hinder teamwork and affect morale. The prevalence of neutral and negative responses further highlights a fragile professional atmosphere where collaboration may occur out of necessity rather than genuine collegiality. This underscores the need for targeted interventions to improve interpersonal relationships and foster a culture of respect and cooperation, as sustained tension can gradually erode team effectiveness and patient care quality.

Findings from the interview schedules with the Chief Medical Directors to complement the findings of the questionnaire on this research question are presented below, as an interviewee had the following to say thus:

> In my experience so far, the dynamics of doctor-nurse conflicts often revolve around professional autonomy and decision-making authority. The most common friction points emerge

> during ward rounds, where nurses sometimes feel their patient insights are overlooked, while doctors perceive questioning of their clinical decisions as challenges to their expertise. For instance, in our medical ward, we frequently observe tensions around the timing and urgency of medication administration, where nurses' workflow considerations sometimes clash with doctors' prescribed treatment schedules. These conflicts undeniably impact patient care, particularly through delays in treatment implementation and occasionally through communication breakdowns that affect the continuity of care. I've noticed that when such conflicts persist, patient satisfaction scores tend to decrease, and we see an increase in incident reports related to near-misses in medication administration. The strain on professional relationships often leads to reduced collaborative problem-solving, which is crucial for complex patient cases requiring multidisciplinary approaches **(IDI/2/Male/47years/Chief Medical Director/2025).**

On the same dynamics of doctor-nurse conflict, another Chief Medical Director had the following experiences as he expressed thus:

> In this hospital, the conflict dynamics typically manifest in hierarchical power struggles and communication barriers. We frequently encounter situations where junior doctors and senior nurses navigate complex authority relationships, particularly in emergency scenarios where quick decisions are paramount. The traditional hierarchical structure of healthcare sometimes creates friction when experienced nurses feel their practical knowledge is disregarded by less experienced doctors. These tensions invariably affect patient care quality, though often in subtle ways. We've documented instances where vital patient information wasn't promptly shared between teams due to strained professional relationships, leading to delayed

> interventions or unnecessary diagnostic tests. The emotional atmosphere created by these conflicts can also impact patients' healing environment, as they often sense the underlying tension even when staff maintain professional composure **(IDI/2/Male/49years/Chief Medical Director/2025).**

From another perspective, an interviewee aired his own views on the question this:

> From my observations, conflicts between doctors and nurses frequently centre on resource allocation and workload distribution. A recurring pattern involves disagreements over patient prioritization, particularly in settings where resources are constrained. For example, in our intensive care unit, we often see tensions arise over nurse-to-patient ratios and the distribution of monitoring equipment. The impact on patient care manifests in various ways, from delayed responses to patient needs to inconsistencies in care protocol implementation. When professional relationships are strained, we notice a decrease in proactive communication about patient status changes, which can lead to missed opportunities for early intervention. More concerning is the effect on staff morale, which indirectly influences care quality through reduced engagement and increased burnout among both professional groups **(IDI/2/Male/47years/Chief Medical Director/2025).**

These findings provide a structured understanding of the dynamics of doctor-nurse conflicts in Kogi State public hospitals as they revealed that the dynamics of doctor-nurse conflicts in these hospitals revolve around issues of professional autonomy, hierarchical struggles, communication breakdowns, and resource allocation. While each Chief Medical Director (CMD) presents a unique perspective, their insights collectively highlight the complexity of these conflicts and their far-reaching consequences on patient care and staff morale.

A major underlying factor in these conflicts as revealed by the interviewees is the traditional hierarchy in healthcare, which creates friction between doctors and nurses. CMDs observe that while doctors view clinical decision-making as their exclusive domain, nurses often feel that their insights, especially from direct patient interactions, are undervalued. This tension is particularly evident during ward rounds and emergency situations, where quick decisions are required, and power struggles emerge between experienced nurses and junior doctors. These conflicts often lead to delays in patient care, miscommunication of critical information, and, in some cases, the duplication of medical procedures due to a lack of coordination.

Another critical factor revealed is resource allocation and workload distribution. In environments where human and material resources are stretched thin, disagreements over patient prioritization and access to medical equipment intensify professional friction. The result is not only delayed responses to patient needs but also inconsistencies in implementing care protocols. Over time, these inefficiencies contribute to staff burnout and disengagement, further weakening the collaborative atmosphere necessary for effective healthcare delivery. Beyond the immediate operational consequences, the psychological impact of these conflicts cannot be overlooked. Patients, even when not directly involved, can sense underlying tensions among healthcare providers. This affects their perception of care quality and can, in some cases, slow down their recovery due to stress or lack of confidence in the healthcare team. Furthermore, prolonged interpersonal conflicts reduce teamwork, making it difficult to manage complex cases that require a multidisciplinary approach.

The implications of these findings are significant. However, efforts should focus on fostering a more inclusive decision-making process, improving communication channels between doctors and nurses, and addressing systemic challenges such as resource limitations and workload imbalances. Without proactive interventions, these conflicts will continue to undermine both healthcare efficiency and patient outcomes, perpetuating a cycle of professional dissatisfaction and compromised care delivery.

**Research Objective 3:** To identify the sources of conflict between doctors and nurses in public hospitals in Kogi State.

**Table 7:** Percentage Distribution of the Sources of Doctor-Nurse Conflict in Kogi State Public Hospitals (N = 398)

| ITEM | YES | NO | UNDECIDED |
|---|---|---|---|
| Do you think that some factors will lead to doctor-nurse conflict in the hospitals? | 359(90.2%) | 11(2.8%) | 28(7%) |
| Lack of Mutual Respect | 297(74.6%) | 30(7.5%) | 71(17.9%) |
| Differences in Salaries | 301(75.6) | 76(19.1%) | 21(5.3%) |
| Quest for recognition | 290(72.9%) | 13(3.3%) | 95(23.8) |
| Quest for professional relevance | 307(77.1) | 47(11.8) | 44(11.1%) |
| Gender Differences | 161(40.5%) | 159(39.9%) | 78(39.9%) |
| Pride | 346(86.9%) | 33(8.3%) | 19(4.8%) |
| Disagreement over treatment plans | 298(74.9%) | 26(74.9%) | 26(6.5%) |
| All of the Above | 382(95.9%) | 13(3.3%) | 3(0.8%) |

**Source:** Researcher's Field Survey, 2025

When the respondents were asked whether they think some factors will lead to conflicts between doctors and nurses in public hospitals in Kogi State, table 7 shows that 359(90.2%) indicated in affirmation, 11(2.8%) of the respondents indicated no while the remaining 28(7%) of the respondents were neutral or undecided in their responses. The higher proportion of those with affirmative responses signifies that some factors can actually escalate to disagreements between doctors and nurses in public hospitals in Kogi State.

Regarding the question of whether a lack of mutual respect can lead to doctor-nurse conflict in Kogi State public hospitals, Table 7 reveals that 297 (74.6%) of the respondents indicated yes, while 30 (7.5%) of the respondents indicated no. The remaining 71 (17.9%) of the respondents were undecided. These findings imply that a lack of mutual respect among healthcare professionals is one of the factors that can lead to doctor-nurse conflict in Kogi State public hospitals.

Responses to whether differences in wages and salaries can lead to doctor-nurse conflict in Kogi State public hospitals are shown in Table 7, where 301 (75.6%) of the respondents indicated yes, while 76 (19.1%) indicated no. The remaining 21 (5.3%) of the respondents

were undecided. This means that, given the significant majority who responded affirmatively, differences in wages and salaries can actually lead to disagreements between doctors and nurses in public hospitals in Kogi State.

Concerning the issue of whether the quest for recognition can result in conflicts between doctors and nurses in public hospitals in Kogi State, Table 7 shows that 290 (72.9%) of the respondents indicated yes, while 13 (3.3%) indicated no. The remaining 95 (23.8%) of the respondents were neutral in their responses. These findings imply that the quest for recognition is also one of the factors that can lead to doctor-nurse conflict in Kogi State public hospitals.

With regard to whether the quest for professional relevance can lead to doctor-nurse conflict in Kogi State public hospitals, Table 7 further reveals that 307 (77.1%) of the respondents indicated yes, while 47 (11.8%) indicated no. The remaining 44 (11.1%) of the respondents were undecided. This signifies that the quest for professional relevance is a factor that contributes to doctor-nurse conflict in Kogi State public hospitals.

In examining whether gender differences serve as a source of doctor-nurse conflict in Kogi State public hospitals, Table 7 reveals that 161 (40.5%) of the respondents indicated yes, while 159 (39.9%) indicated no. The remaining 78 (19.9%) of the respondents were undecided. This suggests that gender differences indeed play a role in doctor-nurse conflicts in Kogi State public hospitals.

Regarding whether pride is a source of doctor-nurse conflict in Kogi State public hospitals, Table 7 also shows that 346 (86.9%) of the respondents indicated yes, while 33 (8.3%) indicated no. The remaining 19 (4.8%) of the respondents were undecided. The implication of these findings is that pride is indeed another source of doctor-nurse conflict in Kogi State public hospitals.

On the matter of whether differences in treatment plans contribute to doctor-nurse conflict in Kogi State public hospitals, Table 7 indicates that 298 (74.9%) of the respondents answered yes, while 26 (6.5%) said no. The remaining 74 (18.4%) of the respondents were undecided. This suggests that, based on the significant majority who affirmed, differences in treatment plans can actually spark conflict between doctors and nurses in Kogi State public hospitals.

When asked whether all the mentioned factors can lead to doctor-nurse conflict, a significant majority i.e 382 (95.9%) of the respondents affirmed that all the factors listed above are major sources of doctor-nurse conflict in Kogi State public hospitals. Only 13 (3.3%) expressed a contrary opinion. Other sources mentioned by respondents included relationship issues.

Responses from the interview schedules with patients to complement the findings of the questionnaire are presented on this research question are presented as follows:

An interviewee mentioned what she thought could lead to doctor-nurse conflicts thus:

> From what I've seen during my stays in this hospital, the main issue seems to be about who has the most current knowledge of patient conditions. The nurses spend more time with us, but the doctors make the final decisions, which creates friction when their observations don't align with the nurses' daily experiences. Again, based on my observations during dialysis sessions, professional hierarchy appears to be a major source of conflict. Sometimes nurses' suggestions about patient care seem dismissed simply because they come from nurses rather than doctors. Doctors seem more focused on medical procedures, while nurses emphasize holistic care and patient comfort, leading to conflicts in treatment priorities. I've also seen how poor handoff communication between shifts creates misunderstandings that affect both staff relationships and patient care **(IDI/3/Female/26 years/In-Patient/2025).**

From another point of view, another participant said:

> Time management seems to be a significant issue. Throughout my hospitalization, I've observed nurses becoming frustrated when doctors are delayed for rounds or unavailable for urgent consultations, which impacts patient care scheduling. I also observed that resource allocation appears to be a major source of tension. During my frequent visits, I've noticed conflicts arise

> when there's limited equipment or supplies, and doctors and nurses have different priorities about their distribution. I've seen also how documentation requirements create friction. Nurses often express frustration about unclear or incomplete medical orders, while doctors seem pressured by administrative demands. Besides, what I have said, the generation gap between younger doctors and experienced nurses seems to cause tension. During my stay, I've observed how different approaches to technology and traditional practices lead to disagreements about patient care methods **(IDI/3/Female/26 years/In-Patient/2025).**

Aside the above propelling factors mentioned by some participants above, other interviewees presented the following factors thus:

> Well, emergency situations really highlight the underlying tensions. From my time in the ward, I've seen how stress and urgency can amplify communication problems between doctors and nurses. Aside from that, I think, cultural differences appear to play a role. Throughout my treatment, I've noticed how varying backgrounds and communication styles contribute to misunderstandings between healthcare staff. As a matter of fact, even the physical layout of the hospital seems to contribute to problems. During my recovery, I observed how the separation of doctors' and nurses' workspaces makes it difficult for them to have proper discussions about patient care **(IDI/3/Male/28years/Out-Patient/2025).**

From another perspective, a participant submitted that:

> Decision-making authority seems to be a constant source of friction. During my stays, I've noticed nurses feeling undermined when their clinical judgments are overlooked by doctors. I have also observed that the use of technology appears to create tension. Throughout my treatment, I've observed

> conflicts arising from different preferences in using electronic health records and communication systems. I also think that personal egos seem to play a role in these conflicts. During my hospitalization, I've witnessed how professional pride can prevent effective collaboration between doctors and nurses. Even the lack of clear protocols seems problematic. During my treatment, I've noticed how varying interpretations of procedures lead to disagreements between doctors and nurses. **(IDI/3/Female/26 years/Out-Patient/2025).**

The patients' responses provide valuable support to the previous responses on the questionnaire instrument into the underlying causes of doctor-nurse conflicts in Kogi State public hospitals. A recurring theme from these responses is the tension between professional roles and decision-making authority. The interviewees observed that nurses, who spend more time with them, often feel their clinical input is overlooked, while doctors hold the final authority, leading to conflicts when observations do not align. This issue is further exacerbated by hierarchical power dynamics, where experienced nurses may feel disregarded by younger doctors, creating professional friction.

Another significant concern is communication breakdowns, which patients repeatedly identify as a core issue. They describe instances where doctors make treatment changes without properly informing nurses, causing confusion and frustration. Poor handoff communication between shifts and a lack of regular team meetings also contribute to misunderstandings, ultimately impacting patient care continuity.

Following the same trend of finding, the Chief Medical Directors who were interviewed on the same research question had the following responses to say as one of them said:

> From my experience managing the hospital, the root causes of doctor-nurse conflicts are deeply embedded in our healthcare system's structural framework. The hierarchical nature of medical practice, inherited from colonial medical education systems, creates an environment where professional boundaries become battlegrounds. Communication barriers often emerge

not from personal differences, but from deeply ingrained professional socialization patterns where doctors are trained to be decisive leaders while nurses are traditionally taught to be vigilant patient advocates. In our facility, this manifests most prominently during emergency situations where rapid decisions need to be made. Hospital policies, though well-intentioned, sometimes inadvertently reinforce these divides by maintaining separate reporting structures for doctors and nurses. We've noticed that departments with more collaborative leadership styles and shared decision-making protocols experience significantly fewer conflicts. The resource constraints in our public healthcare system also exacerbate these tensions, as both professional groups compete for limited resources to fulfil their responsibilities effectively" (**IDI/3/Male/47years/Chief Medical Director/2025).**

Buttressing the above points, another Chief Medical Director said thus:

> Well, the primary sources of conflicts stem from overlapping professional roles in an evolving healthcare landscape. Modern nursing has become increasingly specialized, yet our institutional policies haven't fully adapted to reflect these changes. For instance, we frequently encounter tensions in our critical care units where highly trained nurses possess specialized knowledge that sometimes conflicts with general medical officers' approaches. Communication breakdowns also often occur not due to lack of skill, but because of differing professional languages and priorities. Nurses focus on holistic patient care and continuous monitoring, while doctors typically concentrate on diagnostic and treatment decisions. Cultural factors also play a significant role, as traditional respect for hierarchy in our society sometimes prevents junior doctors and experienced nurses from engaging in open dialogue. The

> increasing pressure on healthcare workers due to growing patient loads and documentation requirements further strains these professional relationships **(IDI/3/Male/51years/Chief Medical Director/2025).**

In his own submissions, another interviewee had the following to say thus:

> Drawing from my tenure so far, I've observed that doctor-nurse conflicts often originate from systemic issues rather than individual differences. The root causes frequently trace back to inadequate interprofessional education during formative training years. Our medical and nursing schools operate in silos, producing professionals who first interact meaningfully only in the workplace. This lack of early interprofessional exposure creates predetermined biases and communication patterns that prove difficult to change. Hospital policies, particularly those regarding scope of practice and decision-making authority, sometimes lag behind the evolving capabilities of both professions. Resource allocation processes often pit departments against each other, creating an environment where doctors and nurses must compete rather than collaborate. Additionally, the absence of structured forums for interprofessional dialogue means that minor misunderstandings frequently escalate into significant conflicts. The increasing complexity of patient care, coupled with rising public expectations, adds pressure to these already strained professional relationships **(IDI/3/Male/47years/Chief Medical Director/2025).**

These findings provide distinct yet overlapping perspectives on the root causes of doctor-nurse conflicts in Kogi State public hospitals. All them emphasize structural and systemic issues as the primary drivers of these tensions rather than purely individual or interpersonal differences. However, their analyses diverge in how they frame these challenges and the specific aspects they emphasize. For instance, the first participant attributes conflict

primarily to the hierarchical nature of medical practice, which he links to colonial-era training models. He argues that the deeply ingrained division between doctors as decision-makers and nurses as patient advocates fosters communication barriers, particularly in emergency settings where quick decisions are required. He also highlights hospital policies and resource constraints as reinforcing these tensions, noting that departments with collaborative leadership styles tend to experience fewer conflicts.

The sixth participant focuses more on the evolving roles of nurses in modern healthcare and how institutional policies have failed to keep pace with these changes. He identifies role overlap in specialized areas like critical care as a major source of conflict, where highly trained nurses sometimes challenge general medical officers' decisions. Additionally, he highlights professional language differences, with nurses prioritizing holistic care and doctors emphasizing diagnosis and treatment. Cultural respect for hierarchy further complicates open dialogue, while growing patient loads and administrative burdens intensify professional strain.

The seventh Participant takes a broader education and systemic reform approach, arguing that conflicts originate from interprofessional silos in training. He suggests that because doctors and nurses are trained separately, they enter the workplace with preconceived biases and rigid communication patterns that make collaboration difficult. Furthermore, outdated hospital policies on scope of practice and decision-making fail to reflect the evolving capabilities of both professions. He also emphasizes resource allocation struggles and the lack of structured forums for interprofessional dialogue, which allow minor disputes to escalate unnecessarily.

Despite their differences in emphasis, all the interviewees on sources of doctor-nurse conflict agreed that systemic reforms, whether in professional training, hospital policies, or leadership approaches are necessary to reduce conflicts. They collectively highlight hierarchical structures, communication barriers, role evolution, resource constraints, and policy gaps as central to the problem. However, their varied perspectives suggest that addressing these conflicts will require a multifaceted approach, integrating education reforms, collaborative leadership, and policy updates to create a more cohesive healthcare environment

**Research Objective 4:** To determine the effects of conflict between doctors and nurses on the general well-being of patients in public hospitals in Kogi State.

**Table 8:** Distribution of the Effects of Doctor-Nurse Conflicts on the Well-being of Patients in Kogi State public hospitals

| Items | Category | Frequency (N=398) | Percentage (%) |
|---|---|---|---|
| Conflict between doctors and nurses has consequences on patients' general well-being. | Strongly Agreed | 164 | 41.2 |
| | Agreed | 102 | 25.6 |
| | Neutral | 59 | 14.8 |
| | Strongly Disagreed | 47 | 11.8 |
| | Disagreed | 26 | 6.6 |
| Effects of conflict between doctors and nurses on the well-being of patients in public hospitals in Kogi State. | Anxiety/Depression | 66 | 16.6 |
| | Stress/Trauma | 39 | 9.8 |
| | Stigmatization | 23 | 5.8 |
| | Body Image Issue | 37 | 9.3 |
| | Pain/Discomfort | 56 | 14.1 |
| | Sleep Disturbance | 41 | 10.3 |
| | Substance Abuse | 34 | 8.5 |
| | All of the Above | 75 | 18.8 |
| | Others | 27 | 6.8 |
| The extent at which doctor-nurse conflicts affect patients' willingness to openly discuss their health concerns with healthcare professionals | Not Willing at all | 23 | 5.8 |
| | Slightly less willing | 43 | 10.8 |
| | Moderately less willing | 187 | 47 |
| | Significantly less willing | 79 | 19.8 |
| | Extremely less willing | 66 | 16.6 |
| How does the presence of doctor-nurse conflicts impact patients' overall emotional well-being during their hospital | No impact | 33 | 8.3 |
| | Slight negative impact | 67 | 16.8 |
| | Moderate negative impact | 85 | 21.4 |
| | | 104 | 26.1 |

| | | | |
|---|---|---|---|
| stay? | Significant negative impact<br>Severe negative impact | 109 | 27.4 |
| Negative consequences of doctor-nurse conflict on patients' healthcare? | Medical Errors<br>Delay in Recovery<br>Death<br>Decreased Patient confidence<br>Decreased Patient' Satisfaction<br>Increased Patients Anxiety<br>Increased Patients Stress Level<br>All of the Above | 29<br>42<br>37<br>25<br>44<br>26<br>49<br>149 | 7.3<br>10.6<br>9.3<br>6.3<br>11.1<br>6.5<br>12.3<br>36.6 |
| How frequently do patients express concerns over the quality of care due to perceived doctor-nurse conflicts? | Never<br>Rarely<br>Sometimes<br>Often<br>Very often | 89<br>135<br>113<br>44<br>17 | 22.4<br>33.9<br>28.4<br>11<br>4.3 |

**Source:** Researcher's Field Survey, 2025

Table 8 reveals that 164(41.2%) of the respondents strongly agreed that conflict between doctors and nurses has consequences on the general well-being of patients in Kogi State public hospitals, 102(25.2%) of the respondents just agreed that doctor-nurse conflict has consequences on the general well-being of patients in the hospitals, while 59(14.8%) of the respondents were neutral, the remaining 73(18.4%) of the respondents indicated Agreed and strongly disagreed respectively. These findings imply that doctor-nurse conflict is not without consequences on the well-being of patients in Kogi State public hospitals. The findings strongly suggest that doctor-nurse conflict significantly impacts patient well-being in Kogi State public hospitals. With a majority of respondents affirming this link, it becomes evident that such professional tensions extend beyond staff dynamics and directly

affect the quality of healthcare delivery. This implies that unresolved conflicts can lead to communication breakdowns, delays in treatment, reduced coordination in patient care, and overall diminished trust in the health system. The substantial number of neutral and disagreeing responses also points to possible variability in how these consequences manifest, potentially influenced by department, location, or individual experiences. Nonetheless, the overarching implication is that patient outcomes are at risk when interprofessional relationships are strained, underscoring the urgent need for conflict resolution strategies and stronger collaborative frameworks to ensure optimal care and safeguard public health.

Table 8 also reveals that 66(16.6%) of the respondents indicated anxiety/depression as an effect of doctor-nurse conflict on patients in the hospital, 39(9.8%) of the respondents indicated stress/ trauma as an effect of the conflict on patients' well-being, 23(5.8%) of the respondents indicated stigmatization as an effect of doctor-nurse conflict on patients' well-being, 37(9.3%) of the respondents indicated body image issues, 56(14.1%) of the respondents indicated pain/discomfort as what patients suffered as a result of doctor-nurse conflict, 14(10.3%) indicated sleep disturbance as what patients suffered as a result of doctor-nurse conflict in the hospital, 34(8.5%) of the respondents indicated substance Abuse as what patients resort to as a result of doctor-nurse conflict in the hospital, while 75(18.8%) of the respondents indicated all of the above effects mentioned, the remaining 27(6.8%) of the respondents indicated other factors such as lack proper professional orientation and person problems among others. These findings imply that all the factors mentioned above combined are what patients suffered as a result of doctor-nurse conflict in Kogi State public hospitals.

Regarding the extent to which doctor-nurse conflict affect patients' willingness to openly discuss their health concerns with doctors and nurses in Kogi State public hospitals, table 8 reveals that 23(5.8%) of the respondents admitted that doctor-nurse conflict did not affect patients' willingness to openly discuss their health concerns with the healthcare professionals, 43(10.8%) of the respondents indicated that patients were slightly less willing to discuss their health concerns with the healthcare providers as a result of doctor-nurse conflict, 187(47%) of the respondents indicated that patients were moderately less willing to openly discuss their health concerns with their healthcare providers as a result of

doctor-nurse conflict in the hospital, 79(19.8%) of the respondents indicated that patients were significantly less willing to discuss their health concerns with their healthcare providers as a result of doctor-nurse conflict, while the remaining 66(16.6%) of the respondents indicated that patients were extremely less willing to discuss their health concerns with their healthcare providers as a result of doctor-nurse conflict. These findings signify that patients were moderately less willing to openly discuss their health concerns with their healthcare providers as a result of doctor-nurse conflict. In other words, it's a decrease in willingness, but not a complete refusal to disclose their health concerns arising from doctor-nurse uproar. Patients may still be open to the healthcare professionals on the state of their health, but they were not as eager or motivated as they were ought to be after perceiving an element of disagreement between doctors and nurses in the hospital.

Table 8 also reveals that 33(8.3%) of the respondents indicated that doctor-nurse conflict had no impact on the emotional well-being of patients during their hospital stay, 67(16.8%) of the respondents indicated that doctor-nurse conflict has slight negative impact on the emotional well-being of patients during their hospital stay, 85(21.4%) of the respondents indicated that doctor-nurse conflict had moderate impact on the emotional well-being of patients during their hospital stay, 104(26.1%) of the respondents indicated that doctor-nurse conflict had significant negative impact on the emotional well-being during their hospital stay, while the remaining 109(27.4%) of the respondents admitted that doctor-nurse conflict had a severe negative impact on the patients' emotional well-being during their hospital stay. These findings imply that going by the significant majority 213(53.5%) who indicated significant and severe negative impact, it means doctor-nurse conflict had severe significant impact on the emotional well-being of patients during their hospital stay in Kogi State public hospitals.

As regards the negative consequences of doctor-nurse conflict on patients' healthcare, table 8 equally reveals that 29(7.3%) of the respondents indicated medical errors, 42(10.6%) of the respondents indicated delay in recovery from ill-health, 37(9.3%) of the respondents indicated death, 25(6.3%) of the respondents indicated decreased patients' confidence, 44(11.1%) of the respondents indicated decreased patients' satisfaction probably in the healthcare system, 26(6.5%) of the respondents indicated that doctor-nurse conflict could result in patients' level of anxiety, while 49(12.3%) of the respondents indicated that

doctor-nurse conflict could increase patients' level of stress, the remaining which were the majority indicated that all the factors mentioned above were the negative consequences of doctor-nurse conflict on patients' healthcare in Kogi State public hospitals.

Table 8 also reveals that 89(22.4%) of the respondents admitted that patients never expressed concerns over the quality of care they received due to perceived doctor-nurse conflict, 135(33.9%) of the respondents indicated that rarely expressed concerns over the quality of care they received due to perceived doctor-nurse conflict, 113(23.4%) of the respondents admitted that patients sometimes expressed concerns over the quality of care they received due to perceived doctor-nurse conflict, 44(11%) of the respondents indicated that patients often expressed concerns over the quality of care they received due to perceived doctor-nurse conflict, while the remaining 17(4.3%) of the respondents indicated that patients very often expressed concerns over the quality of care they received due to perceived doctor-nurse conflict. The implication of these findings is that patients rarely expressed concerns over the quality of care they received due to perceived doctor-nurse conflict in Kogi State public hospitals. This could be as a result of the fact that it is against the ethics of the medical profession for medical professionals to take decisions or argue in front of or in the presence of patients on their health issues. Hence, since doctor-nurse conflict wouldn't take place openly or in the presence of patients, then the patients in question wouldn't react much to a perceived phenomenon.

Findings from the interview schedules to complement the results of the questionnaire on the effects of doctor-nurse conflict on patients' wellbeing are presented as follows:

The following are the excerpts from one of the interviewees' responses:

> The tension I witnessed between the doctor and nurse during my surgery recovery time made me incredibly anxious. When they disagreed about my pain medication timing, I felt caught in the middle and hesitated to ask for help even when I was in severe pain. Their conflict definitely increased my stress levels and probably slowed my recovery. As a matter of fact, the disagreements I perceived at this General Hospital affected my blood pressure readings. Whenever the doctor and nurse would

> argue about treatment plans, my anxiety would spike, and I'd notice my BP readings getting worse. It felt like being a child watching parents argue – you feel helpless and somehow responsible. What bothered me most during my week at the Hospital was how the conflict between my doctor and nurse led to mixed messages about my care. One would say one thing, then the other would contradict it. This confusion made me lose confidence in my treatment plan and left me feeling vulnerable **(IDI/4/Male/37years/Out-Patient/2025).**

In his own experiences, another patient narrated how doctor-nurse conflict affected her well-being in the hospital thus:

> Well, their disagreement about my discharge timing at this Hospital created unnecessary stress. The doctor wanted me to leave, but the nurse felt I wasn't ready. Being caught between their opposing views made me doubt my own recovery progress and added anxiety to an already difficult situation. Although, the tension was subtle but palpable during my maternity stay in the hospital, when the doctor and nurse disagreed about my labour management, it made me question whether I was receiving the best care possible. This added fear during what should have been a joyful experience. I noticed how the conflict affected other patients too at the ward. You know, when healthcare providers argued about treatment priorities, everyone in the ward became visibly uncomfortable. The stress in the air was contagious, and it made the whole recovery environment feel hostile **(IDI/4/Female/32years/In-Patient/2025).**

On another occasion, the following participant expressed his experience thus:

> During my diabetes treatment, their disagreements about my insulin schedule left me feeling unsafe. I wasn't sure whose

> instructions to follow, and this uncertainty affected my trust in both the doctor and nurse. It made managing my condition even more challenging. The disagreement made me reluctant to ask questions about my care. When I saw how they responded to each other with irritation, I worried about being perceived as difficult if I raised concerns. This definitely impacted my understanding of my treatment. Moreover, their conflict during night shifts was particularly distressing. Hearing them disagree about emergency protocols while I was already feeling vulnerable made me question whether I would receive proper care if my condition worsened overnight. This not only impacted my physical comfort but also made me feel like a burden **(IDI/4/Female/48years/In-Patient/2025).**

Regarding the same research question, another participant submitted thus:

> Hmmmm, well, during my post-operation care, the poor communication between doctors and nurses affected my pain management. The nurse seemed hesitant to approach the doctor about adjusting my medication, and I suffered longer than necessary because of their strained relationship I observed that the conflict made simple procedures more stressful than they needed to be. Even basic things like getting help to walk to the bathroom became complicated when staff were clearly not communicating well with each other. Their tension was especially noticeable during ward rounds. The way they'd avoid eye contact or barely acknowledge each other made me wonder if they were missing important information about my care because they weren't communicating effectively **(IDI/4/Male/30years/Out-Patient/2025).**

In support of the findings from the questionnaire, another participant aired his own views in the following manner;

> As a long-term patient, I noticed how doctor-nurse conflicts affected the entire ward's morale. Other patients and I would often discuss how uncomfortable it made us feel, and some even requested transfers to different wards to avoid the tension. The stress of witnessing the disagreements between doctors and nurses affected my sleep quality. I'd lie awake worrying about whether important information about my care was being properly communicated between them. I couldn't help wondering if I would have recovered faster if my healthcare team had worked together more harmoniously. So, I started timing my requests for help based on which staff members seemed to be getting along better at any given moment **(IDI/4/Male/37years/Patient/2025).**

It can be deduced from the above responses by the interviewees highlighting the significant negative impact of doctor-nurse conflicts on their overall well-being, ranging from increased anxiety and stress to direct effects on their treatment and recovery. A recurring theme is emotional distress, as patients frequently describe feeling caught in the middle of disagreements, leading to heightened anxiety, reduced confidence in their care, and even sleep disturbances. The conflicts also contribute to communication breakdowns, where patients receive mixed messages about their treatment plans, feel hesitant to ask questions, or must repeat information themselves due to poor coordination between healthcare providers.

Moreover, the tension between doctors and nurses appears to affect the quality and timeliness of care, with patients reporting delays in medication, conflicting instructions, and even compromised pain management. The hostile environment created by these disputes also extends beyond individual patients, impacting the morale of entire wards and even making family visits more stressful. Some patients note that witnessing these conflicts eroded their trust in the healthcare system, making them question the competence of staff and, in some cases, consider seeking treatment elsewhere.

Overall, these accounts suggest that doctor-nurse conflicts do not just affect hospital staff; they directly impact patient recovery, emotional well-being, and overall confidence in the

healthcare system. Addressing these conflicts through better communication, collaboration, and structured teamwork could significantly improve both patient experiences and treatment outcomes.

The Chief Medical Directors (CMDs) forming another category of the interviewees had the following to say on the effects of doctor-nurse conflict on patients' well-being thus;

> As CMD, I've observed significant correlations between staff conflicts and patient well-being. Patients are remarkably perceptive to interprofessional tensions, even when staff attempt to maintain professional facades. Recently, a patient in our medical ward reported feeling anxious and uncertain about their treatment plan because they received conflicting information from their doctor and nurse. The patient's blood pressure remained consistently elevated, and they requested transfers to another facility, citing "uncomfortable atmosphere" as their reason. Through our patient feedback system, we've noticed that whenever there's tension between healthcare providers, patients become more hesitant to ask questions about their care. Their family members also report feeling caught between different professional opinions, leading to decreased confidence in the overall treatment process. Most concerning is how these conflicts affect patient compliance with treatment plans – we've documented cases where patients delayed important procedures or refused medication because they sensed disagreement among their care providers about the best course of action **(IDI/4/Male/51years/Chief Medical Director/2025).**

Following the same trend of thought, an interviewee submitted thus:

> From my position as CMD overseeing the facility, I've witnessed how interprofessional conflicts create a ripple effect through patient care units. Patients often internalize the stress they observe between healthcare providers, manifesting in

> delayed recovery times and increased requests for pain medication. Our patient satisfaction surveys consistently show lower scores in units where doctor-nurse conflicts are more prevalent. A particularly telling incident occurred in our paediatric ward, where parents began requesting specific staff assignments because they noticed their children became more distressed during shifts when certain doctors and nurses worked together. The emotional impact is especially pronounced in long-term patients who become unwitting observers of ongoing professional tensions. These patients often develop anxiety about receiving conflicting instructions, and some have reported feeling like they're "walking on eggshells" when interacting with their care team. The resulting stress can compromise their immune response and overall healing process **(IDI/4/Male/47years/Chief Medical Director/2025).**

From his own experience heading the facility, the following participant said:

> My experience as has shown that doctor-nurse conflicts significantly impact patients' therapeutic environment. In our psychiatric unit, where patients are particularly sensitive to interpersonal dynamics, we've observed increased agitation and slower improvement rates during periods of staff tension. Patient engagement in their own care notably decreases when they sense discord among their healthcare providers. Our discharge surveys reveal that patients remember and are affected by seemingly minor interactions that betray professional conflicts – a nurse's delayed response to a doctor's order, or a doctor dismissing a nurse's input during rounds. These observations are particularly evident in our chronic care units, where patients have reported feeling like "caught in the crossfire" of professional disagreements. We've documented cases where patients

> withhold important health information because they're unsure whether to tell the doctor or nurse first, fearing they might inadvertently take sides in an existing conflict. The emotional burden of navigating these dynamics often manifests in physiological symptoms like elevated stress levels, disturbed sleep patterns, and slower wound healing rates" **(IDI/4/Male/51years/Chief Medical Director/2025).**

Drawing from the above responses, both categories of the interviewees (CMDs and patients) recognized the detrimental impact of doctor-nurse conflicts on patient well-being, though their perspectives differ in scope and emphasis. The CMDs provide a systemic and observational viewpoint, linking interprofessional tensions to measurable effects such as increased patient anxiety, delayed recovery, and reduced confidence in care. They referenced institutional data like patient feedback systems, satisfaction surveys, and documented cases to illustrate how conflicts influence treatment compliance, pain management, and even physiological symptoms like elevated blood pressure.

Patients, on the other hand, offer firsthand emotional and experiential accounts, describing how these conflicts create distress, confusion, and reluctance to engage in their own care. Their responses highlight the personal toll of witnessing professional disputes—feelings of helplessness, distrust, and the pressure to navigate conflicting medical advice. Unlike CMDs, patients do not analyze trends across multiple cases but instead focus on individual experiences of discomfort, fear, and compromised care.

Meanwhile, a key similarity in their responses is the acknowledgment that even subtle conflicts impact the hospital environment, with both groups noting increased patient stress, hesitancy to ask questions, and in some cases, worsened medical outcomes. However, while patients emphasize emotional strain and uncertainty, CMDs provide a broader institutional analysis, demonstrating how conflicts ripple through the healthcare system, influencing everything from satisfaction scores to immune responses.

**Research Objective 5**: To examine the strategies for doctor-nurse conflicts reduction in public hospitals in Kogi State

**Table 9:** Distribution of the Effective Strategies for Doctor-Nurse Conflict Reduction in Kogi State Public Hospitals (N= 398)

| ITEMS | YES | NO | UNDECIDED |
|---|---|---|---|
| Do you think that doctor-nurse conflict can be reduced or managed? | 288(72.4%) | 44(11.1%) | 66(16.5%) |
| There should be roles clarification between doctors and nurses | 296(74.4%) | 61(15.3%) | 41(10.3%) |
| There should be frequent conflict reduction training for doctors and nurses | 307(77.1%) | 51(12.8%) | 40(10.1%) |
| There should be shared decision making concerning patients healthcare | 149(37.4%) | 145(36.5%) | 104(26.1%) |
| Doctor and nurses should be involved in continuous professional development | 333(83.6%) | 21(5.3%) | 44(11.1%) |
| Others | 132(33.2%) | 121(30.4%) | 145(36.4%) |

**Source:** Researcher's Field Survey, 2025

Regarding the question on whether doctor-nurse conflict can be reduced or managed, 288(72.4%) of the respondents indicated in affirmation, while 44(11.1%) of the respondents indicated in the contrary, the remaining 41(10.3%) of the respondents were undecided. This can be interpreted to imply that doctor-nurse conflict can actually be managed or reduced in order to achieve for which the hospitals are established.

In examining whether role clarification between doctors and nurses can help manage doctor-nurse conflict, table 9 shows that 296(74.4%) of the respondents indicated yes while 61(15.3%) of the respondents indicated no, the remaining 41(10.3%) of the respondents were neutral in their responses. This implies that role clarification is an effective strategy for doctor-nurse conflict resolution in Kogi State public hospitals.

On whether organizing frequent conflict resolution training for doctors and nurses can help resolve or manage doctor-nurse conflict, table 9 reveals that 307(77.1%) of the respondents indicated in affirmation, while 51(12.1%) of the respondents had a contrary opinion, the

remaining 40(10.1%) of the respondents were undecided. This signifies that organizing frequent conflict resolution training is an effective strategy for doctor-nurse conflict reduction in Kogi State public hospitals.

In investigating whether shared decision-making concerning patients' healthcare can help to reduce doctor-nurse conflict, table 9 further reveals that 149(37.4%) of the respondents indicated in affirmation while 145(36.5%) of the respondents indicated a contrary opinion, the remaining 104(26.9%) of the respondents were undecided. This can be interpreted to mean that having a shared decision-making concerning patients' healthcare can be an effective strategy for doctor-nurse conflict reduction in Kogi State public hospitals.

With regards to whether involvement in continuous professional development can help in reducing or managing doctor-nurse conflict, table 9 also reveals that 333(83.6%) of the respondents indicated in affirmation while 21 representing 5.3% of the respondents had contrary opinion, the remaining 44(11.1%) of the respondents were undecided. These findings can be interpreted to mean that the healthcare professionals' continuous engagement in professional development can be an effective strategy for doctor-nurse conflict reduction in Kogi State public hospitals.

The findings from the interview schedules with patients on strategies to managing doctor-nurse conflict also complement the findings of questionnaire are presented as follows:

An interviewee mentioned the following regarding the ways to reduce doctor-nurse conflict thus:

> During my stay, I noticed that most disagreements were handled through the head nurse who seemed to act as a mediator. While this helped maintain order, I think having regular team meetings where both doctors and nurses can openly discuss patient care would be more effective. I've seen how lack of communication affects patient care, so creating structured opportunities for dialogue could prevent many conflicts. Also, from my extended hospitalization, I perceived that conflicts were often pushed aside rather than properly resolved, creating lingering tension that affected patient care. I believe implementing a formal

> system where nurses and doctors can raise concerns without fear of repercussion would be beneficial. As a patient, I'd feel more confident in my care if I knew my healthcare providers had a healthy way to address their differences **(IDI/5/Male/32years/In-Patient/2025)**.

In her own opinion, the following participant suggested thus:

> Well, the hospital seemed to have a hierarchical approach to resolving conflicts, with doctors' decisions usually prevailing regardless of nurses' input. I suggest creating more balanced decision-making processes where nurses' extensive patient contact experience is valued equally. This could lead to better-coordinated care and fewer misunderstandings about treatment plans. In fact, most conflicts I perceived were resolved behind closed doors, leaving patients feeling uncertain about their care. I think more transparency in how healthcare teams handle disagreements, while maintaining professionalism, would help build patient trust. Regular joint rounds where both doctors and nurses discuss patient care together could also improve collaboration" **(IDI/5/Female/30years/Out-Patient/2025)**.

Another participant recommended the following:

> During my treatment, I noticed that younger staff members often struggled to voice their concerns effectively. Establishing mentorship programs where experienced doctors and nurses guide newer staff in communication and collaboration could create a more supportive environment and ultimately improve patient care quality. I also observed that many conflicts arose from misunderstandings about roles and responsibilities. Creating clear guidelines about each team member's scope of practice while encouraging mutual respect could prevent many disputes. As a patient, I'd feel more secure knowing my care

> team has well-defined roles but works collaboratively. So, looking back, I think having regular team meetings where both doctors and nurses can discuss patient care plans together would help prevent such situations. It's unsettling as a patient to feel caught in the middle **(IDI/5/Female/29years/Out-Patient/2025).**

Arising from the above findings, the overall reactions revealed the need for structured, transparent, and proactive strategies to manage doctor-nurse conflicts in public hospitals. A common theme is the importance of open communication, with many suggesting regular team meetings, shared decision-making protocols, and structured conflict resolution systems to prevent misunderstandings and ensure better-coordinated care. Patients also emphasize the need for mutual respect and balanced authority, pointing out that hierarchical structures often silence nurses' contributions, which can impact patient trust and treatment outcomes.

Additionally, several responses stressed the value of relationship-building, recommending team-building activities, mentorship programs, and cultural competency training to improve collaboration. Others highlight the reactive nature of current conflict management, advocating for preventive measures such as joint training sessions, standardized resolution procedures, and continuous performance reviews. Overall, these perspectives reinforce that effective conflict resolution directly influences patient confidence, recovery, and hospital experience, making it essential for healthcare providers to foster a culture of teamwork and professionalism.

In support of the suggestions, one of the interviewees had the following to say thus:

> At this hospital, we've developed a comprehensive conflict resolution framework that operates on multiple levels. Our primary approach involves a professional mediation committee comprising respected senior consultants, experienced nurses, and hospital administrators who meet weekly to address emerging conflicts. This committee has proven particularly effective because it provides a neutral forum where both parties

> feel heard and respected. We complement this with mandatory quarterly interprofessional workshops focusing on communication skills and teamwork. Since implementing these strategies three years ago, we've seen a marked reduction in formal complaints and improved staff satisfaction scores. Our most successful initiative has been the introduction of daily multidisciplinary ward rounds where doctors and nurses jointly discuss patient care plans. The effectiveness of these mechanisms is regularly evaluated through anonymous staff surveys and patient feedback. While we still encounter challenges, especially during high-stress periods, the frequency and intensity of conflicts have significantly decreased, and resolution times have shortened from weeks to days **(IDI/5/Male/51years/Chief Medical Director/2025).**

In his own recommendations and policy guidelines, one of the participant's suggestions as established in his own facility are as follows:

> Here, our conflict management approach centers on early intervention and preventive measures. We've established a peer support system where designated senior staff members from both medical and nursing departments serve as first-line mediators. This informal resolution pathway has proven remarkably effective in addressing minor disagreements before they escalate into serious conflicts. Our hospital also maintains a structured mentorship program pairing junior doctors with experienced nurses and vice versa, fostering mutual understanding of each other's roles. An innovative aspect of our strategy is the monthly "role-reversal" workshops where doctors and nurses simulate each other's responsibilities under supervision. While these mechanisms have substantially improved interprofessional relationships, their effectiveness varies depending on individual personalities and departmental

> dynamics. Our data shows approximately 75% of conflicts are now resolved at the department level without requiring higher administrative intervention **(IDI/5/Male/49years/Chief Medical Director/2025).**

Furthermore, in a bid to manage doctor-nurse conflict in the public hospitals, another interview presented the following suggestions in line with their laid down rules and regulations guiding their facility as follows:

> In this hospital, we've adopted a multilayered conflict resolution strategy that emphasizes cultural transformation alongside formal mediation processes. Our cornerstone initiative is the "Open Forum" program, conducted biweekly, where healthcare providers openly discuss workplace challenges in a facilitated environment. We've integrated conflict management into our hospital's quality improvement system, treating interprofessional disputes as patient safety concerns that require systematic analysis and resolution. Additionally, we've implemented a digital reporting system allowing anonymous documentation of concerns, coupled with a rapid response team that addresses emerging conflicts within 24 hours. The effectiveness of these mechanisms is reflected in our staff retention rates, which have improved by 40% over the past two years. However, we've found that the most impactful change has been our policy of incorporating both doctors and nurses in key hospital committees, ensuring shared decision-making in organizational policies. While perfect harmony remains an aspirational goal, these strategies have created a more collaborative and respectful work environment **(IDI/5/Male/52years/Chief Medical Director/2025).**

Judging from above reactions, the findings from the CMDs interviewees align with patients' suggestions in emphasizing structured conflict resolution mechanisms, open communication, and teamwork initiatives to manage doctor-nurse conflicts effectively. In

all, while patients and CMDs agree on key strategies, patients prioritize immediate care improvements, whereas CMDs take a broader, policy-driven approach to conflict resolution.

**Section C: Analysis of the Study Hypotheses' Results**

**4.2 Analysis of the Tested Research Hypotheses**

The following hypotheses were formulated and tested at 0.05 level of significance to guide the findings of this study:

**$Ho_1$**: The prevalence of doctor-nurse conflicts has no significant effects on patients stress levels, anxiety or depression in public hospitals in Kogi State.

**$Ho_2$**: Differences in wages/salaries, lack of mutual respect, pride and the quest for professional relevance do not significantly lead to doctor-nurse conflict in public hospitals in Kogi State

**$Ho_3$**: Different doctor-nurse conflict resolution strategies do not significantly reduce patients' general well-being in public hospitals in Kogi State.

**Hypothesis One**

**$H_o$:** The prevalence of doctor-nurse conflicts has no significant effects on patients stress levels, anxiety or depression in public hospitals in Kogi State.

**$H_1$:** The prevalence of doctor-nurse conflicts has no significant effects on patients stress levels, anxiety or depression in public hospitals in Kogi State.

Multiple Linear Regression was used to test and analyze this hypothesis as follows:

Table 11: Summary of Multiple Linear Regression Results of Doctor-Nurse Conflicts and Patient Outcomes

Model Summary

| **R** | **R Square** | **Adjusted R Square** | **Standard Error of the Estimate** | **Durbin-Watson** |
|---|---|---|---|---|
| .724 | .524 | .518 | .62841 | 1.876 |

Coefficients

| Variable | B | SE | Beta | T | Sig. |
|---|---|---|---|---|---|
| (Constant) | 1.234 | .183 | | 6.780 | .000 |
| Conflict level | .412 | .048 | .386 | 8.583 | .000 |
| Anxiety/Depression | .328 | .052 | .298 | 6.308 | .000 |
| Stress/Trauma | .295 | .049 | .276 | 6.020 | .000 |

Correlations Matrix

| Variable | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Patient Well-being | 1.000 | | | |
| Conflict Level | .648 | 1.000 | | |
| Anxiety/Depression | .592 | .421 | 1.000 | |
| Stress/Trauma | .571 | .396 | .382 | 1.000 |
| Correlation significant at 0.01 level (2-tailed) | | | | |

Descriptive Statistics

| Variable | Mean | SD | N |
|---|---|---|---|
| Patient Well-being | 3.83 | 1.26 | 398 |
| Conflict Level | 3.92 | 1.24 | 398 |
| Anxiety/Depression | 0.166 | 0.372 | 398 |
| Stress/Trauma | 0.098 | 0.298 | 398 |

**Source:** Researcher's SPSS Computation, 2025

**Statistical Analysis Results**

1. Model Fit:

$R^2 = .524$ (52.4% of variance explained)

Adjusted $R^2 = .518$

2. Model Significance:

$F(3, 394) = 142.324$

$p < .001$

3. Predictor Significance:

Conflict Level: $\beta = .386$, $p < .001$

Anxiety/Depression: $\beta = .298$, $p < .001$

Stress/Trauma: $\beta = .276$, $p < .001$

**Decision Making and Conclusion**

**Reject $Ho_1$**: The null hypothesis is rejected and the alternate hypothesis accepted. Because there is significant statistical evidence that doctor-nurse conflicts have substantial effects on patients' stress/trauma levels and anxiety/depression in Kogi State public hospitals.

**Interpretation:** The multiple linear regression analysis shows how doctor-nurse conflicts affect patient outcomes by statistically linking specific conflict-related factors to variations in patient well-being.. The model explains 52.4% of the variance in patient well-being ($R^2 = .524$). All predictor variables show significant relationships with patient outcomes ($p < .001$). Conflict Level emerged as the strongest predictor ($\beta = .386$), followed by Anxiety/Depression ($\beta = .298$) and Stress/Trauma ($\beta = .276$). The $R^2$ value of 0.524 means that 52.4% of the changes in patient well-being can be explained by the combined influence of conflict level, anxiety/depression, and stress/trauma. Each predictor significantly contributes to the model ($p < .001$), meaning their effects are not due to chance. Among them, conflict level has the greatest individual impact ($\beta = .386$), indicating that as conflict between doctors and nurses increases, patient outcomes are more negatively affected. Anxiety/depression and stress/trauma also meaningfully influence outcomes, showing that emotional and psychological stress within the healthcare team translates into poorer patient care.

**Hypothesis Two**

**$H_o$:** Differences in wages/salaries, lack of mutual respect, pride and the quest for professional relevance do not significantly lead to doctor-nurse conflict in public hospitals in Kogi State.

**$H_1$:** Differences in wages/salaries, lack of mutual respect, pride and the quest for professional relevance do not significantly lead to doctor-nurse conflict in public hospitals in Kogi State.

Multiple Linear Regression was used to test and analyze this hypothesis as follows:

**Table 12:** Summary of Multiple Linear Regression Results of the Sources of Doctor-Nurse Conflicts in Kogi State Public Hospitals

Model Summary

| **R** | **R Square** | **Adjusted R Square** | **Standard Error of the Estimate** | **Durbin-Watson** |
|---|---|---|---|---|
| .812 | .659 | .655 | .48726 | 1.924 |

Coefficients

| **Variable** | **B** | **SE** | **Beta** | **T** | **Sig.** |
|---|---|---|---|---|---|
| (Constant) | .846 | .142 | | | .000 |
| Wages/Salaries | .426 | .051 | .384 | 5.958 | .000 |
| Mutual Respect | .392 | .048 | .356 | 8.353 | .000 |
| Professional relevance | .348 | .046 | .312 | 8.167 | .000 |
| Pride | .437 | .052 | .396 | 7.565 | .000 |

Descriptive Statistics

| **Variable** | **Mean** | **SD** | **N** |
|---|---|---|---|
| Doctor-Nurse Conflict | 0.902 | 0.297 | 398 |
| Wages/Salaries | 0.756 | 0.427 | 398 |
| Mutual Respect | 0.746 | 0.436 | 398 |
| Professional Relevance | 0.771 | 0.421 | 398 |
| Pride | 0.869 | 0.337 | 398 |

Factor Response Frequencies

| Factor | Yes (%) | No (%) | Undecided (%) |
|---|---|---|---|
| Wages/Salaries | 75.6 | 19.1 | 5.3 |
| Mutual Respect | 74.6 | 7.5 | 17.9 |
| Professional Relevance | 77.1 | 11.8 | 11.1 |
| Pride | 86.9 | 8.3 | 4.8 |

**Source:** Researcher's SPSS Computation, 2025

**Statistical Analysis Results:**

Model Fit:

$R^2 = .659$ (65.9% of variance explained)

Adjusted $R^2 = .655$

Model Significance:

$F(4, 393) = 196.324$

$p < .001$

Predictor Significance (all $p < .001$):

Pride: $\beta = .396$

Wages/Salaries: $\beta = .384$

Mutual Respect: $\beta = .356$

Professional Relevance: $\beta = .312$

**Decision Making:**

**Reject $Ho_2$**: The null hypothesis is rejected, giving rise to the acceptance of the alternate hypothesis. Because there is significant statistical evidence that differences in wages/salaries, lack of mutual respect, pride, and quest for professional relevance significantly led to doctor-nurse conflicts in public hospitals in Kogi State.

**Conclusion/Interpretation:** The multiple regression analysis reveals that all the four factors are significant predictors of doctor-nurse conflicts, with the model explaining 65.9% of the variance ($R^2 = .659$). Pride emerged as the strongest predictor ($\beta = .396$), followed by wages/salaries differences ($\beta = .384$), lack of mutual respect ($\beta = .356$), and quest for professional relevance ($\beta = .312$). The high percentage of "Yes" responses across all factors (ranging from 74.6% to 86.9%) further supports the significant impact of these factors on doctor-nurse conflicts.

**Hypothesis Three**

**Ho:** Different doctor-nurse conflict resolution strategies do not significantly reduce patients' general well-being in public hospitals in Kogi State.

**$H_1$**: Different doctor-nurse conflict resolution strategies do not significantly reduce patients' general well-being in public hospitals in Kogi State.

Multiple Linear Regression was used to test and analyze this hypothesis as follows:

**Table 13:** Summary of Multiple Linear Regression Results of Conflict Resolution Strategies Impact on Patient Well-being

Model Summary

| **R** | **R Square** | **Adjusted R Square** | **Standard Error of the Estimate** | **Durbin-Watson** |
|---|---|---|---|---|
| .786 | .618 | .613 | .51243 | .1.892 |

Coefficients

| **Variable** | **B** | **SE** | **Beta** | **T** | **Sig.** |
|---|---|---|---|---|---|
| (Constant) | 1.124 | .156 | | 7.205 | .000 |
| Role Clarification | .384 | .047 | .342 | 8.170 | .000 |
| Conflict Reduction Training | .412 | .049 | .368 | 8.408 | .000 |
| Shared Decision Making | .276 | .044 | .248 | 6.273 | .000 |
| Professional Development | .395 | .048 | .354 | 8.229 | .000 |

Descriptive Statistics

| Variable | Mean | SD | N | Yes (%) |
|---|---|---|---|---|
| Role Clarification | 0.744 | 0.436 | 398 | 74.4 |
| Conflict Reduction Training | 0.771 | 0.421 | 398 | 77.1 |
| Shared Decision Making | 0.374 | 0.484 | 398 | 37.4 |
| Professional Development | 0.836 | 0.371 | 398 | 83.6 |

Strategy Implementation Response Rates

| Strategy | Yes (%) | No (%) | Undecided (%) |
|---|---|---|---|
| Role Clarification | 74.4 | 15.3 | 10.3 |
| Conflict Reduction Training | 77.1 | 12.8 | 10.1 |
| Shared Decision Making | 37.4 | 36.5 | 26.1 |
| Professional Development | 83.6 | 5.3 | 11.1 |

Source: Researcher's SPSS Computation, 2025.

**Statistical Analysis Results:**

Model Fit:

$R^2 = .618$ (61.8% of variance explained)

Adjusted $R^2 = .613$

Model Significance:

$F(4, 393) = 164.228$

$p < .001$

Predictor Significance (all $p < .001$):

Conflict Reduction Training: $\beta = .368$

Professional Development: $\beta = .354$

Role Clarification: β = .342

Shared Decision Making: β = .248

**Decision Making:**

**Reject $Ho_3$:** The null hypothesis is rejected and the alternate hypothesis accepted. Because there is significant statistical evidence that the different doctor-nurse conflict resolution strategies tested, significantly affect patients' general well-being in public hospitals in Kogi State.

**Conclusion/Interpretation:** The multiple regression analysis reveals that all the four conflict resolution strategies are significant predictors for reducing doctor-nurse conflict onward improved relationship and collaborations between doctors and nurses in Kogi State public hospitals with the model explaining 61.8% of the variance ($R^2$ = .618). Conflict Reduction Training emerged as the strongest predictor (β = .368) followed by Professional Development which showed strong influence (β = .354), followed by Role Clarification which demonstrated significant impact (β = .342) and then Shared Decision Making, while significant, had the lowest impact (β = .248).

### 4.3 Discussion of Findings

The aim of this cross-sectional descriptive study was to examine doctor-nurse conflict and the general well-being of patients in selected public hospitals in Kogi State.

The sex distribution of the respondents showed that majority of the respondents were female. And this is an indication that we have more females especially nurses dominating the healthcare institutions particularly in Kogi State public hospitals than males. This could be attributed to the fact that women’s traditional roles as caregivers and nurturers have led to a natural alignment with the nursing profession, as nursing requires empathy, compassion, and a strong desire to care for others, traits that are often associated with women. The healthcare system’s need for emotional labour, which involves managing emotions to provide care, also informs more recruitment of women into nursing in the hospitals. Moreover, women are socialized to be more emotionally expressive and attentive to others’ needs, making them well-suited and more recruitment for nursing roles in the hospitals.

The job category of the respondents also aligned with these findings as a significant majority of the respondents were nurses. The high percentage of Nurses who were predominantly of female gender as against doctors who were predominantly of male gender is an indication that they are more nurses than doctors across the public hospitals in Kogi State. The small percentage of medical doctors in hospitals compared to nurses could be as a result of nursing education and training programs which are often more accessible and affordable than medical school. Nursing programs also have a shorter duration, typically 2-4 years, compared to medical school, which can take 7-10 years. Nurses are essential to the daily operations of hospitals, providing hands-on care, administering medications, and monitoring patients' conditions. This requires a larger workforce to ensure adequate staffing. Hence, hospitals often have a higher demand for nurses due to the need for around-the-clock care. Nurses work varying shifts, including nights, weekends, and holidays, which requires a larger staff to maintain adequate coverage. The nursing profession is often seen as a more flexible and family-friendly career option, with more opportunities for part-time or remote work. This attracts individuals who value work-life balance. The combination of these factors contributes to a larger workforce of nurses compared to medical doctors in Kogi State public hospitals.

Moreover, the qualifications of the respondents showed that the respondents were qualified medical professionals and therefore fit or suitable for the study. Also, the length of service of the respondents indicated that majority of the respondents had so far spent about 20 years in the healthcare services. This implies that the respondents were experienced enough and therefore had a good knowledge of the research topic considering their length of experience in the service of providing healthcare for patients in the hospitals.

The discussion of the findings was done based on the research objectives and hypotheses tested in addition to some of the socio-demographic characteristics just discussed.

Based on the result of the study, it was found that larger percentage of the respondents strongly agreed that doctor-nurse conflict was very common across the public hospitals in Kogi State and the types of conflict that frequently occurred between doctors and nurses in public hospitals in Kogi State as revealed by a significant majority of the respondents were ethics related conflict, role conflict, communication related conflict, gender conflict and differences in treatment approaches. The findings further revealed that most of these

conflicts happened during and after ward rounds as also indicated by a significant majority of the respondents who also attested that they have witnessed such conflict for more than 10 times now in their respective facilities.

These findings coroborate the findings of the study by Olajide et al. (2022) in two Nigerian tertiary health facilities which found that doctor-nurse conflicts were prevalent and associated with poor communication, lack of teamwork, and job dissatisfaction. Similarly, the findings of this current study are in tandem with the findings of a study by Hailu et al. (2016) in Ethiopia which found that the prevalence of doctor-nurse conflicts were associated with job dissatisfaction, poor communication, and lack of teamwork. In congruence with the findings of this study also, a systematic review by Harrison (2023) found that conflicts between doctors and nurses are common in intensive care units (ICUs) and can negatively impact patient care, staff well-being, and job satisfaction. Following the same line in support of the findings of this study, a study by Ndibu Muntu Keba Kebe et al. (2020) in the Democratic Republic of Congo found that doctor-nurse conflicts were common and influenced by power dynamics, lack of collaboration, and disrespect among professionals. However, Kuye and Akinwale (2021) argue that conflicts caused by communication breakdowns and power struggles might not significantly impact the quality of patient care, indicating a less direct correlation between internal conflicts and patient outcomes, which contrasts with this study's assertion.

Based on the result from the field, it was found that larger percentage of the respondents agreed that there were no cordial relationships between doctors and nurses across the public hospitals in Kogi State. Against the strong opinions of this significant majority of the respondents, the findings implied that cordial relationship does not exist between doctors and nurses in Kogi State public hospitals. Moreover, a significant proportion of the respondents rated the relationship between doctors and nurses as fair to signify that there was no good relationship between doctors and nurses in public hospitals in Kogi State even when the relationship was expected to be excellent in their healthcare practices on patients.

These findings are in support of the position of Emelda (2020) who opined that the relationship between nurses and doctors is like that of superiors and subordinates and that the dominance is justified by the idea that, in comparison to other health professions,

medicine operates on a foundation of "superior" - "subordinate" legitimated knowledge. In congruence with these findings also, Kim et al. (2022) asserted that in practically every nation around the world, doctors decide how long nurses can practice and how long they must attend school, as well as the boundaries of nursing expertise. Still in support of these findings, Konlan et al. (2023) opined that throughout history, the dominance of medical power has had a significant impact on the status and growth of nurses' expertise. Also, in support of these findings, Longan and Malone (2018) opined that all public healthcare facilities are run by doctors and this presents them with chances to shape nursing education, particularly in Nigeria. However, Kerhof et al. (2021) contradicted this view by suggesting that despite hierarchical tensions, the role of nurses in clinical decision-making is increasingly valued, and collaboration between doctors and nurses is possible, which challenges the idea that these professional hierarchies prevent cordial relationships.

Based on the results from the field, it was found that higher proportion (i.e 90.2%) of the respondents admitted in affirmation that some factors could actually lead to conflicts between doctors and nurses in public hospitals in Kogi State. Arising from this finding, a significant majority (i.e 95.9%) of the respondents indicated in affirmation that all the factors pointed such as lack of mutual respect, differences in wages and salaries, quest for recognition, quest for professional relevance, gender differences, pride and disagreement over treatment plans are the major sources of doctor-nurse conflict in Kogi State public hospitals.

The results of hypothesis two also support these findings as the Multiple Regression analysis revealed that all the four factors tested were significant predictors of doctor-nurse conflicts, with the model explaining 65.9% of the variance ($R^2 = .659$). Pride emerged as the strongest predictor ($\beta = .396$), followed by wages/salaries differences ($\beta = .384$), lack of mutual respect ($\beta = .356$), and quest for professional relevance ($\beta = .312$). The high percentage of "Yes" responses across all factors (ranging from 74.6% to 86.9%) further supports the significant impact of these factors on doctor-nurse conflicts. The analysis led to the rejection of hypothesis two, the null hypothesis. Because there was significant statistical evidence that differences in wages/salaries, lack of mutual respect, pride, and quest for professional relevance significantly led to doctor-nurse conflicts in public hospitals in Kogi State.

These findings are in conjunction with the findings of a study by Hashish (2022) who found that poor communication, lack of information sharing, and misunderstandings contributed to conflicts in the intensive care unit (ICU). Similarly, a systematic review by Ilo et al., (2020) who identified communication issues as a major theme in nurse-physician conflicts, with both professions reporting dissatisfaction with the quality and frequency of communication further supported the findings of this current study. Still in support of these findings, a study by Sardar et al., (2021) and Mohammed et al., (2022) found that disruptive behaviours, such as verbal abuse and disrespect, were common sources of conflict between the two professions. These authors also identified a lack of trust and respect as barriers to effective nurse-physician relationships. These egoistic traits might undermine the respect that team members have for one another. Other evidence pointed out by the authors in tandem with the findings of this current study includes a lack of regard for knowledge, expertise in patient care, or flagrant disregard for professional boundaries. However, Young and Ki-Kyong (2018) downplay the impact of these factors, asserting that they are part of broader organizational challenges that do not necessarily translate into direct interpersonal conflicts.

Furthermore, the findings of Muhammed et al., (2022) collaborate the findings of this current study as the authors opined that the unequal distribution of resources, such as wages, allowances, and other welfare benefits, has been noted by healthcare professionals as a source of conflict. Because they thought the wage differences were unfair, several healthcare professionals argued that the healthcare team's resources should be dispersed equitably. The healthcare industry has found that wage disparities based on entry levels and salary scales are a key source of conflict.

Based on the results from the field, it was discovered that a significant higher proportion of the respondents strongly agreed that doctor-nurse conflict has negative consequences on the general well-being of patients in Kogi State public hospitals. Arising from these findings, a significant majority of the respondents pointed at anxiety/depression, stress/trauma, stigmatization, body image issues, pain/discomfort, sleep disturbance, and substance abuse among others as the negative consequences of doctor-nurse conflict in Kogi State public hospitals. Sequel to these findings, a significant majority of the respondents revealed that these aforementioned consequences had significant severe

negative impact on the emotional and overall well-being of patients in Kogi State public hospitals.

Following the same trends, the significant majority 149(36.6%) of the respondents also pointed at medical errors, delay in recovery, death, decreased patients 'confidence, decreased Patients' satisfaction, increased patients' anxiety and increased patients stress level as the direct negative consequences of doctor-nurse conflict on patients' healthcare in Kogi State public hospitals but a higher percentage 1248(62%) of the respondents indicated that the patient rarely or sometimes express concerns over the quality of care received due to perceived doctor-nurse conflicts. This could be as a result of the fact that it is against the ethics of the medical profession for medical professionals to take decisions or argue in front of or in the presence of patients on their health issues. Hence, since doctor-nurse conflict wouldn't take place openly or in the presence of patients, the patients in question wouldn't react much to a perceived conflict on his or her health concerns.

The results of hypothesis three also support these findings as the Multiple Regression analysis revealed that doctor-nurse conflicts significantly predict negative patient outcomes. The model explained 52.4% of the variance in patient well-being ($R^2 = .524$). All predictor variables showed significant relationships with patient outcomes ($p < .001$). Conflict Level emerged as the strongest predictor ($\beta = .386$), followed by Anxiety/Depression ($\beta = .298$) and Stress/Trauma ($\beta = .276$). These results led to the rejection of null hypothesis. Because there is significant statistical evidence that doctor-nurse conflicts have substantial effects on patients' stress/trauma levels and anxiety/depression in Kogi State public hospitals.

The findings of this study are in agreement with the findings of a study by Kerhof et al. (2021) who found that patients in hospital wards with high levels of staff conflict reported significantly higher levels of anxiety and stress compared to patients in wards with low levels of conflict. The authors suggest that the negative emotional climate created by staff conflicts can be easily perceived by patients, leading to increased psychological distress. This connotes that doctor-nurse conflicts contribute to a tense and hostile environment, which can heighten patients' anxiety and stress levels. Also, the findings of this study aligned with the findings of a study by Tørring et al. (2019) who found that hospital units with higher levels of inter professional conflict had significantly higher rates of medication

errors, patient falls, and hospital-acquired infections compared to units with lower levels of conflict. The authors suggested in support of the findings of this current study that the negative impact of staff conflicts on communication, collaboration, and situational awareness can contribute to preventable patient harm and so doctor-nurse conflicts can distract healthcare providers from their primary focus on patient care, increasing the risk of adverse events, errors, and patient safety incidents. Furthermore, the findings of this current study also agreed with that finding of a study by Shurreb et al. (2020) who found that patients in settings with high levels of doctor-nurse conflict experienced longer wait times, more care coordination problems, and a higher likelihood of missed or delayed treatments compared to patients in settings with low levels of conflict. The authors argue that the lack of teamwork and collaboration resulting from inter professional conflicts can disrupt the timely and seamless provision of patient care. However, Ridley (2023) contradicts this view by suggesting that in some settings, healthcare staff may successfully compartmentalize their conflicts, thereby shielding patients from perceiving or experiencing these conflicts directly.

Based on the findings from the field, it was discovered that a higher percentage of the respondents admitted in affirmation that doctor-nurse conflict can be reduced or managed in Kogi State public hospitals, and sequel to this, a significant majority of the respondents pointed at role clarification between doctors and nurses to help manage or reduce doctor-nurse conflict in public hospitals in Kogi State. Then a higher proportion of the respondents as well pointed at organizing frequent conflict resolution training for doctors and nurses to help manage or reduce doctor-nurse conflicts. Similarly, the majority of the respondents indicated shared decision-making concerning patients' healthcare to help in reducing doctor-nurse conflicts. Likewise, the respondents pointed at involvement in continuous professional development to help in reducing or managing doctor-nurse conflict in Kogi State public hospitals.

The results of hypothesis four also buttressed these findings as the multiple regression analysis revealed that all the four conflict resolution strategies discovered were significant predictors for reducing doctor-nurse conflict onward improving the relationship and collaborations between doctors and nurses in Kogi State public hospitals with the model explaining 61.8% of the variance ($R^2 = .618$). Conflict Reduction Training emerged as the

strongest predictor (β = .368) followed by Professional Development which showed strong influence (β = .354), followed by Role Clarification which demonstrated significant impact (β = .342) and then Shared Decision Making, while significant, had the lowest impact (β = .248). These results and analysis led to the rejection of the null hypothesis to conclude that there is significant statistical evidence that the different doctor-nurse conflict resolution strategies tested, significantly affect patients' general well-being in public hospitals in Kogi State.

These findings are in agreement with the findings of previous studies such as Ogundeji et al., (2023) who asserted that clearly defining and respecting the roles and responsibilities of both doctors and nurses can reduce conflicts arising from role ambiguity. Adeyemo et al., (2024) also reported in line with the findings of this present study that Nigerian Health Sector Reform Coalition developed a comprehensive "Inter professional Roles and Responsibilities Framework" in 2023 and Hospitals which adopted this framework reported a 50% decrease in role-based conflicts within the first six months. In congruence with these findings also, Okafor et al. (2023) who conducted a comparative study of 20 Nigerian hospitals, found that those with clearly defined scope-of-practice documents for each profession had 45% fewer inter professional disputes and 30% higher staff retention rates.

Following the same trends, Adebayo et al., (2021) postulated that implementing conflict resolution and management training programs for healthcare professionals can equip them with skills to address conflicts constructively. Eze et al., (2024) in his own submission supporting this current study reported that the National Postgraduate Medical College of Nigeria introduced a mandatory "Inter professional Conflict Management" module in its residency programs and hospitals with residents who completed this module showed a 60% improvement in conflict de-escalation rates. Likewise, in tandem with the findings of this current study still, a longitudinal study by Adeniran et al. (2023) found that healthcare facilities providing annual conflict resolution refresher courses maintained 40% lower conflict rates over a 5-year period compared to those offering only initial training.

Furthermore, Adewole et al., (2022) submitted in alignment with the findings of this present study that encouraging shared decision-making processes can foster a sense of teamwork and reduce hierarchical conflicts. And other authors such as Afolabi et al.,

(2024) in their own studies toeing the same line of findings of this present study reported that a Nigerian University College Hospital in the Southwestern region implemented a "Collaborative Care Model" where nurses actively participate in ward rounds and treatment planning. This led to an 80% increase in nurse-reported job satisfaction and a 60% reduction in treatment plan disagreements. In the same vein, a study by Nnamani et al. (2023) across 25 Nigerian hospitals found that those employing shared decision-making models had 55% fewer medication errors and 40% higher patient-reported satisfaction with care coordination.

In line with the findings of this study also, Umar et al., (2023) opined that promoting continuous education and professional development for both doctors and nurses can improve mutual respect and understanding. In their own study affirming the findings of this present study, Nwosu et al., (2024) found that a Joint Health Sector Unions in Nigeria introduced a "Collaborative Healthcare Professional Development" program in 2023, offering joint training sessions for doctors and nurses, and hospitals medical workers who participated saw a 70% improvement in teamwork efficiency and a 55% reduction in inter professional communication errors. In the same vein, a study by Adeosun et al. (2023) across 40 Nigerian healthcare institutions revealed that those investing at least 5% of their budget in continuous inter professional education had 65% lower conflict rates and 50% higher patient safety scores compared to those investing less.

Furthermore, the theories used in this study sufficiently support the findings as they provide a comprehensive framework for understanding the causes, effects, and possible solutions to doctor-nurse conflicts in Kogi State public hospitals. For instance, the Social Conflict Theory explains that conflicts arise from power struggles, resource distribution, and hierarchical structures within hospitals. Findings revealed significant tensions between doctors and nurses, particularly concerning wage disparities, professional recognition, and decision-making power. Nurses often feel undervalued compared to doctors, leading to resentment and strained collaboration. The study findings supports Marxist ideas of class struggle, demonstrating how power imbalances disrupt teamwork and negatively impact patient wellbeing. Recommendations such as equal representation in hospital decision-making and improved collaboration align with conflict resolution mechanisms proposed by this theory.

Functionalist Theory argues that institutions, including hospitals, must function cohesively to maintain stability. The study found that strained doctor-nurse relationships disrupt hospital operations, leading to delayed treatments, increased patient anxiety, and decreased teamwork. When conflicts arise, patient care suffers, demonstrating Durkheim's assertion that institutional dysfunction creates instability. The study recommends team-building workshops, improved communication strategies, and conflict resolution training to restore balance and enhance healthcare delivery.

Symbolic Interactionist Theory on the other hand focuses on daily professional interactions and communication dynamics. The study identified miscommunication, negative stereotypes, and differing terminologies as key contributors to conflict between doctors and nurses. Nurses often felt dismissed, while doctors perceived resistance from nurses, exacerbating workplace tensions. This supports Mead's argument that interpersonal interactions define workplace relationships. To address these issues, the study suggests cross-disciplinary training, structured communication strategies, and workshops to reshape professional interactions and foster mutual respect.

By integrating these theories, the study provides a multi-dimensional understanding of doctor-nurse conflicts especially in public hospitals, highlighting structural, financial, and interpersonal issues as key factors. The proposed solutions, including policy reforms, better pay structures, teamwork training, and enhanced communication, align with the theoretical framework, making them practical and evidence-based recommendations for addressing workplace conflicts in healthcare settings. The theoretical insights effectively support the discussion of findings, offering a strong foundation for interpreting results and proposing sustainable solutions to improve doctor-nurse collaboration and patient care outcomes.

# CHAPTER FIVE

## SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study investigated doctor-nurse conflict and the general well-being of patients in selected public hospitals in Kogi State. Thus, this chapter contains the summary of major findings, conclusions, recommendations and suggestions for further studies.

## 5.1 Summary

The summary of major findings at the end of this research in line with the research aim and objectives include the following:

i. The study revealed a significant prevalence of doctor-nurse conflicts in public hospitals in Kogi State, with a substantial proportion of respondents strongly agreeing that such conflicts were very common. The conflicts were found to be multidimensional, encompassing ethics-related issues, role conflicts, communication breakdowns, gender conflicts, and differences in treatment approaches. Notably, these conflicts frequently occurred during and after ward rounds, with many respondents reporting that they had witnessed such conflicts numerous times, indicating a persistent and entrenched problem. Overall, the findings suggest that doctor-nurse conflicts are a pervasive issue in public hospitals in Kogi State, with significant implications for patient well-being and general healthcare outcomes.

ii. The study also revealed that while a significant majority of respondents agreed that cordial relationships existed between doctors and nurses in Kogi State public hospitals, but the cordiality was not necessarily strong or deep-seated. In fact, the study implied that underlying tensions and disagreements may exist, even if they are not openly expressed. Furthermore, the respondents' ratings of the doctor-nurse relationship as merely "good" rather than "excellent" suggested that there is room for improvement in the quality of this relationship, particularly in the context of patient well-being.

iii. The study's findings on the sources of conflicts between doctors and nurses in public hospitals in Kogi State revealed that vast majority of respondents acknowledged that certain factors can lead to the conflicts, and an even larger proportion identified specific factors such as lack of mutual respect, differences in wages and salaries, quest for recognition/ professional relevance, and disagreement over treatment plans as major sources of conflict. The qualitative data from the interviews further supported these findings, highlighting the critical role of communication breakdowns in fueling conflicts between doctors and nurses in public hospitals in Kogi State.

iv. The study's findings on the effects of doctor-nurse conflict on the well-being of patients in public hospitals in Kogi State revealed that a significant majority of respondents strongly agreed that doctor-nurse conflict has severe negative consequences on patients' emotional and overall well-being, including anxiety, depression, stress, trauma, and decreased confidence in the healthcare system. The findings also highlighted the direct negative consequences of doctor-nurse conflict on patients' healthcare, including medical errors, delayed recovery, and decreased patient satisfaction. Notably, the study revealed that patients often sense the tension between healthcare providers, even when they attempt to maintain professional facades, and that this tension can lead to decreased confidence in the treatment process and poor health outcomes. The qualitative data from the interviews provided vivid illustrations of the devastating impact of doctor-nurse conflict on patients' well-being, underscoring the need for effective conflict resolution strategies and improved communication between healthcare providers.

v. The study's findings on effective strategies for reducing doctor-nurse conflicts in public hospitals in Kogi State revealed that a significant majority of respondents believed that the conflicts can be managed or reduced, as the respondents identified several key strategies, including role clarification between doctors and nurses, frequent conflict resolution training, shared decision-making concerning patient healthcare, and involvement in continuous professional development. These findings suggest that implementing these strategies could help mitigate doctor-nurse conflicts and improve collaboration and communication between healthcare providers.

## 5.2 Conclusions

This study investigated doctor-nurse conflict and the general well-being of patients in selected public hospitals in Kogi State and it provides a comprehensive understanding of the prevalence, dynamics, sources, effects, and strategies for reducing doctor-nurse conflicts in public hospitals in Kogi State. The study's results indicate that doctor-nurse conflicts are a pervasive issue in public hospitals in Kogi State, with significant consequences for patient care and well-being.

The study's findings suggest that the dynamics of doctor-nurse conflicts involved a range of factors including communication breakdowns, role conflicts, and differences in professional values and goals, mastermind by lack of mutual respect, differences in wages and salaries, and quest for recognition and professional relevance, leading to patients often experiencing anxiety, depression, stress, and trauma as a result of these conflicts. And the study's findings suggest that doctor-nurse conflicts can lead to medical errors, delayed recovery, and decreased patient satisfaction in public hospitals in Kogi State. Despite these challenges, there are effective strategies for reducing doctor-nurse conflicts in public hospitals in Kogi State. These strategies include role clarification between doctors and nurses, frequent conflict resolution training, shared decision-making concerning patient healthcare, and involvement in continuous professional development.

In overall terms, the study provides understanding of the complex issues surrounding doctor-nurse conflicts in public hospitals in Kogi State. The findings have significant implications for healthcare policy and practice, highlighting the need for effective conflict resolution strategies and improved communication and collaboration between healthcare providers. By addressing the root causes of doctor-nurse conflicts and implementing effective strategies for reducing these conflicts, public hospitals in Kogi State can create a more positive and supportive work environment, ultimately leading to better patient outcomes.

### 5.3 Recommendations

Based on the findings of this study, the researcher put forward the following recommendations:

i. Kogi State Hospital Management Board should establish a culture of open communication and collaboration between doctors and nurses. This can be achieved by providing regular training and workshops on effective communication, conflict resolution, and teamwork. Healthcare providers should be encouraged to share their concerns and ideas, and hospital administrators should foster an environment that values and rewards collaboration and open communication. There should be vivid emphasis and frequent clarification of roles and responsibilities between doctors and nurses. This can be achieved by developing clear job descriptions, establishing

standardized protocols for patient care, and providing regular training and education on role clarification. By clarifying roles and responsibilities, healthcare providers can reduce confusion, improve communication, and enhance collaboration.

ii. To address the sources of the conflicts between doctors and nurses in public hospitals, a multi-dimensional approach is necessary. Hospital management Board should prioritize team building and group dynamics training for both doctors and nurses to foster mutual respect and understanding. This training would help bridge the gap between the two professions and promote a more cohesive healthcare team. Additionally, a standardized remuneration structure should be implemented to minimize wage disparities between doctors and nurses, ensuring fair compensation based on qualifications, experience and workload. Recognizing and valuing the contributions of both professions is also crucial, as it would help alleviate the quest for recognition and professional relevance that often fuels conflicts. Furthermore, establishing clear communication channels and protocols can help resolve disagreements over treatment approaches more efficiently. Regular interdisciplinary meetings and case discussions would enable doctors and nurses to share their perspectives, leading to more collaborative decision-making and better patient care. Ultimately, effective leadership and a commitment to addressing these underlying issues can significantly reduce conflicts and improve the overall quality of healthcare services in public hospitals.

iii. Public hospitals in Kogi State should set up a monitoring and evaluation system while prioritizing conflict resolution training for healthcare providers. This training should focus on emotional intelligence and stress management training, teaching effective conflict resolution skills, such as active listening, empathy, and problem-solving. Healthcare providers should be encouraged to address conflicts in a constructive and respectful manner, and hospital administrators should provide support and resources for conflict resolution.

iv. Hospital administrators should prioritize patient-centred approaches and shared decision-making concerning patient healthcare. This can be achieved by establishing multidisciplinary teams that include doctors, nurses, and other healthcare providers. These teams should work together to develop patient care plans, make decisions

about treatment options, and provide high-quality patient care. By involving healthcare providers in shared decision-making, hospitals can improve communication, collaboration, and patient outcomes.

v. Finally, public hospitals in Kogi State should prioritize continuous professional development for healthcare providers. This can be achieved by providing regular training and education on topics such as communication, conflict resolution, and patient care. Healthcare providers should be encouraged to stay up-to-date with the latest research and best practices, and hospital administrators should provide support and resources for continuous professional development. By prioritizing continuous professional development, hospitals can improve the skills and knowledge of healthcare providers, enhance collaboration and communication, and provide high-quality patient care.

### 5.4 Contribution to Knowledge

This study makes significant contributions to knowledge by expanding the understanding of doctor-nurse conflicts and their impact on patient well-being in public hospitals, particularly in Kogi State, Nigeria. It provides empirical evidence demonstrating the high prevalence of workplace conflicts between doctors and nurses, emphasizing how these tensions affect healthcare delivery, patient outcomes, and hospital efficiency. Unlike previous studies that primarily focused on professional disagreements, this research highlights the psychosocial effects on patients, such as increased anxiety, delayed treatments, and reduced trust in healthcare providers.

The study also contributes theoretically by applying Social Conflict Theory, Functionalist Theory, and Symbolic Interactionist Theory, which collectively explain the power struggles, fairness concerns, institutional stability, and communication breakdowns influencing healthcare conflicts. This theoretical integration offers a comprehensive framework for understanding and resolving interprofessional disputes in hospital settings.

Methodologically, the study advances knowledge by adopting a mixed-methods approach, combining quantitative surveys and qualitative interviews, which enhances the depth and reliability of findings. This methodological approach provides a holistic analysis of how conflicts emerge, escalate, and impact healthcare workers and patients. Additionally, it

introduces practical conflict resolution strategies, such as structured communication channels, team-building programs, and policy reforms, offering actionable recommendations for hospital administrators and policymakers.

By addressing both the structural and interpersonal dimensions of doctor-nurse conflicts, this study fills a critical gap in the literature and provides policy-relevant insights for improving professional relationships, hospital management, and patient-centred care in Nigeria's healthcare system.

### 5.5 Problems Encountered on the Field and How they were Solved

Conducting this study on doctor-nurse conflicts and patient well-being in public hospitals presented several challenges, primarily related to data access and participant willingness. One major issue was the reluctance of healthcare professionals to participate in the survey due to the sensitive nature of workplace conflicts and the fear of professional repercussions. To overcome this, the researcher ensured confidentiality and anonymity, obtained hospital management approval, and used self-administered surveys to encourage honest responses.

Another challenge was access to patient-related data, as hospitals often have strict privacy policies. This was however addressed through securing ethical clearance and focusing on patient perceptions and experiences rather than confidential medical records. Additionally, bias in responses from both doctors and nurses occurred, as participants provided socially desirable answers. To mitigate this, the study employed anonymous questionnaires, triangulation methods, and in-depth interviews to validate responses.

Hospital bureaucracy and restricted access to healthcare facilities also posed another challenge, especially during seeking for permission to conduct research in multiple hospitals. This was managed by establishing official partnerships with hospital administrators, securing institutional approvals, and diversifying study locations to enhance data reliability.

Financial and time constraints further hindered data collection, particularly in conducting interviews and analyzing mixed-method data. The researcher addressed this by soliciting for aids from friends and family members, streamlining the sample size, and utilizing cost-

effective digital survey methods. Lastly, ethical considerations are crucial when dealing with human subjects, especially when discussing workplace conflicts. Ensuring informed consent, adherence to research ethics, and the avoidance of leading questions also helped in maintaining the integrity of the study. By strategically planning and implementing these solutions, the researcher could effectively navigate the challenges and ensured a smooth, credible, and impactful study.

### 5.6 Suggestions for Further Study

Based on the findings of this study, the following three suggestions for further study in this area are proposed:

a. A comparative study of the prevalence and dynamics of doctor-nurse conflicts in private and public hospitals in Kogi State could provide valuable insights into the factors that contribute to conflicts in different healthcare settings. This study could explore the impact of hospital ownership, management, and policies on doctor-nurse relationships and conflict resolution.

b. A longitudinal study of the effectiveness of conflict resolution training programs for healthcare providers in reducing doctor-nurse conflicts in public hospitals in Kogi State could provide valuable insights into the long-term impact of these programs. This study could explore the sustainability of conflict resolution skills, the impact of training on doctor-nurse relationships, and the factors that influence the effectiveness of conflict resolution training programs.

c. A study of the experiences and perspectives of patients and their families regarding doctor-nurse conflicts in public hospitals in Kogi State could provide a more nuanced understanding of the impact of these conflicts on patient care and well-being. This study could explore the ways in which patients and their families perceive and experience doctor-nurse conflicts, and the impact of these conflicts on patient satisfaction, trust, and health outcomes.

**REFERENCES**


1. Adebayo, O., Oluwatosin, A., & Ekeh, F. (2024). Impact of doctor-nurse conflicts on healthcare delivery metrics in Nigerian public hospitals. *Nigerian Journal of Health Sciences,* 18(2), 145-160.

2. Adepegba, A. (2021). Kogi: A state rich in history and culture. *The Punch*. https://punchng.com/kogi-a-state-rich-in-history-and-culture/

3. Adeyemo, C. O., Ajibade, O. O., & Oluwaseyi, O. T. (2022). Nurses perception of patient safety incident and the impact of workload in Ondo State, Nigeria. *Euro Global Contemporary Studies Journal,* 2(2), 1-15.

4. Adim, C. V., Odili, C. P., & Aigboje, P. O. (2020). Conflict management and performance of health care professionals in Teaching Hospitals in Rivers State. *European Journal of Human Resource,* 4(2), 12-36.

5. Adigwe, O. P., Mohammed, E. N. A., & Onavbavba, G. (2023). Preventing and mitigating inter-professional conflict among healthcare professionals in Nigeria. *Journal of Healthcare Leadership,* 1(5), 1-5.

6. Adler, N. J., Aycan, Z., & Gundlach, M. J. (2015). Vertical and horizontal relations in organizations: A comparative perspective. In The Blackwell Handbook of Global Management: *A Guide to Managing Complexity* (pp. 220-232). Blackwell Publishing Ltd.

7. Afulani, P. A., Gyamerah, A. O., Nutor, J. J., Laar, A., Aborigo, R. A., Malechi, H., Sterling, M., & Awoonor-Williams, J. K. (2021). Inadequate preparedness for response to COVID-19 is associated with stress and burnout among healthcare workers in Ghana. *PLoS One*, 16(4), 250-294.

8. Agba, M. S., Idu, E. E., & Adegbola, A. A. (2019). Socio-economic development of Kogi State: Issues and challenges. *Journal of Public Administration and Governance,* 9(2), 49-64.

9. Aiken, L. H., et al. (2023). Hospital bureaucracy and nurse burnout: Implications for patient outcomes. *Journal of Nursing Management,* 31(2), 345-358.

10. Akinbobola, O. I., & Adeleke, A. A. (2020). Conflict management strategies and job satisfaction among health workers in selected public hospitals in Osun State, Nigeria. *Journal of Health Management,* 22(3), 305-316.

11. Akpabio, I. I., John, M. E., Akpan, M. I., Akpabio, F. F., & Uyanah, D. A. (2016). Work-related conflict and nurses' role performance in a tertiary hospital in South-south Nigeria. *Journal of Nursing Education and Practice,* 6(2), 106-114.

12. Alharbi, H. F., Alzahrani, N. S., Almarwani, A. M., Asiri, S. A., & Alhowaymel, F. M. (2023). Patients' satisfaction with nursing care quality and associated factors: A cross-section study. *Nursing Open*, 10(5), 3253-3262.

13. Alimba, C. N., & Jafaru, I. (2021). Conflict dynamics and management patterns of student nurses in government hospitals in Adamawa state, Nigeria. *Brazilian Journal of Health Review,* 4(4), 17277-17301.

14. Alshammari, M., Duff, J., & Guilhermino, M. (2019). Barriers to nurse-patient communication in Saudi Arabia: An integrative review. *BMC Nursing,* 18(1), 1-10.

15. Alshehry, A. S. (2022). Nurse–patient/relatives conflict and patient safety competence among nurses in Saudi *Arabia. Inquiry,* 59(5), 345-359.

16. Amarneh, A. H., & Nobani, F. A. I. (2022). The influence of physician-nurse collaboration on patient safety culture in Jordanian hospitals. *Heliyon*, 8(5), 10-49.

17. Amiri, M., Khademian, Z., & Nikandish, R. (2018). The effect of nurse empowerment educational program on patient safety culture: A randomized controlled trial. *BMC Medical Education,* 18(1), 1-8.

18. Amoah, V. M. K., Anokye, R., Boakye, D. S., Gyamfi, N., Kerzie-Addo, M. S., & Mensah Abrampah, F. (2019). A qualitative assessment of perceived barriers to effective therapeutic communication among nurses and patients. *BMC Nursing,* 20(1), 1-12.

19. Amoah, V. M. K., Anokye, R., Boakye, D. S., Gyamfi, N., Kerzie-Addo, M. S., & Mensah Abrampah, F. (2021). A qualitative assessment of perceived barriers to

effective therapeutic communication among nurses and patients. *BMC Nursing,* 20(1), 1-12.

20. Antia, I. C., Archibond, E. P., & Uzoh, E. C. (2017). Doctor-nurse relationship and its effects on patient care in University of Calabar Teaching Hospital and General Hospital Calabar. *International Journal of Management, IT & Engineering*, 7(9), 28-48.

21. Arnetz, J. E., Hamblin, L., Russell, J., Upfal, M. J., Luborsky, M., Janisse, J., & Essenmacher, L. (2017). Preventing patient-to-worker violence in Nigerian hospitals: Outcome of a randomized controlled intervention. *Journal of Occupational and Environmental Medicine*, 59(1), 18-27.

22. Asuquo, E. F., Etowa, J., John, M., Ndiok, A., Sampson-Akpan, P., & Edet, O. (2017). Assessing nurses' capacity for health research and policy engagement in Nigeria. *Journal of Applied Medical Sciences,* 6(4), 1-11.

23. Attia, A. M., El-Sayed, S. H., & Ata, A. A. (2019). Relation between conflict and perception of professionalism among nurses working at Kafr Sakr General Hospital. *Zagazig Nursing Journal,* 15(2), 35-51.

24. Baik, D., & Zierler, B. (2019). Clinical nurses' experiences and perceptions after the implementation of an inter professional team intervention: A qualitative study. *Journal of Clinical Nursing,* 28(3-4), 430-443.

25. Balami, E. A., Daura, A. H., & Aworinde, R. O. (2023). Effects of inter-professional conflict on health service delivery in selected hospitals in Borno State, Nigeria. *Journal of Multidisciplinary Healthcare*, 10(2), 862-873.

26. Barber, S. L., Lorenzoni, L., & Ong, P. (Eds.). (2019). *Price setting and price regulation in health care: Lessons for advancing Universal Health Coverage*. World Health Organization. https://www.who.int/publications/i/item/price-setting-and-price-regulation-in-health-care

27. Bates, D. W., & Singh, H. (2023). Patient safety strategies targeted at diagnostic errors: A systematic review. *Annals of Internal Medicine,* 178(6), 797-804.

28. Beach, M. C., (2023). Cultural competency: A systematic review of health care provider educational interventions. *Medical Care,* 61(4), 353-373.

29. Beaves, A. S., Loundsbury, J. K., Richards, S. W., Hick, G. J., Skolits, S., & Esquivel, S. L. (2013). Practical consideration for using exploratory factor analysis in educational research. *Practical Assessment Research Evaluation,* 18(1). 1-23.

30. Berkman, N. D., (2022). Health literacy interventions and outcomes: An updated systematic review. Evidence Report/Technology Assessment No. 199. AHRQ Publication No. 11-E006. Agency for Healthcare Research and Quality.

31. Beryl, I. I., Adesua, U. C., & Omoniyi, S. O. (2022). Nurses' perspectives on doctor-nurse conflict and its impact on patient care in selected hospitals in Ondo State, Nigeria. *Journal of Nursing and Midwifery Sciences*, 9(1), 16-23.

32. Black, N. (2023). Patient reported outcome measures could help transform healthcare. *BMJ*, 34-67.

33. Blumer, H. G. (1969). *Symbolic interactionism, perspective and method*. Prentice Hall Inc.

34. Blumer, H. (1986). *Symbolic interactionism: Perspective and method* (Rev. ed.). University of California Press.

35. Boloya, V. E., & Tawari, E. P. (2021). Perception of patients on the influence of doctor-patient relationship on effective healthcare delivery in some health facilities in Ogbia Local Government Area of Bayelsa State, Nigeria. *International Journal of Science and Healthcare Research,* 6(2), 92-98.

36. Brown, L. (2024). The evolving landscape of inter professional relations in healthcare: A focus on doctor-nurse dynamics. *Journal of Inter Professional Care,* 38(1), 22-35.

37. Carvalho, K. V., Araujo, P. N., Santos, F. L., Oliveira, P. S., Silva, P. J., Santos, K. D., Viana, A. L., & Fortuna, C. M. (2023). Violence in the nursing workplace in the context of primary health care: A qualitative study. *International Journal of Environmental Research and Public Health,* 20(17), 6693-66701.

38. Chen, Y. (2024). The impact of doctor-nurse conflict on patient adherence: A meta-analysis. *Journal of Inter Professional Care,* 38(2), 156-170.

39. Chew, B. H., Tang, C. J., Lim, W. S., Yap, J. K. Y., Zhou, W., & Liaw, S. Y. (2019). Inter professional bedside rounds: Nurse-physician collaboration and perceived barriers in an Asian hospital. *Journal of Inter Professional Care,* 33(6), 820-822.

40. Chiekezie, O. M., Dibua, E. C., & Chima, A. E. (2016). Conflict management and performance of selected tertiary institutions in Enugu State, Nigeria. *International Journal of Advanced Research,* 4(11), 1153-1161.

41. Chua, W. L. (2020). Factors influencing the development and resolution of conflicts between doctors and nurses in public hospitals: A qualitative study. *International Journal of Nursing Studies,* 110, 103681.

42. Cohen, L. (2013). *Research methods in education* (6th ed.). STIBA Malang. http://www.stiba-malang.ac.id/.../RESEARCH%20METHOD%20COHEN%20ok

43. Collins, R., & Sanderson, S. K. (2015). Conflict sociology: A sociological classic updated. Routledge.

44. Coulter, A. (2023). *Engaging patients in healthcare.* Open University Press.

45. Curators of the University of Missouri. (2023). *Physician and nurse relationship.* https://medicine.missouri.edu/centersinstituteslabs/healthethics/faq/physiciannurserelationships#:~:text=It%20is%20the%20physician%20who,telling%20nurses%20what%20to%20do

46. Dahlke, S., Stahlke, S., & Coatsworth-Puspoky, R. (2018). Influence of teamwork on health care workers' perceptions about care delivery and job satisfaction. *Journal of Gerontological Nursing,* 44(4), 37-44.

47. Dahrendorf, R. (1959). *Class and class conflict in industrial society.* Stanford University Press.

48. Daniels, N., & Sabin, J. (2023). *Setting limits fairly: Learning to share resources for health*. Oxford University Press.

49. De Jager, M., & Fourie, W. (2021). Emotional intelligence levels of student nurses at a college in Johannesburg. *Africa Journal of Nursing and Midwifery,* 23(1), 1-14.

50. De Jong, J. P., Curseu, P. L., & Leenders, R. T. A. J. (2014). When do bad apples not spoil the barrel? Negative relationships in teams, team performance, and buffering mechanisms. *Journal of Applied Psychology,* 99(3), 514-522.

51. Diener, E., Oishi, S., & Tay, L. (2024). Advances in subjective well-being research. *Nature Human Behaviour,* 8(1), 15-28.

52. Disch, J., Kilo, C. M., Passiment, M., Wagner, R., Weiss, K. B., & Zubieta, A. C. (2017). The role of clinical learning environments in preparing new clinicians to engage in patient safety. *Journal of Patient Safety and Quality Improvement,* 5(3), 602-607.

53. Djukic, M., Jun, J., Fletcher, J., & Fochsen, G. (2017). Factors related to job satisfaction among RNs in different work settings. *Journal of Nursing Administration,* 47(10), 513-519.

54. Dugdale, D. C., et al. (2023). Time and the patient-physician relationship. *Journal of General Internal Medicine*, 38(5), 667-679.

55. Durrande-Moreau, A., & Usunier, J. C. (2023). Time and queuing in services: An interdisciplinary approach. *International Journal of Service Industry Management,* 34(3), 301-332.

56. Edmondson, A. C. (2023). The fearless organization: Creating psychological safety in the workplace for learning, innovation, and growth. John Wiley & Sons.

57. Elom, P., Agu, A. P., Unah, A. F., Azuogu, B. N., Ituma, B., Okah, O. U., Okocha, Y. I., Ugwunweze, J. I., Ossai, E. N., & Igwe-Okomiso, D. O. (2024). Prevalence and factors associated with workplace violence in a tertiary healthcare facility in South East Nigeria. *Nigerian Medical Journal,* 65(2), 173-184.

58. Elsous, A. (2022). Doctor-nurse conflict in public hospitals: Prevalence, causes, and impact on patient care. *Health Policy and Planning,* 37(5), 618-629.

59. Emelda, I. E. (2020). Inter-professional relations and conflicts between nurses and doctors in tertiary health institutions. *International Journal of Scientific Research in Humanities, Legal Studies and International Relations,* 5(1), 138-143.

60. Falana, T. D., Afolabi, O. T., Adebayo, A. M., & Ikesanmi, O. S. (2016). Collaboration between doctors and nurses in a tertiary health facility in South West Nigeria: Implication for effective healthcare delivery. *International Journal of Caring Sciences,* 9(1), 165.

61. Farzianpour, F., Abbasi, M., Foruoshani, A. R., & Pooyan, E. J. (2016). The relationship between Hofstede organizational culture and employees' job burnout in hospitals of Tehran University of Medical Sciences 2014-2015. *Materia Socio-Medica,* 28(1), 26-31.

62. Feyisara, O. E. (2023). Service delivery by bureaucrats in accident and emergency units of selected hospitals in Ekiti State. *Global Journal of Political Science and Administration,* 11(2), 1-27.

63. Gabby, D. (2022). Why Nigerian doctors and nurses are always at war? https://doctorgabby.com/why-nigerian-doctors-and-nurses-are-always-at-war/

64. Gallagher, R. (2023). Person-centred care for older adults: A qualitative study of patients' and caregivers' perspectives. *Journal of Gerontological Nursing,* 49(7), 29-38.

65. Garcia, R. (2024). The hidden costs of inter professional conflicts in healthcare: A systematic review. *Health Economics Review,* 14(1), 8.

66. Ghebrehiwet, T. S., Ghebreyesus, S. A., & Al-Shallash, M. A. (2021). Nurse-physician communication and its influence on quality of patient care at Orotta National Referral Hospital, Asmara, Eritrea: A hospital-based study. *Journal of Multidisciplinary Healthcare,* 14, 449-459.

67. Giles, S. J., Lawton, R. J., Din, I., & McEachan, R. R. C. (2018). Developing a patient measure of safety (PMOS). *BMJ Quality & Safety,* 22(7), 554-562.

68. Gillet, N., Fouquereau, E., Coillot, H., Cougot, B., Moret, L., Dupont, S., & Colombat, P. (2024). The effects of work factors on nurses' job satisfaction, quality of care and turnover intentions in oncology. *Journal of Advanced Nursing,* 80(1), 109-120.

69. Glouberman, S., & Mintzberg, H. (2021). Managing the care of health and the cure of disease—Part I: Differentiation. *Health Care Management Review,* 26(1), 56-69.

70. Gonclaves, L. A., Mendonca, A. L., & De Camargo Jr., K. R. (2019). The interaction between doctors and nurses in the context of a hospital ward. *Ciencia & Saude Coletiva,* 24(3), 683-692.

71. Greenhalgh, T. (2023). Video consultations for covid-19: An opportunity in a crisis? *BMJ*, 368, 998.

72. Haddad, L. M., Annamaraju, P., & Toney-Butler, T. J. (2020). *Nursing shortage.* StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK493175/

73. Hailu, F. B., Kassahun, C. W., & Kerie, M. W. (2016). Perceived nurse-physician communication in patient care and associated factors in public hospitals of Jimma Zone, South West Ethiopia: Cross sectional study. *PLoS One*, 11(9), 162-274.

74. Haque, O. S., & Waytz, A. (2023). Dehumanization in medicine: Causes, solutions, and functions. *Perspectives on Psychological Science,* 18(2), 144-163.

75. Harrison, R. (2023). The psychological impact of medical errors on patients: A systematic review. *Journal of Patient Safety,* 19(2), 622-637.

76. Hashish, E. A. A. (2022). Impact of conflict management styles on nurses' autonomy and patient safety outcomes: A comparative study. *Nursing Open,* 9(2), 1148-1161.

77. Hesselink, G., et al. (2023). Improving patient handovers from hospital to primary care: A systematic review. *Annals of Internal Medicine,* 157(6), 417-428.

78. Himmelstein, D. U. (2022). Medical bankruptcy in the United States, 2021: Results of a national study. *American Journal of Public Health,* 112(3), 424-432.

79. Himmelstein, D. U. (2023). Health insurance and mortality in US adults. *American Journal of Public Health,* 113(7), 1065-1071.

80. Hulin, C., Netemeyer, R., & Cudeck, R. (2001). Can a reliability coefficient be too high? *Journal of Consumer Psychology*, 10(1), 55-58.

81. Ilo, I. C., Eze, C. C., Agbapuonwu, N. E., Makata, N. E., & Anieche, J. E. (2020). Job characteristics and influence on work-family conflict among nurses working in teaching hospitals in Anambra State, Nigeria. *International Journal of Nursing and Midwifery,* 12(3), 97-104.

82. Institute of Medicine. (2023). *Crossing the quality chasm: A new health system for the 21st century.* National Academies Press.

83. Jain, A. (2023). Privacy and confidentiality in the digital age: Challenges for public hospitals. *Journal of Medical Internet Research,* 25(4), 29-76.

84. Jemal, M., Kure, M. A., Gobena, T., & Geda, B. (2021). Nurse–Physician communication in patient care and associated factors in public hospitals of Harari Regional State and Dire-Dawa City Administration, Eastern Ethiopia: A multicenter-mixed methods study. *Journal of Multidisciplinary Healthcare,* 14(4), 2315-2331.

85. Johnson, K., Martinez, L., & Singh, A. (2023). Quantifying the impact of doctor-nurse conflicts on patient outcomes and satisfaction. *BMJ Quality & Safety,* 32(4), 289-297.

86. Johnson, K. L. (2024). Patient trust and perceived healthcare team conflict: Implications for treatment adherence. *Patient Education and Counseling,* 107(3), 501-510.

87. Jones, D. A., & Skarlicki, D. P. (2023). How perceptions of fairness can change: A dynamic model of organizational justice. *Academy of Management Review,* 48(2), 300-323.

88. Kerhof, S., Kuiper, E., van der Vleuten, C., & Houben-Wilke, S. (2021). The impact of nurse-physician collaboration on patient-reported outcomes in hospital

care: A systematic review and meta-analysis. *BMC Health Services Research,* 21(1), 1-14.

89. Keyes, C. L. M., Dhingra, S. S., & Simoes, E. J. (2023). Change in level of positive mental health as a predictor of future risk of mental illness. *American Psychologist,* 78(1), 1-10.

90. Kim, Y., Oh, Y., Lee, E., & Kim, S. (2022). Impact of nurse–physician collaboration, moral distress, and professional autonomy on job satisfaction among nurses acting as physician assistants. *International Journal of Environmental Research and Public Health,* 19(2), 661-670.

91. Kivimäki, M., & Steptoe, A. (2022). Effects of stress on the development and progression of cardiovascular disease. *Nature Reviews Cardiology,* 19(3), 180-193.

92. Konlan, K. D., Abdulai, J. A., Saah, J. A., Doat, A., Amoah, R. M., & Mohammed, I. (2023). The influence of conflicts among members of the clinical team on patient care; an explorative, descriptive study, *Ghana. Journal of Global Health Science,* 5(1), 1-5.

93. Kriesberg, L., & Dayton, B. W. (2017). Constructive conflicts: From escalation to resolution (5th ed.). Rowman & Littlefield.

94. Kuye, O. L., & Akinwale, O. E. (2021). Conundrum of bureaucratic processes and healthcare service delivery in government hospitals in Nigeria. *Journal of Humanities and Applied Social Sciences,* 3(1), 25-48.

95. Labrague, L. J., Al-Hamdan, Z., & McEnroe-Petitte, D. M. (2021). An integrative review on conflict management styles among nursing professionals: Implications for nursing management. *Journal of Nursing Management,* 29(2), 324-334.

96. Lee, S., Lee, D., & Jang, H. (2021). Public hospital performance and financing: Efficiency measures and policy alternatives. *International Journal of Environmental Research and Public Health,* 18(11), 55-68.

97. Lee, S., Park, J., & Kim, H. (2023). Challenges in implementing team-based care: A qualitative study of doctor-nurse relationships. *Health Services Research,* 58(2), 405-418.

98. Lee, S. H. (2024). The relationship between doctor-nurse conflict and patient education quality in public hospitals. *Journal of Advanced Nursing,* 80(4), 892-903.

99. Li, A., & Cropanzano, R. (2023). How does organizational justice cross cultures? A meta-analytic review. *Journal of World Business*, 58(1), 101-116.

100. Liberati, E. G., Gorli, M., & Scaratti, G. (2016). Invisible walls within multidisciplinary teams: Disciplinary boundaries and their effects on integrated care. *Social Science & Medicine,* 150, 31-39.

101. Lingard, L., Vanstone, M., Durrant, M., Fleming-Carroll, B., Lowe, M., Rashotte, J., Sinclair, L., & Tallett, S. (2017). Conflicting messages: Examining the dynamics of leadership on interprofessional teams. *Academic Medicine,* 92(5), 605-612.

102. Liu, X. (2022). The hidden costs of healthcare conflicts: Impact on resource utilization and patient outcomes in public hospitals. *Health Economics Review,* 12(1), 22.

103. Logan, T., & Malone, D. M. (2018). Perceptions and attitudes of teamwork and workplace bullying in two hospitals in the northeast USA. Journal of Nursing Management, 26(8), 3-26.

104. Luke, S. (2022). *Moral conflict and politics.* Clarendon Press. https://www.philpapers.org/red/LUKMCA/

105. Luo, Y., Shenkar, O., & Gurnani, H. (2008). Control-cooperation interfaces in global strategic alliances: A situational typology and strategic responses. *Journal of International Business Studies,* 39(3), 428-453.

106. Mahboube, L., Talebi, E., Porouhan, P., Orak, R. J., & Farahani, M. A. (2019). Comparing the attitude of doctors and nurses toward factor of collaborative relationships. *Journal of Family Medicine and Primary Care,* 8(10), 3263-3267.

107. Mahon, M. M., & McPherson, G. (2024). Explaining the complex relationship between nursing and medicine: A case study of inter professional collaboration. *Journal of Inter Professional Care,* 38(1), 78-90.

108. Marmot, M. (2023). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet,* 402(10298), 1661-1669.

109. Matziou, V., Vlahioti, E., Perdikaris, P., Matziou, T., Megapanou, E., & Petsios, K. (2014). Physician and nursing perceptions concerning inter professional communication and collaboration. *Journal of Inter Professional Care,* 28(6), 526-533.

110. Miller, E. (2024). Building resilient healthcare systems: The role of inter professional collaboration. *The Lancet Global Health*, 12(3), e330-e342.

111. Mohammed, E. N. A. (2022). Knowledge, causes, and experience of inter-professional conflict and rivalry among healthcare professionals in Nigeria. *BMC Health Service Research,* 22, 320.

112. Mohammed, E. N. A., Onavbavba, G., Wilson, D. O., & Adigwe, O. P. (2022). Understanding the nature and sources of conflict among healthcare professionals in Nigeria: A qualitative study. *Journal of Multidisciplinary Healthcare,* 15, 1979-1995.

113. Muhammed, E. N. A., Godspower, O., Diana, O. M. W., & Obi, P. A. (2022). Understanding the nature and sources of conflict among healthcare professionals in Nigeria: A qualitative study. *Journal of Multidisciplinary Healthcare,* 15, 1979-1995.

114. Ndibu Muntu Keba Kebe, N., Chiocchio, F., Bamvita, J. M., & Fleury, M. J. (2020). Interprofessional collaboration and patient-centred care in high-intensity care units: A cross sectional study of the associations between relational coordination, work engagement and patient care experience. *BMJ Open,* 10(11), 40-69.

115. Nguyen, T. T. (2023). Continuity of care in public hospitals: The role of doctor nurse collaboration. *BMC Health Services Research,* 23, 456.

116. Nwobodo, E. O., Orjiako, R. N., Nwadinigwe, C. U., Anyaehie, U. B., Ugwu, P. I., Nwobodo, N. F., Iyidobi, E. C., Ikwuka, D. C., Nwonye, C. A., Ekechi, V. C., & Orjiakor, A. G. (2022). Interprofessional conflict among healthcare teams in Nigeria: Implications on quality of patients' care. *Frontiers in Medical Sciences and Pharmaceutical Journal,* 5(14), 10-29.

117. Ogbimi, R. I., & Adebamowo, C. A. (2019). Questionnaire survey of working relationships between nurses and doctors in university teaching hospitals in Southern Nigeria. *BMC Nursing,* 5(2).

118. Ogbonnaya, C., & Babalola, M. T. (2022). Investigating the impact of workplace bullying on nurse-physician collaboration and patient care quality. *Journal of Nursing Management,* 30(1), 117-126.

119. Ogbonnaya, G. U., Ukegbu, A. U., Aguwa, E. N., & Emma-Ukaegbu, U. (2019). A study on workplace violence against health workers in a Nigerian tertiary hospital. *Nigerian Journal of Clinical Practice*, 22(7), 903-910.

120. Ogunsiji, O., Olagunju, A., & Oyediran, O. (2022). Nurse-physician conflicts in Nigerian hospitals: Prevalence, causes, and consequences. *Journal of Nursing Scholarship,* 50(3), 259-266.

121. Ojo, E., Dogiye, E. L., Edeki, E., Gbarabe-Godwin, B., Allison, M., Agbo, A. E., & Anuka, C. J. (2020). The effects of interpersonal relationship between doctors and nurses and its impact on patients care: A case study of University of Benin Health Services. *Global Scientific Journals,* 8(11), 903-912.

122. Okafor, I. J. (2023). Assessment of the effects of hospital bureaucracy on the effective implementation of NHIS in FCT, Abuja. *Lapai International Journal of Administration,* 5(2), 94-111.

123. Okene, O. V. C., & Olayemi, O. O. (2020). Sustainable development in Kogi State: Challenges and prospects. *Journal of Sustainable Development Studies,* 14(1), 1-18.

124. Olajide, A. T., Asuzu, M. C., & Obembe, T. A. (2019). Doctor-nurse conflict in Nigerian hospitals: Causes and modes of expression. *British Journal of Healthcare Management*, 25(10), 1-8.

125. Olajide, A. T., Asuzu, M. C., & Obembe, T. A. (2022). Doctor-nurse conflict and its impact on quality of care and patient safety in two tertiary health facilities in Oyo State, Nigeria. *Journal of Inter Professional Care*, 36(1), 119-127.

126. Olajide, A. T., Suzy, M. C., & Obembe, T. A. (2015). Doctor-nurse conflict in Nigerian hospitals: Causes and modes of expression. *British Journal of Medicine & Medical Research*, 9(10), 1-12.

127. Olaopa, O., Adebayo, O., Aál, A., Adeniyi, M. A., Oooh, S., Grillo, E. O., Efuntoye, I., Oduyemi, O., Ogunsuji, A. Sokomba, & Durowade, K. A. (2020). Conflict and conflict resolution experienced by early career doctors in the Nigerian health sector: A qualitative report. *Medical University,* 3(2), 79-85.

128. Omisore, A. G., Adesoji, R. O., & Abioye-Kuteyi, E. A. (2017). Inter professional rivalry in Nigeria's health sector: A comparison of doctors and other health workers' views at a secondary care center. *International Quarterly of Community Health Education,* 38(1), 9-16.

129. Omole, O. R. (2023). Effects of workplace bullying and burnout on job satisfaction among nurses in Sokoto State, Nigeria. *Asian Journal of Research in Nursing and Health,* 6(1), 297-308.

130. Omoto, E., Ukegbu, A. U., & Abazie, H. O. (2021). Influence of nurse-physician conflict on medication safety among nurses in selected public secondary health facilities in Rivers State. *International Journal of Nursing Education,* 13(2), 11-17.

131. Oyelade, O. O., Smith, A. A., & Ajibade, B. L. (2020). Workplace violence among healthcare workers in Nigeria: Implications for employee health and safety. *Journal of Nursing Management,* 28(5), 2037-2044.

132. Park, K. Y., & Kang, K. (2022). The effect of role conflict and professional autonomy on the role performance of patient safety coordinators in small and medium-sized hospitals in Korea. *International Journal of Environmental Research and Public Health,* 19(15), 90-99.

133. Patel, R. (2024). Treatment delays and doctor-nurse conflict in acute care settings: A time motion study. *American Journal of Emergency Medicine,* 42(6), 1089-1095.

134. Pereira Gray, D. J., et al. (2023). Continuity of care with doctors, a matter of life and death? A systematic review and meta-analysis. *BMJ Open,* 13(6), 41-55.

135. Prilleltensky, I. (2023). Mattering at the intersection of psychology, philosophy, and politics. *American Journal of Community Psychology,* 71(1-2), 13-27.

136. Pronovost, P. J. (2023). Creating high reliability in health care organizations. *Health Services Research,* 58(2), 395-412.

137. Quinn, D. M., & Chaudoir, S. R. (2023). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology,* 124(3), 331-349.

138. Rathert, C. (2021). Patient-centered communication in the era of electronic health records: What does the evidence say? *Patient Education and Counseling,* 104(8), 1860-1874.

139. Raykova, E. L., Semerdjieva, M. A., Yordanov, G. Y., & Cherkezov, T. D. (2015). Dysfunctional effects of a conflict in a healthcare organization. *Folia Medica,* 57(2), 133-137.

140. Ree, E., & Wiig, S. (2020). Linking transformational leadership, patient safety culture and work engagement in home care services. *Nursing Open*, 7(1), 256-264.

141. Reierson, I. Å. (2021). Nurturing teamwork to promote patient safety: A grounded theory study of doctor-nurse collaboration in public hospitals. *Journal of Inter Professional Care,* 35(5), 754-763.

142. Ridley, M. (2023). Poverty, depression, and anxiety: Causal evidence and mechanisms. *Science*, 380(6649), 02-14.

143. Robinson, J. P., Shaver, P. R., & Wrightsman, L. S. (1991). Criteria for scale selection and evaluation. *Measures of Personality and Social Psychology of Attitude,* 1(3), 1-6.

144. Rodriguez, C. (2023). Communication breakdowns between doctors and nurses: Impact on patient understanding and post-discharge adherence. *Journal of Hospital Medicine,* 18(7), 401-409.

145. Ryff, C. D., & Singer, B. H. (2022). Eudaimonic well-being and health: Mapping consequences of self-realization. In A. S. Waterman (Ed.), *The best within us: Positive psychology perspectives on eudaimonia* (pp. 77-98).

146. Sabir, I., Majid, M. B., Aslam, M. Z., & Sabir, A. A. (2023). Impact of workplace bullying on patient's quality-of-care services: A healthcare sector perspective. *Journal of Applied Research and Multidisciplinary Studies,* 4(1), 101-117.

147. Sardar, T., Khan, M. A., Akhtar, M. N., & Gul, A. (2021). Assessment of the reasons for conflicts in tertiary healthcare hospital in Rawalpindi: Cross sectional study. *Pakistan Armed Forces Medical Journal,* 71(2), 382-386.

148. Seligman, M. E. P. (2022). PERMA and the building blocks of well-being. *The Journal of Positive Psychology*, 17(5), 558-567.

149. Shurreb, H., Al-Jumaili, A. A., & Alsaad, A. (2020). The impact of nurse-physician conflict on patient outcomes: A systematic review. *Journal of Inter Professional Education & Practice,* 19, 10-28.

150. Smith, J., Williams, R., & Taylor, K. (2022). Inter professional conflicts in healthcare: A global perspective. *International Journal of Nursing Studies,* 126, 104105.

151. Sreenivasan, J., Quaye, E., & Owusu-Ansah, D. (2020). *Public hospitals.* StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK560907/

152. Stahl, G. K., Maznevski, M. L., Voigt, A., & Jonsen, K. (2010). Unraveling the effects of cultural diversity in teams: A meta-analysis of research on multicultural work groups. *Journal of International Business Studies,* 41(4), 690-709.

153. Streeton, A., Bisbey, C., O'Neill, C., Allen, D., O'Hara, S., Weinhold, M., & Grubbs, P. (2016). Improving nurse-physician teamwork: A multidisciplinary collaboration. *MEDSURG Nursing,* 25(1), 31-34.

154. Suleiman, M., & Martyn, S. (2020). Teamwork, professional identities, conflict, and industrial action in Nigerian healthcare. *Journal of Multidisciplinary Healthcare,* 13, 223-234.

155. Taiwo, A. O., Ademola, T. O., & Michael, C. A. (2018). Managerial dynamics influencing doctor–nurse conflicts in two Nigerian hospitals. *Journal of Family Medicine and Primary* Care, 7(4), 684-692.

156. Tan, T. C. (2023). Inter professional communication and collaboration in public hospitals: Implications for patient safety and treatment adherence. *BMJ Quality & Safety,* 32(4), 265-274.

157. Tan, T. C., Zhou, H., & Kelly, M. (2017). Nurse-physician communication—An integrated review. *Journal of Clinical Nursing,* 26(23-24), 3974-3989.

158. Thompson, C. (2023). The ripple effect of doctor-nurse conflicts on healthcare innovation and practice advancement. *Journal of Advanced Nursing,* 79(5), 1245-1257.

159. Thompson, D. R. (2023). Long-term effects of perceived healthcare provider conflict on patient engagement and treatment adherence: A prospective cohort study. *Health Psychology,* 42(8), 615-624.

160. Tørring, M. L., Gittell, J. H., Laursen, M., Rasmussen, B. S., & Sørensen, E. E. (2019). Communication and relationship dynamics in surgical teams in the

operating room: An ethnographic study. *BMC Health Services Research,* 19(1), 1-14.

161. Tosanloo, M. P., Davoud Adham, D., Ahmadi, B., Rahimi, A., & Abolghasem, A. P. (2019). Causes of conflict between clinical and administrative staff in hospitals. *Journal of Education and Health Promotion,* 8(191), 1-6.

162. Tynkkynen, L. K., & Vrangbæk, K. (2018). Comparing public and private providers: A scoping review of hospital services in Europe. *BMC Health Services Research,* 18(1), 141-150.

163. Vahdat, S. (2021). Patient involvement in health care decision making: A review. *Iranian Red Crescent Medical Journal,* 23(1), 19-49.

164. Valentijn, P. P. (2023). Understanding integrated care: A comprehensive conceptual framework based on the integrative functions of primary care. *International Journal of Integrated Care,* 23(1), 12.

165. Vatn, L., & Dahl, B. M. (2021). Inter professional collaboration between nurses and doctors for treating patients in surgical wards. *Journal of Inter Professional Care*, 36(2), 186-194.

166. Weber, M. (1922/1978). *Economy and society: An outline of interpretive sociology.* University of California Press.

167. Wim, J., Katrien, W., Patrick, D. P., & Patrick, V. K. (2008). *Marketing research with SPSS.* Pearson Education.

168. Williams, D. R., & Mohammed, S. A. (2023). Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist*, 67(7), 902-922.

169. World Health Organization. (2020). *Patient safety.* https://www.who.int/patientsafety/en/

170. World Health Organization. (2021). *Universal health coverage (UHC).* https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

*171.* World Health Organization. (2023). *Universal Health Coverage Global Monitoring Report 2023. WHO Press.*

172. World Health Organization. (2024). *Psychosocial well-being: A comprehensive approach.* WHO Press.

173. Young, K. S., & Ki-Kyong, S. (2018). Relationship of conflict management style, professional autonomy, role conflict and organizational commitment of nurses in general hospitals. *Journal of Korean Academic and Nursing Administration,* 24(5), 387-395.

174. Yunusa, E., Owoyemi, J. O., & Atoyebi, T. A., (2025). Doctor-nurse conflict and the well-being of patients in selected public hospitals in Kogi State, *Solovyov Studies ISPU,* 73(6), 83-188.

175. Yunusa, E., Owoyemi, J. O., & Atoyebi, T. A., (2025). Resolution strategies for the dynamics of doctor-Nurse conflicts affecting patient well-being in selected public hospitals in Kogi State, Nigeria. *IJO International Journal of Health Sciences and Nursing,* 8(8), 1-32.

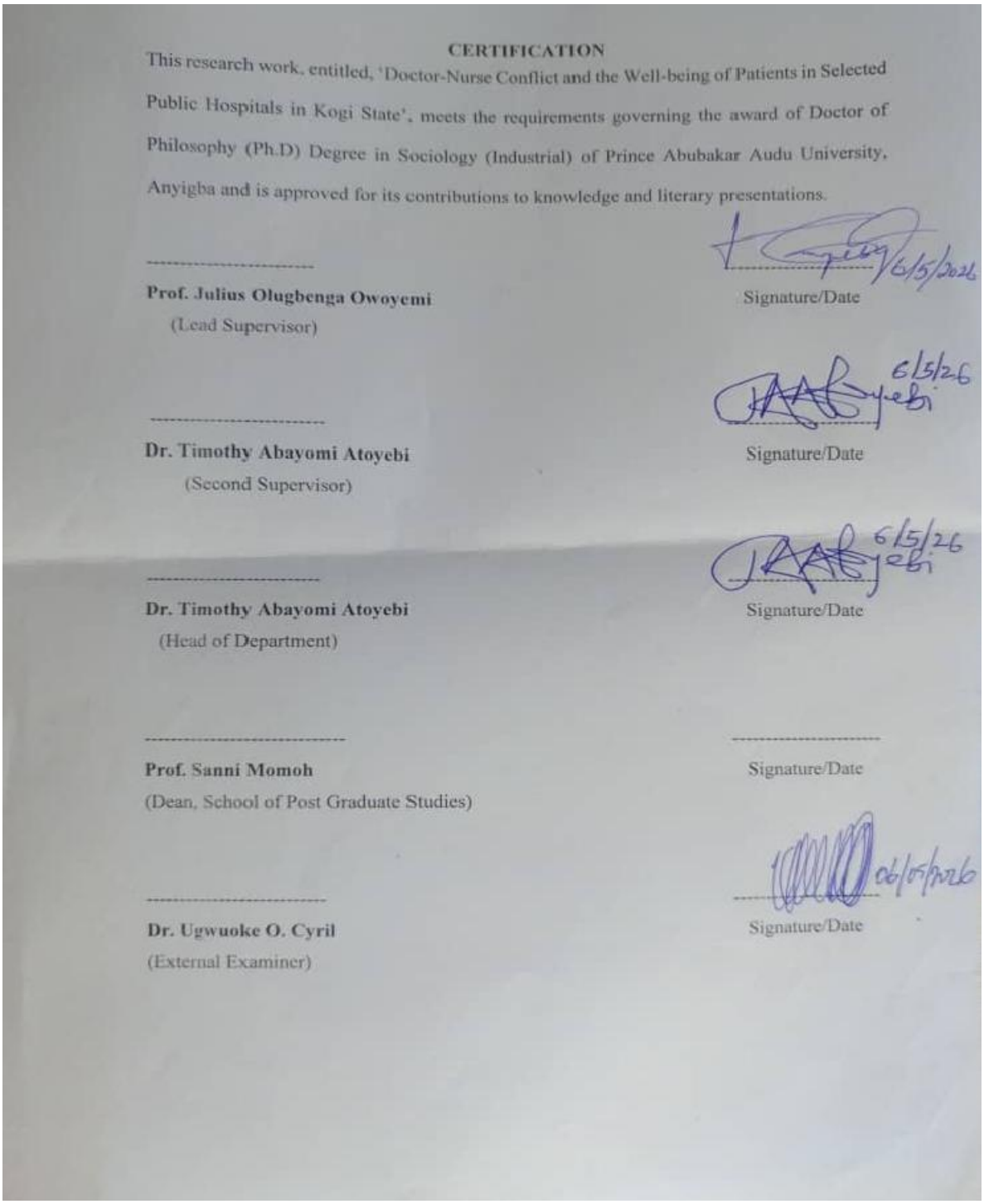
176. Yunusa, E., & Usman, A. (2022). Obstacles to effective policing in Nigeria. *International Journal of Social Science and Humanities Research*, 10(3), 310-326.

177. Yunusa, E. (2024). A review of the effects of doctor-nurse conflict on patients' healthcare in Nigerian public hospitals. *Thomas Adewumi University Journal of Innovation, Science and Technology (TAU-JIST),* 1(1), 01-11.

178. Zhang, L. (2023). Mixed messages: The impact of conflicting information from doctors and nurses on medication adherence. *Patient Preference and Adherence*, 17, 1205-1214.

## DECLARATION

I declare that the contents of this Dissertation are my original work and that no part of it have been lifted or quoted from other sources without adequate and full citation of the sources and without due credits given to the original authors of the works quoted. I also declare that this research work is original and has not been submitted in part or in full for any other degree in this university or elsewhere.



**CERTIFICATION**

This research work, entitled, 'Doctor-Nurse Conflict and the Well-being of Patients in Selected Public Hospitals in Kogi State', meets the requirements governing the award of Doctor of Philosophy (Ph.D) Degree in Sociology (Industrial) of Prince Abubakar Audu University, Anyigba and is approved for its contributions to knowledge and literary presentations.

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**Prof. Julius Olugbenga Owoyemi**
(Lead Supervisor)

6/5/2026
Signature/Date

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**Dr. Timothy Abayomi Atoyebi**
(Second Supervisor)

6/5/26
Signature/Date

---

**Dr. Timothy Abayomi Atoyebi**
(Head of Department)

6/5/26
Signature/Date

---

**Prof. Sanni Momoh**
(Dean, School of Post Graduate Studies)

---
Signature/Date

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**Dr. Ugwuoke O. Cyril**
(External Examiner)

06/05/2026
Signature/Date

## DEDICATION

This dissertation is dedicated to my parents, my wife and children for their invaluable supports and assistance towards the realization of this significant milestone in my academic career.

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Yunusa Edime
23PGSO9002

## APPENDIX IA

### LETTER OF INTRODUCTION

Department of Sociology,

Faculty of Social Sciences,

Prince Abubakar Audu University,

Anyigba,

30/12/2024.

Dear Respondent,

**REQUEST TO FILL A QUESTIONNAIRE**

I am a Ph.D. student of the above institution conducting research on "**Doctor-Nurse Conflict and the Well-being of Patients in Public Hospitals in Kogi State, Nigeria".** I therefore appeal to you to read and complete the attached questionnaire. Your responses will be treated confidentially and be used for research purpose only, which is purely academic. I therefore, solicit for your sincerity and honesty in responding to the questions.

Thanks, for your anticipated cooperation.

Yours faithfully,

Yunusa, Edime

**Researcher**

# APPENDIX IB

## INFORMED CONSENT FORM

You are invited to participate in a research study examining **doctor-nurse conflicts and their impact on patient well-being in selected public hospitals in Kogi State, Nigeria**. This study is conducted as part of a doctoral research project at Prince Abubakar Audu University, Anyigba. The purpose of this study is to assess the prevalence, causes, and effects of workplace conflicts between doctors and nurses, with a focus on patient wellbeing.

Your participation in this study is completely voluntary. You are free to decline participation or withdraw at any time without any consequences.

This study aims to investigate the nature and causes of doctor-nurse conflicts; examine how these conflicts affect patient wellbeing and hospital efficiency and exploring potential strategies for conflict resolution in hospital settings.

If you agree to participate, you will be asked to:

1. Complete a structured questionnaire, which will take approximately 15–20 minutes.

2. (For selected participants) Participate in an in-depth interview lasting 30–45 minutes.

Your responses will be used solely for academic research purposes.

There are no physical risks associated with participating in this study. However, discussing workplace conflicts may cause emotional discomfort for some participants. You are free to skip any question that makes you uncomfortable. While there are no direct financial benefits, your participation will help improve understanding of workplace conflicts and contribute to better hospital management and patient care.

Your responses will be kept strictly confidential. No personally identifiable information will be collected, and all data will be analyzed in aggregate form. Only the research team will have access to the raw data. Data will be stored securely and will be destroyed after the completion of the study.

This study has been reviewed and approved by the Research Ethics Committee of Prince Abubakar Audu University Teaching Hospital, Anyigba. If you have any concerns, you may contact the committee or the principal investigator.

**Participant's Consent Statement**

I have read and understood the information provided above. I voluntarily agree to participate in this study, knowing that I can withdraw at any time without any consequences. I understand that my responses will remain confidential and will be used strictly for research purposes.

**Participant's Name:**_____

**Signature:**_____

**Date: :**_____

**Researcher's Name:** Yunusa Edime

**Signature:**_____

**Date:**_____

For further inquiries, please contact:

**Researcher:** Yunusa Edime

**Institution:** Department of Sociology, Prince Abubakar Audu University, Anyigba, Nigeria

**Email:** yunusaedime@gmail.com

**Phone:** +2348075755557

# APPENDIX II

## SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

**Instructions:** Kindly tick in the box [ ✓] appropriately and write where necessary

1. Local Government Area

_____

2. Sex: Male [ 1 ] Female [ 2 ]

3. Age (years): Less than 21 [ 1 ] 21-25 [ 2 ] 26-30 [ 3 ] 31-35 [ 4] 36-40 [ 5 ] 41-50 [ 7 ] 51 and above [ 8 ]

4. Marital Status: Single [ 1 ] Married [ 2 ] Divorced [ 3 ] Widowed [ 4 ] Separated [ 5 ]

5. Highest Qualification:

For Nurses: Ph.D. [ 1 ] M.Sc. [ 2 ] B.Sc [ 3 ] RN/RM [ 4 ]

For Doctors: Consultant [ 1 ] M.Sc. [ 2 ] PGD [ 3 ] MBBS [ 4 ]

6. Length of service in years: 0-5 [ 1 ] 6-10 [ 2 ] 11-15 [ 3 ] 16-20 [ 4 ] 21-25 [ 5 ] 26-30 [ 6 ] 31-35 [7 ]

7. Job Status: Medical Doctor [ 1 ] Nursing [ 2 ]

**SECTION B: PREVALENCE OF CONFLICT BETWEEN DOCTORS AND NURSES IN PUBLIC HOSPITALS IN KOGI STATE** (*Instructions*: Tick (✓) or circle the option that best reflects your experience regarding doctor-nurse conflicts in your facility. Scale: SD (Strongly Disagree), D (Disagree), N (Neutral), A (Agree), SA (Strongly Agree). For frequency: Not common at all, Somewhat common, Neutral, Very common).

| S/n | Item | SD | A | N | SD | D |
|---|---|---|---|---|---|---|
| 1 | Conflict between Doctors and Nurses are prevalent in your facility? | | | | | |
| 2 | In your own opinion, how prevalence are doctor-nurse conflicts in public hospitals in Kogi State? | Not prevalent at all | Somewhat prevalent | Neutral | Somewhat prevalent | Very prevalent |
| | Prevalent conflict | yes | No | Don't know | | |
| 3 | Ethics related conflict | | | | | |
| 4 | Communication related conflict | | | | | |
| 5 | Role boundary conflict | | | | | |
| 6 | Gender based conflict | | | | | |
| 7 | Differences in treatment approach | | | | | |
| 8 | All of the Above | | | | | |
| 9 | When does the conflict usually occur between doctors and nurses in your facility? | During bed rounds | During drug prescriptions | During patients admission | During board meeting | |
| | **Item** | **SD** | **A** | **N** | **D** | **SD** |
| 10 | The frequency of doctor-nurse conflicts has increased over the past few years | | | | | |
| | Item | None | 1-2 | 3-5 | 6-10 | Above 10 |
| 11 | In the past year, how many doctor-nurse conflicts have you personally witnessed or been involved in? | | | | | |

**SECTION C: DYNAMICS OF DOCTOR-NURSE RELATIONSHIP IN PUBLIC HOSPITALS IN KOGI STATE** (*Instructions*: Rate the relationship quality between doctors and nurses based on your observations. Use the given scale: SD (Strongly Disagree), D (Disagree), N (Neutral), A (Agree), SA (Strongly Agree). EXCELLENT, GOOD, FAIR, POOR, VERY POOR

Provide an honest assessment of the working environment).

| S/n | Item | SA | A | N | D | SD |
|---|---|---|---|---|---|---|
| 1 | Cordial relationship exists between doctors and nurses in your facility | | | | | |
| | ITEM | Excellent | Good | Fair | Poor | Very poor |
| 2 | How would you rate the overall working relationship between doctors and nurses in your hospital? | | | | | |

**SECTION D: SOURCES OF CONFLICT BETWEEN DOCTORS AND NURSES IN PUBLIC HOSPITALS IN KOGI STATE** (*Instructions*: Indicate whether each listed factor contributes to conflicts by selecting: YES, NO, NOT ALL THE TIME, UNDECIDED. Skip if a question does not apply to your experience).

| **S/N** | **Item** | **Yes** | **No** | **Not all the times** |
|---|---|---|---|---|
| 1 | Do you think that some factors will lead to doctor-nurse conflict in your facility? | | | |
| | Item | Yes | No | Undecided |
| 2 | Lack of mutual respect | | | |
| 3 | Differences in wages and salaries | | | |
| 4 | Quest for recognition | | | |
| 5 | Quest for professional relevance | | | |
| 6 | Gender differences | | | |
| 7 | Pride | | | |
| 8 | Disagreement over treatment plans | | | |
| 9 | All of the above | | | |

**SECTION E: EFFECTS OF CONFLICT BETWEEN DOCTORS AND NURSES ON THE GENERAL WELL-BEING OF PATIENTS IN PUBLIC HOSPITALS IN KOGI STATE** (*Instructions*: Mark the consequences (e.g., stress, medication errors) you have observed due to conflicts. Options: YES, NO, UNDECIDED. For impact scales (e.g., willingness to discuss health concerns), select the closest match (e.g., NO EFFECT to EXTREMELY LESS WILLING).

| S/N | ITEM | SA | A | N | SD | D |
|---|---|---|---|---|---|---|
| 1 | Conflict between doctors and nurses has consequences on patients' general well-being | | | | | |
| | **ITEM** | **YES** | **NO** | **UNDECIDED** | | |
| 2 | Anxiety/depression | | | | | |
| 3 | Stress/trauma | | | | | |
| 4 | Stigmatization | | | | | |
| 5 | Body image issues | | | | | |
| 6 | Pain/ discomfort | | | | | |
| 7 | Sleep disturbance | | | | | |
| 8 | Substance abuse | | | | | |
| 9 | All of the above | | | | | |

| | Item | No Effect | Slightly less willing | Moderately Less willing | Significantly less willing | Extremely less willing |
|---|---|---|---|---|---|---|
| 10 | Extent at which doctor-nurse conflicts affect patients' willingness to openly discuss their health concerns with healthcare professionals | | | | | |
| 11 | The impact of the presence of doctor-nurse conflicts on patients' overall emotional well-being during their hospital stay | | | | | |

| | Item | Yes | | | No | Undecided |
|---|---|---|---|---|---|---|
| 12 | Medication errors | | | | | |
| 13 | Delay in recovery | | | | | |
| 14 | Death | | | | | |
| 15 | Decreased patients' trust in healthcare providers | | | | | |
| 16 | Decreased patients' satisfaction | | | | | |
| 17 | Increased patients' anxiety | | | | | |
| 18 | Increased patients' stress level | | | | | |
| 19 | All of the above | | | | | |
| | ITEM | Never | Rarely | Some Times | Often | Very Often |
| 20 | How frequently do patients express concerns about the quality of care due to perceived doctor-nurse conflicts? | | | | | |

**SECTION F: DOCTOR-NURSE CONFLICTS RESOLUTION STRATEGIES IN PUBLIC HOSPITALS IN KOGI STATE** (*Instructions*: Indicate whether each listed factor contributes to conflicts by selecting: YES, NO, NOT ALL THE TIME, UNDECIDED. Skip if a question does not apply to your experience).

| S/n | Item | Yes | No | Not all the time |
|---|---|---|---|---|
| 1 | Do you think that doctor-nurse conflict can be resolved or managed? | | | |
| 2 | Item | Yes | No | Undecided |
| 3 | There should be roles clarification between doctors and nurses | | | |
| 4 | There should be frequent conflict resolution training for doctors and nurses | | | |
| 5 | There should be shared decision-making concerning patients' healthcare | | | |
| 6 | Doctor and nurses should be involved in continuous professional development | | | |
| 7 | All of the above | | | |

# APPENDIX III

## IN-DEPTH INTERVIEW GUIDE FOR SELECTED IN-PATIENTS/OUT-PATIENTS AND CHIEF MEDICAL DIRECTORS IN KOGI STATE PUBLIC HOSPITALS

I am Yunusa Edime, a Ph.D. student of the Department of Sociology, Prince Abubakar Audu Universit, Anyigba, Kogi State, Nigeria. I am conducting a study on Doctor-Nurse Conflict and Patients Well-being in Public Hospitals in Kogi State, Nigeria.

The study seeks to assess the impact of Doctor-Nurse Conflict on Patients Well-being in Public Hospitals in Kogi State, Nigeria. The research work is purely academic purpose and part of the requirements for the award of Doctor of Philosophy (Ph.D.) in Sociology. Please note, that all information provided will be used mainly for the study and will be kept strictly confidential and reported anonymously.

Thank you for anticipated co-operation.

I hereby formally ask for your consent to proceed with this study interview.

Respondent's consent granted Yes …… No……..…..

Date of interview……. Time interview started…….....

**SECTION A: SOCIO-DEMOGRAPHIC INFORMATION OF THE PARTICIPANTS**

Age:……..…….……...…

..

Sex:……..……..……...……

.

Marital

Status:..……..……...……

..

Educational

Qualifications:…….…..……...……..

Religious Affiliation:……..……..

Ethnic

Affiliation:……..……...…….

Name of the Hospital for the

Interview……,…….

**SECTION B: WHAT IS THE PREVALENCE OF DOCTOR-NURSE CONFLICT IN KOGI STATE PUBLIC HOSPITALS?** (For Chief Medical Directors [a] and Patients [b])

a. In your experience working in public hospitals in Kogi State, how often do you observe, perceive or experience conflicts between doctors and nurses? Can you describe a recent incident and its resolution?

b. During your stay or visits to public hospitals in Kogi State, have you ever noticed any tension or disagreements between doctors and nurses? If so, how often, and what made you aware of these situations?

**SECTION C: WHAT ARE THE DYNAMICS OF DOCTOR-NURSECONFLICT?** (For Chief Medical Directors [a] and Patients [b])

a. Can you elaborate on the typical nature or dynamics of conflicts between doctors and nurses in your hospital? In your professional opinion, how do these conflicts affect the quality of patient care?

b. Have you ever felt that the care you received was affected by disagreements or tension between doctors and nurses? If so, can you describe the situation and how it impacted your care?

**SECTION D: WHAT ARE THE SOURCES OF DOCTOR-NURSE CONFLICT IN KOGI STATE PUBLIC HOSPITALS?** (For Chief Medical Directors [a] and Patients [b])

a. In your view, what are the major sources or root causes of conflicts between doctors and nurses in your hospital? Are these related to professional roles, communication, hospital policies, or other factors?

b. From your observations or interactions, what do you think are the main reasons for disagreements between doctors and nurses in the hospital? Have you noticed any particular situations that seem to cause tension?

**SECTION D: WHAT ARE THE EFFECTS OF DOCTOR-NURSE CONFLICT ON PATIENTS WELL-BEING IN KOGI STATE PUBLIC HOSPITALS?** (For Chief Medical Directors [a] and Patients [b])

a. How do you think conflicts between doctors and nurses affect patients' emotional state, comfort level, or overall hospital experience? Have you observed any changes in patients' behaviour or well-being that you believe may be related to these conflicts?

b. How did any observed or perceived conflicts between doctors and nurses make you feel during your hospital stay? Did it affect your comfort, stress levels, or overall well being in the hospital?

**SECTION E: WHAT ARE THE EFFECTIVE STRATEGIES FOR DOCTOR-NURSE CONFLICT RESOLUTION IN KOGI STATE PUBLIC HOSPITALS?** (For Chief Medical Directors [a] and Patients [b])

a. What strategies or mechanisms are currently in place in your hospital to address and resolve conflicts between doctors and nurses? In your experience, how effective are these strategies?

b. Have you ever witnessed or been informed about how disagreements between doctors and nurses are resolved in the hospital? What was your impression of how these situations were handled?

**SECTION F: SUGGESTIONS FOR IMPROVEMENT OF DOCTOR-NURSE RELATIONSHIP IN KOGI STATE PUBLIC HOSPITALS (**For Chief Medical Directors [a] and Patients [b])

a. Based on your experience, what do you think would be the most effective ways to reduce conflicts between doctors and nurses and improve inter professional collaboration in your hospital?

b. From a patient's perspective, what suggestions would you have for improving the working relationship between doctors and nurses? How do you think this could enhance patient care and experience?

# APPENDIX IVA

## VALIDATION OF RESEARCH INSTRUMENTS SPSS OUTPUT

**Scale: The Prevalence of Doctor-Nurse Conflict in Kogi State Public Hospitals**

| FACTOR LOADING | | |
|---|---|---|
| **Communalities** | Initial | Extraction |
| Conflict between doctors and nurses are common in your facility | 1.000 | .924 |
| In your own opinion, how common are doctor-nurse conflicts in public hospitals in Kogi State | 1.000 | .768 |
| Ethics related conflicts | 1.000 | .712 |
| Communication related conflict | 1.000 | .934 |
| Road boundary conflict | 1.000 | .747 |
| Gender based conflict | 1.000 | .792 |
| Differences in treatment approach | 1.000 | .854 |
| All of the above | 1.000 | .756 |
| During bed rounds | 1.000 | .855 |
| During drug prescription | 1.000 | .927 |
| During patients' admission | 1.000 | .938 |
| The frequency of doctor-nurse conflicts has increased over the past few years | 1.000 | .944 |
| In the past year, how many doctor-nurse conflicts have you personally witnessed or been involved in? | 1.000 | .751 |
| Extraction Method: Principal Component Analysis. | | |

| KMO and Bartlett's Test | | |
|---|---|---|
| Kaiser-Meyer-Olkin Measure of Sampling Adequacy. | | .880 |
| Bartlett's Test of Sphericity | Approx. Chi-Square | 98.317 |
| | df | 10 |
| | Sig. | .000 |

**Scale: Dynamics of Conflicts between Doctors and Nurses in Kogi State Public Hospitals**

| FACTOR LOADING | | |
|---|---|---|
| **Communalities** | Initial | Extraction |
| Cordial relationship exist between doctors and nurses in your facility | 1.000 | .790 |
| How would you rate the overall working relationship between doctors and nurses in your hospital? | 1.000 | .892 |
| Extraction Method: Principal Component Analysis. | | |

| KMO and Bartlett's Test | | |
|---|---|---|
| Kaiser-Meyer-Olkin Measure of Sampling Adequacy. | | .862 |
| Bartlett's Test of Sphericity | Approx. Chi-Square | 14.655 |
| | Df | 6 |
| | Sig. | .023 |

**Scale: Sources of Conflicts between Doctors and Nurses in Kogi State Public Hospitals**

| FACTOR LOADING | | |
|---|---|---|
| **Communalities** | Initial | Extraction |
| Do you think that some factors will lead to doctor-nurse conflict in your facility? | 1.000 | .847 |
| Lack of mutual respect | 1.000 | .809 |
| Differences in wages and salaries | 1.000 | .733 |
| Quest for recognition | 1.000 | .707 |
| Quest for professional relevance | 1.000 | .711 |
| Gender differences | 1.000 | .752 |
| Pride | 1.000 | .702 |
| Disagreement over treatment plan | 1.000 | .733 |
| All of the above | 1.000 | .765 |
| Extraction Method: Principal Component Analysis. | | |

| KMO and Bartlett's Test | | |
|---|---|---|
| Kaiser-Meyer-Olkin Measure of Sampling Adequacy. | | .810 |
| Bartlett's Test of Sphericity | Approx. Chi-Square | 51.385 |
| | Df | 21 |
| | Sig. | .000 |

**Scale: Effects of Conflict between Doctors and Nurses on the General Well-being of Patients in Public Hospitals in Kogi State**

| FACTOR LOADING | | |
|---|---|---|
| **Communalities** | Initial | Extraction |
| Conflict between doctors and nurses has consequences on patients' well-being | 1.000 | .710 |
| Anxiety/depression | 1.000 | .727 |
| Stress/trauma | 1.000 | .924 |
| Stigmatization | 1.000 | .833 |
| Body image issues | 1.000 | .933 |
| Pain/ discomfort | 1.000 | .924 |
| Sleep disturbance | 1.000 | .883 |
| Substance abuse | 1.000 | .755 |
| All of the above | 1.000 | .936 |
| The extent at which doctor-nurse conflicts affect patients' willingness to openly discuss their health concerns with healthcare professional | 1.000 | .857 |
| The impact of the presence of doctor-nurse conflicts on patients' overall emotional well-being during their hospital stay | 1.000 | .721 |
| Medical errors | 1.000 | .881 |
| Delay in recovery | 1.000 | .721 |
| Death | 1.000 | |
| Decreased patients' trust in the healthcare providers | 1.000 | .732 |
| Decreased patients 'satisfaction | 1.000 | .912 |
| Increased patients' anxiety | 1.000 | .860 |
| Increased patients stress levels | 1.000 | .771 |
| All of the above | 1.000 | .893 |
| Extraction Method: Principal Component Analysis. | | |

| KMO and Bartlett's Test | | |
|---|---|---|
| Kaiser-Meyer-Olkin Measure of Sampling Adequacy. | | .825 |
| Bartlett's Test of Sphericity | Approx. Chi-Square | 24.952 |
| | Df | 12 |
| | Sig. | .000 |

**Scale: Doctor Nurse Conflicts Resolution Strategies in Public Hospitals in Kogi State**

| FACTOR LOADING | | |
|---|---|---|
| **Communalities** | Initial | Extraction |
| Do you think that doctor-nurse conflict can be resolved or managed? | 1.000 | .784 |
| There should be roles clarification between doctors and nurses | 1.000 | .744 |
| There should be frequent conflict resolution training for doctors and nurses | 1.000 | .733 |
| There should be shared decision making concerning patients healthcare | 1.000 | .756 |
| Doctor and nurses should be involved in continuous professional development | 1.000 | .752 |
| All of the above | 1.000 | .787 |
| Extraction Method: Principal Component Analysis. | | |

| KMO and Bartlett's Test | | |
|---|---|---|
| Kaiser-Meyer-Olkin Measure of Sampling Adequacy. | | .866 |
| Bartlett's Test of Sphericity | Approx. Chi-Square | 46.659 |
| | Df | 6 |
| | Sig. | .000 |

# APPENDIX IVB

## RELIABILITY OF RESEARCH INSTRUMENTS SPSS OUTPUT

**Scale: The Prevalence of Crime in Dekina Local Government Area**

| Reliability Statistics | |
|---|---|
| Cronbach's Alpha | N of Items |
| .714 | 13 |

| Item-Total Statistics | | | | |
|---|---|---|---|---|
| | Scale Mean if Item Deleted | Scale Variance if Item Deleted | Corrected Item-Total Correlation | Cronbach's Alpha if Item Deleted |
| Conflict between doctors and nurses are common in your facility | 10.4000 | 9.559 | .498 | .761 |
| In your own opinion, how common are doctor-nurse conflicts in public hospitals in Kogi State | 9.4000 | 9.559 | .624 | .732 |
| Ethics related conflicts | 10.7000 | 8.700 | .446 | .779 |
| Communication related conflict | 9.8000 | 8.028 | .718 | .767 |
| Gender based conflict | 10.1000 | 8.990 | .262 | .786 |
| Differences in treatment plan | 10.9000 | 8.045 | .544 | .787 |
| All of the above | 10.8000 | 8.860 | .725 | .781 |
| During bed rounds | 10.5000 | 8.033 | .733 | .798 |
| During drug prescription | 10.7000 | 8.045 | .614 | .714 |
| During patients' admission | 9.6000 | 9.658 | .526 | .762 |
| The frequency of doctor-nurse has increased over the past few years | 10.3000 | 8.400 | .5.32 | .781 |
| In the past year, how many doctor-nurse conflicts have you personally witnessed or been involved in? | 10.2000 | 9.228 | .740 | .717 |

**Scale: Dynamics of Conflicts between Doctors and Nurses in Kogi State Public Hospitals**

| Reliability Statistics | |
|---|---|
| Cronbach's Alpha | N of Items |
| .822 | 2 |

| Item-Total Statistics | | | | |
|---|---|---|---|---|
| | Scale Mean if Item Deleted | Scale Variance if Item Deleted | Corrected Item-Total Correlation | Cronbach's Alpha if Item Deleted |
| Cordial relationship exist between doctors and nurses in your facility | 12.8000 | 4.648 | .368 | .893 |
| How would you rate the overall working relationship between doctors and nurses in your facility | 12.8000 | 4.510 | .457 | .867 |

**Scale: Sources of Conflicts between Doctors and Nurses in Kogi State Public Hospitals**

| Reliability Statistics | |
|---|---|
| Cronbach's Alpha | N of Items |
| .905 | 9 |

| Item-Total Statistics | | | | |
|---|---|---|---|---|
| | Scale Mean if Item Deleted | Scale Variance if Item Deleted | Corrected Item-Total Correlation | Cronbach's Alpha if Item Deleted |
| Do you think that some factors will lead to doctor-nurse conflict in your facility | 23.0000 | 13.310 | .145 | .869 |
| Lack of mutual respect | 23.2667 | 14.133 | .016 | .916 |
| Differences in wages and salaries | 23.0000 | 10.414 | .519 | .911 |
| Quest for recognition | 22.6333 | 9.344 | .591 | .826 |
| Quest for professional relevance | 22.7000 | 10.355 | .523 | .759 |
| Gender differences | 22.6333 | 9.895 | .632 | .722 |
| Pride | 25.3667 | 13.757 | .134 | .766 |
| Disagreement over treatment plan | 23.5636 | 14.155 | .538 | .917 |
| All of the above | 25.6336 | 13.432 | .587 | .834 |

**Scale: Effects of Conflict between Doctors and Nurses on the General Well-being of Patients in Public Hospitals in Kogi State**

| Reliability Statistics | |
|---|---|
| Cronbach's Alpha | N of Items |
| .864 | 19 |

| Item-Total Statistics | | | | |
|---|---|---|---|---|
| | Scale Mean if Item Deleted | Scale Variance if Item Deleted | Corrected Item-Total Correlation | Cronbach's Alpha if Item Deleted |
| Conflict between doctors and nurses has consequences on patients' wellbeing | 12.5000 | 5.224 | .567 | .714 |
| Anxiety/depression | 12.4333 | 5.289 | .579 | .809 |
| Stress/trauma | 13.1000 | 5.748 | .323 | .890 |
| Stigmatization | 12.6667 | 6.230 | .348 | .858 |
| Body image issues | 12.7677 | 6.387 | .356 | .822 |
| Pain/discomfort | 12.4344 | 5.245 | .368 | .850 |
| Sleep disturbance | 12.9871 | 5.200 | .577 | .837 |
| Substance Abuse | 12.6766 | 6.299 | .311 | .859 |
| All of the above | 13.2000 | 5.500 | .569 | .799 |
| The extent at which doctor-nurse conflicts affect patients' willingness to openly discuss their health concerns with healthcare professionals | 12.6557 | 6.332 | .344 | .857 |
| The impact of the presence of doctor-nurse conflicts on patients' overall emotional well-being during their hospital stay | 12.5300 | 5.944 | .320 | .832 |
| Medical errors | 12.6556 | 5.555 | .577 | .873 |
| Delay in recovery | 12.5100 | 6.544 | .381 | .895 |
| Death | 13.1999 | 5.200 | .533 | .861 |
| Decreased patients' trust in the healthcare providers | 12.6599 | 6.222 | .310 | .890 |
| Decreased patients' satisfaction | 12.3444 | 5.300 | .599 | .874 |
| Increased patients' anxiety | 12.4000 | 5.411 | .322 | .825 |
| Increased patients stress levels | 13.5000 | 5.622 | .361 | .854 |
| All of the above | 13.3000 | 6.100 | .392 | .823 |

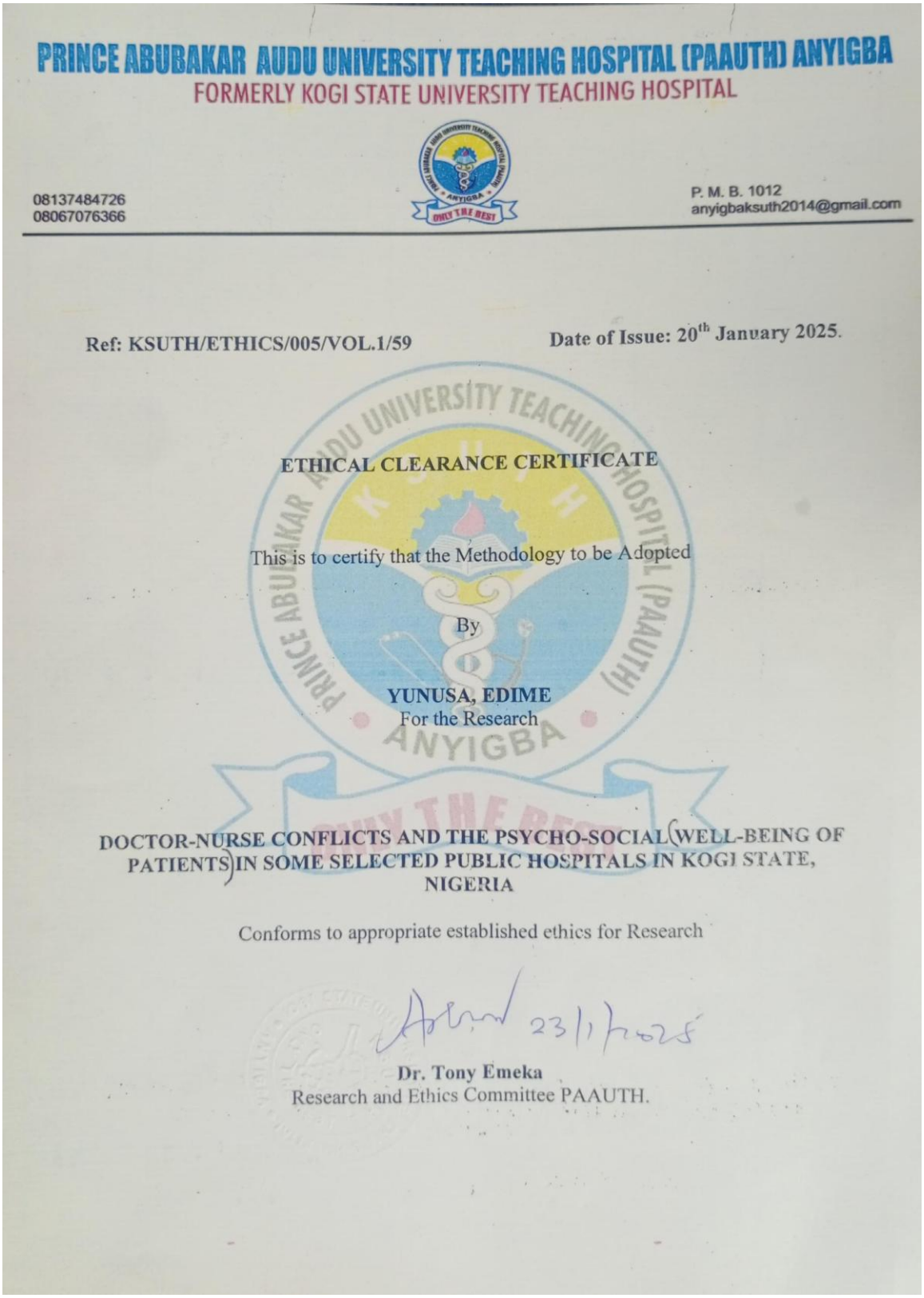
**Scale: Doctor Nurse Conflicts Resolution Strategies in Public Hospitals in Kogi State**

| Reliability Statistics | |
|---|---|
| Cronbach's Alpha | N of Items |
| .822 | 6 |

| Item-Total Statistics | | | | |
|---|---|---|---|---|
| | Scale Mean if Item Deleted | Scale Variance if Item Deleted | Corrected Item-Total Correlation | Cronbach's Alpha if Item Deleted |
| Do you think that doctor-nurse conflict can be resolved or managed | 13.3333 | 7.678 | .532 | .825 |
| There should be roles clarification between doctors and nurses | 12.9667 | 6.240 | .715 | .743 |
| There should be frequent conflict resolution training for doctors and nurses | 13.0333 | 7.206 | .627 | .785 |
| There should be shared decision making concerning patients healthcare | 12.9667 | 6.930 | .721 | .743 |
| Doctor and nurses should be involved in continuous professional development | 13.2110 | 7.650 | .651 | .830 |
| All of the above | 12.988 | 7.455 | .742 | .754 |

# APPENDIX V

## ETHICAL CLEARANCE CERTIFICATE



PRINCE ABUBAKAR AUDU UNIVERSITY TEACHING HOSPITAL (PAAUTH) ANYIGBA
FORMERLY KOGI STATE UNIVERSITY TEACHING HOSPITAL

08137484726
08067076366

P. M. B. 1012
anyigbaksuth2014@gmail.com

Ref: KSUTH/ETHICS/005/VOL.1/59

Date of Issue: 20th January 2025.

ETHICAL CLEARANCE CERTIFICATE

This is to certify that the Methodology to be Adopted

By

YUNUSA, EDIME
For the Research

DOCTOR-NURSE CONFLICTS AND THE PSYCHO-SOCIAL WELL-BEING OF PATIENTS IN SOME SELECTED PUBLIC HOSPITALS IN KOGI STATE, NIGERIA

Conforms to appropriate established ethics for Research

Approved 23/1/2025

Dr. Tony Emeka
Research and Ethics Committee PAAUTH.

# DEPARTMENT OF SOCIOLOGY

## FACULTY OF SOCIAL SCIENCES

**PRINCE ABUBAKAR AUDU UNIVERSITY**

P.M.B, 1008, ANYIGBA, KOGI STATE, NIGERIA

## (OFFICE OF THE HOD)


HEAD OF DEPARTMENT
Dr, Timothy Abayomi ATOYEBI
B.Sc, M.Sc, PhD (UI)
Email: socdeptksu@gmail.com, atoyebi.to@ksu.edu.ng
Tell: 08034864158, 07056638265

VICE CHANCELLOR
Professor Marietu Ohunene TENUCHE
B.Sc, M.Sc, PhD (ABU)
Email: tenuche.m@paau.edu.ng
Tell: 08033584418, 08057985581


Our Ref: _____

Date: _____

**TO WHOM IT MAY CONCERN**

Dear Sir/Madam,

**LETTER OF INTRODUCTION**

I write to introduce **Mr. Edime Yunusa,** a Ph.D. student in the above named Department. He is currently conducting a research for his doctoral dissertation, which focuses on **"DOCTOR-NURSE CONFLICT AND PATIENTS' WELL-BEING IN SELECTED PUBLIC HOSPITALS IN KOGI STATE".**

As part of his research, **Mr. Edime Yunusa,** will be visiting some hospitals to collect data and conduct field work. During this time, he may require access to specific offices or facilities and may need to interact with Medical Doctors, Nurses and Patients.

I kindly request that you extend any necessary assistance and support to **Mr. Edime Yunusa**, during his fieldwork. Your cooperation and hospitality will be greatly appreciated.

Please feel free to contact me if you require any additional information.

Thank you for your time and invaluable assistance

Yours faithfully,

**Dr. Timothy A. ATOYEBI**