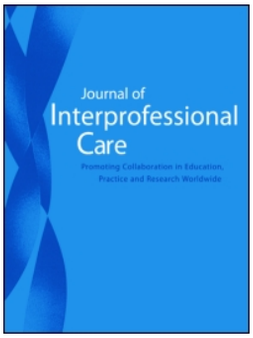

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Individual, interpersonal, and organisational factors of healthcare conflict: A scoping review

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ABSTRACT

Unresolved conflicts among healthcare professionals can lead to difficult patient care consequences. This scoping review examines the current healthcare literature that reported sources and consequences of conflict associated with individual, interpersonal, and organisational factors. We identified 99 articles published between 2001 and 2015 from PubMed, Cumulative Index to Nursing and Allied Health Literature, and Excerpta Medical Database. Most reviewed studies relied on healthcare professionals' perceptions and beliefs associated with conflict sources and consequences, with few studies reporting behavioural or organisational change outcomes. Individual conflict sources included personal traits, such as self-focus, self-esteem, or worldview, as well as individuals' conflict management styles. These conflicts posed threats to one's physical, mental, and emotional health and to one's ability to perform at work. Interpersonal dynamics were hampered by colleagues' uncivil behaviours, such as low degree of support, to more destructive behaviours including bullying or humiliation. Perceptions of disrespectful working environment and weakened team collaboration were the main interpersonal conflict consequences. Organisational conflict sources included ambiguity in professional roles, scope of practice, reporting structure, or workflows, negatively affecting healthcare professionals' job satisfactions and intent to stay. Future inquiries into healthcare conflict research may target the following: shifting from research involving single professions to multiple professions; dissemination of studies via journals that promote interprofessional research; inquiries into the roles of unconscious or implicit bias, or psychological capital (i.e., resilience) in healthcare conflict; and diversification of data sources to include hospital or clinic data with implications for conflict sources.

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Collaboration; communication; conflict; interprofessional relations; scoping review

Introduction

Conflicts arise when goals, expectations, and interests between individuals are perceived to be incompatible (Boulding, 1963). Deutsch (2011) defined conflict as constructive or destructive. Constructive conflict can lead to cognitive benefits such as better judgment, decision making, or understanding of others' positions (Cosier & Dalton, 1990), improved team performance (De Dreu & Weingart, 2003), and stronger team cohesion (Tekleab, Quigley, & Tesluk, 2009). Employees may re-engage with their work after resolving constructive conflict with new learning that promotes performance and positive culture (Pondy, 1967). On the other hand, destructive conflict weakens collaboration, problem solving, and communication among employees (Deutsch, 2011). The Joint Commission, which is an accrediting body of the healthcare organisations in the United States, has called for an honest admission and assessment of the impact of disruptive behaviours, such as verbal outbursts or refusal to perform tasks, on healthcare professionals' and patients' well-being (The Joint Commission, 2008).

What makes healthcare conflict particularly challenging? Healthcare professionals function in what West and Lyubovnikova (2012) termed 'real' teams with interdependent, shared objectives, such as palliative care teams or operating room teams, and 'pseudo' teams with independent objectives. An example of a pseudo team may include an intensive care unit nurse and a hematology-oncology medical fellow. Both care for the same patient but with possibly conflicting goals: keeping the patient stable (nurse) versus pursuing an aggressive curative treatment (medical fellow). The goals pursued by real and pseudo teams, coupled with the acuity of patient status, resource availability, patient preferences, and hierarchy in decision making, can create conflicting interests among healthcare professionals.

The scoping literature review presented in this article addresses the following research question: what are the main individual, interpersonal, and organisational sources and consequences of conflicts that occur among healthcare

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professionals during patient care? The premise of the current review is grounded in the complex and multidimensional nature of workplace conflict in healthcare. Following the recommended scoping review protocols (Levac, Colquhoun, & O'Brien, 2010), the current study builds upon a previously reported structured interview study that involved healthcare professionals and patients (Kim et al., 2016). Key themes identified from 156 narratives provided by 93 interviewees who experienced or witnessed conflict pointed to conflicts that emerged from and resulted in various individual, interpersonal, and organisational factors (Kim et al., 2016). We provide below examples of conflict factors identified from the structured interview study.

Individual conflict factors

Self-focus is a belief that the reality the person perceives is accurate and indisputable (De Dreu & Nauta, 2009; Pinkley & Northcraft, 1994; Ross, 1977; Swann, Polzer, Seyle, & Ko, 2004). When one's concept of self is threatened by others' disagreement, consequences include misinterpretation of other's motives, worldviews, or abilities as flawed (De Dreu & Nauta, 2009; Edmondson & Smith, 2006; Friedman, Tidd, Currall, & Tsai, 2000; Ross, 1977). Evidence also shows that resource depletion, such as exhaustion or stress in individuals, increases the risk of judging others' motives as selfish or lacking integrity (Kiefer & Barclay, 2012; Maslach, Schaufeli, & Leiter, 2001; Muraven, Tice, & Baumeister, 1998). Furthermore, an individual's state of resource depletion leads to diversion of cognitive and emotional resources from patient care priorities to a point of impairment or reduced concentration (Azoulay et al., 2009; De Wit, Greer, & Jehn, 2012; Rogers et al., 2011).

Interpersonal conflict factors

Communication breakdown is a key interpersonal conflict source that occurs in the absence of timely and specific feedback to one another, clear expectations around task completion, or information sharing (Duffy, Ganster, & Pagon, 2002). Another source is linked to power differentials in positions, expertise, and roles (Janss, Rispens, Segers, & Jehn, 2012; Overbeck, Tiedens, & Brion, 2006; Raven, 2008). Power is defined as 'strategies used by leaders to influence those in subordinate or follower positions to achieve important goals' (Power, 2012, p. 1153). Social distance may be a consequence of power differentials, particularly when those in authority are perceived to pursue their own agenda over collective goals or resort to coercion of or retaliation against employees as decision-making tools (Galinsky, Magee, Inesi, & Gruenfeld, 2006; Krugman, Jones, & Lowenstein, 2014; Nugus, Greenfield, Travaglia, Westbrook, & Braithwaite, 2010).

Dehumanisation—stereotyping, stigmatising, or ignoring others' individuality—also creates interpersonal conflict (Friedman et al., 2000; Haslam & Loughnan, 2014; Leape et al., 2012). Individuals may experience a sense of isolation from teams or humiliation when treated disrespectfully (Krugman et al., 2014). Such incivility may range from rudeness or discourteous action to an extreme form manifesting as bullying, which refers to 'repeated, unwanted, and harmful actions' (American Nurses Association, 2015, p. 3). As a result, trust between individuals may be broken, leading to strained subsequent interactions and further weakening teamwork (Fletcher, Simpson, & Thomas, 2000).

Organisational conflict factors

Organisational conflicts are rooted in workflow complexity, such as tasks, procedures, and resources (Bresman & Zellmer-Bruhn, 2013; De Wit et al., 2012). For example, task-based conflict (Janssen, Van De Vliert, & Veenstra, 1999), such as ambiguity in hospital standards, policies, workflow coordination or scope of practice among healthcare professionals, can compromise the quality of patient care. Additionally, process conflict is tied to perceptions of team members, who may regard task assignment to be demeaning, unfair, or insulting to one's capabilities or reputation compared to tasks delegated to others. Employees' professional disengagement may be a consequence arising from process conflict (Friedman et al., 2000).

Considering the complex and ubiquitous nature of conflict in healthcare that affects both healthcare professionals and patients, research into sources and consequences of these conflicts remains underexplored. The significance of this study lies in (1) synthesising individual, interpersonal, and organisational factors of healthcare conflict based on a comprehensive, large-scale review of the literature and (2) exploring research opportunities for expanding the knowledge base of healthcare conflict.

Methods

We followed the four-step approach for conducting a scoping review as recommended by Levac et al. (2010).

Step 1: Identify the research question

The following research question guided the scoping review: what are the main individual, interpersonal, and organisational sources and consequences of conflicts that occur among healthcare professionals?

Step 2: Identify relevant studies

We identified studies published in English between 2001 and 2015 with explicit study aims targeting workplace conflicts experienced by healthcare professionals with patient care responsibilities such as physicians, nursing professionals, technicians, and other professionals. The search year 2001 was selected for the following reasons: (1) the Joint Commission began the publication of sentinel event alerts involving medical errors (Joint Commission Sentinel Event Library), building up on the Institute of Medicine's report, To Err is Human, which highlighted the crucial importance of communication among healthcare professionals (Kohn, Corrigan, & Donaldson, 2000); (2) the Accreditation Council for Graduate Medical Education (ACGME), which is an

accrediting body of residency and fellowship programs in the US, started instituting core competencies in training that included interpersonal skills and communication (Swing, 2007); and (3) the Journal of Interprofessional Care, a leading journal in the field of interprofessional education, practice, and research, became PubMed and MEDLINE indexed in 2001.

We searched PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Excerpta Medical Database (EMBASE) databases. In addition, we searched references of the reviewed articles to identify additional studies that met the inclusion criteria. Table 1 presents the search terms applied to identifying studies across the three literature databases. Search strategies included conflict as the major search term in conjunction with related terms including: communication, interpersonal, interprofessional relations, leadership, negotiation, power, and organisation. We repeated this search process by replacing the term, conflict, with bullying, incivility, gossip, and disruptive behaviours, respectively.

Table 1. Search strategies in PubMed, CINAHL, and EMBASE.

Database	Search strategies
PUBMED: 2001–2015	1. MeSH Major Topic Conflict [MeSH Major Topic] AND communication [MeSH Major Topic] interpersonal [MeSH Major Topic] interprofessional relations [MeSH Major Topic] leadership [MeSH Major Topic] negotiation [MeSH Major Topic] power [MeSH Major Topic] organisation [MeSH Major Topic] patient care team [MeSH Major Topic] 2. Keywords (in combination with the above terms) Bullying Incivility Gossip Disruptive Behaviours
CINAHL: 2001–2015	1. Mesh Headers Conflict [MH Exact Subject Heading] AND interprofessional relations [MH Exact Subject Heading] negotiation [MH Exact Subject Heading] communication [MH Exact Subject Heading] interpersonal [MH Exact Subject Heading] leadership [MH Exact Subject Heading] organisation [MH Exact Subject Heading] power [MH Exact Subject Heading] 2. Keywords (in combination with the above terms) Bullying Incivility Gossip Disruptive Behaviours
EMBASE: 2001–2015	1. Focused Searches Conflict [/exp/mj] AND interprofessional relations [/exp/mj] negotiation [/exp/mj] communication [/exp/mj] interpersonal [/exp/mj] leadership [/exp/mj] organisation [/exp/mj] power [/exp/mj] 2. Keywords (in combination with the above terms) Bullying Incivility Gossip Disruptive Behaviours

Step 3: Select studies

Studies were included if they reported data collected through surveys, questionnaires, interviews, focus groups, or other methods that yielded findings associated with individual (i.e., self-focus, resource depletion, perception of conflict incidents), interpersonal (i.e., relational dynamics, prior history, power differentials), or organisational (i.e., structure, job functions, job satisfaction, turn-over) factors. We excluded studies that met the following criteria: (1) publications such as opinion pieces lacking direct data collection from healthcare professionals; (2) conflict between healthcare professionals and patients; (3) primary study aims of targeting teamwork, collaborative practice, or healthcare professionals' mental health where conflict-related findings emerged as part of larger sets of results; (4) development and psychometric validation of measurements associated with conflict; and (5) non-healthcare study settings involving primary, secondary, post-secondary education, and professional education (e.g., engineering, law, etc.).

Figure 1 presents a flowchart of study selection processes. The search strategies generated an initial pool of 2,373 articles, of which 2,258 were excluded based on title and abstract reviews. Sixteen articles were later excluded from the remaining 115 articles following full manuscript screening (See Appendix 1 for references—available online as Supplemental Material), thus resulting in a total of 99 articles that were included in the present review (See Appendix 2 for references —available online as Supplemental Material).

Step 4: Chart, collate, summarise, and report results

The following iterative process guided the review. First, three core team members (YL, NB, SK) developed a coding scheme for extracting targeted information from articles including study profile (authors, journal, publication year, purpose), data collection and analysis methods, and key findings associated with individual, interpersonal, and organisational conflict factors. Second, six collaborators from the first author's conflict management research team were invited to serve as coders. They included healthcare professionals, educators, and research coordinators, who were trained to review and code articles. Third, collaborators read 5–24 articles and extracted key findings using the coding scheme. Their submitted information was maintained and updated in a Microsoft Word file. The core members independently reviewed and revised the article entries for completeness by reviewing the full papers. We synthesised the key results through iterative reviews and team discussions of predominant themes associated with conflict sources and consequences that emerged at the individual, interpersonal, and organisational levels. The themes were continuously refined until consensus was achieved among the team members.

Results

Overall characteristics of reviewed studies

Table 2 presents the overall characteristics of the reviewed studies. The majority of the studies were conducted in North America (69%) and published mainly in nursing journals

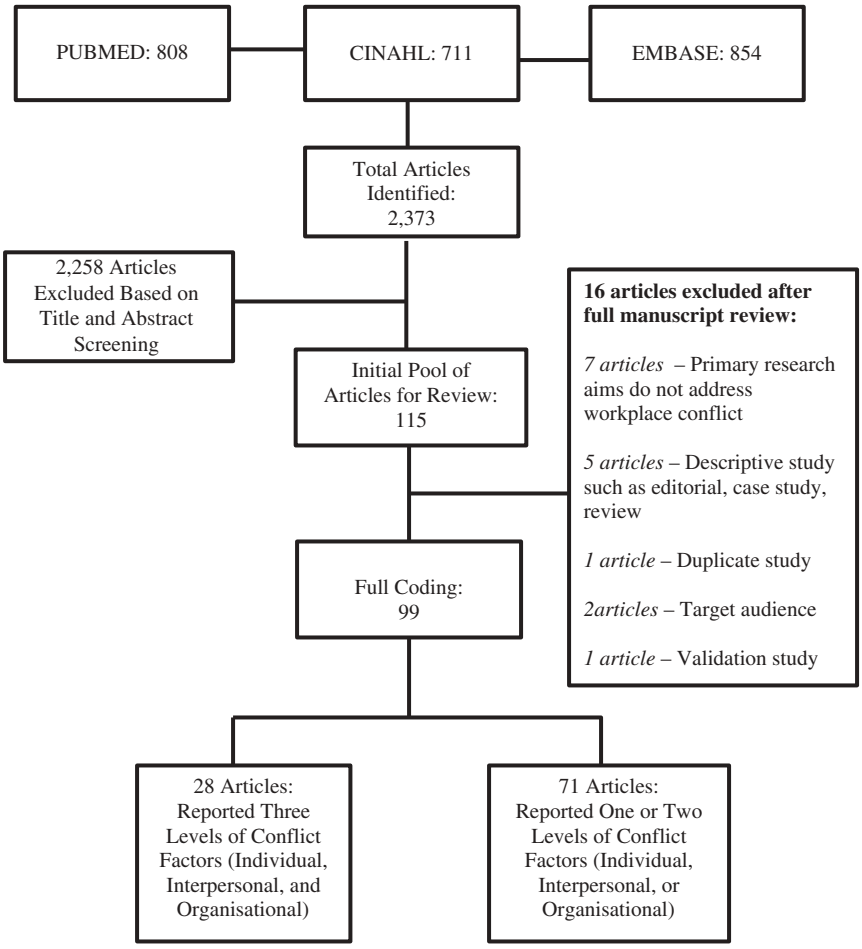

Figure 1. Overview of literature search results.

Table 2. Profile of studies (n = 99).

Category	No.	%
Region		
Africa	2	2
Asia	6	6
Europe	16	16
North America	68	69
Oceania	6	6
Multiple	1	1
Journal specialisation		
Healthcare quality	12	12
Interprofessional	9	9
Medicine	15	15
Nursing	53	54
Other (e.g., radiation therapy)	9	9
PhD dissertation	1	1
Single vs. interprofessional		
One profession	61	62
MD	7	7
Nursing	48	48
Other	6	6
Two professions	10	10
MD + nursing	8	8
Nursing + non-MD	2	2
Three and more professions	28	28
Setting		
Hospital setting (inpatient, wards)	73	74
Outpatient setting, clinic	5	5
Combined	14	14
Other healthcare setting (e.g., pharmacy)	7	7
Design		
Mixed	4	4
Qualitative	25	25
Quantitative	70	71

(54%), followed by medicine (15%), healthcare quality (12%), interprofessional (9%), and other journals (9%). Most studies had collected data from a single profession (62%), particularly nursing (48%); 38% of the studies recruited subjects from two or more professions. Hospital settings were the predominant research context (74%). Data collection largely relied on quantitative measures, such as surveys, questionnaires, or validated instruments (71%), and 25% of studies applied qualitative study design methods including interviews, focus groups, or narrative, journal, and document logs.

Conflict sources and consequences

The key findings we report below largely constitute a summary of healthcare professionals' perceptions or beliefs associated with workplace conflict sources and consequences. Two exceptions are studies that reported organisational data, such as the hospital patient safety and incident reports (Hamblin et al., 2015; Jones & Jones, 2011). Appendix 3 (available online as Supplemental Material) presents 28 studies that reported findings involving all three individual, interpersonal, and organisational conflict factors; and Appendix 4 (available online as Supplemental Material) presents 71 studies with findings associated with one or two conflict factors.

Individual factors

The predominant sources of conflict that are grounded in individual factors included personal traits, such as self-focus, self-esteem, efficacy, locus of control, world view, perceptions of legitimacy, competency, or social isolation (Aberese-Ako, Agyepong, Gerrits, & Van Dijk, 2015; Austin, Gregory, & Martin, 2010; Nayeri & Negarandeh, 2009; Katrinli, Atabay, Gunay, & Cangarli, 2010; Kirschbaum, 2012; Walrath, Dang, & Nyberg, 2010); and individual's conflict management and communication styles including tendencies to avoid, normalise, or tolerate conflict (Austin et al., 2010; Brown et al., 2011; Kirschbaum, 2012; Mahon & Nicotera, 2011; Rogers et al., 2013). Additional conflict sources included low psychological capital in the form of hope, resilience, and optimism (Laschinger, Grau, Finegan, & Wilk, 2010), lack of ability to recognise what constitutes conflict-triggering behaviours (Brown et al., 2011; Jones & Jones, 2011), individuals' moral characteristics (Nayeri & Negarandeh, 2009), or need for power (Katrinli et al., 2010).

Among a number of consequences healthcare professionals perceived to be important, threats to emotional and mental health emerged as being particularly problematic, as 28 of the 99 studies reported burnout, emotional exhaustion, anxiety, depression, or diminished sense of empowerment. Equally detrimental to healthcare professionals' well-being were the following: (1) their physical health (n = 9) such as sleep deprivation, headaches, or weight loss; (2) sense of impairment and immobilisation from fear, defeatism, damaged self-image, or self-esteem (n = 10); and (3) diminished performance from distraction from work, loss of concentration, low morale or confidence, apathy, and cynicism towards work (n = 12). Lastly, ineffective uses of conflict management skills were addressed as consequences of conflict (n = 15). This finding suggests that one's conflict handling abilities can serve as both triggers, as reported earlier, and consequences of conflict situations. One study reported healthcare professionals' improved ability to recognise bullying behaviours as a result of training (Stagg, Sheridan, Jones, & Speroni, 2013).

Interpersonal factors

Interpersonal conflict sources perceived by healthcare professionals ranged from a mild form of incivility to blatant intent to harm others. Sixteen studies addressed low degree of support by colleagues or supervisors where interpersonal interactions lacked recognition, mutual trust, fairness, or transparency devoid of cliques or favouritism. More extreme forms of interpersonal conflict were described as disruptive or even destructive behaviours in the form of verbal abuse, shouting, personal attacks, physical threats, humiliation, intimidation, bullying, and psychological aggressions (n = 15). Other sources included poor communication or disagreement among team members around advancing patient care plans (n = 11), or differences in education, experiences, or generational gaps among healthcare professionals (n = 8). Conflict associated with power differentials between individuals, abuse of authority such as unequal power distribution in teams, or use of status to control others was only examined in seven out of 99 studies (Aberese-Ako, Agyepong, Gerrits, & Van Dijk, 2015; Askew et al., 2012; Brown et al., 2010; Cochran & Elder, 2014; Kim, Nicotera, & McNulty, 2015; Li et al., 2010; Wing, Regan, & Laschinger, 2015).

Major consequences of conflict at the interpersonal level were perceived to be lack of trust or respect that impaired relations (n = 13) or diminished teamwork (n = 12). Examples of breakdown in team communication included the following: weakened group cohesion and collaboration (Brewer, Kovner, Obeidat, & Budin, 2013); reduced information transfer between healthcare professionals (Rosenstein & O'Daniel, 2008; Schlitzkus, Vogt, Sullivan, & Schenarts, 2014); or instructions and orders that were ignored and left undone (Schlitzkus et al., 2014). Other less commonly noted consequences included healthcare professionals' inability to speak up against the power gradient (Cochran & Elder, 2014; McKenna, Smith, Poole, & Coverdale, 2003; Ovayolu, Ovayolu, & Karaday, 2014), perceived decrease in bullying behaviours such as backbiting or undermining activities (Stagg et al., 2013), missed opportunity to learn from one another due to conflicts (McKenna et al., 2003), and being held responsible for others' mistakes (Ovayolu et al., 2014).

Organisational factors

Organisational conflict sources predominantly involved alignment of professional functions, organisational structure and workflow, resource constraints, and work environment. The top perceived conflict sources included the scope of professional roles and practice, which created unclear or multiple lines of authority, ambiguous task assignment, or mismatched goals (n = 13). System-based factors as major conflict sources included structural barriers to decision making, lack of or unclear policies, variability of patient care approaches, or incompatibility of rules (n = 12). Additionally, resource constraints encompassed time, composition, and sufficiency of staffing, or financial resources that healthcare professionals had to negotiate under pressure in delivering care in high patient volume and complex environments (n = 12). Other sources included perceived management style and leadership quality or reward, recognition, and incentive structures (n = 12) as well as job control, such as autonomy and perceived independence over workload (n = 8).

Consequences associated with organisational factors were predominantly job dissatisfaction, low intent to stay, low commitment to organisation, sick leave, turnover, or workforce attrition (n = 31), perceived organisational culture and climate (n = 10), and low quality of patient care due to inefficiencies, wasted time, delays in cases, or unnecessarily prolonged length of patient stay in hospitals (n = 10). Less frequently explored consequences were increased healthcare professionals' perceptions of adverse events or medical errors (Jones & Jones, 2011; Laschinger, 2014), unprofessional or illegal acts such as falsifications of medical records or perceived mistreatment of patients (Baldwin & Daugherty, 2008).

A framework of conflict sources and consequences

Out of 99 studies, five synthesised the key study findings into a framework of conflict sources and consequences involving individual, interpersonal, and organisational factors (Aberese-Ako et al., 2015; Austin et al., 2010; Cochran & Elder, 2014; Leever et al., 2010; Walrath et al., 2010). Six studies tested models of conflict frameworks as follows:

- A conceptual framework of antecedents, core process, and consequences of conflict (Almost, Doran, Hall, & Laschinger 2010);
- A model of antecedents and outcomes of workplace mistreatment among new graduate nurses targeting both personal and organisational characteristics and outcomes (Read & Laschinger, 2013);
- A theoretical framework of structurational divergence that examines structural and systems barriers, such as resources and rules, with implications for relationships and task completion (Nicotera & Clinkscales, 2010);
- The theory of structural empowerment involving social structure as a catalyst for employees' task completion (Laschinger et al., 2010; Wing, Regan, & Laschinger, 2015);
- The authentic leadership model that explains transparency and behavioural integrity (Laschinger, Wong, & Grau, 2012).

Discussion

To our knowledge, this is the first scoping review of healthcare conflict studies that is grounded in the premise that workplace conflict is complex and requires a multi-dimensional understanding of individual, interpersonal, and organisational factors (Almost et al., 2010; De Wit et al., 2012). The reviewed articles reported the sources and consequences of workplace conflicts predominantly based on one-time sampling of participants' self-reported data. Only 28 out of 99 studies took holistic approaches to examining conflict sources and consequences across individual, interpersonal, and organisational factors, suggesting that the current research falls short of generating findings that can sufficiently explain the complex nature of conflicts occurring in dynamic healthcare environments.

Individual factors included subjects' core traits (e.g., motivation, efficacy, locus of control) as antecedents of conflict, as well as their consequences on subjects' mental and physical health. Subjects' conflict handling styles and preferences emerged both as sources and consequences of conflicts but were often examined in isolation of interpersonal or organisational implications. Interpersonal conflicts were rooted in disagreement around healthcare goals, or in extreme cases, behaviours that disrupted patient care, workflows, or collegial relationships. Breakdown in interpersonal communication occurred when colleagues engaged in conduct that compromised trust or perceived transparency, resulting in neglected orders, or information withholding from others. Few studies addressed hierarchical differences as conflict sources in interpersonal or team dynamics. Organisational conflicts triggered by unclear professional roles among health professions, scope of practice, or workflow were reported to have diminished not only job satisfaction, morale, or retention but also were perceived to be detrimental to patient care. In summary, our scoping review highlighted a variety of factors that emanated from and affected perceptions that individuals held about themselves, towards others they interacted with in their professional spheres, and regarding the larger organisational environment they functioned in as healthcare professionals.

We now discuss major gaps in the current research and propose recommendations to advance healthcare conflict as a research domain. First, given the integral role of team-based planning, coordination, and delivery of patient care by interprofessional teams, studies targeting single professions may not fully elicit the role and impact of conflict that occurs in complex relational team dynamics across multiple professions. The finding that only 38% of the reviewed studies involved interprofessional team members substantiates this point. Additionally, journals dedicated to the nursing profession were the predominant dissemination sources (54% of studies). Future opportunities for expanding the knowledge base of conflict in team settings may be pursued via article submissions to journals with emphases on interprofessional care. Special calls by interprofessional journals for studies focusing on healthcare conflicts may also contribute to generating new knowledge and sharing key findings with broader audiences.

Second, 11 studies reported conceptual models for the purpose of synthesising study results or testing the model's robustness based on data associated with individual, interpersonal, and organisational conflict sources and consequences. We highlight areas of further inquiry. We believe the core self-evaluation that encompasses the overall value a person places on oneself, self-efficacy, or locus of control is foundational to understanding the nature of conflict. One's self-focus largely shapes the interpretations of others' motives and intent in conflict situations (Almost et al., 2010; Stone, Patton, & Heen, 2010). In this regard, a sole focus on individuals' conflict handling style as conflict sources or consequences may be limiting as this line of inquiry falls short of explaining the core personal traits that influence how and why one may prefer a particular conflict style. We advocate for extending the current research involving self-perception of conflict management style to address individuals' implicit or unconscious bias as possible conflict sources (Sabin, Rivara, & Greenwald, 2008) that may possibly affect an individual's interpretation of, and subsequent engagement with, others' motives and intent when conflicts arise.

Similarly, the construct of psychological capital (i.e., hope, resilience) examined by Laschinger et al. (2012) represents a novel inquiry into understanding how individuals' psychological capacity influences their approaches to conflict handling. A related concept, resource depletion (i.e., exhaustion, stress), was previously reported (Kim et al., 2016) as the main source of conflict that might affect individuals' ability to regulate their perceptions and actions in conflict situations. In this scoping review, the majority of the studies focused on

resource depletion in the forms of mental and physical well-being as consequences of conflict. Resource depletion as a source of conflict may be examined in relation to one's psychological capital that may accelerate or mitigate reactions to conflict situations.

Few of the included studies examined differentials in hierarchical positions or power status as explicit interpersonal sources of healthcare conflict. This gap echoes the findings of the previous review conducted by Paradis and Whitehead (2015). The authors only identified six studies that explicitly addressed the topic of power and conflict out of 2,191 studies they reviewed and concluded that 'most educators are not attending to these fundamental issues, or that they may be attending to them in a subdued manner…' (Paradis & Whitehead, 2015, p. 405). Our finding thus aligns with this conclusion that points to the need for further understanding the role of perceptions and beliefs associated with power and status as conflict triggers among healthcare professionals as well as at the organisational level (e.g., surgical services to internal medicine services). Furthermore, examination of barriers associated with healthcare professionals' ability to speak up against the power gradient has implications for healthcare conflicts. These barriers may encompass individual concerns (i.e., fear of public humiliation or negative performance evaluation), contextual issues (i.e., urgency of issues, appropriate settings), or organisational culture that promotes or suppresses an act of speaking up (Entwistle et al., 2010; Martinez et al., 2015).

We noted that few studies reported the use of available institutional data, such as hospital systems that routinely monitor metrics associated with patient safety and quality of care. These systems-level data could potentially illuminate sources of patient harm that might stem from individual, interpersonal, and organisational conflicts. We urge researchers to augment healthcare professionals' perceptions and self-evaluations by exploring the direct relationship between conflicts and hospital outcome variables including occurrences of adverse events or medical errors or patient satisfaction with healthcare professionals' communication skills. Additional outcomes may include staff turnover, absenteeism, use of conflict mediation resources within organisations, or exit interviews with staff leaving their jobs. For advancing the future research in examining conflicts that are rooted in organisational structures and processes, we propose three key interventions: policies, leadership competencies, and training. First, it is imperative that organisations develop and enforce policies for professional code of conduct and non-punitive error-reporting mechanisms (Aberese-Ako et al., 2015). Existing institutional data should be mined to establish the long-term impact of policy effectiveness in institutional responses to incidents that violate the culture of safety and respect. Second, we suggest examining the relationship between unit morale or team cohesion and organisational leaders' competencies including conflict assessment and management, reflective practice, communication skills, and giving and receiving feedback (Scott & Gerardi, 2011a, 2011b). This represents an area of gap in the current healthcare conflict research based on our scoping review.

Third, formal training for healthcare professionals is critical to providing them with knowledge, attitudes, and communication skills in multiple domains, including self-awareness, identifying and managing conflicts, and recognising personal contributions, such as bias, to triggering or escalating conflicts. For developing and testing training interventions in healthcare conflict, we recommend the existing evidence-based conflict management and resolution training models. Zweibel, Goldstein, Manwaring, and Marks (2008) examined the effectiveness of a conflict resolution workshop and demonstrated that residents and faculty members who attended the workshop (both soon after the workshop and 12 months later) exhibited greater readiness to engage in conflict, empowerment, handling of emotional reaction, and communication skills for proactive management of conflicts. Similarly, Haraway and Haraway (2005) provided a two-day conflict management and resolution training to hospital managers and supervisors. They reported that participants' ability to manage stress from workload as well as psychological and interpersonal strain improved a month after completing the training. We advocate for training for interprofessional teams, rather than silos of professionals, which requires leadership support for making scheduling logistics and incentive structures feasible for such training to be a reality in healthcare organisations.

There are several limitations in our review which should be noted. First, the scope of our review was limited to the past 15 years of publications of healthcare conflict studies. Second, by solely focusing on health sciences databases, we acknowledge that possible relevant studies published in journals outside of healthcare were not consulted in the scoping review. Third, our review focused on workplace conflicts that involved healthcare professionals' experiences with colleagues and organisations. Findings we reported may not generalise to conflict dynamics involving patients. Fourth, excluding patients or healthcare as explicit search terms might have precluded studies that linked conflicts among healthcare professionals to patient outcomes, such as satisfactions, morbidity, mortality, or other metrics (e.g., length of stay). Lastly, due to the heterogeneity of study designs, target populations, and data collection instruments, we reported the findings of the reviewed studies in a narrative manner that we believed was appropriate for a scoping review.

Concluding comments

Conflicts among healthcare professionals across multiple specialties and roles as well as within teams arise at various stages of patient care. The complexity involved in healthcare conflict requires exploration of sources and consequences of conflicts at the interface of human responses to conflicts, interpersonal and group dynamics, and the organisational structure and culture. By advancing the field of healthcare conflict research, appropriate interventions can target specific conflict sources with their effectiveness established based on a variety of data that encompass perceptions, satisfactions, behavioural changes, and/or shifts in organisational culture.

Declaration of interest

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