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Original Research Article

Conflict Resolution Strategies among Surgical Team Members in a Nigerian Tertiary Health Institution

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Abstract: This study assessed conflict resolution strategies among surgical team of Obafemi Awolowo University Teaching Hospitals Complex Ile-Ife, Nigeria. This study adopted descriptive cross- sectional design. Purposive sampling was adopted to select 155 respondents. Data were collected with a structured questionnaire and were analysed using the SPSS version 25 while descriptive and inferential techniques were used to present the data at a statistically significant level of $p > 0.05$. Findings revealed that more than 1/3rd of the respondents explore issues with one another, some resolve conflict by negotiating and adopting a "give-and-take" approach to situations, some by meeting the expectations of other team members, few generally argue their case and insist on the merits of their points, while some figure out what needs to be done and they avoid hard feelings by keeping disagreements with other members. The study concluded that conflict occur in the operating theatre and often due to competition, unhealthy rivalry and incursion into another professional role, Inadequate Communication, Excessive Work Stress, etc.

Keywords: Conflict; Resolution Strategies; Surgical; Team Members; Nigeria; Health Institution.

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INTRODUCTION

Conflict exists in every organization where people interact and work together (Pitsillidou *et al*, 2018) and consequently has become a subject of interest for many researchers (Giannikas, 2014; Rovithis *et al.*, 2017). Meanwhile, many people have defined the term in diverse ways, ranging from violence and akin to war, to a negative experience with poor outcome (Thistlewaite & Jackson, 2014). In general, conflict is a serious state which is often prolonged and arises from incompatibility or divergent interests and values.

Conflict is a global phenomenon and has been part of all dimensions of human existence and functioning (Kelly, as cited in Ayandiran *et al.*, 2015). When poorly managed, catastrophic consequences including major confrontations between the interest parties have been the result. Such devastating outcomes have ranged from mere altercations to full blown wars. There has been no time in human history that there has been no conflict occurring in one geographical location or the other in the world. In the recent past, major armed conflicts have ravaged different regions of the world, from insurgent – driven and civil wars in Algeria, Burma, Columbia, Nigeria and more recently, full scale wars in Afghanistan and Iraq (Mbe, 2009). These conflicts have been fuelled by complex contemporary issues such as the global distribution of goods.

In a similar vein, healthy, conflict – free work environment is a product of complex, harmonious cooperation and partnerships among members within an

organization and across different organizations (Abu Bakar, 2014). Failure to attain the foregoing will result in conflicts. The increasingly common occurrence of conflict within a work space or across different work spaces has drawn keen attention from many researchers (Giannikas, 2014; Rovithis *et al.,* 2017) particularly its constructive or destructive roles in organizational building process (Hill, as cited in Ayandiran *et al.,* 2015).

The health care sector, like other workplace, has had its own fair share of conflict, particularly when all the interest groups fail to harmonize their interests through interdisciplinary collaboration and compromise (Thistlethwaite & Jackson, 2014).

In the highly heterogenous Nigerian health sector, anecdotal evidence has documented the existence of incessant rancour among healthcare professionals with an attendant full-blown conflicts and sometimes industrial dispute, occasioned by failure to adequately address them by all parties involved. Despite the complex, high pressured, and fragile attributes of the Nigerian health sector with an attendant high propensity for conflicts, Ayandiran *et al.,* (2015) observed that only very few enquiries have explored the sensitive concept of conflict within this scope.

In a more specific view, the surgical work space, like other fields within medical practice, has witnessed conflicts. The operating room (OR), on the average, presents four conflicts per surgical procedure (Waal *et al.,* 2014). Most of the conflicts occur between personnel working within the work space, particularly between nurses, operating room staffs, patients and the surgeons. This largely has been blamed on major discrepancy in their perceptions of the term 'collaboration', poorly managed multidisciplinary coordination, poor collaboration, inadequate communication, excessive work stress, unresolved competing priorities, exclusion, threats, and unwarranted criticism at work (Maddinneshat, Hashemi & Tabatabaeichehr, 2017; Jerng *et al.,* 2017; Waal *et al.,* 2014; Patton, 2014; Lee, *et al.,* 2008) with breakdown in communication, taking the largest share of the blame (Lee *et al.,* 2008).

Conflicts, when properly managed, are capable of generating positive outcomes; conversely, poor applications of conflict management techniques can be counterproductive (Alshammari & Dayrit, 2017) and subsequently generate negative impact on the consumers of health care. Within the surgical work space, interpersonal conflicts have been documented to result in dire consequences, ranging from inability to attaining the desired clinical and administrative goals (Al-Hamdan *et al.,* 2016; Mckibben, 2017; Papadopoulou, 2014) and large number of operative and post-operative complications as well as increased chances of patient's mortality (Kirschbaum, McAuliffe & Swanson, 2018; Lee *et al.,* 2008).

Conflicts within the hospital workplace, according to Pitsillidou *et al.,* (2018) have been managed using myriads of techniques, among which include avoidance, negotiation and compromise. However, Alshammari & Dayrit, (2017) after observing the approaches to managing conflict between the nurse managers and staff nurses, posited that avoidance and competitions were the most and least deployed methods respectively.

Similarly, anecdotal observations have yielded that, poorly managed multidisciplinary coordination has resulted in many, often unreported conflicts among members of surgical team in many Nigeria public hospitals; which in some instance, degenerates to the level of suspending or outright cancellation of the planned surgical procedure. Furthermore, unresolved conflict is capable of impairing the expected coordination and team – spirit which are necessary for surgical team effectiveness and overall efficiency. The dearth of publications on conflict resolution within the surgical team unit in Nigeria is the main motivation for the study. In view of the foregoing, this study is necessary to evaluate conflict and its resolution among surgical team in Obafemi Awolowo University Teaching Hospitals complex, Ile-Ife.

MATERIAL AND METHODS

This study adopted a descriptive design to study a cross – section of the entire members of the surgical team working in the Obafemi Awolowo University Teaching Hospital Complex (OAUTHC), Ile-Ife, Osun State. OAUTHC is a Federal healthcare facility, which was established in 1967 by the Government of Federal Republic of Nigeria. The healthcare facility provides primary, secondary and tertiary – level healthcare to the entire Nigerian population, and particularly, those residing in the Oyo, Ondo, Ekiti, Kogi Lagos, Kwara and Edo states, all located in the western region of the country. The facilities also receive referrals from other hospitals within the catchment region of Nigeria. It has a total of 770 beds spaces and 36 dental chairs and over 1300 clinicals and paramedical personnel who are scattered across Ile-Ife (Ife Hospital Unit), Ilesa (Wesley Guild Hospital Unit), and primary and comprehensive health care centres located in Eleyele, Ile Ife, and Imesi-Ile respectively. The facility provides a wide range of specialty medical and nursing care in the Medical, Surgical, Dental and Maternity fields of medical practice. The facility, as one of the tier one federal facilities in Nigeria, participates in training students of medicine, nursing and other paramedical disciplines and therefore, contributes to knowledge through research endeavours.

The operating theatre department of OAUTHC was considered for the study because it houses organized surgical team units over different surgical specialities, which conducts an average of 20 procedures daily.

The study targeted all the members of the surgical team across all the surgical subspecialties within the entire surgical care unit of OAUTHC. This is important to ensure adequate coverage and give enough power to statistical analyses.

The size of the sample used for the study was determined using Kennan's formula. The output yielded 142 respondents. An additional 10% was added to the sample size in order to ameliorate non – response. The final sample size was ascertained to be 156 members of the surgical unit.

The sample was recruited using a quota sampling technique in order to ensure all the strata of the surgical team members were equally represented. Surgical team members, who have worked within the surgical suite and have participated actively in surgical procedures for a minimum of six months, were considered eligible for the study while the unskilled, non – clinical staff and clinical staffs, who have spent less than 6 months working within the surgical team were excluded.

Specialty	**Number**	**Sample**
Perioperative nurses	62	43
Nurse Anaesthetists	9	6
Surgeons	102	71
Physician Anaesthetists	13	9
Theatre attendants	22	15
Anaesthetists attendants	16	11
Total	224	155

The table above revealed the proportionate manner in which the research samples were selected across different surgical subspecialty units.

Data was collected with a structured questionnaire. The questionnaire consists of five sections; The first four sections, labelled A to D were self – developed while the fifth section, labelled section E was an adapted version of the conflict management questionnaire. Section A of the questionnaire collected respondents' sociodemographic data. Also, section B of the questionnaire is a 3 – item section which collected data on the occurrence of conflict among surgical team members on a yes and no scale. Furthermore, section C presents 10 items which collected data on the factors responsible for conflicts in the operating room on a yes or no scale. Also, the fourth section contains 9 items which elicited data on the consequences of conflicts among surgical team members on a 5 – point likert-like scale, ranging from strongly disagree through undecided to strongly agree. Finally, the fifth section contains 14 items which collected data conflict resolution methods among team members using a 4 – point semantic differential scale namely rarely, sometimes, often and always.

The instrument was scrutinised by experts in the fields of human resource and conflict management, clinical nurses and Doctors as well as statisticians in order to ascertain the face and content validity of the instrument. Furthermore, the instrument was pilot tested in among 10 proportionately selected members of the surgical team working at Ladoke Akintola University of Technology Teaching Hospital in Osogbo, using a test – retest method. This was used to fine – tune the contents of the instrument. Moreover, the responses elicited were analysed and Cronbach's alpha based on standardized test items was determined to determine its reliability. The overall Cronbach α coefficient of the instrument yielded 0.83, and the instrument was therefore adjudged reliable.

Ethical permission to conduct the study was obtained from the Ethics and Research Committee of a teaching hospital in Nigeria with protocol number of ERC/2020/02/18. In addition, a letter of introduction and permission to collect data were collected from the Department of Nursing Science of the Obafemi Awolowo University, Ile-Ife. The foregoing letters were presented to the Surgical Unit heads and each willing respondent as part of the process of obtaining their informed consent. This was complemented with a thorough explanation of the purpose of the study to them. Also, all the respondents' data collected during the study were kept confidential and anonymous. The respondents were subsequently recruited voluntarily into the study without coercion.

Following expression of interest to participate in the study, each respondent was directly given the questionnaire to complete during visits to the surgical suit. This was also sequel to obtaining permissions from the leaders of the surgical unit and personal interaction between the researcher and the intended research participant. Most of the selected participants completed the questionnaire within 2 – 5 minutes, after which it was retrieved and checked whether it was properly completed. After satisfying this, the questionnaire was assigned a unique numerical code and a tag bearing the code was given to the surveyed respondent to keep. This is in order to guide against repeated surveying of one person during subsequent visits to the unit. The surgical unit was visited four times in one month until the projected sample size for each specialty was attained.

The spreadsheet was exported into Statistical package for social sciences (SPSS), version 25.0 and was subsequently cleaned. The clean data was then plotted using a box plot and histogram to determine their distribution patterns. Descriptive analyses of the

respondents' sociodemographic data, Occurrence of Conflict among Surgical Team Members, Factors Responsible for Conflict in the Operating Room, consequences of conflicts and conflict management methods were presented with frequency distribution tables, percentages, measures of central tendency and pie chart. Furthermore, the inferential statistics was done at a statistical significance of ≥ 0.05.

RESULTS

Table-1 Socio-demographic Characteristics of Respondents

Variables	Frequency N= 155	Percentage (%)
Age: Mean = 35.49 ± 7.55		
20-29	31	20.0
30-39	78	50.3
40-49	36	23.2
50 and above	10	6.5
Gender		
Male	77	49.7
Female	78	50.3
Religion		
Christian	99	63.9
Muslim	53	34.2
Other	3	1.9
Marital status		
Single	34	21.9
Married	112	72.3
Divorced	7	4.5
Widow	2	1.3
Education		
BNSc	56	36.2
Diploma Nursing qualification	54	34.8
MBBS	45	29.0
Status of employment		
Permanent appointment	96	61.9
Temporary appointment	59	38.1

The table above reveals the socio-demographic distribution of the respondents. The average age of the respondents was 35.49±7.55 years and most of them (40.0%) were aged between 30 – 39 years. Furthermore, just above half of them were of the female gender (50.3%) when compared to the male gender. Also, most of them practised the Christian faith (63.9%); were married (72.3%); belonged to the nursing profession (71%) and had a permanent employment with the research setting (61.9%).

Table-2: Occurrence of Conflict among Surgical Team Members

Variables	Frequency	Percentage
Have you at any point been involved in conflict with any of the surgical team members in the past		
Yes	104	67.1
No	51	32.9
If yes, how many times have you been involved in conflict situation with any of the team members in the last 12 months		
1	6	3.8
2	16	10.3
3	11	7.0
Above 3	71	45.8
How often do you think conflict occur among team members in the operating room?		
Rarely	22	14.2
Sometimes	79	51.0
Often	43	27.7
Always	11	7.1

The table 2 above showed the incidence of occurrence of conflict among surgical team member. Majority (67.1%) of the respondents reported that they had had personal conflict with any member of the surgical team member in the past. In the same vein, more than one third (45.8%) had involved in the conflict situation more than 3 times and just above half of the respondents (51.0%) reported that interpersonal conflict occurs sometimes among team members in the operating room.

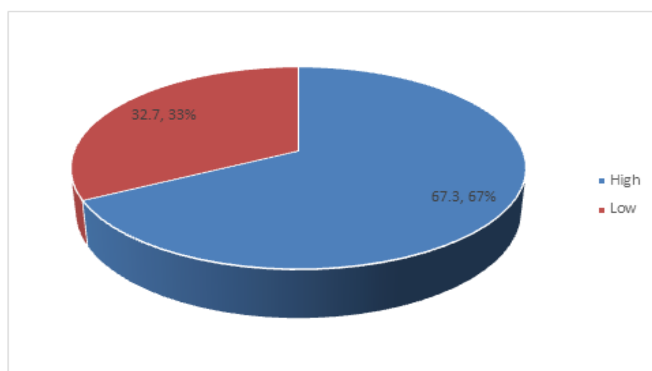

Fig-1: Summary of rate of Occurrence of Conflict among Surgical Team Members

The figure 1 above presents the summary of respondents' views on the occurrence of conflict among surgical team members. Majority of them (67.3%) rated the rate of conflict among surgical team members as high while the remaining 32.7% rated this low.

Table-3: Factors Responsible for Conflict in the Operating Room

Variables	Yes	No	Mean±SD	Rank
High handedness on the part of team members	103(66.5)	52(33.5)	1.27±0.44	1
Competition for Leadership	107(69.0)	48(31.0)	1.25±0.43	2
Unhealthy Rivalry	109(70.3)	46(29.7)	1.24±0.43	3
Incursion into Somebody else professional role	115(74.2)	40(25.8)	1.20±0.39	4
Role ambiguity and Confusion	114(73.5)	41(26.5)	1.20±0.39	4
Insufficient Resources	119(76.8)	36(23.2)	1.20±0.39	4
Unsolicited Interference to another Team member's duty	118(76.1)	37(23.9)	1.17±0.37	5
Inadequate Communication	129(83.2)	26(16.8)	1.12±0.32	6
Excessive Work Stress	129(83.2)	26(16.8)	1.11±0.31	7
Enormous Workloads	128(82.6)	27(17.4)	1.11±0.31	7

The table 3 above showed the factors perceived to be responsible for conflict in the operating room. Majority of the respondents blamed the occurrence of interpersonal conflicts between members of the surgical team on inadequate communication (83.2%); unhealthy rivalry (70.3%); competition for leadership (69.0%); high handedness on the part of team members (66.5%); incursion into Somebody else professional role (74.2%); excessive work stress (83.2%); enormous workloads (82.6%); role ambiguity and Confusion (73.5%); and insufficient resources can be factors responsible in operating (76.8%).

Table-4: Perceived Consequences of Interpersonal Conflicts among members of the Surgical Team in the Operation Room

Variables	Yes	No
Staff – related consequences		
Increase Stress among Team Members	138(89.0)	17(11)
Less Job Satisfaction	121(78.1)	34(21.9)
Decrease Job Commitment	120(77.4)	35(22.6)
Higher Level of Staff Burn out	116(74.8)	39(25.2)
Higher rate of Surgical and Medical Errors	122(78.7)	33(21.3)
Patient – related consequences		
Low Quality of Patient Care	128(82.6)	27(17.4)
Increase intra and post-operative Complications	125(80.6)	30(19.4)
Increase Patient's Morbidity and Mortality	105(67.7)	50(32.3)
Increase Cost of Care	91(58.7)	64(41.3)

The table 4 above presents the perceived consequences of conflict among members of the surgical team in the operation room on the staff and patients. On the order of magnitude, more than the 70th percentile of the respondents reported that conflicts among members of the surgical team can result in staff related consequences such as increased stress among team members (89%); low job satisfaction (78.1%) and Commitment (77.4%) as well as high levels of burnout experiences (74.8%). Furthermore, the highlighted patient related complications include low quality care (82.6%); increased chances of peri-operative complications (80.6%); patients' morbidity and mortality (67.7%) as well as increased cost of care (58.7%).

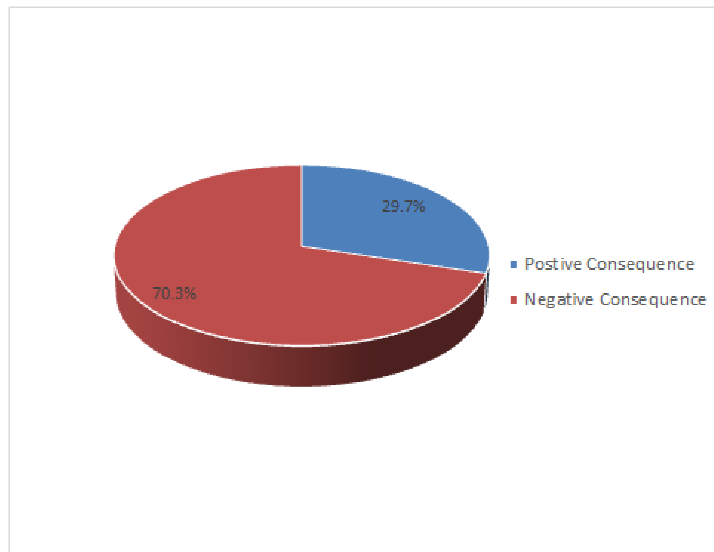

Fig-II: Summary of Perceived Consequences of Interpersonal Conflicts among members of the surgical team in the operation room

The figure 2 above presents the summary of respondents' perceived consequences of conflict among surgical team members. The figure revealed that, majority of the respondents (70.3%) rated the consequences of interpersonal conflicts to be negative.

Table-5: **Conflict Resolution Methods deployed by the study respondents**

Variables	Rarely	Sometimes	Often	Always
I avoid hard feelings by keeping my disagreements with other team members	18 (11.6)	52 (33.5)	51(32.9)	34(21.9)
I try to see conflicts from both sides. What do I need? What does the other person need? What are the issues involved?	15 (9.7)	56 (36.1)	55(35.5)	29(18.7)
I try to accommodate the wishes of my other team members.	27 (17.4)	44 (28.4)	44(28.4)	40(25.8)
When there is a disagreement, I gather as much information as I can to keep the lines of communication open.	18 (11.6)	54 (34.8)	57(36.8)	26(16.8)
When I find myself in an argument, I usually say very little and try to leave as soon as possible.	20 (12.9)	64 (41.3)	44(28.4)	27(17.4)
I can figure out what needs to be done and I am usually right.	17 (11.0)	65 (41.9)	47(30.3)	26(16.8)
I explore issues with others to find solutions that meet everyone's needs.	28 (18.1)	54 (34.8)	46(29.7)	27(17.4)
I may not get what I want, but it is a small price to pay for keeping the peace.	18 (11.6)	73 (47.1)	45(29.0)	19(12.3)
I try to negotiate and adopt a "give-and-take" approach to problem situations.	40 (25.8)	50 (32.3)	44(28.4)	21(13.5)
I try to meet the expectations of other team members.	39 (25.2)	61 (39.4)	42(27.1)	13(8.4)
I find conflicts challenging and exhilarating. I enjoy the battle of wits that usually follows	52 (33.5)	63 (40.6)	28(18.1)	12(7.7)
I generally argue my case and insist on the merits of my point of view.	56 (36.1)	59 (38.1)	30(19.4)	10(6.5)
Being at odds with other team members makes me feel uncomfortable and anxious.	96 (61.9)	33 (21.3)	16(10.3)	10(6.5)

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The table 5 above revealed conflict resolution methods deployed by the study respondents. More than one third (34.8%) of the respondents said sometime they explore issues with others to find solutions that meet everyone's needs in order to resolved conflict, 32.3% said sometime they resolve conflict by negotiate and adopt a "give-and-take" approach to problem situations, 39.4% said sometime they resolve conflict by meet the expectations of other team members, 38.1% said sometimes generally argue my case and insist on the merits of my point of view, 41.3% said sometimes when they find themselves in an argument, I usually say very little and try to leave as soon as possible while 41.9% said sometime they figure out what out what needs to be done and 33.5% said that sometime they avoid hard feelings by keeping my disagreements with other team members.

Hypotheses Testing

Hypothesis one: There is no relationship between occurrence of conflict in the Operating room of OAUTHC and Gender of the surgical team members.

Table-5: Chi-square test showing the association between occurrence of conflict in the Operating room of OAUTHC and Gender of the surgical team members

Occurrence of conflict	Gender		χ^2	*p-value*
	Male	Female		
Rarely	5(22.7)	17(77.3)	8.931	0.030
Sometimes	38(49.4)	39(50.6)		
Often	26(61.9)	16(38.1)		
Always	5(45.5)	6(54.5)		

χ^2= 8.931 *df*= 3 *p-value*>0.030

Table 5 above shows chi-square to test the significant association between occurrence of conflict in the Operating room of OAUTHC and Gender of the surgical team members. The chi-square derived a value of 8.931, a degree of freedom of 3 and a significant value of 0.030. The sig. value is lesser than critical value of 0.05. Thus, there was significant association between occurrence of conflict in the Operating room of OAUTHC and Gender of the surgical team members. Thus, large proportion of the male agreed that conflict occur often time.

Hypothesis Two: There is no significant difference between male and female on conflict resolution. This hypothesis was tested using an independent t-test to compare the mean difference.

Table-6: Showing the difference of means in the conflict of resolution between male and female

Conflict resolution	Group	N	Mean	t	df	Sig.
Conflict resolution	Female Male	78 77	11.38±2.10 10.85±2.01	4.02	153	0.03

*p-value<0.05

An independent sample t-test was conducted to compare the conflict resolution scores for male and females. There was significant difference in score for female {M = 11.38, *SD* = 2.10} and male {M= 10.85, *SD* =2.01; t (153) =4.02, *p* =.03, two tailed). Thus, the male respondents resolve conflict well than their counterpart female.

Hypothesis Three: There is no significant difference between conflict resolution strategy and members of surgical team.

Conflict Resolution	Sum of Square	df	Mean Square	F	Sig
Between groups	526.178	5	105.236	2.04	0.07
Within groups	7687.718	150	51.595		
Total	8213.897	155			

A one-way anova test was conducted to determine the difference in conflict resolution strategies across specialties within surgical team. There was no significant difference between conflict resolution strategies across specialties in surgical team (*p* =0.07).

DISCUSSION OF FINDINGS

This study provides explanation of the results presented in the previous chapter in relation to existing literatures. It discusses knowledge of individualized care among patient and care givers in selected general hospitals in Lagos.

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Predominantly, the study had more female health worker as respondents than male respondents. Large proportion were diploma holder, more than half of the respondents were permanent worker in the institution. This was similar with the study conducted in Pennsylvania teaching hospital, Philadelphia by Patton, 2014 were large number of their respondents were nurses and tertiary holder which is contrary a bit to this present study. Consistent with a quantitative correlational study conducted by Higazee (2015) in private and government hospitals in Jordan in his findings majority of participant were within the mean age of 34.54+5.46 and more of female participated in the study. The study also showed that there was significant association between occurrence of conflict in the Operating room of OAUTHC and Gender of the surgical team members.

The study revealed that majority of the study subject were involved in conflict with surgical team member in the past while more than one third had involved in the conflict situation. However, slightly above half of the study subject sometimes had conflict among team members in the operating room. This finding was similar with Waal *et al*., (2014) who revealed that an average of four conflicts erupts per Surgical Procedure. Also, Ayandiran *et al*., (2015) reported that they also found out that conflict is fairly rampant among health care professionals. As a matter of facts, it was discovered that health care professionals had been involved in conflict situation at one point or the other in the course of delivery of health care service. In contrast Todorova & Mihaylova-Alakidi (2009) in their study declared that mutual activity between colleagues with different specialties and status and patients is prerequisite for occurrence of conflicts.

The study identified High handedness on the part of team members, competition, unhealthy rivalry, incursion into somebody else professional role, role ambiguity and confusion, insufficient resources, Unsolicited Interference to another Team member's duty, Inadequate Communication, Excessive Work Stress and Enormous Workloads. However, Chipps *et al.,* 2013 identified factors like Complexity of the health care in relation to time pressure, critical life and death decisions, unmet expectation from peers and enormous workloads contribute to conflict. The result of this study showed that health care organization is very complex characterized by numerous intricate, interdependent relationships. Alshammari & Dayrit, 2017 also reported something similar by identifying common conflict in health care organization were competition between professionals, disparities in economic and professional values among members of the health care team; limited resources, change, lack of clearly define roles and expectations, capacity to function as team, interpersonal communication skills and varied expectations related to level of performance of the different roles of nurses.

The study indicated a substantial number of the participants who indicate that the consequences of conflict may have adverse effect on the patients. The result of the study pointed to the following consequences of conflict: Low Quality of Patient Care; Higher rate of Surgical and Medical Errors; Increase Patient's Morbidity and Mortality; Increase intra and post-operative Complications**;** Increase Stress among Team Members**;** Higher Level of Staff Burnout and Increase Cost of Care**.** A similar study by Waal, *et al.,* (2014), reported that conflict cause errors that increase patients' morbidity and mortality, hazardous to the wellbeing of the patients and to their care teams. The result of this study was in accordance with Thistleth, *et al.,* (2014) study which report that its study subjects believe Inter and intra-professional conflict affects patient safety and outcomes, as well as having detrimental effects on staff morale and on physical and mental health.

The result of the study pointed to the following conflict resolution methods: they explore issues with others to find solutions that meet everyone's needs; they try to negotiate and adopt a "give-and-take" approach to problem situations; they try to meet the expectations of other team members; they generally argue my case and insist on the merits of my point of view; When there is a disagreement, they gather as much information as they can to keep the lines of communication open; When they find themselves in an argument, they usually say very little and try to leave as soon as possible; they try to see conflicts from both sides. What do I need? What does the other person need? What are the issues involved? They find conflicts challenging and exhilarating. They enjoy the battle of wits that usually follows among others. However, Shah (2017) reported that there are many strategies to resolve conflict effectively to minimize its negative impacts Similarly, Thomas & Kilmann, (2010) reported that avoidance, accommodating, compromising, and competition and collaboration techniques will help in resolving conflict which was synonymous to these study findings.

CONCLUSION

This study concluded that there is a significant association between occurrence of conflict in the Operating room of OAUTHC and Gender of the surgical team members. High handedness on the part of team members, competition, unhealthy rivalry, incursion into somebody else professional role, role ambiguity and confusion, insufficient resources, Unsolicited Interference to another Team member's duty, Inadequate Communication, Excessive Work Stress and Enormous Workloads are factors responsible for conflict in the operating room which needs to be resolved through exploring issues with others to find solutions that meet everyone's needs likewise trying to negotiate and adopt a "give-and-take" approach to problem situations or trying to meet the expectations of other team members. Inclusively, generally arguing of

cases and insisting on the merits of my point of view among others cited in the study.

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