ROLE CONFLICTS EXPERIENCED BY NURSES AND MIDWIVES AT THE UNIVERSITY TEACHING HOSPITAL OF KIGALI (CHUK)

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COLLEGE OF MEDICINE AND HEALTH SCIENCES

School of Nursing and Midwifery

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I. DECLARATION

I do here by declare that this research project submitted in partial fulfilment of the requirements for the Master's degree in Nursing, at University of Rwanda-College of Medicine and Health Sciences (UR-CMHS), School of Nursing and Midwifery, is my own original work and has not previously been submitted elsewhere. I do also declare that a complete list of references is provided indicating all sources of information quoted or cited.

MANIRAGUHA Beatrice

Signed……..

Date……..

II. DEDICATION

This work is dedicated to the Almighty God who helped me during this journey of education, UR-CMHS staff and all my classmates for the best moment and discussions we have had together. I dedicate this work also my Religious family "ORDRE DE CHANOINESSES REGULIERES DU SAINT SEPULCRE, PRIEURE DE LA RESURRECTION AU RWANDA" and to my family members and my friends for their continuous sacrifice, advice, encouragement and valuable financial support they gave me until the completion of the Master's Degree in Nursing.

III. ACKNOWLEDGMENT

I express my appreciation to the Government of Rwanda through the Ministry of Health for sponsoring my studies. I thank the University of Rwanda-College of Medicine and Health Sciences (UR-CMHS) administration, staff and all lecturers from the Nursing Department, for their precious support and guidance during my education activities up to this level.

I also wish to extend my love and appreciation to my parents, brothers and sisters, to my friends and relatives for their unselfish support towards my completion of studies.

I also air out special gratitude to my classmates for their genuine cooperation, supplements and encouragement during the courses, sharing experiences and knowledge that led to completion of this program.

Last not least I express my special thanks to however helped me in one way or the other for the achievement of this study.

IV. ABSTRACT

Background: Conflict is inevitable and can be found in all settings. It can co-exist between and among health care professionals such as doctors and nurses and their patients. The roles of the nurses in each scenario and the kind of strategies they utilized to mitigate such conflicts also vary. This study aimed at describing types and level of role conflicts experienced by nurses as well as mitigation strategies used at Centre Hospitalier Universitaire de Kigali (CHUK).

Methods: A quantitative descriptive research design was used to achieve the study objectives, while a convenience sampling method was applied with sample of 216 nurses from a selected referral hospital responded to the Nursing Conflict Scale (NCS). NCS consists of thirty-six items classified into five categories of conflict: disruptive, interpersonal, intrapersonal, intergroup, intragroup, and competitive. The instrument utilizes a score of (0-2), and the total instrument score is 72. The total instrument reliability is (0.86) and its scoring system was calculated.

Results: The majority of participants were less than 30 years old while majority were female (59%), the three quarters had the advanced diploma. Just above a half (54%) have less than 5 years of nursing experience, most of them were working in the general ward.

Nurses in the selected hospital experienced moderate level of conflict (52.8%); intragroup (1.26), competitive conflict (1.13) and disruptive conflict (mean=1.05) are the types of conflict mostly experienced at the facility. Collaborative (28.2%; n =61) and accommodating (28.2%; n =61) . Other-strategies include-compromising (23.1%; n = 50); and avoiding (18.1%; n = 39). Findings also revealed significant relationship between participants 'age and conflict resolution strategies used (P value = 0.01).

Conclusions: Intragroup and competitive conflicts are the most common types of conflicts experienced by the nurses. Nurses experienced moderate level of conflict. Therefore, nurse managers in the selected hospital need to employ effective strategies to decrease nurses' experience of conflict, develop collaboration between nurses and physicians to create healthier and more productive work environment which positively affect the quality of nursing care.

Key words: Conflict, nurse, role conflict.

VI. LIST OF SYMBOLS AND ABBREVIATIONS

%: Percent

CMHS: College of Medicine and Health Sciences

IRB: Institutional Board Review

NCS: Nursing Conflict Scale

SPSS: Statistical Package for Social Studies

UK: The United Kingdom

UR: University of Rwanda

CHUK: Centre Hospitalier Universitaire de Kigali

US: United States (of America)

TABLE OF CONTENTS

I. DECLARATION i

II. DEDICATION ii

III. ACKNOWLEDGMENT iii

IV. ABSTRACT iv

VI. LIST OF SYMBOLS AND ABBREVIATIONS v

TABLE OF CONTENTS vi

VII. LIST OF TABLES ix

VII. LIST OF FIGURES x

CHAPTER ONE. INTRODUCTION 1

1.2. BACKGROUND TO THE STUDY 1

1.3. Problem statement 4

1.4. Objectives of the study 5

1.4.1. Main objective: 5

1.4.2. Specific objectives 5

1.5. Research questions 5

1.6. Significance of the study 6

1.7. Subdivision of the project 6

1.8. Definition of key terms 6

CHAPTER TWO: LITERATURE REVIEW 8

2.1 Introduction 8

2.2. THEORETICAL LITERATURE REVIEW 8

2.2.1 Dynamics of the conflict 8

2.2.2 Antecedents of conflict 9

2.2.3 Personality differences 9

2.2.4 Value differences 10

2.2.5. Blurred job boundaries 10

2.2.6. Battle for limited resources 14

2.2.7. Decision-making 14

2.2.8. Communication 15

2. 3. Empirical literature review 16

2.3.1 Effects of unresolved conflict 16

2.3.2 Patient impact 16
2.3.3 Job satisfaction 17
2.3.4 Effect on individual 18
2.3.5 Positive outcomes 18
2.3.6 Conflict-handling styles 18
CHAPTER THREE: RESEARCH METHODOLOGY 21
3.1. Introduction 21
3.2. Study Design and Approach 21
3.3. Study Area 21
3.4. Population 21
3.5 Eligibility criteria 22
3.5.1 Inclusion criteria 22
3.5.2 Exclusion criteria 22
3.6. Sample Size and sampling method 22
3.7. Data Collection Methods, Procedures and Instruments 23
3.7.1. Data collection instrument 23
3.7.2. Data collection procedure 24
3.7.3. Reliability and Validity of the instrument 24
3.7.3.2. Validity 24
3.8. Data Analysis and Presentation 24
3.9. Ethical Considerations. 25
3.10. Data Dissemination 25
3.12. Problems and limitation 25
CHAPTER FOUR: RESULTS 26
4.1. Introduction 26
4.2. Demographic characteristics 26
4.3. The types and level of conflicts experienced by study participants. 28
4.4 Factors contributing to role conflicts among study participants. 29
4.5. The conflict resolution strategies. 32
CHAPTER FIVE: DISCUSSION 35
CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS 40
6.1 CONCLUSION 40
6.2 RECOMMENDATIONS 40
REFERENCES 42

APPENDICES 50
1. PARTICIPANT INFORMATION SHEET 50
2. LETTRE D'INFORMATION DESTINEE AUX PARTICIPANTS 52
3. DATA COLLECTION TOOL 54
3. OUTIL DE COLLECTE DES DONNEES 57
Work plan 62

VII. LIST OF TABLES

Table4.1 Distribution of study participants according to age 26

Table4. 2 Types of conflicts experienced by study participants 29

Table4. 3 Relationship between demographic characteristics and intragroup conflict..... 30

Table4. 4 Relationship between demographic characteristics and competitive conflict ... 31

Table 4.5 Relationship between demographic characteristics and disruptive conflict 32

Table 4.6 Frequency and percentage distribution in the conflict resolution strategies used by nurses 32

Table4. 7 Nurse's use of conflict resolution strategies and their age 33

Table4. 8 Nurse's use of conflict resolution strategies and their level of education 33

Table4 9 Nurse's use of conflict resolution strategies and their nursing experience..... 34

VII. LIST OF FIGURES

Figure 2. 1 Integrated theoretical framework of conflict in health care organization (Moore, 2003). 20

Figure 4. 2 Distribution of study participants according to gender 26

Figure 4.3 Distribution of study participants according to the level of education..... 27

Figure 4.4 Distribution of study participants according to work experience..... 27

Figure 4. 5 Distribution of study participants according to the department 28

Figure 4. 6 Level of conflict experienced by study participants..... 29

CHAPTER ONE. INTRODUCTION

1.1. INTRODUCTION

This chapter includes, the background to the study, main purpose of study, research objectives, research questions, significance of study, definitions of key terms and concepts and subdivision of the research report.

1.2. BACKGROUND TO THE STUDY

Globally, nursing conflict traditionally generated negative feelings that many nurses use avoidance as a coping mechanism (Baddar et al., 2016).Conflict is one of the most experienced issues by nurses and other healthcare team members. In fact, the Nursing Administration is also faced with challenges in resolving conflicts within the units of their nurses, outside their units, with other departments and even with the Hospital Administration.

Managing one's conflict in the workplace is time-consuming but necessary task for the nurses (Cox 2003). Simple to heavy interventions leading to litigations in any hospital settings may occur in different types of role conflicts. Conflicts have an adverse effect on the individual and organization such as productivity, morale, and patient care of all the healthcare team that might lead to a rapid turnover of employees or dissatisfaction (Sportsman, 2005).

Viewing issues or situations from different perspectives, these relationships can be compromised by conflict. Such that, conflict is referred to as a power struggle in which a person intends to harass, neutralize, injure or eliminate a rival (Sportsman 2005). According to Marshall (2006). Conflict is neither good, no bad.it can lead to positive and negative outcomes for nurses, their colleagues, patients and organization. If managed effectively by nurses, it can, while if ineffectively managed, teamwork, productivity and quality patient care can be compromised. There can be negative impact to the organization of the hospital and its goals (Marshall 2006).

There are several types of conflicts such as intrapersonal, interpersonal, intra-group, and inter-group, conflicts (Sullivan 1996). Intrapersonal conflict is discord or dissention within an individual, it occurs when one is facing with two or more incompatible demands.

Inter-personal conflict occurs between two or more individuals, whose values, goals, and beliefs are incompatible. Intra-group conflict occurs regularly within an established group, it may arise due to lack of support, new problem, which necessitate changes within group member roles and relationships, imposed values and role conflict inside the group. Inter-group conflict, arises between groups with different goals, the achievement of which by one group can occur at the expense of the other (Sullivan 1996; Conerly & 2004).

A conflict situation may be identified where at least two parties are involved, with different goals and/or values, where behaviors can lead toll defeat, reduce, or suppress the opponent, or gain a victory, with opposing actions and counteractions; and create in imbalance, or favored power position (Baddar et al. 2016).

Conflict resolution requires specific leadership skills, problem solving abilities and decision making skills (Brown et al. 2011). When conflicts go unaddressed, they can have a negative impact on productivity and teamwork. Using conflict resolution strategies in the workplace will help maintain a healthy work environment.

In the study of Hyde et al. (2006), importance of the psychosocial working environment for the health of employees is now well documented, but the effects of managerial strategy have received relatively little attention. These results suggested that the workplace conflict resolution is important to the traditional psychosocial work environment risk factors (Hyde et al. 2006).

This therapeutic relationship can be threatened whenever there is conflict, either with the patient, the patients' family, the patients' friends, or colleagues. Nurses share the responsibility with their employers to create a healthy workplace environment, ensuring that conflict does not negatively affect the patients' health outcomes or the relationships among colleagues (Baddar et al. 2016).

Competing, Accommodating, Avoiding, Collaborating and Compromising are five modes for responding to conflict situations (Thomas & Kilmann 2015).

The emerging themes were: 1) the nurses' perceptions and reactions to conflict; 2) organizational structure; 3) hospital management style; 4) the nature and conditions of job assignment; 5) individual characteristics; 6) mutual understanding and interaction; and 7) the consequences of conflict.

The first six themes describe the sources of the conflict as well as strategies to manage them (Nayeri & Negarandeh 2009). Further, Nayeri concluded that the sources of conflict

are embedded in the characteristics of nurses and the nursing system, but at the same time these characteristics can be seen as strategies to resolve conflict.

He added that the sources of conflict can be seen as strategies to resolve conflict (Nayeri & Negarandeh 2009). Conflict is one of many issues found in any organization, including hospitals, where constant human interaction occurs (Xu et al. 2004).

The sources of conflict among hospital nurses and health care personnel include authority positions and hierarchy, the ability to work as a team, interpersonal relationship skills, and the expectations of performing in various roles at various levels (Kleinman 2004).

Other authors emphasized on the recognition of conflict how to moderate and control them according to viewpoints (Eason et al. 1999; Bartol et al. 2001) . Xu et al. (2004) opined that addressing the conflict enhances professional development and reduces burnout among nurses.

Cox (2001) concluded that inadequate communication between medical practitioners and nurses can lead to conflicts, that not all the outcomes of conflict are negative; conflict can be constructive if it enhances decision-making quality. Skeels (1994) conducted a descriptive study on disruptive sources of conflict in the nursing unit and the conflict resolution mode most frequently used by nurses.

Various levels of registered nurses employed at three acute care hospitals in Beaumont, Texas, in relation to conflict source to conflict resolution mode and hospital site. The voluntary participants completed the Thomas-Kilmann.

In Rwanda, there is no studies were conducted on role conflicts experienced by nurses in the various hospitals in Rwanda. Therefore, this study was undertaken to fill this gap and contribute to the global body of knowledge on the topic.

Conflict Mode Instrument and ranked disruptive sources of conflict prior to a program on conflict management. The findings from which were the most disruptive source of conflict were not clearly evident with all five possible sources listed having combined medians of 3 or 4.

Clinical implications on patient care may be in jeopardy with nurses using primarily the non-assertive modes of compromising, avoiding, and accommodating rather than the more effective mode of collaboration. A greater awareness and careful choice by the nurse of the most effective Role conflict resolution mode is important.

With these literatures and studies, we aimed to describe types and level of role conflicts experienced by nurses as well as mitigation strategies at the selected district hospital.

In Rwanda, there is no study were conducted on role conflicts experienced by nurses in the various hospitals. Therefore, this study was undertaken to fill this gap and contribute to the global body of knowledge on the topic.

1.3. Problem statement

Health care managers like any other leaders certainly encounter conflicts. Nurses like any other staff in various hospitals experience conflict quite frequently in the workplace (Berman-Kishony 2011; Guidroz et al. 2012) due to its high-stress nature (Chipps et al. 2013a) and the variety of stakeholders involved (Shin 2009).

The consequences of health care workers' conflict are many. At best, conflicts result in beneficial changes in the workplace.

At worst, it can impact patients' lives. Several authors reported patients who expired due to immediate conflict or Role conflicting opinions between nurses and physicians about patient treatment (Cox 2001; Patton 2014).

In addition, unresolved Role conflicts also have the potential of impacting quality patient care. In a U.S. survey of 213 nurses in a Philadelphia, Pennsylvania teaching hospital, 13% of respondents stated that being involved in verbally abusive encounters led them to "make a caregiving error" (Michelle Rowe & Sherlock 2005).

Continued conflict results in stressed employees. Consequently, "interpersonal conflict has been noted as one of the major sources of stress for nurses" (Michelle Rowe & Sherlock 2005). Research shows that stressed people have less ability to focus, memory lapses, slow healing, and diminished nutritional uptake (Forte 1997).

Leever et al. (2010) assert, "Poor collaboration is likely to be caused by, or to result in conflict". Interpersonal relationships suffer with conflict, as negative emotions induce poor perceptions of the person who sparked the disagreement.

Despite all these negative impacts of the conflicts among nurses at workplace, many researches in this field were conducted in developed countries. There is a strong need for evidence on nurse conflict in poor resourced countries including Rwanda.

To our knowledge, no studies were conducted on role conflicts experienced by nurses in the various hospitals in Rwanda. Therefore, this study was undertaken to fill this gap and contribute to the global body of knowledge on the topic.

1.4. Objectives of the study

1.4.1. Main objective:

The main purpose of this study was to assess the types and level of role conflicts experienced by nurses as well as mitigation strategies at University Teaching Hospital of Kigali.

1.4.2. Specific objectives

1. To determine the level of role conflicts experienced by nurses and midwives at University Teaching Hospital of Kigali.

2. To identify the types of role conflicts experienced by nurses and midwives at University Teaching Hospital of Kigali.

3. To identify the factors contributing to role conflicts among nurses and midwifes at University Teaching Hospital of Kigali.

4. To identify the conflict resolution strategies applied by the nurses and the midwives at University Teaching Hospital of Kigali.

1.5. Research questions

1. What is the level of role conflicts experienced by nurses and midwives at University Teaching Hospital of Kigali?

2. What are the types of role conflicts experienced by nurses and midwives at University Teaching Hospital of Kigali?

3. What are the factors contributing to role conflicts among nurses and midwifes at University Teaching Hospital of Kigali?

4. What are the conflict resolution strategies applied by the nurses and the midwives at University Teaching Hospital of Kigali?

1.6. Significance of the study

This study would be significant in three major areas:

Nursing practice: Results of this study would inform the national healthcare policy makers in referral hospitals' administration, particularly CHUK, to recognize the challenges imposed by the role conflict among the nurses, so develop appropriate approaches to alleviate and mitigate the role conflict among the nurses in order to improve the nursing practice.

Nursing education: The results of the study would be an added source of information to the existing literature on this subject as well as contribution to additional nursing knowledge.

Nursing research: This study has assess the role conflict among the nurses at Kigali University Teaching Hospitals, Rwanda by providing information on role conflict among nurses, this would provide a basis to further researches

Nursing leadership: The study findings would help the decision makers in designing strategies for prevention and better mitigation strategies for conflicts arising during various nursing roles.

1.7. Subdivision of the project

This research report has six chapters. Apart from the current chapter which is the general introduction to the study, chapter two literature reviews provides a detailed review on studies pertaining role conflicts among nurses, chapter three describes the methodology of the study as well as research instruments that was used. Chapter four deal with presentation of the findings, chapter five tackles discussion and lastly of findings, chapter includes the conclusion and recommendations.

1.8. Definition of key terms

Conflict: Although there is no universal definition of conflict (Cox 2001; Kelly 2006), it can be described as "a process in which one party perceives that its interests are being opposed or negatively affected by another party" (Kreitner & Kinicki 2009).

Nurse: is a person who has completed a program of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing in his/her country.

The nurse is prepared and authorized to engage in the general scope of nursing practice, including the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages and in all health care and other community settings; to carry out health care teaching; to participate fully as a member of the health care team; to supervise and train nursing and health care auxiliaries; and to be involved in research (International Nursing Council, 2017).

Role conflict:

Role conflict is a conflict among the roles corresponding to two or more statuses.

Role conflict occurs when an individual is subject to competing or conflicting sets of expectations and demands in the organization, or when the principle of unity of command is violated. It diminishes job satisfaction and effectiveness (Tarrant, 2008).

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The common causes of role conflict are unclear expectation, poor communication, lack of clear jurisdiction, incompatibilities or disagreements based on differences on temperament or attitudes, individual or group conflict of interest, and operational of staffing changed. All of these types of role conflict can disrupt working relationships and result in lower productivity (Marquis & Huston, 2009)**.**

Conflict is an inevitable social phenomenon when individuals work together on a team or project. In a hospital setting, there are a large number of separate professions that need to work together to achieve the collective goal of patient health, safety, and well-being.

Due to the interprofessional nature of health care teams and the separate education, ethics, and ideologies that come with each profession, these teams are at especially high risk for conflict (McNeil et al. 2013). This chapter reviews literature relevant to role conflicts experienced by nurses. It provides an insight on the conflict dynamics, its causes and the management strategies.

2.2. THEORETICAL LITERATURE REVIEW

2.2.1 Dynamics of the conflict

Conflict is a complex behaviour. It can occur on various levels – intrapersonal, interpersonal, intragroup, or intergroup. Intrapersonal conflicts occur within the person, whereas interpersonal conflict takes place between people. Likewise, intragroup conflict happens within one group of people and intergroup conflict occurs between two or more groups of people (Forte 1997).

According to the definition of conflict, "one party perceives that its interests are being opposed or negatively affected by another party," perception plays an important role in conflict. The issues that arise to cause conflict may be genuine or illusory (Kreitner & Kinicki 2009).

Dysfunctional conflict refers to the negative types of conflict that "hinder organizational performance" (Kreitner & Kinicki 2009). However, not all conflict results in damage. Functional conflict involves the "healthy and vigorous challenge of ideas, beliefs, and assumptions" (Menon et al. 1996).

Since conflict can result in necessary changes within an organization, Haraway and Haraway (2005) suggest leaders "not to try to eliminate conflict" but instead manage differences productively in order to increase efficiency and proficiency. This is contradicted by (Dougan & Mulkey 1996) who posit, "elimination of conflict is always the goal," even if the role conflict seems constructive in the onset. This latter view of conflict corresponds to the traditional understanding of conflict that stemmed from the 1930s that viewed conflict as destructive, dysfunctional, and disruptive.

It was to be "avoided, suppressed, or eliminated" (Almost 2006). Only later, circa 1956, were the positive effects of conflict studied, beginning with Coser (Lewicki et al. 1992). Nonetheless, Almost (2006) posits that resolution of conflict is necessary due to the fact that if allowed to be prolonged will eventually generate new causes of conflict.

2.2.2 Antecedents of conflict

What situations generate conflict? Conflict is more apt to take place under certain circumstances; by making themselves aware of these antecedents, hospital leaders can prepare for it and intervene when appropriate (Kreitner & Kinicki 2009). Most conflict research reveals that the majority of health care conflict arises from "interpersonal or professional communication difficulties" (Shin 2009).

2.2.3 Personality differences

(Almost et al. 2010) noted that dispositional characteristics were found to be a major cause of conflict in the nursing field in three separate Canadian research studies. Incompatibilities between and amongst persons can include "personality clashes, tension and annoyance". Individuals have unique personalities and vary in "attitudes, opinion, beliefs, culture emotional stability, maturity, education, gender, language, etc." (Jha & Jha 2012). Therefore, their reactions to specific stimuli also differ.

These differences cause some individuals to perceive some matters as undermining their positions or refuting their worldviews or values. Oftentimes, individual differences can adopt moral and/or emotional undertones, turning a disagreement over who is factually right or wrong into "a bitter squabble over who is morally correct". Though Jha & Jha (2012) seem to suggest that differences contribute to situations of conflict, it is noteworthy to consider Dougan & Mulkey (1996) study that concluded, "conflict may be absent when organizations try to recruit members from different age categories.

2.2.4 Value differences

Frederich and colleagues (2002) discuss a case of value differences resulting in micro-level conflict within a hospice inpatient unit. Physician-nurse conflict arose when a nurse refused to follow a physician-prescribed order to administer a potent sedative to a 47-year-old patient. The physician, the patient and the patient's wife had earlier agreed to initiate controlled sedation to the patient, who was seeking to hasten death.

A nurse who worked during the previous shift felt uncomfortable with the order as well because it seemed excessive at that point in the patient's disease progression. Health care workers are able to refuse patient care assignments when they are "ethically or morally opposed to interventions or procedures in a particular case". The polarity of values on the hospice unit created role conflict among the physician, the nurses, the patient, and the patient's family.

2.2.5. Blurred job boundaries

Role boundary issues A lack of understanding of each other's roles was described as a source of conflict on PHCTs: ''people don't understand each other's role and how important each other's roles are on that interdisciplinary team'' (Social Worker) (Wright et al. 2014). Role boundary issues were complicated and encompassed: ''who is in charge of what and who shouldn't be doing what'' (Family Physician). However, some participants described how role boundary issues were changing on their teams:

''There used to be a real 'I'm the doctor, I'm the nurse, I'm the pharmacist, I'm the social worker.' I find that those lines are blurring in the sense that people don't get uptight about delineating their role so much now'' (Pharmacist).

Scope of practice Conflict could ensue when there was a lack of understanding of the scope of practice of other professions:

''It is a problem with other people doing the things that I do now

It's going to be a concern whether they [nurse practitioner] can actually do those sorts of things [well baby care] in an efficient manner as the physician and will they have the training to do it as well'' (Family Physician) (Wright et al. 2014).

Therefore, conflict related to scope of practice was amplified when new professions were added to teams, particularly when the professional roles and responsibilities of new members potentially ‘‘threatened’’ established scopes of practice: ‘‘If I get the nurse practitioner to see all the simple stuff, it increases my burden, because I’m stuck with difficult stuff’’ (Family Physician). Those in more established roles were not the only participants to express frustration and concern. New professionals, such as nurse practitioners, described how a lack of sharing and collaboration impeded their integration into existing teams (Wright et al. 2014).

‘‘I am still not getting a lot of sharing with the physician I mean physicians isn’t educated for collaborative practice. They are educated for solo practice and that’s the way they think and unless structures are set up to inform them differently, then we are not going to have collaborative practice’’ (Nurse Practitioner).

Accountability Issues of accountability could also be a source of conflict on PHCTs.) (Wright et al. 2014).

Health care requires interdependence among its caregivers. This interdependence is often regarded as a “structural antecedent to conflict” (Wright et al. 2014). Multiple scholars reveal that conflicts among interdependent health care workers may occur from discrepancies about which professional is responsible for performing certain roles or making treatment decisions rather than disagreement over the procedure plan chosen (Jameson 2003).

Blurred boundaries between nurses and physicians lead to conflict when senior-level nurses, who are experts in their specialties, “frequently fail to observe the formal boundaries of nursing practice” (Bonner & Walker 2004).

This corroborates with Kaitelidou et al.’s (2012) study of physician nurse conflict in Greece that concluded physicians “reported having more conflict with nurses with a higher (university) education”.

Nurse practitioners are advanced nurses who, in some states within the United States have prescriptive privileges and may set up autonomous clinical practices, much to the consternation of some physicians who at one time did not have to share that right. One nurse practitioner was opening her private practice and noted the following comment from a physician who objected to her new undertaking, “one radiologist stated that he would never accept a request from a nurse for an X-ray – funny he does now” (Norris & Melby

2006). The advancement of the nursing field creates inter-professional conflict between nurses and physicians who are unwilling to accept the evolution of the nurse practitioner profession.

Many nurses today hold equal or increased academic qualifications as physicians (Ashworth 2000). Norris & Melby (2006) explain that while this nurse advancement is more developed in the United States (U.S.) and Canada, in the United Kingdom (U.K.) the role of nurse practitioners is still in its early stages. This advancement is recognized as the relatively new challenge of blurring of existing barriers that was found in the authors' research that U.K. physicians "were more unwilling to accept that nurses should be allowed to undertake certain advanced skills".(Ihemedu et al. 2010) also address these advancements of nursing roles in Nigeria.

They note that the "boundaries between doctors as diagnosticians and prescribers of treatment and nurses as obeyers of orders and dispensers of treatment [are] less clear and more permeable". Ihemedu et al. (2010) assert that the contrasting reactions to these changes have led to conflict and poor working conditions.

In an editorial about this physician-nurse friction regarding advanced practice nurses, (Karlsen et al. 2011) relayed the story of a nurse practitioner in the U.S. that also worked as a clinical specialist and a university instructor was asked to leave a tumor board meeting when she arrived with a physician coworker. The decision to ask for her exit was catalyzed a week earlier when a different nurse filled in for an absent physician by presenting a patient case at the tumor board meeting, which infuriated the physicians.

Eventually, the nurse received a letter from the Cancer Committee chairman stating that she was welcome to attend the meetings but could not present patient cases but could "add information and participate in the discussion about patients being presented from her physician colleague's office". The author conceived that many physicians preferred the hierarchical structure of the past and "refuse to acknowledge or value the contributions nurses can make during any phase of the patient care continuum".

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catalyzed a week earlier when a different nurse filled in for an absent physician by presenting a patient case at the tumor board meeting, which infuriated the physicians. Eventually, the nurse received a letter from the Cancer Committee chairman stating that she was welcome to attend the meetings but could not present patient cases but could "add information and participate in the discussion about patients being presented from her physician colleague's office". The author conceived that many physicians preferred the hierarchical structure of the past and "refuse to acknowledge or value the contributions nurses can make during any phase of the patient care continuum".

2.2.6. Battle for limited resources

Competition for resources in health care has grown significantly over the past few decades. With the exponential rising costs of health care, hospitals are forced to do more with less. Fewer employees, tighter budgets for equipment purchases, and workflow changes contribute to intergroup and intragroup conflicts (Tomajan 2012). The health plans/managed care prefers paying physicians through the pay for performance model, while physicians disagree and believe that increased reimbursements would "improve payer/physicians relationships".

2.2.7. Decision-making

Discontent and frustration occur among health care workers when there are "constraints on the decision-making process" (Dougan & Mulkey 1996). In the past, nurses had little to do with complex decisions in health care.

However, the roles of nurses and doctors have changed significantly over the past two decades. This change to a more collaborative environment led to conflict in health care practices. Some physicians have a difficult time realizing that "nurses are now independent professionals" (LeTourneau 2012). Coombs (2013) conducted an ethnographic study of intensive care nurses and physicians. Though much of the doctor-nurse interactions were "mutual or satisfying," clinical decision-making caused Role conflict between the groups of professionals. Both groups expressed disagreements concerning input with clinical decision-making but the disparate interpretations were noted. Physicians appreciated the fact that the nursing staff held patient knowledge. Coombs noted that this knowledge often was not considered as information in clinical decision-making, however. By ignoring or failing to take into account their knowledge, the nursing staff "felt frustrated and devalued".

They also considered it “an insult to their clinical skills and professional experiences in intensive care”. By feeling that they lacked a sufficient power base in making decisions, nurses believed that opportunity to offer valuable input was limited. Some physicians failed to validate these feelings. One in particular stated that the working relationship between the two groups was collaborative. Yet, when discussing nursing concerns posited, “I think that some of the nurses may feel that there is a hierarchy, but I think that it’s their problem. They’re shit scared of medicine, but that’s their problem”.

In addition to the decision-making process as an antecedent in the aforementioned example, disrespect is noted. Almost (2006) expresses that interactional justice entails two factors, interpersonal justice and informational justice. The former is the extent to which individuals are respected; the latter involves how much the individual is provided justification for the decision-making process.

2.2.8. Communication

Numerous studies include communication as a major cause of interpersonal conflict among nurses, including Almost (2006), Johnson (2009), and Warner (2001). Kreitner and Kinicki (2010) specifically mention “inadequate communication” as an antecedent, an element that corresponds with much of the literature (Wright et al. 2014). Other researchers, such as Almost (2006) point to the style of the communication within the health care field as lending to the development of conflict.

That style could certainly consist of lack of communication, but can also include verbal or non-verbal communication. A high-stress workplace such as an operating room lends itself to conflict producing verbal communication. This type of communication can include gossip, harsh language, rumor spreading, criticizing, bickering, and degrading comments (Chipps et al. 2013; Johnson 2009; Rowe & Sherlock 2005; Wright, et al. 2014). Conflict among nurses often results from sudden outbursts of anger (Duddle & Boughton, 2007).

Rosenstein (2009) offers that some physicians create conflict inadvertently in the midst of making life or death decisions that may be “carried out with an autocratic domineering tone” that offend others. Non-verbal cues such as ignoring, facial expressions, and body language can trigger conflict. According to Wright et al (2014), one nurse reported the following regarding non-verbal catalysts of conflict: “A nurse working in an adjoining department consistently refrains from speaking to me.

This seems deliberate as she speaks freely to others all around me. It just feels unfriendly and awkward". Bullying in the health care workplace is an example of dysfunctional communication that results in conflict (Chipps et al. 2013b)

2. 3. Empirical literature review

2.3.1 Effects of unresolved conflict

The consequences of health care workers' conflict are many. At best, Role conflicts result in beneficial changes in the workplace. At worst, it can impact patients' lives. This review will illustrate the effects across the continuum.

2.3.2 Patient impact

Johnson (2009) cites an example of a worst-case scenario due to conflict. An intensive care nurse alerted the attending physician when a patient suffered post-operative complications. The physician verbally abused the nurse and refused to come to the unit to assess the patient. Later, when the patient's symptoms showed no improvement, the nurse again contacted the physician, which resulted in the physician becoming "even more verbally upset". The nurse declined to call the doctor a third time until the patient was beginning to hemorrhage internally. At that time, the patient was immediately returned to surgery, where the patient expired.

In an Internet survey of over 100 St. Louis nurses, the majority of nurses correctly answered textbook questions about physician-nurse scenarios of decision-making conflict that are commonplace in the labor and delivery department.

However, they also noted that in the workplace, they would not respond according to those textbook ideals (Phillips 2008). One of the scenarios involved a doctor ordering additional doses of oxytocin, a hormonal drug that increases contractions, when the woman was currently experiencing "too many contractions". A mere 23% of respondents stated that they would actually refuse the order, which most knew was the correct action. Another 23% replied that they would not increase the drug but agree to do so to the physician. The remaining 54% would increase the hormone while monitoring the fetal heart rate and decrease the dosage if necessary". The latter choice would not only increase liability risks but also potentially harm the patient.

Though the respondents in this case were “highly educated and experienced nurses”, many would fail to respond accurately due to “hospital hierarchy between doctors and nurses, fears of reprisal, belief that the hospital administration would not support a nurse who reported inappropriate behavior and a general desire to avoid conflict”.

Fear of reprisal led to another case of impacting the patient in a case where a nurse was aware that a physician’s “aggressive treatment plan” conflicted with a terminally ill patient’s wish. The nurse failed to request a review of the case from the ethics committee, which would have been the proper action to take, because of her worry of the repercussions from the doctor (Thrall 2000).

Besides immediate conflict and conflicting opinions of treatment, unresolved conflicts also have the potential of impacting quality patient care. Haraway and Haraway (2005) reveal that nearly every health care worker “can recall delays or inadequacies in patient care caused by a provider refusing to consult the ‘on call’ physician or group for a problem outside of their area of expertise because of some unresolved past conflict”. In a U.S. survey of 213 nurses in a Philadelphia, Pennsylvania teaching hospital, 13% of respondents stated that being involved in verbally abusive encounters led them to “make a caregiving error” (Michelle Rowe & Sherlock 2005).

2.3.3 Job satisfaction

In a study of 141 nurses working in 13 inpatient units within a hospital system, Cox (2001) found that the perception of better unit morale was associated with less intradepartmental conflict and lower expected turnover. Cox (2003) reported that increased levels of intragroup conflict led to less job satisfaction among nurses.

Conflict in the nursing field is associated with higher job turnover, decreased job commitment, absenteeism, an increase in grievances, continual orientation of nursing staff, and considerations of leaving the profession (Almost, 2006; Jameson, 2003; Rowe & Sherlock, 2005; Tabak & Koprak, 2007). Recent studies conclude that Canadian nurses have decreased their working hours due to conflict and Japanese nurses left their current roles as a result to unresolved conflict (Almost 2006).

Considering changes occurring in health care, job satisfaction and retention is particularly important regarding health care workers. The PPACA is the “largest expansion of health care coverage since the passage of Medicare and Medicaid by President Lyndon B. Johnson in 1965”.

With this expansion comes new patients seeking health care, which is anticipated to increase demand in health care workers, though a recent study noted that there was no significant patient surge in the first few months of 2014, though poor weather patterns in that time period may play a part in those findings (Chester, 2014).

However, the aging population is expected to increase the need for health care workers. It is estimated that three million baby boomers are reaching retirement age each year for approximately the next twenty years (Barr 2014). With this increased stress on the health care market, it would behoove health care managers to pay attention to retention efforts.

2.3.4 Effect on individual

Continued conflict results in stressed employees. Consequently, "interpersonal conflict has been noted as one of the major sources of stress for nurses" (Rowe & Sherlock 2005. Research shows that stressed people have less ability to focus, memory lapses, slow healing, and diminished nutritional uptake (Forte 1997). Stress can produce psychosomatic illnesses such as stomachache, headache, depression, and anxiety. Conflict educes fear, repugnance, and irritability (Almost 2006). It can eventually undermine an individual's self-esteem and confidence level (Almost 2006; Berman-Kishony 2011).

Some specific conflict consequences may involve failing to return telephone messages or emails from patients or colleagues, tendency to isolate oneself, charting by wrote to avoid criticism, taking everything personal, and victim portrayal (Forte 1997).

2.3.5 Positive outcomes

Of course, as noted in the introduction, some effects of conflict may be positive. Reasonable degrees of conflict can lead to the generation of ideas as well as foster team cohesion. It can "lead to a sharpening of critical issues" and catalyze important changes that benefit the organization (Haraway & Haraway 2005). Once conflict is resolved, those involved feel more united and capable (Almost, 2006).

2.3.6 Conflict-handling styles

There are five styles of handling conflict, according to the Rahim and Bonoma model: avoidance, compromise, obliging, dominating, and integrating (Kreitner and Kinicki, 2010; Leever et al., 2010). Avoidance and compromise are common styles used among physicians and nurses (Leever, 2010; Tabak & Koprak 2007). According to Kreitner and

Kinicki, these two choices are temporary fixes. In certain circumstances, however, they may be useful (Afzalur Rahim 2002).

Nonetheless, when dealing with complex issues, the preferred style of conflict handling is integrating (Kreitner & Kinicki, 2010; Rahim, 2002). Kelly (2006) reported that a study of intensive care nurses revealed that they tended to use avoidance in order to protect relationships, prevent open arguments, act as proper role models in the presence of students and so they are not "branded [as] emotional or unfeminine women". Those who avoid conflict "neglect their own needs, goals, and concerns" in order to satisfy others. This self-sacrificial approach may be considered an expectation in a career that ascribes to the philosophy of altruism. However, compromise was found to be the most prominent style of choice among doctors and nurses working in five Israeli hospitals, whereas a qualitative study done in a Norwegian hospital determined that physicians and nurses used avoidance, compromise, and dominating styles depending on the contextual factors of perceived interrelationship between the members, and the urgency of taking action regarding the situation (Leever et al., 2010).

2.3.7. Conceptual framework

This study will use the modified integrated theoretical framework as a guide (Moore, 2003). According to more (2003), a health care organization is part of a larger health system both influenced by prevailing political, economic, structural and cultural factors. The integrated framework (Fig.2.1) describes conflict in organization as a cycle of events that occur from the source or antecedent which sets the stage for conflict to the conflict outcome which is largely a consequence of the conflict handling modes of the disputants (Havenga, 2005; Moore, 2006; Tjosvold, 2007, 2008). The conceptual framework provides a basis for understanding conflict in organization by examining the contexts, the interactions or interrelatedness of the different social elements/levels (individuals, groups, organization, health system) and the effects of these interactions on the emergence of conflict. However, because of the interrelatedness of the different social elements/levels, personal contexts could be brought into focus when exploring people's experiences with conflict between different groups.

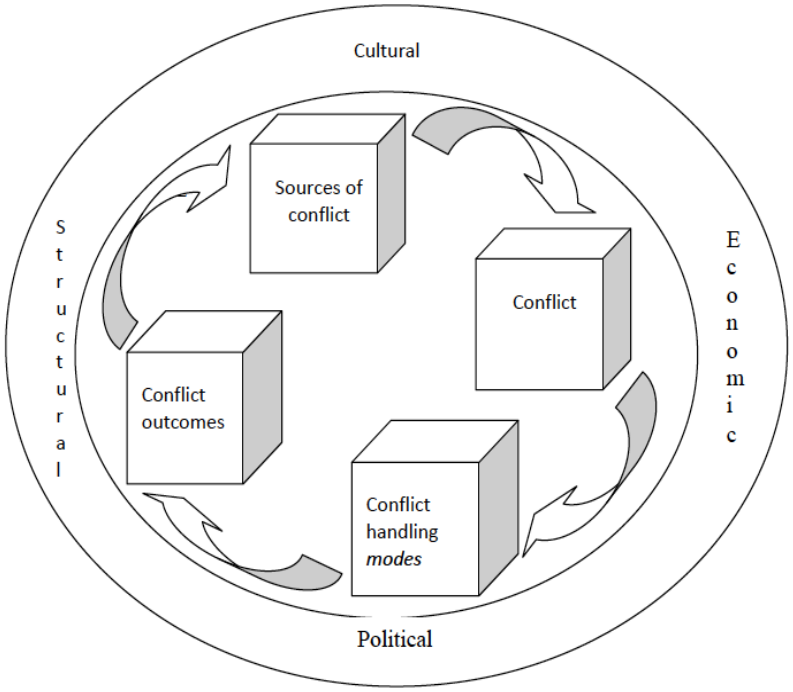


Figure 2. 1 Integrated theoretical framework of conflict in health care organization (Moore, 2003).

CHAPTER THREE: RESEARCH METHODOLOGY

3.1. Introduction

This chapter describes how the study was conducted in the CHUK. It describes the research design that was used in the study, including the pilot study, data collection (the population, sampling etc), ethical considerations and measures to ensure validity and reliability.

3.2. Study Design and Approach

A quantitative, cross sectional study design was used. This approach was chosen because the researcher aims at to providing a complete picture of the role conflicts experienced by nurses in CHUK (Vos & Strydom 1998).

The study is explorative in nature because the literature was explored in order to gain more insight and understanding of the concept "role conflict", factors that impede conflicts among nurses as well as different strategies for conflict resolution among nurses of the selected hospital. It was descriptive in nature because it will describe the phenomenon as accurately as possible by using statistical, quantitative results from a sample representing population (Polit & Hungler 1999).

3.3. Study Area

The current study was carried out at University Teaching Hospital of Kigali. The CHUK is a 510-bedded referral hospital located in Nyarugenge district, Kigali City. It is the main public health institution in the country. It was built in 1918. In 1928, it functioned as a health centre and later, in 1965 as a hospital. From April 1994 to 1996, CHUK has served as a health centre, a district hospital and as a referral hospital.

For study purposes hospitals' departments, were divided into three categories: Inpatient, outpatient, and critical care departments.

3.4. Population

The "population" in includes all members of a defined group that we are studying or collecting information on for data driven decisions. In this study the population will refer to all nurses and midwives working at the CHUK.

A target population is defined as the entire group of people that is of interest to the researcher or in other words the entire group that meets the criteria the researcher is

interested in studying (Burns et al. 2001). The accessible population in this study will include all 430 nurses working at the selected hospital at the time of our study.

3.5 Eligibility criteria

3.5.1 Inclusion criteria

All nurses and midwives working in the inpatients and outpatients departments who will have consented to participate in the study were included in the study.

3.5.2 Exclusion criteria

The study excluded newly recruited nurses (less than six months as well as nurses who have refused to provide consent to participate to the study). The nurses' managers, physicians and allied health professionals will also be excluded from the study.

3.6. Sample Size and sampling method

Sample size was calculated using the Yamane's formula (Yamane 1967).

$$n = \frac{N}{1 + N(e)^2}$$

n = is the sample,

N= the study population (475),

e = the standard error with a 95% confidence interval (0.05).

$n=475/1+475(0.05)^2$

n=475/2.075

n=216

Then the sample size needed for our study was 216 nurses.

3.7. Sampling Strategy

Convenience sampling method was used in this study; convenience sampling method consists of a group of individuals who are most conveniently available and whose are ready during the period of research.

This kind of sampling method was chosen since it was most appropriate as most nurses rotate on a daily basis; thus, it will not be possible to have all nurses at the same time to make a random sampling.

3.7. Data Collection Methods, Procedures and Instruments

3.7.1. Data collection instrument

This study will use a self-administered questionnaire to collect data. The data collection instrument consists of three main sections. The first section comprises demographic and professional information of the study participants. The second section aims at assessing the types and level of conflict experienced by nurses in the hospital setting. In this section the researcher will use the Nursing conflict scale (NCS) as for data collection.

The NCS was primarily developed and tested in Ain Shams University Hospital; Cairo, Egypt by El-shimy, Abdel El-Megid, and Mohamed in 2002. For this study author have contacted the tool developer and she provided permission to use it and confirmed its validity and reliability have been tested. The tool was originally designed in English but the investigator will translate it in French as most nurses use this language.

The instrument consists of thirty-six items uses three-point scales (0-2): 0= no, 1=sometimes, and 2=yes with a total score of (72). NCS is categorized into five categories of conflicts: Disruptive conflict (5 items), interpersonal conflict (7 items), intrapersonal conflict (6 items), intergroup conflict (6 items), intragroup conflict (6 items), and competitive conflict (6 items). The scoring system of the instrument was calculated as: Low conflict experience level ranges from 0 to 24 (<33.3%), moderate conflict experience level ranges from 25 to 48 (33.3 - <66.7%), and high conflict experience level ranges from 49-72 (≥ 66.7%).

The third section aims at assessing the conflict handling strategies. For this regard, the study will use the conflict management questionnaire. There are 15 statements which corresponds to 5 conflict handling strategies namely: “accommodating (indicators 1,2,3), competing avoiding (indicators 4,5,6), avoiding collaborating (indicators 7,8,9), collaborating competing (indicators 10,11,12) and compromising (indicators 13,14,15) styles”.

Participants were asked to scale every statement with a corresponding score of 1 for "Rarely", 2 for "Sometimes", 3 for "Often" and 4 for "Always". The conflict handling style with the highest scores will constitute the most preferred style by the participants.

3.7.2. Data collection procedure

After getting the authorization (Ethical clearance) to collect data from Institutional Review Board (IRB); University of Rwanda/College of Medicine and Health Sciences, the Student researcher will explain the study to the participants, its purpose, how they could take part in this study. After signing the consent form, data were collected by interview while completing the questionnaires to get opinions and information from the participants towards types and levels of conflicts in their workplace.

3.7.3. Reliability and Validity of the instrument

3.7.3.1. Reliability

Reliability refers to the consistency with which an instrument measures the attribute (Polit-O'Hara & Beck 2006).

The reliability of the NCS was tested by the original author in a validation study conducted by Elshimy and colleagues in 2002 and was found the cronbatch alpha of 0.86 which literally translates "acceptable".

3.7.3.2. Validity

Validity refers to the degree to which the instrument measures what it is supposed to be measuring (Polit-O'Hara & Beck 2006). The content validity was ensured by designing the questionnaire that will capture important aspects covered in the literature review. In order to improve content validity, expert health professionals were asked to review the questionnaire and their opinions and suggestions were incorporated in the final version of the questionnaire (Brink et al. 2006).

3.8. Data Analysis and Presentation

The SPSS version 21 was used for data entry coding and analysis. The description of the study sample was carried out by descriptive statistics such as percentages. In order to compute the level of conflict the data collection items frequencies were considered. Types of conflicts were expressed in form of means and standard deviation.

The Chi^2 was computed to establish factors contributing to the development of conflicts. Finally, Results were presented in form of tables and figures.

3.9. Ethical Considerations.

During the study and throughout the research process, the several ethical aspects were taken into consideration. Permission to conduct the study was sought from the Institutional Review Board (IRB) of the College of Medicine and Health Sciences. The data collection process will start after the CHUK ethical committee has provided permission for data collection. Moreover, the respondents were informed that participation in the study is voluntary and that they can withdraw from the study at any given time to ensure informed consent and voluntary participation.

Anonymity was ensured because no names or other personal details were provided on the questionnaires. Confidentiality was further enhanced by ensuring that the information is kept private and only the researcher and the supervisor have access to the information. No information was disclosed or discussed with any irrelevant authority or third party.

3.10. Data Dissemination

All participants in the research were given a report of the findings, and were encouraged to comment on them. The final copy of the report will be availed in the College library to which students have access. Furthermore, the researcher assisted by the supervisor will work on the manuscript to be submitted for publication. A copy of this report will also be sent to the concerned hospital administration to make them aware of the results as well as key recommendations from this study.

3.11. Data management plan

After data collection data on hard copies and those within computer were kept in high security and nobody was allowed to have access or sharing without ethical permission. The paper was destroyed after five year. Data stored on the computer were removed from the program files and recycle bin after this period.

3.12. Problems and limitation

The study is about nurses and midwives in a central government hospital. The study findings would only be applicable to this hospital or the region. The study's external validity or generalizability to other hospitals might be limited.

CHAPTER FOUR: RESULTS

4.1. Introduction

This chapter presents the findings and provides their interpretation focusing on role conflicts types, levels and handling styles among nurses at CHUK. The findings presented in this chapter were obtained from a sample of population from nurses working at CHUK.

4.2. Demographic characteristics

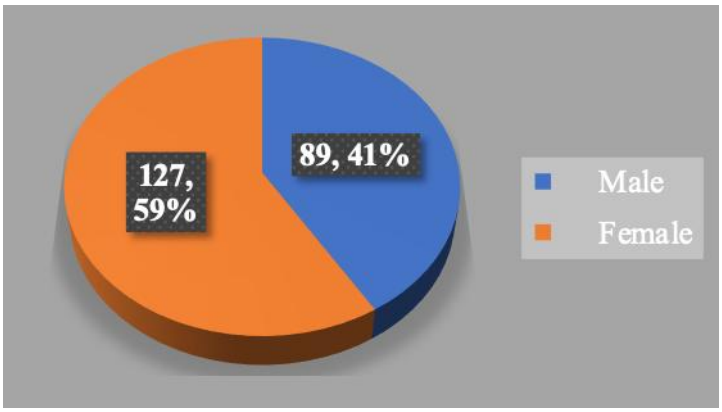
The table 4.1 below shows the distribution of study participants according to age. The table reveals that the majority of nurses included in the study were of age less than 30 years old, n= 138 (63.9%) while a minority 1.9%, n=4, were aged above 60.

Table4.1 Distribution of study participants according to age

Categories	Frequency	Percentage
20-29	138	63.9
30-39	34	17.7
40-49	27	12.5
50-59	13	6.0
≧ 60	4	1.9

The figure 4.2 displays the distribution of study participants according to gender. Most of participants were female with 59% (n=127), followed by male participants with 41%, (n=89).

Figure 4. 2 Distribution of study participants according to gender



The figure 4.3 displays the distribution of study participants according to the level of education. There are three quarters of participants with advanced diploma and another quarter with bachelor's degree.

Figure 4.3 Distribution of study participants according to the level of education

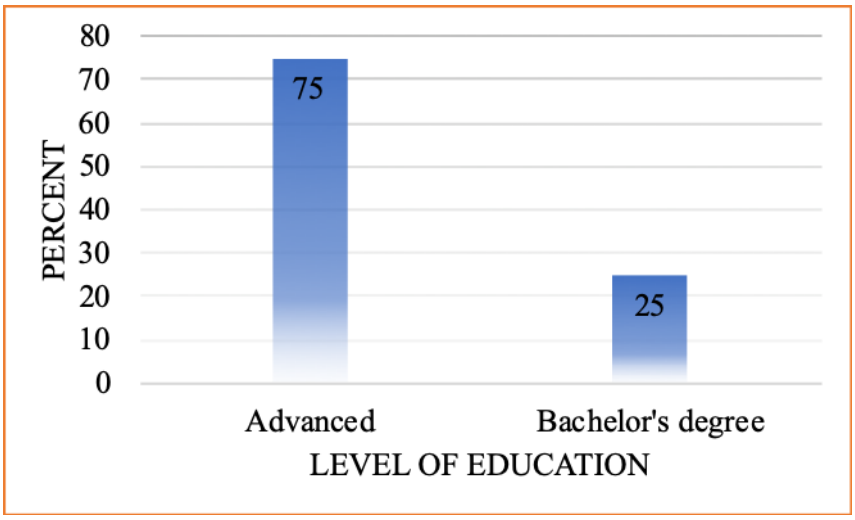
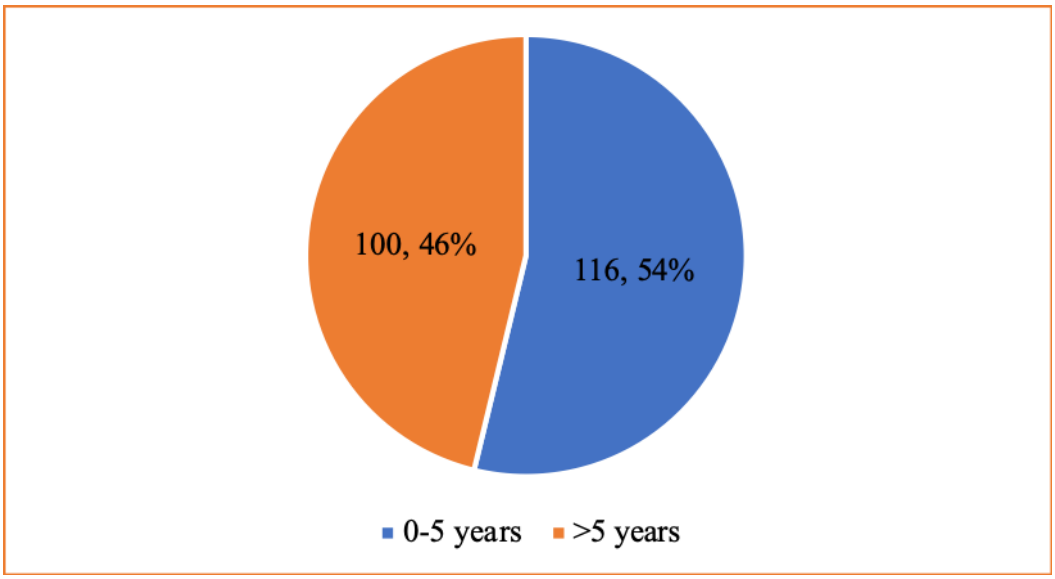


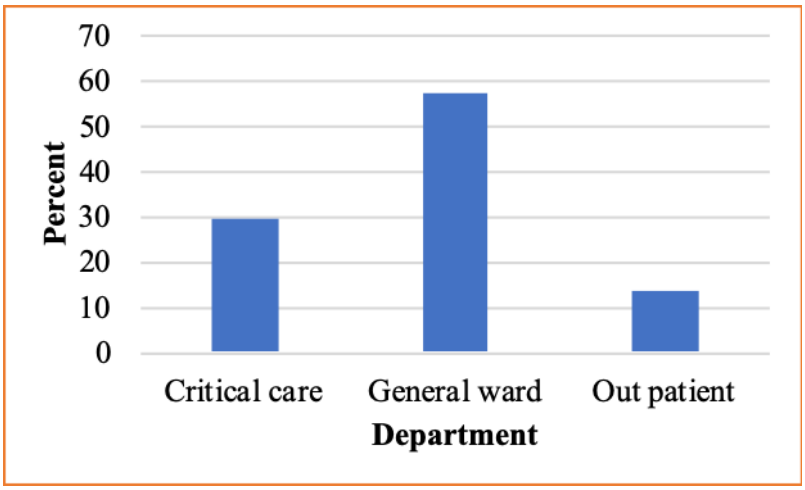
Figure 4.4 Distribution of study participants according to work experience. Just above a half (54%, n=116) of the study participants have less than 5 years of nursing experience as described in figure 4.4 below.

Figure 4.4 Distribution of study participants according to work experience



The figure 4.5 shows that 57.4% of participants were working in the general ward, followed by the critical care department with 29.5%.

Figure 4. 5 Distribution of study participants according to the department



4.3. The types and level of conflicts experienced by study participants.

The table 4.2 below revealed the type of conflicts experienced by study sample. Every statement related to a given type of conflict on the data collection tool was rated with a score ranging 0 to 2.

The maximum score for five items in intragroup type of conflict was 10, competitive had 7 items and was accordingly scored out of 14.

Disruptive, intergroup, intrapersonal and interpersonal types of conflicts had 6 items each and scored a maximum of 12 points.

All maximum scores for every type of conflict were calculated out of 2 points, and a type of conflict with higher score was considered as the most prevalent for the concerned participant.

The table 4.2 therefore indicated that the highest mean scores of experienced conflicts among study sample were intragroup (1.26), competitive (1.13) followed by disruptive (1.05) conflict respectively.

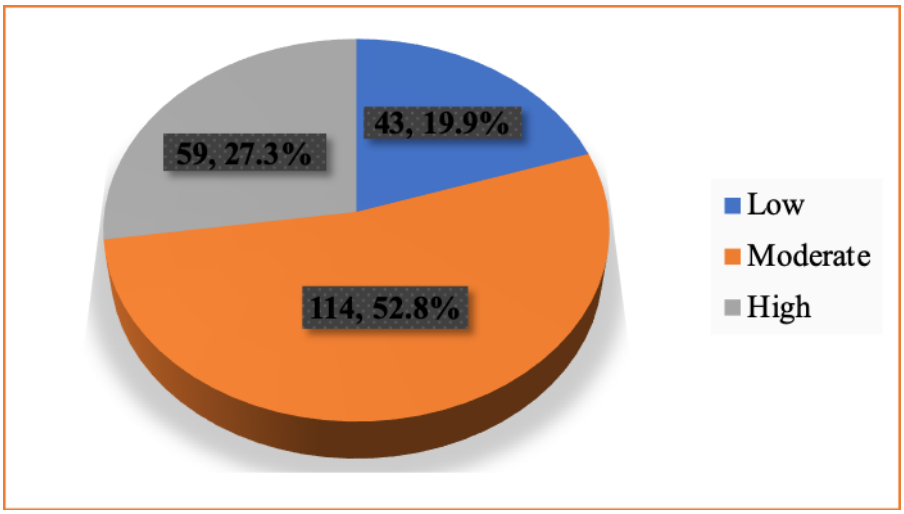
Table4. 2 Types of conflicts experienced by study participants

Type of conflict	Conflict scores			
	Minimum	Maximum	Mean	Std. Deviation
Intragroup	0.7	1.9	1.26	0.30
Competitive	0.6	1.9	1.13	0.22
Disruptive	0.6	1.8	1.05	0.21
Intergroup	0.6	1.4	0.88	0.19
Intrapersonal	0.6	1	0.80	0.13
Interpersonal	0.6	1	0.80	0.13

The figure 4.6 displayed below illustrates the average level of conflict scores experienced by participants.

The study emphasized that just above a half of study sample (n=114, 52.8%) have moderate level, while 27.3%, (n=59) of all participants experienced high level of conflict. The study also demonstrated that 19.9%, (n=43) of participants experienced low levels of conflict.

Figure 4. 6 Level of conflict experienced by study participants



4.4 Factors contributing to role conflicts among study participants.

The Table 4.3 below illustrates the relationship between demographic characteristics and intragroup conflict.

The findings revealed that within the intragroup conflict, it is the medical staffs that do not always respect the nursing job (NCS item 29).

This observation was predominant with the age category of 40-49 years, and mainly with female and those with advanced diploma.

However, there was no statistical association (p values >0.05) between age, gender, level of education and years of experience with intragroup conflict.

Table4. 3 Relationship between demographic characteristics and intragroup conflict

Variable		Sometimes	Always	Chi^2	P value
Age	20-29	34 (24.6%)	104 (65.0%)	4.69	0.32
	30-39	13 (38.2%)	21(61.8%)		
	40-49	4 (14.8%)	23 (85.2%)		
	50-59	4 (30.8%)	9 (69.2%)		
	>60	1(25.0%)	3 (75.0%)		
Gender	Male	22 (24.7%)	67 (75.3%)	0.11	0.43
	Female	34 (26.8%)	93 (73.2%)		
Level of education	Bachelors	19 (35.2%)	35 (64.8%)	0.07	0.05
	Advanced diploma	37 (22.8%)	125 (77.2%)		
Experience (years)	0-5	27 (23.3%)	89 (76.7%)	0.91	0.21
	>5	29 (29.0%)	71 (71.0%)		

The Table 4.4 below shows the relationship between demographic characteristics and competitive conflict.

The findings revealed that within the competitive conflict, most study participants emphasised that “policies must be clear before implementing nursing responsibilities” (NCS item 31).

This observation was predominant with young participants within the age category of 20-29 years, and mainly with female and those with advanced diploma.

However, there was no statistical association (p values >0.05) between age, gender, level of education and years of experience with competitive conflict.

Table4. 4 Relationship between demographic characteristics and competitive conflict

Variable		Sometimes	Always	Chi^2	P value
Age (years)	20-29	27 (24.6%)	111 (65.0%)	5.03	0.75
	30-39	9 (38.2%)	26(61.8%)		
	40-49	3 (14.8%)	24 (85.2%)		
	50-59	3 (30.8%)	10 (69.2%)		
	>60	2 (50.0%)	2 (50.0%)		
Gender	Male	23 (25.8%)	66 (74.2%)	3.40	0.18
	Female	21 (16.5%)	105 (82.7%)		
Level of education	Bachelors	11 (20.4%)	43 (79.6%)	0.07	0.84
	Advanced diploma	33 (20.4%)	171 (79.2%)		
Experience (years)	0-5	20 (17.2%)	95 (81.9%)	0.91	0.21
	>5	24 (24.0%)	76 (76.0%)		

The following Table 4.5 depicts the relationship between demographic characteristics and disruptive conflict.

The study findings yielded most disruptive conflicts among nurses are due to "Physicians who always interfere in the nursing decisions" during their daily work.

This observation was predominant with young participants within the age category of 20-29 years, and mainly with female and those with advanced diploma.

However, there was no statistical association (p values >0.05) between age, gender, level of education and years of experience with disruptive conflict.

Table 4.5 Relationship between demographic characteristics and disruptive conflict

Variable		Sometimes	Always	Chi^2	P value
Age	20-29	31 (22.5%)	107(77.5%)	2.11	0.71
	30-39	8 (23.5%)	26(76.5%)		
	40-49	6 (22.2%)	21 (77.8%)		
	50-59	2 (22.2%)	11 (84.6%)		
	>60	2 (50%)	2 (50.0%)		
Gender	Male	19 (21.3%)	70 (78.7%)	0.15	0.41
	Female	30 (23.6%)	97 (76.4%)		
Level of education	Bachelors' degree	11 (18.5%)	44 (81.5%)	0.17	0.45
	Advanced diploma	39 (24.1%)	123		
Experience (years)	0-5	29 (25%)	87 (75.0%)	0.76	0.23
	>5	20 (20.0%)	80 (80.0%)		

4.5. The conflict resolution strategies.

The table 4.6 below shows the distribution of conflict resolution strategies used by study participants. Nurses utilized the following conflict resolution strategies such as accommodating and collaborative (28.2%; n = 61), and the least is avoiding (18.1%; n = 39).

Table 4.6 Frequency and percentage distribution in the conflict resolution strategies used by nurses

High use of conflict resolution strategies	Frequency	Percent
Collaborative	61	28.2
Accommodating	61	28.2
Competing	47	21.8
Compromising	50	23.1
Avoiding	39	18.1

Table 4.7 below illustrates the relationship between conflict resolution strategies and the age of participants. It showed that there is a significant relationship between nurses' use of conflict resolution strategies consistent with collaborative style and their age with p values of 0.01 considering the statistical significance cut off of 0.05.

This literally means that as the age of participants increases, they tend to adopt a collaborative approach as the preferred conflict resolution style.

Table4. 7 Nurse's use of conflict resolution strategies and their age

Strategy	**Age**					**Chi^2 test**	**p-value**
	20-29	**30-39**	**40-49**	**50-59**	**≧60**		
Collaborative	28 (45.9)	16	10 (16.4)	6 (9.8)	1(1.6)	13.35	0.01*
Accommodating	33 (54.1)	11	9 (14.8)	7 (11.5)	1	6.13	0.19
Competitive	28 (59.6)	12	3 (6.4)	3 (6.4)	1(2.1)	5.67	0.22
Compromising	25 (50.0)	11	7 (14.0)	4 (8.0)	3	10.17	0.38
Avoiding	25 (64.1)	5 (12.8)	4 (10.3)	3(7.7)	2(5.1)	3.43	0.48

The table 4.8 below displays the relationship between conflict resolution strategies and their level of education, there is a significant relationship between nurses' use of conflict resolution strategies at competing with colleagues and their nursing qualification (p value=0.03).

Table4. 8 Nurse's use of conflict resolution strategies and their level of education

Strategy	**Level of education**				**Chi^2 test**	**p-value**
	Diploma		Bachelor			
	Frequency	Percent	Frequency	Percent		
Collaborative	43	26.5	18	33.3	0.92	0.21
Accommodating	43	26.5	18	33.3	0.38	0.21
Competitive	**19**	**18.5**	**17**	**31.5**	**0.46**	**0.03***
Compromising	36	22.2	14	25.9	0.31	0.35
Avoiding	27	22.2	13	16.7	0.84	0.23

Table 4.9 reveals the relationship between conflict resolution strategies and their nursing experience that there is no significant relationship between nurses' use of conflict resolution strategies with colleagues and their total nursing experience.

Table4 9 Nurse's use of conflict resolution strategies and their nursing experience

Strategy	**Work experience (Years)**				**Chi^2 test**	**p-value**
	0 - 5		More than 5			
	Frequency	Percent	Frequency	Percent		
Collaborative	41	35.3	20	20.0	6.24	0.09
Accommodating	30	25.9	31	31.0	0.70	0.24
Competitive	26	22.4	21	21.0	0.06	0.31
Compromising	28	37.0	22	22.2	0.03	0.46
Avoiding	29	25.0	21	21.0	0.48	0.29

CHAPTER FIVE: DISCUSSION

The current study aimed at describing types and level of role conflict experienced by nurses, determines the conflict resolution styles and the relationship between those and demographic characteristics the study sample at CHUK.

5.1. Level of role conflicts experienced by nurses and midwives.

The study revealed that nurses experienced a moderate level of conflict according to the NCS scoring system. Finally, intragroup conflict between nurses, competitive conflict that arises between nurses as a result of the injustice from the side of nurse managers, followed by disruptive conflict that arises between nurses and physicians were the most common types of conflict experienced by the study sample.

Intragroup and competitive conflicts are related to each other's as both arise among nurses for instances, because of competition on opportunities for growth and development and the injustice from some nurse managers in the way all nurses are treated.

The findings of this study revealed that within the competitive conflict, most study participants emphasised that "policies must be clear before implementing nursing responsibilities" (NCS item 31). This observation was predominant with young participants within the age category of 20-29 years, and mainly with female and those with advanced diploma. However, there was no statistical association (p values >0.05) between age, gender, level of education and years of experience with competitive conflict

Additionally, disruptive conflict from the attending physician arises because of the interaction between nurses and physicians during patient care.

This type of conflict also called interprofessional conflict which is inherent in working teams such as health care teams. Role boundary issues; scope of practice; responsibility; accountability and people in dominant positions are all sources of interprofessional conflict. This type of conflict negatively affects work environment that lead to nurses work dissatisfaction, turnover, poor patients' satisfaction and outcomes (Brown et al. 2011).

These results were supported by the study conducted by Elshimy et al. (2002) which aimed to develop an instrument to measure conflict among nurses and examines its validity and reliability. The study was conducted on 80 nurses selected randomly from the hospital setting.

The study indicated that the developed nursing conflict scale is a reliable and valid scale, and the nurses experienced a moderate level of conflict (38.1%). Moreover, Kunaviktikul et al. (2000) described level of conflict, conflict management styles, level of job satisfaction intent to stay and turnover among nurses in Thailand. The study reflected that nurses had a moderated level of conflict and accommodation was the most used strategy to resolve conflict by nurses.

Another study aimed to explore the relationships between scope of practice and communication among teams of nurses from Sydney metropolitan hospitals in New South Wales. Nurses asserted that unless they realize their roles and scope of practice intra-professional workplace conflict may arise. In addition intra-professional conflict may negatively affect both nurses and patients (Eagar et al. 2010).

Additionally, Zakari et al. (2010) examined the relationship between nurses' perceptions of conflict and professionalism in three health care sectors in Saudi Arabia. The Perceived Conflict Scale was employed to assess level of conflict, and the Valiga Concept of Nursing Scale was utilized to assess perception of professionalism among nurses.

The study showed a low perception of professionalism among nurses and intragroup type of conflict had a statistically significant correlation with the perception of professionalism.

5.2 Types of Role Conflicts Experienced by Nurses and Midwives .

Furthermore, a study aimed to determine type and frequency of interpersonal conflict, an explanation of the most distressing event experienced, consequences of the behavior; and training to manage such events among nurses in their first year of practice in New Zealand.

The results reflected that many nurses in their first year of practice experienced interpersonal conflict; which lead to a higher rate of absenteeism and affected their intent to leave the profession, nurses also reported that they did not receive any training to handle such events (McKenna et al. 2003).

In addition, Bishop (2004) implemented an exploratory descriptive research design to explore frontline nurses' incidents of conflict at work. Data were collected through an interview for five participants.

The study emerged the following themes: what happens (nurses consume younger nurses, the nurse-doctor competition, and lack of cooperation from nurse leaders), why it happens (dominated group behavior, power over), and how nurses respond (lack of commitment, lack of expectation, reaction, communication, keep forward). The results indicated a negative impact on the quality of work life. The study also developed implications for nursing education and practice.

On the contrary, a study was performed at the Federal University of Minas Gerais Hospital to examine how nurses handle conflicts in the work environment. Data were collected on two stages: questionnaire followed by semi-structured interview for research participants. Data was categorized into thematic content. Some participants emphasized the experience of intrapersonal, interpersonal and intergroup type of conflict (Spagnol et al. 2010).

Nurses used various conflict resolution strategies. The findings of this current study yielded a high utilization of conflict resolution strategies by nurses were accommodation and collaboration (with 28.2% each), and the least strategy utilized by nurses with patients in rank was avoiding (18.1%). This result may provide evidence that the profession is based on collaborative relationships where nurses are able to select strategies in different situations in conflict resolution that may reflect the value they place on the importance of relationship with patients and colleagues.

Nurses have high concern for patients, attend very closely to their needs and ignore her or his own needs. While collaboration is the most preferred of the conflict strategies, it involves attending to others' concerns while not sacrificing one's own concerns. By using these strategies, nurses may try to avoid stress, tension, which may arise from conflict situation in order to decrease the intensity of conflict.

According to Blake & Mouton (1982), accommodation, collaboration are used by individuals who want to move away from the uncomfortable feelings of struggle, similar with the studies (Cavanagh 1991; Valentine 2001; Vivar 2006; Kelly 2006).

On the other hand, with regard use of conflict resolution strategies by nurses with doctors, the study's findings revealed that the number one priority for conflict resolution strategies was "accommodating" for patients which was regarded the least for the doctors. Conversely, the least strategy "competing" with patients was the number one strategy of nurses with doctors. These results may attribute to the fact that doctors conflict with

nurses are due to the changing, more advanced roles and the rejection of the traditional paradigm of doctor dominance (Kaitelidou et al. 2012).

However, competitive approaches to conflict can have positive results but more often counterproductive than productive, whereas, attempting to solve conflict with dominance and control, communication can easily become negative, creating unstable situations. Competition can create discomfort which can direct energy away from patient care objectives toward unnecessary inter-professional struggles. This result is in line with the other studies (Valentine 2001; Kaitelidou et al. 2012).

5. 3 Factors contributing to Role Conflicts among Nurses and Midwifes

Additionally, the current study indicated a significant relationship between nurses' use of conflict resolution strategies and qualification. It was found that nurses holding Diploma degree used compromising with doctors, while the Bachelor's degree nurses used collaborative strategy. Such results might be attributed to those nurses with higher level of education associated with nurse's age and experience which leads to higher expectations for managing conflict constructively.

Using collaborating also, might be due to interpersonal conflict in the hospital between doctors, nurses, which needs accepting and understanding one another's needs and expectation to improve the quality of the relationships.

Hendel et al. (2007) in their study found that collaborating was chosen significantly more frequently among qualified nurses. But, on the other hand, the results of the current study are inconsistent with Abudahi (2012) who revealed no statistical significant relationship between demographic characteristics such as age, experience and job, qualification and the used conflict management strategy.

In addition, the findings of the present study indicated no significant difference between nurses' use of conflict resolution strategies with patients and doctors and their total years of experience in nursing.

This result inconsistent with the results of Hendel et al. (2007) which revealed that accommodation, avoiding and competing each had a statistically significant relationship with years of experience in current position. As years of experience in current position increased, the use of the accommodation, avoiding, and competing strategies also increased. When years of experience in current position increased, the use of the

compromising conflict resolution strategies is decreased, but did not show a relationship to years of experience in current position.

5.4. Conflict Resolution Strategies applied by the nurses and the midwives.

Our study also revealed a significant relationship between nurses' use of conflict resolution strategies and their age that young nurses less than 30 years old tend to make more use of the accommodating conflict resolution strategies with colleagues while older generations prefer collaborative, with p -value 0.01.

This may be attributed to the fact that young nurses seek other people approval, tend to have good or at least tolerable interpersonal relations with their patients, and disfavor having enemies in their working environment. Therefore, compromising conflict resolution strategy for both nurses and doctors brings medium benefits by not harming anyone.

However, the findings of the current study are consistent with Antonioni (1998) study results which showed that the older population prefer collaboration and compromising. On the other hand, the findings of this study is inconsistent with the finding of Vokic & Sanja (2000) who reported that, the average score of conflict resolution strategies was for avoiding and competing, while highest in accommodating and compromising, and collaborating declines with age. Conversely, Gordon (2008) found no differences of conflict management strategies by age, all ages preferred the collaborative strategy.

STUDY LIMITATIONS

Actual behaviors of the nurses were not directly observed. Behavioral measures such as direct observations, peer assessment and related methods can be added in future studies in order to assess the actual conflict handling strategies. The study was conducted in only one referral hospital, and the sample was selected conveniently. Therefore, the results cannot be generalized. A bigger sample population in more than one hospital is recommended.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The current study concluded that intragroup and competitive conflicts are the most common types of conflicts experienced by the nurses. Nurses experienced moderate level of conflict.

Therefore, nurse managers in the selected hospitals need to employ effective strategies to decrease nurses' experience of conflict, develop collaboration between nurses and physicians to create healthier and more productive work environment which positively affect the quality of nursing care.

6.2 RECOMMENDATIONS

Based on the findings of this study, following recommendations were formulated:

- **Education:**
    - Nurses especially managers need to know that conflict exist and education on mitigating strategies has to be emphasized. We also recommend that regular trainings should conducted on roles conflicts especially those which predominantly arise from within groups (intragroup)
    - Develop concept of health care team and identification of roles within that team through integrated education between nurses and physician especially in practical courses.
- **Research:**
    - Since most factors elucidated in this study were nit statistically significant, there is a need to conduct a qualitative study in order to explore different factors that influence the occurrence of conflicts among nurses.
- **Leadership and management:**
    - The study recommends that nurse managers in the selected hospital need to employ effective conflict management strategies to decrease conflict between nurses.
    - There is a need to develop collaboration between nurses and physicians to create healthier and more productive work environment which positively affect the quality of nursing care.

- Finally, role clarification for nurses and physicians to avoid role ambiguity is essential. Nurse managers must improve their supervisory role, communication, and use justice in the way all nurses are treated to decrease the experience of interpersonal and competitive conflicts among nurses.

- **Nursing practice:**
  - To promote team work/good communication/ mutual collaboration/ inter-professional relationships to prevent and mitigate the role conflict among the health professionals.

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APPENDICES

1. PARTICIPANT INFORMATION SHEET

TITLE: **ROLE CONFLICTS EXPERIENCED BY NURSES AND MIDWIVES AT UNIVERSITY TEACHING HOSPITAL OF KIGALI**

Introduction

I, MANIRAGUHA Beatrice, am a Masters student in Education and Leadership Management at the College of Medicine and Health Sciences/University of Rwanda. I am conducting a study on **Role conflicts experienced by nurses and midwives at University Teaching Hospital of Kigali,** as part of my post-graduate program requirements. I will strive to answer any queries that may arise before and during the course of the intended study.

Purpose of the research

The aim of this study is to assess the Role conflicts experienced by nurses and midwives at University Teaching Hospital of Kigali.

Research intervention

There will be no interventions in this study.

Study participants

All nurses and midwives of CHUK.

Voluntary Participation

Your participation in this research is entirely voluntary. No monetary incentives will be given or asked for participating in this survey. You are free to withdraw from the study at any point during the study without any adverse consequences to you.

Duration

The research is intended to take place over a period of 8 weeks. During that time questionnaires, will be administered to all consenting participants.

Risks and harms

By participating in this research, you will not be exposed to any risk or harm.

Benefits

We do not anticipate direct benefits from the study to the participants however knowledge gathered will be helpful in solving nurse and midwives conflicts in their working place.

Confidentiality

The information that we collect from this research project will be kept confidential. Any information about you will have your initials to which a serial number will be assigned instead of your name.

Whom to Contact

If you have any questions you may ask them now, during the period of the study or even after the study is over. If you wish to ask questions later, please use the contacts below:

MANIRAGUHA Beatrice–0785414493 maniraguhabeatrice@gmail.com / maniraguhabeatrice@yahoo.fr

INFORMED CONSENT FORM

I have read the foregoing information. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I hereby consent to participate in this research.

Serial no. of Participant:……

Date: …….

Statement by the researcher

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Name of Researcher…….

Signature: ……..…. Date: ……

2. LETTRE D'INFORMATION DESTINEE AUX PARTICIPANTS

TITRE : CONFLITS DE ROLES VECUS PAR DES INFIRMIERES ET DES SAGES-FEMMES A L'HOPITAL UNIVERSITAIRE DE KIGALI.

Introduction

Moi, MANIRAGUHA Beatrice, suis étudiante en Maitrise en Sciences Infirmières au Collège de Médecine et des Sciences de la Santé / Université du Rwanda. Je mène une étude sur « CONFLITS DE ROLES VECUS PAR DES INFIRMIER(E)S ET DES SAGES-FEMMES A L'HOPITAL UNIVERSITAIRE DE KIGALI» dans le cadre de l'accomplissement partiel des exigences du Maîtrise en Profession d'Infirmière . Nous nous efforcerons de répondre à toutes les questions qui pourraient se poser avant et pendant l'étude prévue.

But de l'étude

Décrire les types et le niveau de conflits de rôles vécus par les infirmières, ainsi que les stratégies d'atténuation à l'Hôpital Universitaire de Kigali (CHUK).

Intervention de la recherche

Il n'y aura pas d'interventions dans cette étude.

Participants

La population accessible dans cette étude comprendra les 430 infirmièr(e)s et sage-femmes travaillant dans l'hôpital sélectionné au moment de notre étude. (CHUK).

Participation volontaire

Votre participation à cette recherche est entièrement volontaire. Aucune incitation financière ne sera accordée ou demandée pour participer à cette enquête. Vous êtes libre de vous retirer de l'étude à n'importe quel moment de l'étude sans subir de conséquences négatives pour vous.

Durée

La recherche devrait avoir lieu sur une période d'un mois. Pendant ce temps, des questionnaires seront administrés à tous les participants consentants.

Risques et inconvénients

En participant à cette recherche, vous ne serez exposé à aucun risque ou préjudice.

Avantages

Nous ne prévoyons pas d'avantages directs de l'étude pour les participants, mais les connaissances recueillies seront utiles pour améliorer le travail d'équipe. Les résultats de l'étude seront présentés aux infirmiers du CHUK utilisés pour faire des recommandations sur la prévention et résolution des conflits parmi les infirmiers et les sages-femmes.

Confidentialité

Les informations que nous recueillons sur ce projet de recherche resteront confidentielles. Toute information à votre sujet aura vos initiales auxquelles un numéro de série sera attribué à la place de votre nom.

Contact

Si vous avez des questions, vous pouvez les poser maintenant, pendant la période de l'étude ou même après la fin de l'étude. Si vous souhaitez poser des questions plus tard, veuillez utiliser les contacts ci-dessous :

MANIRAGUHA Beatrice (Étudiante) –0785414493. maniraguhabeatrice@gmail.com / maniraguhabeatrice@yahoo.fr

FORMULAIRE DE CONSENTEMENT INFORME

J'ai lu les informations précédentes. J'ai eu l'occasion de poser des questions à ce sujet et toutes les questions que j'ai posées ont été répondues à ma satisfaction. Je consens par la présente à participer à cette recherche.

Numéro de série du participant : .....

Date: …….

Déclaration du chercheur

Je confirme que le participant a eu l'occasion de poser des questions sur l'étude et que toutes les questions posées par le participant ont été répondues correctement et au mieux de mes capacités. Je confirme que l'individu n'a pas été contraint à donner son consentement et que le consentement a été donné librement et volontairement.

Nom du chercheur .....

Signature : ……..….

3. DATA COLLECTION TOOL

Section I: Demographic data

1. Age (in years) ……..
2. Sexe: a) Male b) Female
3. Department:

Critical care General Ward Outpatient clinic

4. Work experience

a) 0–5 years

b) More than years

5. level of education

Advanced diploma Bachelor's degree Masters degree

II. Nursing conflict Scale

Items **(Types of Conflict)**	**No (0)**	**Sometimes (1)**	**Yes (2)**
Disruptive (5 items)			
1. I can satisfy all parties during my work.			
2. Always there is disagreement between the physician and me.			
3. There are disagreements between medical and nursing staff.			
4. Physicians always interfere in the nursing decisions.			
5. There is wrong concept about nursing in the hospital.			
Interpersonal (7 items)			
6. I feel that my job is not necessary to others.			
7. I do my best to take my colleague's work.			
8. I feel uneasy to work with my colleagues.			
9. I revenge medical staff when there is a disparity with them.			
10. I do not feel safe during my work with other personnel.			
11. There is unfair incentives distribution among nurses.			
12. There is disagreement among the nursing personnel.			

Intrapersonal (6 items)			
13. I can accept to work without resources.			
14. I am dissatisfied with my work.			
15. I work without desire.			
16. I will change my job when there is chance to do this.			
17. I want to change my job but I cannot.			
18. I am not motivated to work because of the hospital's policies.			
Intergroup (6 items)			
19. I do not cooperate with the nursing personnel.			
20. There is no congruency between the nursing personnel and other personnel in the hospital.			
21. There is no problem-solving meetings.			
22. Objectives of the nursing department are not clear.			
23. There is no system to exchange information among the nursing			
24. There are disagreements in the nursing decisions while doing			
Intragroup (6 items)			
25. I work with diverse nursing personnel.			
26. My work is accepted by some personnel and unaccepted by others.			
27. To agree with some colleagues I must disagree with others.			
28. I consider myself in continuous race with my colleagues.			
29. Medical staff always does not respect the nursing job.			
30. There are differences in interpretation of nursing policies			
Competitive (6 items)			
31. Policies must be clear before implementing my responsibilities.			
32. I compete with my colleagues to be entrusted by my supervisors.			
33. There is always unresolved competition for staff development			
34. I compete to be included in staff development activities.			
35. I compete with my colleagues to do distinguished work.			
36. I fear punishment so I work well.			

Adopted from: El-shimy, Abdel El-Megid, and Mohamed (2002)

III. Conflict management

Directions: Answer the questions by indicating how you would behave rather than how you think you should behave. Each question provides a strategy for dealing with a conflict.

Rate each statement on a scale of 1 to 4.

Item **(Conflict resolution Strategies)**	**Rarely** **(1)**	**Sometimes** **(2)**	**Often** **(3)**	**Always** **(4)**
Accommodating				
1. I explore issues with others to find solutions that meet everyone's needs.				
2. When there is a disagreement, I gather as much information as I can to keep the lines of communication open.				
3. I try to see conflicts from both sides. What do I need? What does the other person need? What are the issues involved?				
Competing .				
4. I generally argue my case and insist on the merits of my point of view.				
5. I find conflicts challenging and exhilarating. I enjoy the battle of wits that usually follows				
6. I can figure out what needs to be done and I am usually right				
Avoiding				
7. When I find myself in an argument, I usually say very little and try to leave as soon as possible				

8. Being at odds with other people makes me feel uncomfortable and anxious				
9. I avoid hard feelings by keeping my disagreements with others to myself				
Collaborating				
10. I try to meet the expectations of others				
11. I try to accommodate the wishes of my friends and family				
12. I may not get what I want, but it is a small price to pay for keeping the peace				
Compromising				
13. I try to negotiate and adopt a "give-and-take" approach to problem situations.				
14. I prefer to compromise when solving problems and just move on				
15. To break deadlocks, I would meet people halfway				

3. OUTIL DE COLLECTE DES DONNEES

ETUDE SUR LES CONFLITS DE ROLES VECUS PAR DES INFIRMIERES ET DES SAGES-FEMMES A L'HOPITAL UNIVERSITAIRE DE KIGALI.

Section I: Données démographiques

1. Age (en années) .....
2. Sexe : a) Masculin ... .. b) Féminin.
3. Département:

Soins intensifs Salle des Soins Soins ambulatoires

4. L'expérience professionnelle

a) 0–5 ans

b) Plus de 5 ans **5. Niveau d'études**

Diplôme d'études supérieures (A1) Baccalauréat Maitrise

II. Échelle des conflits infirmiers

Articles **(Types des Conflits)**	**Non (0)**	**Parfois (1)**	**Oui (2)**
Perturbateur (5 items)			
1 .Je peux satisfaire toutes les parties pendant mon travail.			
2 Il y a toujours un désaccord entre le médecin et moi.			
3 Il y a des désaccords entre le personnel médical et infirmier.			
4 Les médecins interviennent toujours dans les décisions			
5 La conception d'infirmière à l'hôpital est erroné.			
Interpersonnelle (7 items)			
6 Je pense que mon travail n'est pas nécessaire pour les autres.			
7 Je fais de mon mieux pour prendre le travail de mon collègue.			
8 Je me sens mal à l'aise de travailler avec mes collègues.			
9 Je venger le personnel médical quand il y a une disparité avec			
10 Je ne me sens pas en sécurité lorsque je travaille avec d'autres			
11 Il y a une répartition incitative injuste parmi les infirmières.			
12 Le personnel infirmier est en désaccord.			
Intrapersonnel (6 items)			
13 Je peux accepter de travailler sans ressources.			
14 Je ne suis pas satisfait de mon travail.			
15 Je travaille sans désir.			
16 Je changerai de travail quand il y aura une chance de le faire.			
17 Je veux changer de travail mais je ne peux pas.			
18 Je ne suis pas motivé à travailler en raison des politiques de			
Intergroupe (6 items)			

19	Je ne coopère pas avec le personnel infirmier.			
20	Il n'y a pas de convergence entre le personnel infirmier et les autres membres du personnel de l'hôpital.			
21	Il n'y a pas de réunions de résolution de problèmes.			
22	Les objectifs du service infirmier ne sont pas clairs.			
23	Il n'existe aucun système d'échange d'informations entre le personnel infirmier.			
24	Les décisions relatives aux soins infirmiers divergent lors des			
Intragroupe (6 items)				
25	Je travaille avec divers membres du personnel infirmier.			
26	Mon travail est accepté par certains membres du personnel et non accepté par d'autres.			
27	Pour être d'accord avec certains collègues, je dois être en désaccord avec d'autres.			
28	Je me considère en course continue avec mes collègues.			
29	Le personnel médical ne respecte toujours pas le travail			
30	Il existe des différences d'interprétation des politiques			
Compétitif (6 items)				
31	Les politiques doivent être claires avant de mettre en œuvre			
32	Je suis en concurrence avec mes collègues pour être confié			
33	Il y a toujours une concurrence non résolue pour les activités			
34	Je suis en compétition pour participer aux activités de			
35	Je suis en concurrence avec mes collègues pour faire un			
36	Je crains la punition alors je travaille bien.			

Adopté: El-shimy, Abdel El-Megid, and Mohamed (2002)

La gestion des conflits

Instructions: Répondez aux questions en indiquant comment vous vous comporteriez plutôt que de la manière dont vous pensez que vous devriez vous comporter. Chaque question fournit une stratégie pour traiter un conflit. Évaluez chaque énoncé sur une échelle de 1 à 4.

Article **Stratégies pour résoudre les Conflits**	**Rarement** **(1)**	**Parfois** **(2)**	**Souvent** **(3)**	**Toujours** **(4)**
Accommodation.				
1. J'explore les problèmes avec d'autres pour trouver des solutions qui répondent				

aux besoins de chacun.				
2. En cas de désaccord, je recueille autant d'informations que possible pour garder les lignes de communication ouvertes.				
3. J'essaie de voir les conflits des deux côtés. De quoi ai-je besoin? De quoi l'autre personne a-t-elle besoin? Quels sont les problèmes impliqués?				
compétions				
4. Je plaide généralement mon cas et insiste sur le bien-fondé de mon point de vue.				
5. Je trouve les conflits difficiles et exaltants. J'aime la bataille des esprits qui suit habituellement				
6. Je peux comprendre ce qui doit être fait et j'ai généralement raison				
Eviter				
7. Quand je me trouve dans une dispute, je dis généralement très peu et j'essaie de partir le plus tôt possible				
8. Être en conflit avec d'autres personnes me met mal à l'aise et inquiète				
9. J'évite les rancunes en gardant mes désaccords avec les autres pour moi seul				

Collaboration				
10. J'essaie de répondre aux attentes des autres				
11. J'essaie de satisfaire les souhaits de mes amis et de ma famille				
12. Je ne peux pas obtenir ce que je veux, mais c'est un petit prix à payer pour maintenir la paix				
Compromis				
13. J'essaie de négocier et d'adopter une approche «donner et prendre» aux situations problématiques.				
14. Je préfère faire des compromis pour résoudre les problèmes et passer à autre chose				
15.Pour sortir des impasses, je rencontrais des gens à mi-chemin.				

Work plan

Months/ Activities	**Oct-17**	**Dec-17**	**Jan-18**	**Jun-18**	Nov-18	**18-Dec**	**19-Jan**	**19-Feb**	**19-Mar**	**Apr-19**
Preparation of research proposal	X	X	X	X	**X**	**X**				
Defense of research proposal						**X**				
Ethical clearence						**X**	**X**			
Correction of defended research proposal							**X**	**x**	**X**	
Field work							**X**	**X**	**X**	
Data coding								**X**	X	**X**
Data Analysis									**X**	**X**
Presentation of findings									**X**	**x**
Correction of findings										**x**
Final report										**X**

DETAILED BUDGET

N^{o}	**Description of items**	**Units**	**Quantity**	**Unit price**	**Total price**
1	Paper	Ream	2	4,000	8,000
2	Pens	Bics	50	100	5,000
3	**Typing**	**Page**	**100**	**500**	50,000
4	Printing	Page	100	50	5,000
5	Bindings	Books	12	500	6,000
Sub-Total					**74,000**
6	Lunch	Time	50	2,000	100,000
7	Drinks	Water	100	300	30,000
8	Transport	Time	20	5,000	100,000
Sub- Total					**230,000**
COMMUNICATION					
9	Airtime	Cards	4	5,000	20,000
10	Internet	Hours	300	400	120,000
Sub-Total					**36 5,000**

Data analysis expert					
Data coding	**Questionnaire**	1	**100000**	**0,000**	**10**
Data analysis		1	**300000**	**0,000**	**30**
Data discussion		1	**150000**	**0,000**	**15**
				0,000	**55**
Sub total					
TOTAL				**1,219,000**	