Conflict Management and Service Delivery in the Health Sector: A Case Study of University of Benin Teaching Hospital (UBTH)

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Abstract

Conflict is inimical to organization but could be an important tool for improving the quality of service delivery in health sector in Nigeria if properly managed. This study examined conflict management and service delivery in University of Benin Teaching Hospital (UBTH). The study employed the survey research design on the bases of which data were sourced from targeted medical workers. Simple percentage and criterion mean statistical instruments were utilized for the analysis of data. The findings revealed that there is a relationship between the modes of communication among clinical workers and quality health care service delivery in UBTH. Secondly, the results indicated there is relationship between unhealthy rivalries among medical workers and quality health care service delivery in UBTH. The findings also showed that there is relationship between the attitude (preferential treatment/ favouritism) of medical workers and quality health care delivery to patients in UBTH. It further showed that pattern and timing of remuneration has influence on the quality of health care service delivery in UBTH. Based on the findings, it therefore recommended that poor communication among UBTH clinical workers should be addressed by the management in order to avoid conflict among medical workers. Also, the management should reward clinical workers according to their professional commitment to avoid unhealthy rivalry. Moreover, management should ensure that all clients received adequate treatment from clinical workers. Furthermore, there should be ultimate payment of remuneration as at when due by the federal government.

Key words: Conflict, Management, Health Care, Service Delivery,

Introduction

The Nigerian health sector is bewildered by several internal challenges especially conflict. Conflict between clinical workers and patients is inimical and could lead to poor health care delivery. Though the negative impact of conflict may be indisputable, but conflict can as well be constructive; providing personal gain; acting as incentive for creativity; and serving as a powerful motivator if well managed effectively within the health sector (Kanter & Pauly, 2019). Management of conflict can provide opportunity for learning among the clinical workers that could promote quality health care service delivery (Kapusuzoglu, 2010). A well-managed conflict in an interdisciplinary team can enhance result oriented service delivery resulting on patient benefitting more from treatment decisions that are a product of careful deliberation and combined expertise (Brinkert, 2010).

However, managing conflict in the workplace is time-consuming but necessary task for the physician leader. Conflicts may exist between physicians, between physicians and staff, and between the staff or the health care team and the patient or patient's family (Ayandiran, Ola, Salami & Agunbiade, 2015). The conflicts may range from disagreements to major controversies that may lead to litigation or violence. Conflicts have an adverse effect on productivity, morale, and patient care, as well as impact negatively on health care service delivery (Kanter & Pauly, 2019).

But there had been measures to manage conflict in health care service delivery in Nigeria. Program for readjustment to better cope and manage conflict transformation, by addressing the root causes are to be tried in strategic measure that can find lasting solution to conflict in health care service delivery (Olajide, Asuzu & Obembe, 2015). Some of these were: promotion of health as human right, protecting the rights of the health workers, safe guarding the neutrality of health facilities, promotion of good governance in health, targeting the poor and marginalized, and social inclusion to balance disparities, and focus on youth (Yazan& Natasha, 2019). In the short and long run it will promote health care service delivery (Guidroz, Wang& Perez, 2012). Improving the enabling environment, by improving emergency preparedness and response by strengthening district hospital, securing supplies, strengthening referral, up-grading communication system, essential infrastructure support and staff detainment incentives were all considered important and hence being tried, thereby enhancing quality health care service delivery (Chan, Bakewell, Orlich& Sherbino, 2014; Madhu, 2005).

There have been concerns about conflict in the health sector and its impact on the healthcare service delivery from the workers (Niiyama, Okamura, Kohama, Taniguchi,

Sounohara& Nagao, 2009). A variety of individual, including doctors, nurses, co-workers, managers and administrative workers might have experienced conflicts. Lack of management of conflicts in health care setting are commonly encountered in most public health care delivery setting, operating rooms and emergency rooms (Katz, 2007). These high-risk health care areas often require intensive patient care, timely decision-making and multidisciplinary coordination among the workers. Unmanaged conflicts in health care setting might be the consequence of poor or negative communication, excessive work stress and unsolved competing priorities of tasks (Lancman, Ma-Angia& Muramoto, 2013). This research will seek to answer the following questions: What are the modes of communication among clinical workers and quality health care service delivery in UBTH?; How does unhealthy rivalry among medical workers affect quality health care service delivery in UBTH?;Does the attitude (preferential treatment/favouritism) of medical workers affect quality health care delivery to patients in UBTH?;Has the pattern and timing of remuneration of health workers affected the quality of health care service delivery in UBTH?;What possible suggestions can help manage conflict in the health sector, particularly UBTH?. The objective of this paper is to examine the mode of communication among clinical workers and health care service delivery in UBTH if it is effective; find out whether there is unhealthy rivalry among medical workers in the health sector; find out how the attitude (preferential treatment/favoritism) of medical workers affects quality health care delivery to patients in UBTH; determine whether the pattern and timing of remuneration affect the quality of health care service delivery in UBTH and to make recommendations on how to effectively manage conflict and subsequently improve the quality of service delivery in the health sector

Hypotheses

This paper adopts the null hypotheses to enable us determine the relationship between the variables stated in the objectives :There is no relationship between the modes of communication among clinical workers and quality health care service delivery in UBTH; There is no relationship between unhealthy rivalries among medical workers and quality health care service delivery in UBTH.; There is no relationship between the attitude (preferential treatment/favoritism) of medical workers and quality health care delivery to patients in UBTH.; The pattern and timing of remuneration does not affect the quality of health care service delivery in UBTH.

Theoretical Discourse

This paper adopts the Conflict transformation theory assumes that conflict is caused by real problems of inequality and injustice expressed by competing social, cultural and economic frameworks (Vayrynen, 1991). The goals of work based on conflict

transformation theory are: i. To change structure and frameworks that cause inequality and injustice, including economic redistribution; ii. To improve longer-term relationships and attitudes among the conflicting parties, iii. To develop processes and systems that promotes empowerment, justice, peace, forgiveness, reconciliation, recognition etc. Spencer and Spencer (1995) recommend that conflict transformation can take the form of change in the political agenda of the conflict, downplaying the importance of original conflicting issues and emphasizing shared concern for new issues. He further said a re-definition of the norms can help those involved what they are expected to observe when dealing with each other. Theoretical literature analyzing conflict management had adapted the term conflict transformation as applied to this study on the basis of resolution/peacemaking with ethical inclination. Conflict transformation,' as opposed to 'conflict resolution (Schrock-Shenk, 2000),' It poses the question whether conflict transformation has truly bring about new theoretical notions on application for practice to make peace and manage conflict, or whether it is in essence simply a reformulation of the term conflict resolution.. However, it is also argued that the term conflict transformation still needs to be defined in more distinctive ways to express an advance resolution of conflict either in an organization or with a group of person, in order to illustrate how it replace the term conflict resolution or exist alongside it (Hans-Jürgen, 1993).

The term conflict transformation has become relatively widely used – in other words, it has been named - but it would not be true to say that its attendant definitions have been universally accepted (Wallensteen, 1991). However, while there is a definite movement of how to make clear distinctions between the terms conflict resolution and conflict transformation, they are still often used interchangeably both in common language usage and in the academic literature. The abundance of different definitions and interpretations of conflict transformation creates semantic difficulties. It underscores the need for clarity regarding this term that is now used as a way to describe, explain and put into operation the work of practitioners and theorists (Paul & Fit-Simmons, 1988).

As a proponent of overlapping definitions, Diamond (1994) defines conflict resolution as activities that "seek to discover, identify and resolve the underlying root causes of the conflict," and conflict transformation as endeavors that "seek to change the conditions that give rise to the underlying root causes of the conflict." According to this distinction, conflict resolution activities are problem-solving or conflict analysis workshops; research, training, and educational programs; inter-group dialogue; reconciliation; and peace-building. Consequently, conflict transformation processes are seen more in terms of nation building, national reconciliation and healing, change agentry, and social transformation. Conflict transformation refers to the process of moving from conflict-habituated systems

to peace systems. This process is distinguished from the more common term of conflict resolution because of its focus on systems change. Social conflicts that are deep-rooted or intractable get these names because the conflict has created patterns that have become part of the social system. With the social system as the unit of analysis, the term "resolution" becomes less appropriate. Transforming deep-rooted conflicts is only partly about "resolving" the issues of the conflict – the central issue is systemic change or transformation. Systems cannot be "resolved," but they can be transformed, thus we use the term conflict transformation (Notter & Diamond, 1996). This study adopts the conflict transformation theory which asserts that there should be systems conflict management that will bring a lasting integration between parties involved.

Conflict management is therefore an integrative approach to conflict resolution, it involves a re-definition of the relationship between the conflict parties through which opportunities are opened and new compensation arrangements are introduced. This can create a framework based on a positive-Sum, rather than a Zero –sum agreement. New cooperative arrangements are initiated in which the previously disputed issues become less or no longer have relevant and other issues or values become more relevant to all parties to the conflict (Schmid, 2000)

Review of Relevant Literature

Ayandiran, Ola, Salami and Agunbiade (2015) examined healthcare professionals' perceptions and attitude to conflict, as well as their experiences of conflict in their day-to-day interaction within the context of teamwork environment. The author adopted a concurrent mixed method design that consisted of structured questionnaire and face-to-face interviews. The study was conducted among six categories of health workers (nurses, doctors, pharmacists, physiotherapists, laboratory scientists, and medical records officers) at the Obafemi AwolowoUniversity Teaching Hospitals Complex (OAUTHC), Ile-Ife. A multi-stage sampling technique was employed to select 150 health professionals for the survey. Six in-depth interviews were also conducted with senior health professionals currently occupying administrative positions at the hospital. The quantitative results showed that certain health occupations/professions are more conflict prone than others. Analysis of the health professionals' responses to statements assessing attitude to conflict showed that a majority (77.3%) had positive attitude. Ayandiran, Ola, Salami and Agunbiade (2015) findings revealed a significant relationship between occupation/specialty and frequency of occurrence of conflict among the healthcare professionals ($F = 3.54$; $P < 0.05$). No significant relationship was found between gender and the occurrence of conflict among the professionals ($F = 0.66$; $P > 0.05$).However, the

qualitative findings inter alia linked conflicts with high handedness, unhealthy rivalry, overzealousness and stepping out of job descriptions by some individuals.

Omisore, Adesoji and Abioye-Kuteyi (2017) examined inter-professional rivalry in Nigeria'shealth sector: A comparison of doctors and other health workers' views at a secondary care center. The study adopted descriptive cross-sectional design comprising of 120 health workers (24 doctors and 96 other health workers) at the State Specialist Hospital, Okitipupa, Ondo State, Nigeria. The study employed the survey administration of semi-structured questionnaire on the basis of which data were sourced from the targeted respondents, the data was analyzed using SPSS version17.0.Omisore, et al., (2017) findings revealed that inter-professional rivalry is perceived to be the leading cause of conflicts among health workers. They found that doctors and other workers had significantly divergent opinions on the leadership of the health team, patient management, establishment positions, and monetary issues as well as on the effects of inter-professional rivalry with more doctors recognizing its hazards. Nearly half of the respondents believe that strikes are justifiable and the most recommended antidote is for the government to attempt to meet group needs.

Alshammari and Dayrit (2017) examined conflict and conflict resolution among the medical and nursing personnel of selected hospitals in Hail City. The study adopted the survey research design using questionnaire as instrument which included respondent demographics, frequency of types of conflict encountered by the respondents at the workplace and the Conflict Self-Assessment test by Hurst that determined conflict resolution strategies was used for data-gathering. The presence of a statistically significant difference was observed in (i) the means at which types of conflict were experienced by the respondents in each hospital; (ii) the conflict resolution strategies utilized by the respondents within KKH and HGH when grouped according to gender; (iii) the conflict resolution strategies utilized by the respondents within HGH when grouped according to profession and age; and (iv) the conflict resolution strategies the respondents between the selected hospitals utilized when grouped according to their demographic profile. Hospital administrators need to implement specific interventions in medical and nursing personnel supervision and management geared toward enhancing conflict resolution and foster teamwork in the workplace at the individual, departmental and organizational levels.

Conceptualization of Conflict

Conflict management can be conceptualized as the methods and processes involved in facilitating the peaceful ending of conflict and retribution. Committed group members attempt to resolve group conflicts by actively communicating information about their

conflicting motives or ideologies to the rest of group (e.g., intentions; reasons for holding certain beliefs) and by engaging in collective negotiation (Forsyth, 2009). Conflict management can be seen as cognitive resolution which is the way disputants understand and view the conflict, with beliefs, perspectives, understandings and attitudes. Emotional resolution is in the way disputants feel about a conflict, the emotional energy. Behavioral resolution is reflective of how the disputants act their behaviour (Mayer, 2012).

Ultimately a wide range of methods and procedures for addressing conflict exist, including negotiation, mediation, mediation-arbitration, diplomacy, and creative peace-building. Healthcare is unique in many ways. Many institutional processes and structures exist that describe the preferred communications pathways for dealing with these events. These structures each depend on people putting aside their personal fears and emotional filters and behaving professionally. These processes also exist independently of each other for the most part. Because each process has a different purpose and" owner," this independence is intentional in many respects. Whether it is due to the structure necessary for applicability of alegally-recognized privilege that protects information from discovery (such as peer review) or the historical separation between quality functions and direct administrative processes, when an event occurs, several independent systems engage which compete for and often limit access to critical information necessary to reduce conflict and to allow the organization to learn and improve.

The term conflict management may also be used interchangeably with dispute resolution, where arbitration and litigation processes are critically involved. The concept of conflict management can be thought to encompass the use of nonviolent resistance measures by conflicted parties in an attempt to promote effective resolution (Roberts & Ash, 2009).

Methodology

The research design adopts a cross-sectional survey to seek the views of the doctors, nurses and patients in University of Benin Teaching Hospital, Edo State, Nigeria. Targeted population of this study comprises all the medical staff in University of Benin Teaching Hospital. The sample size of study is 400, using convenience and purposive sampling techniques from all departments. A sampling fraction of 15% was estimated to the minimum sample size of 400 doctors/nurses and patients to be approached for participation. With each health professional's category as a stratum, proportionate random sampling was employed to select 15% of respondents per stratum. The populations of the study consist of all thirty five (35) departments as stated above in UBTH, employing between the ages of adolescent - 18 years and above.

The study used a combination of stratified sampling and convenience sampling techniques to choose sample of four hundred (400) respondents. The sample is made of four hundred 400 respondents, chosen ten (10) doctors, and ten (10) nurses' each from the 35 different department, were stratified. This was done in order to know the action of different doctors and nurses, using Yaro Yami's estimation for sample size.

The total number of the of 400 medical staffs was chosen (because this study focuses only on medical staffs), using a population sample of approximately 400 of an error limit of 5% sample size. Questionnaire was framed for the doctors, and nurses' to elicit information on several parameters of patients' bill of right. The areas of the questionnaire were same as those of the interview schedule for doctors and nurses. The questionnaire is a proto typed open ended scale based on Strongly Agree, Agree, Strongly Disagree, and Disagree pattern. It is designed to assess the conflict management among medical workers in University of Benin Teaching Hospital, as determined by preferences of the respondents. The purpose of using the knowledge scale is to identify the potential respondents positive and negative knowledge towards professional ethics, guiding conflict management among clinical workers and patients, during health care service delivery as both positive (favorable) as well as negative items will be equally distributed in the scale. The strongly agree=3.50-4.00, Agree = 2.50-3.49, is taking for test of hypotheses. The criterion means value of 2.50 from table. In other words, any item that had mean score of 2.50 and above was accepted while any that had a mean score less than 2.50 was rejected.Data collected in this research were analyzed using simple percentage and frequency tables to facilitate objectivity and clarity.

Results and Discussion

Table 1: What are the modes of communication among clinical workers and quality health care service delivery in UBTH?

S/N	Item Statement	SA	A	D	SD	X	Decision
1.	Communication style can affect health care service delivery in UBTH.	140 (41.18)	125 (37.76)	60 (17.65)	15 (4.40)	3.95	Accept
2.	Improper communication among clinical workers can lead to error that could bring about medical accident.	134 (39.41)	142 (41.76)	46 (13.53)	20 (5.88)	4.06	Accept

3.	Communication in the health sector if not very clear to patients/family could generate strive.	139 (40.88)	129 (37.94)	58 (17.06)	14 (4.12)	3.94	Accept
4.	Informal communication among health workers could be very offensive to patients leading to poor health care service delivery.	135 (39.71)	138 (40.59)	45 (13.23)	40 (11.76)	4.02	Accept
5.	If conflict is not properly managed in clinical wards it could generate poor relation between patients and health workers in UBTH	144 (42.35)	145 (42.65)	41 (12.06)	20 (5.88)	4.25	Accept
Total						4.04	Accept

N=340, Criterion mean = 2.50 aggregate mean = 4.04 (Accept)

From the analysis in table 1, it shows a calculated mean value of 3.57 which is more than criterion 2.50. From this analysis, the mean value is higher than the test value. Therefore, this implies that null hypothesis one is rejected and the alternative accepted which states that there is relationship between the modes of communication among clinical workers and quality health care service delivery in UBTH.

Table 2: How does unhealthy rivalry among medical workers affect quality health care service delivery in UBTH?

S/N	Item Statement	SA	A	D	SD	X	Decision
1.	The disparities between the doctors and nurses salaries and allowances in our hospital are very wide.	125 (36.76)	130 (38.24)	40 (11.76)	45 (13.24)	3.75	Accept
2.	Too much responsibility committed to doctors in terms of leadership	132 (38.82)	122 (35.88)	60 (17.65)	26 (7.65)	3.74	Accept

	could lead to unhealthy rivalry.						
3.	It has been observed that doctors do not stand by their patients but the nurses do.	155 (45.59)	140 (41.18)	30 (8.82)	15 (4.41)		Accept
4.	The remuneration and allowance gap between doctors and nurse is too distinct seeing that nurses spend more time with the patients.	172 (50.89)	98 (28.82)	20 (5.88)	40 (11.76)	3.99	Accept
5.	Unhealthy rivalry could affect the attention given to patients in the ward.	157 (46.18)	100 (29.41)	40 (11.76)	43 (12.65)	3.78	Accept
Total						3.05	Accept

N=340, Criterion mean = 2.50 aggregate mean = 3.05 (Accept)

Table 2 shows that the mean value of 3.05 which is more than criterion value of 2.50 was computed. From this analysis, the mean value is higher than the test value. Therefore, the null hypothesis is rejected and the alternative accepted which states that there is relationship between unhealthy rivalries among medical workers and quality health care service delivery in UBTH.

Table 3: Does the attitude (preferential treatment/favouritism) of medical workers affect quality health care delivery to patients in UBTH?

S/N	Item Statement	SA	A	D	SD	X	Decision
1.	Some of our clinical workers exhibit some element of favouritism in giving attention to patients due to their socioeconomic status.	144 (42.35)	129 (37.94)	30 (8.82)	37 (10.88)	4.02	Accept
2.	There could be preferential treatment among health professional on certain ailment	148 (43.53)	132 (38.82)	40 (11.76)	20 (5.88)	4.11	Accept

3.	Some patients prefer female doctor to male doctors.	110 (32.35)	120 (35.29)	60 (17.65)	50 (14.71)	3.38	Accept
4.	More attention is given to highly political patients than others.	98 (28.82)	125 (36.76)	41 (12.06)	76 (22.35)	3.28	Accept
5.	There should be policy to address partiality among clinical workers and patients	133 (39.12)	140 (41.18)	30 (8.82)	37 (10.88)	4.02	Accept
Total						3.76	Accept

N=340, Criterion mean = 2.50 aggregate mean = 3.76 (Accept)

Table 2 indicates that the mean value of 3.76 which is more than criterion value of 2.50 was computed. From this analysis, the mean value is higher than the test value. Therefore, this result implies that the null hypothesis three is rejected and the alternative accepted which states that there is relationship between the attitude (preferential treatment/favouritism) of medical workers and quality health care delivery to patients in UBTH.

Table 4: Has the pattern and timing of remuneration of health workers affected the quality of health care service delivery in UBTH?

S/N	Item Statement	SA	A	D	SD	X	Decision
1.	Most health administrators may reduce the job satisfaction of clinical workers due to emergency.	127 (37.35)	140 (41.18)	30 (8.82)	43 (12.65)	3.93	Accept
2.	Allowances which are supposed to enhance service delivery could either be delayed or not paid.	130 (38.24)	138 (40.59)	36 (10.59)	36 (10.59)	3.94	Accept
3.	Motivation through regular payment of allowances should be imbibed to enhance health care delivery.	136 (40.00)	142 (41.76)	42 (12.35)	20 (5.88)	4.09	Accept

4.	Staff satisfaction should be an ethical code to promote integrated team work.	157 (46.18)	130 (38.34)	20 (5.88)	23 (6.76)	4.23	Accept
5.	In order to avoid conflict, staff satisfaction and allowances, should be responsive as at when due.	144 (42.35)	136 (40.00)	30 (8.82)	30 (8.82)	4.12	Accept
Total						4.06	Accept

N=340, Criterion mean = 2.50 aggregate mean = 4.06 (Accept)

Table 4 reveals that the mean value of 4.06 which is more than criterion value of 2.50 was computed. From this analysis, the mean value is higher than the test value. Therefore, this result is another display that the null hypothesis four is rejected and the alternative accepted which states that the pattern and timing of remuneration affect the quality of health care service delivery in UBTH.

The result of the analysis demonstrates that the computed mean value of 3.57 which is more than criterion value of 2.50. Since result indicates that the mean value is higher than the test value, the null hypothesis one is rejected and the alternative confirmed which is, there is relationship between the modes of communication among clinical workers and quality health care service delivery in UBTH. This support the findings by Sullivan and Decker (2001) who found conflict to be the root cause of any mishap in quality health care delivery such as medication error, improper communication, lack of respect, delayed care, cultural and religious values, violation.

The result also revealed that the mean value of 3.05 which is more than criterion value of 2.50 is an indication rejection of the null hypothesis two. Therefore, since the tested mean value of 3.05 is lower than the criterion value, hence the null hypothesis is rejected and the alternative accepted which states that there is relationship between unhealthy rivalries among medical workers and quality health care service delivery in UBTH. This findings support the study by Aregbeshola and Decoster (2018) and Omisore, Adesoji and Abioye-Kuteyi (2017) found that inter-professional rivalry is perceived to be the leading cause of conflicts among health workers in Nigeria.

Again, the analysis display that the mean value of 3.76 which is greater than criterion value of 2.50 leading to rejection of hypothesis three. This result indicates that the tested mean value is greater than the test value. Therefore, this result implies that the null hypothesis three is rejected and the alternative accepted which states that there is relationship between the attitude (preferential treatment/favouritism) of medical workers and quality health care delivery to patients in UBTH.This findings support the study by Søren (2011) claim that health care professionals have an independent moral obligation to treat everyone objectively and not to discriminate in favour of anyone. Conversely, Govender and Penn-Kekana (2007)found that clients are discriminatory, marginalizing, abusive and mirroring the social stratifications of society at large.

From the analyses the result shows that the mean value of 4.06 which is greater than criterion value of 2.50. Therefore, since the analysis, show that the tested mean value is greater than the test value. It can be inferred from this result the null hypothesis four is rejected and the alternative accepted which states that the pattern and timing of remuneration affect the quality of health care service delivery in UBTH. This finding corroborate with WHO, (2014) who found that the wages for performance of clinical workers impacts on the development of a culture of performance measurement and monitoring as well as improving providers performance todrive and sustain performance improvement. But contradict the findings by CIHI (2016) who found physician services, fee-for-service remuneration is not tied to quality health service delivery.

Conclusion

From the findings it was observed that improper communication, lack of respect, delayed care, cultural and religious values violation have a direct impact on image of organization, as a result staff turnover and job dissatisfaction are escalated. So it is essential for a nurse leader to identify the causes and sources of conflict, for which the leader should have specific skills to avoid it and improve the quality of patient care. The negative effects of conflict between doctors and nurses in UBTH include modes of communication among clinical workers, unhealthy rivalries among medical workers, the attitude (preferential treatment/favoritism) of medical workers and pattern and timing of remuneration.

The research had empirical investigation determinant of conflict among UBTH clinical workers since there is relationship between the modes of communication among clinical workers and quality health care service delivery in UBTH. This revealed that avoiding and competing were the most and least utilized conflict management style by the respondents, respectively. Communication conflict ranked as the most common type of conflict experienced by the study respondents from the three hospitals surveyed. Numerous

studies conducted on the subject of conflict reveal that interpersonal or professional communication difficulties are the cause of a majority of conflict in the healthcare setting.Conflict comes from preferential treatment exhibited by UBTH clinical workers and this is done as a result of socioeconomic status and ethnic inequality in health care delivery process engender strive among patients and health care service providers, evidence on how to enhance quality of care and reduce inequalities remains limited.

Rivalry among health-care professionals in UBTH was prevalence. There is awareness that professional interests are responsible for conflicts or differences among health workers. Professional interests were placed above class or responsibility-level within the same group of health-care professionals and individual differences between workers.

It was observed from the findings that high-quality health services involve the right care without preferential treatment, at the right time, responding to the service users' needs and preferences, while minimizing harm and resource waste. The findings also revealed that quality health care increases the likelihood of desired health care service delivery outcomes and is consistent with seven measurable characteristics: effectiveness, safety, people-centeredness, timeliness, equity, integration of care and efficiency. Conflict seems to arise from management reduction of staff satisfaction / allowance which hinged on quality health care service delivery the findings demonstrates that health administrators reduce the job satisfaction of clinical workers due to emergency. Allowances which is a performance measure is often delayed or not paid leading to lack of motivation hence, regular payment of allowances should be imbibed to enhance health care delivery. Again, staff satisfaction is not based on ethical code to promote integrated team work.

Recommendations

In order to avoid poor communication among UBTH clinical workers the doctors should cease from applying power and the conflict resolution strategy of competing, due to the still existing notion that doctors take the lead role and that nurses in the team must follow their orders. Unhealthy rivalry can be minimized or eradicated if both the management and government alike seek to reward each clinical worker according to their professional commitment.; Since preferential treatment/favoritism can cause conflict in the ward, clinical workers should exhibit equality among clients as this can influence health care service delivery.; From the findings, pattern and timing of remuneration can influence the quality of health care service delivery in UBTH. There should be ultimate payment of remuneration as at when due by the federal government.

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