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ASSESSMENT OF THE FACTORS RESPONSIBLE FOR INDUSTRIAL DISHARMONY AMONG HEALTHCARE PROFESSIONALS IN TERTIARY HEALTHCARE INSTITUTIONS IN BAYELSA STATE

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INTRODUCTION

The healthcare sector is one of the most complex and multidisciplinary industries globally, requiring the coordinated efforts of professionals from diverse disciplines to provide safe, effective, patient-centred, and high-quality healthcare services. Contemporary healthcare delivery has shifted from a profession-centred model to an integrated, team-based approach that recognizes the complementary roles of physicians, nurses, pharmacists, medical laboratory scientists, radiographers, physiotherapists, health information management professionals, nutritionists, and other allied healthcare practitioners. Effective collaboration among these professionals has become increasingly essential for improving patient outcomes, enhancing healthcare quality, reducing medical errors, and strengthening health systems.

Healthcare delivery is inherently collaborative because no single professional possesses all the knowledge, skills, and competencies required to meet the diverse healthcare needs of patients. Rather, the successful management of patients depends on coordinated interdisciplinary practice, mutual professional respect, effective communication, shared decision-making, and collective responsibility for patient outcomes. Studies have consistently shown that healthcare organizations characterized by strong interprofessional collaboration experience better clinical outcomes, improved patient safety, enhanced employee satisfaction, and greater organizational efficiency, whereas poor collaboration is associated with

communication breakdown, medical errors, reduced staff morale, and poor quality of care (Reeves et al., 2017; Wei et al., 2022).

The World Health Organization recognizes collaborative practice as one of the fundamental strategies for strengthening health systems and achieving universal health coverage. Effective teamwork among healthcare professionals enhances continuity of care, facilitates evidence-based clinical decision-making, reduces duplication of services, and promotes efficient utilization of limited healthcare resources. Conversely, strained professional relationships, ineffective communication, and organizational conflict undermine healthcare delivery by disrupting teamwork, increasing occupational stress, reducing employee engagement, and compromising patient safety (World Health Organization, 2023).

Industrial harmony refers to a state of peaceful and cooperative relationships among employers, employees, labour unions, and other organizational stakeholders characterized by mutual trust, fairness, respect, effective communication, and equitable conflict resolution mechanisms. Within healthcare organizations, industrial harmony promotes employee commitment, organizational stability, workforce motivation, and uninterrupted healthcare service delivery. Industrial harmony enables healthcare professionals to focus on their primary responsibility of providing quality patient care while simultaneously fostering innovation, professional development, and organizational growth.

Industrial disharmony, on the other hand, represents persistent disagreements, conflicts, unhealthy professional rivalry, mistrust, dissatisfaction, and strained relationships among healthcare workers or between employees and management. Industrial disharmony may manifest through interpersonal conflicts, interprofessional rivalry, strikes, work stoppages, poor communication, grievances, low morale, and diminished organizational commitment. Such conflicts frequently arise from perceived inequities in remuneration, promotion, leadership appointments, workload distribution, professional recognition, resource allocation, and organizational decision-making processes.

Healthcare institutions are particularly susceptible to industrial disharmony because they comprise professionals with diverse educational backgrounds, professional identities, statutory responsibilities, and organizational expectations. Although this diversity enriches healthcare delivery by bringing together specialized expertise, it also creates opportunities for professional competition, role ambiguity, jurisdictional disputes, and conflicting perceptions regarding organizational leadership and professional autonomy. Without effective leadership and institutional mechanisms for conflict management, these differences may escalate into prolonged industrial disputes that adversely affect healthcare delivery.

Recent empirical evidence demonstrates that workplace conflict remains a significant challenge within healthcare organizations worldwide. Studies have shown that unresolved interprofessional conflicts negatively influence employee engagement, job satisfaction, organizational commitment, patient safety culture, and quality of healthcare services (Almost et al., 2023; Wei et al., 2022). Healthcare professionals who operate within environments characterized by persistent conflict are more likely to experience emotional exhaustion, occupational stress, burnout, reduced collaboration, and increased intention to leave their organizations. These consequences ultimately affect organizational productivity and the overall performance of healthcare systems.

In low- and middle-income countries, including Nigeria, the challenge of industrial disharmony has assumed greater significance due to persistent shortages of healthcare personnel, inadequate healthcare financing, poor working conditions, inequitable remuneration systems, insufficient infrastructure, limited opportunities for career advancement, and inconsistent implementation of human resource policies. These structural weaknesses have created an environment in which professional dissatisfaction and organizational conflicts frequently culminate in industrial actions that disrupt healthcare service delivery.

Nigeria has experienced repeated industrial disputes involving healthcare professionals over the past three decades. These disputes have involved physicians, nurses, pharmacists, medical laboratory scientists, health information management professionals, physiotherapists, and other allied health workers. While many industrial actions have focused on salary reviews, improved working conditions, hazard allowances, and implementation of government agreements, numerous studies suggest that underlying interprofessional tensions, leadership disputes, professional hierarchy, inequitable recognition, and perceived marginalization of certain professional groups continue to fuel industrial disharmony within Nigerian healthcare institutions (Adigwe et al., 2023; Okafor et al., 2022).

One of the recurring issues in Nigerian healthcare institutions is the perception of professional dominance and unequal participation in organizational leadership. Leadership positions within many public healthcare institutions have historically been occupied predominantly by specific professional groups, generating perceptions of exclusion and inequity among other healthcare professionals. Such perceptions have contributed to unhealthy competition, diminished trust, reduced collaboration, and frequent disputes regarding professional recognition and organizational governance. Research has shown that inclusive leadership structures and equitable participation in organizational decision-making

significantly improve teamwork and reduce workplace conflict among healthcare professionals (Wei et al., 2022).

Another important determinant of industrial disharmony is inequity in remuneration and career progression. Although healthcare professionals work collaboratively toward common organizational objectives, differences in salary structures, promotion opportunities, professional allowances, and conditions of service often generate dissatisfaction and resentment among professional groups. Organizational justice theory suggests that employees' perceptions of distributive, procedural, and interactional fairness strongly influence organizational commitment, job satisfaction, and workplace behaviour. Consequently, perceived inequities frequently trigger industrial disputes, employee disengagement, and reduced organizational citizenship behaviours.

Communication also represents a critical determinant of industrial harmony within healthcare organizations. Effective communication facilitates teamwork, promotes shared understanding, minimizes professional misunderstandings, and enhances coordinated patient care. Conversely, ineffective communication contributes to interpersonal conflict, duplication of responsibilities, delayed clinical decisions, medication errors, and reduced patient satisfaction. Recent evidence indicates that communication failures remain one of the leading contributors to adverse events within healthcare organizations, emphasizing the need for healthcare managers to strengthen communication systems and collaborative practice (Manser, 2021).

Healthcare leadership plays a pivotal role in preventing industrial disharmony. Transformational leadership, participatory decision-making, transparent governance, and equitable human resource management have been associated with improved employee engagement, stronger professional relationships, reduced workplace conflict, and higher organizational performance. Conversely, autocratic leadership, poor conflict management skills, inadequate employee involvement, and perceived favouritism often intensify industrial tensions and reduce employee commitment. Contemporary healthcare organizations increasingly recognize leadership competence as a strategic determinant of organizational resilience, workforce stability, and healthcare quality (Specchia et al., 2021).

The consequences of industrial disharmony extend beyond organizational performance to directly affect patient care. Frequent industrial disputes interrupt essential healthcare services, delay diagnosis and treatment, increase patient waiting time, reduce continuity of care, and contribute to preventable morbidity and mortality. Furthermore, prolonged workplace conflict undermines staff morale, weakens interdisciplinary collaboration, increases employee

turnover, and erodes public confidence in healthcare institutions. These consequences are particularly concerning within tertiary healthcare institutions, where specialized clinical services, medical education, and health research depend heavily on sustained interprofessional collaboration.

Bayelsa State is home to two major tertiary healthcare institutions Niger Delta University Teaching Hospital (NDUTH), Okolobiri, and Federal Medical Centre (FMC), Yenagoa which serve as referral centres for specialized healthcare services within the Niger Delta region. These institutions rely on multidisciplinary teams comprising physicians, nurses, pharmacists, medical laboratory scientists, health information management professionals, radiographers, physiotherapists, and several other healthcare professionals. Despite their strategic importance, anecdotal reports and periodic industrial disputes suggest the existence of persistent organizational and interprofessional challenges that may undermine collaborative practice and healthcare delivery. However, empirical evidence specifically examining the determinants of industrial disharmony among healthcare professionals within tertiary healthcare institutions in Bayelsa State remains limited.

Existing Nigerian studies have largely concentrated on strike actions, labour relations, or interprofessional rivalry at the national level, with relatively few studies exploring the broader organizational, managerial, interpersonal, and professional factors responsible for industrial disharmony within individual tertiary healthcare institutions. This gap in empirical knowledge limits the development of context-specific interventions capable of promoting sustainable industrial harmony and strengthening healthcare service delivery.

Against this background, this study seeks to assess the factors responsible for industrial disharmony among healthcare professionals in tertiary healthcare institutions in Bayelsa State. Specifically, the study aims to identify the organizational, professional, managerial, and interpersonal factors contributing to industrial disharmony, examine their implications for healthcare service delivery, and provide evidence-based recommendations for promoting harmonious interprofessional relationships and improving healthcare system performance.

Conceptual Review

Concept of Industrial Harmony

Industrial harmony refers to a stable and cooperative relationship between employers, employees, labour unions, and other stakeholders within an organization, characterized by mutual trust, effective communication, fairness, and shared commitment to organizational objectives (Amah & Ahiauzu, 2022). In healthcare organizations, industrial harmony

promotes collaboration among multidisciplinary professionals, enhances employee morale, improves organizational productivity, and ultimately contributes to better patient outcomes.

The healthcare environment is inherently multidisciplinary, requiring physicians, nurses, pharmacists, medical laboratory scientists, health information management professionals, radiographers, physiotherapists, and other allied health professionals to work collaboratively toward common healthcare goals. Effective industrial harmony facilitates interprofessional collaboration, reduces workplace conflict, enhances communication, and promotes organizational efficiency (World Health Organization [WHO], 2023).

Recent studies indicate that organizations characterized by harmonious labour-management relationships experience higher employee engagement, improved organizational commitment, lower staff turnover, and enhanced healthcare quality (Wei et al., 2022). Conversely, organizations experiencing frequent industrial disputes often report poor staff morale, reduced productivity, interrupted healthcare services, and diminished patient satisfaction (Adigwe et al., 2023).

Industrial Disharmony

Industrial disharmony refers to persistent conflicts, disagreements, dissatisfaction, mistrust, and strained relationships among employees, employers, professional associations, or labour unions within an organization (Okolie et al., 2022). It manifests through strikes, work stoppages, protests, absenteeism, poor communication, interprofessional rivalry, and breakdown of organizational relationships.

Within healthcare institutions, industrial disharmony frequently arises from disputes concerning remuneration, career progression, professional recognition, inequitable leadership appointments, inadequate working conditions, poor organizational communication, and ineffective conflict management (Adigwe et al., 2023).

According to the International Labour Organization (ILO, 2022), industrial disharmony negatively affects workforce stability, healthcare quality, organizational performance, and patient safety. Studies further reveal that unresolved workplace conflict contributes to burnout, psychological distress, reduced teamwork, and increased medical errors (Almost et al., 2023).

Healthcare Professionals

Healthcare professionals are individuals licensed and trained to provide preventive, promotive, curative, rehabilitative, and palliative healthcare services. They include

physicians, nurses, pharmacists, medical laboratory scientists, radiographers, physiotherapists, dentists, health information management professionals, dietitians, occupational therapists, and other allied healthcare workers (WHO, 2023).

Modern healthcare increasingly emphasizes collaborative practice among healthcare professionals because effective patient management requires integrating diverse expertise and professional competencies. Reeves et al. (2017) argue that collaborative healthcare practice improves patient safety, clinical outcomes, staff satisfaction, and organizational efficiency.

However, differences in professional identities, educational backgrounds, organizational expectations, and statutory responsibilities may create tension among healthcare professionals, particularly when organizational policies are perceived as inequitable (Orchard et al., 2022).

Factors Responsible for Industrial Disharmony

Several organizational and professional factors contribute to industrial disharmony within tertiary healthcare institutions.

Leadership and Organizational Governance

Leadership significantly influences workplace relationships. Inclusive and transformational leadership promotes trust, collaboration, and employee engagement, whereas autocratic leadership increases dissatisfaction and conflict (Specchia et al., 2021).

Poor Communication

Communication failures remain among the leading causes of workplace conflict within healthcare organizations. Ineffective communication undermines teamwork, delays decision-making, and increases professional misunderstanding (Manser, 2021).

Professional Rivalry

Professional rivalry remains a major challenge in Nigeria's healthcare system. Competition for leadership positions, professional autonomy, remuneration, and organizational recognition frequently generates conflict among healthcare professionals (Adigwe et al., 2023).

Remuneration and Welfare

Perceived inequities in salaries, allowances, promotion opportunities, and welfare packages significantly influence employee satisfaction and industrial relations (Okolie et al., 2022).

Working Conditions

Poor infrastructure, inadequate equipment, workforce shortages, excessive workload, and occupational stress increase employee dissatisfaction and contribute to industrial disputes (WHO, 2023).

Consequences of Industrial Disharmony

Industrial disharmony negatively affects both healthcare workers and patients. Research has linked workplace conflict with reduced job satisfaction, burnout, poor teamwork, low productivity, increased staff turnover, and compromised patient safety (Almost et al., 2023).

Healthcare institutions experiencing frequent industrial disputes often report prolonged patient waiting time, interruption of healthcare services, increased mortality, and declining public confidence in healthcare systems (Adigwe et al., 2023).

Theoretical Framework

This study is anchored on **Social Identity Theory** and **Organizational Justice Theory**.

Social Identity Theory

Social Identity Theory, developed by Henri Tajfel and John Turner (1979), explains that individuals derive their identity from membership in social groups. Healthcare professionals often identify strongly with their respective professions, resulting in in-group loyalty and out-group competition.

Within tertiary healthcare institutions, physicians, nurses, pharmacists, medical laboratory scientists, and other professionals may perceive themselves as belonging to distinct professional groups with competing interests. Such professional identities may generate rivalry regarding leadership positions, remuneration, authority, and professional recognition.

Recent studies have shown that professional identity strongly influences interprofessional collaboration and organizational relationships within healthcare institutions (Orchard et al., 2022).

Organizational Justice Theory

Organizational Justice Theory posits that employees evaluate fairness based on organizational decisions, procedures, interpersonal treatment, and distribution of organizational rewards.

Healthcare professionals who perceive unfair promotion practices, salary structures, leadership appointments, or workload distribution are more likely to experience dissatisfaction and participate in industrial disputes (Colquitt et al., 2021).

The theory therefore provides an appropriate explanation for industrial disharmony arising from perceived inequity within healthcare organizations.

Empirical Review

Several empirical studies have examined industrial relations and interprofessional conflict in healthcare settings.

Adigwe et al. (2023) investigated interprofessional conflict among Nigerian healthcare professionals and reported that professional rivalry, poor leadership, inequitable

remuneration, and ineffective communication were the primary causes of industrial disputes. The study recommended inclusive leadership and collaborative governance to strengthen industrial harmony.

Almost et al. (2023) conducted a systematic review of workplace conflict in healthcare organizations and found that unresolved interpersonal conflict significantly reduced teamwork, increased burnout, and compromised patient safety. The authors advocated structured conflict management interventions and organizational support systems.

Wei et al. (2022) examined teamwork within healthcare organizations and concluded that transformational leadership, mutual respect, and effective communication significantly improved interprofessional collaboration and organizational performance.

Okolie et al. (2022) reported that organizational justice significantly predicted employee commitment and industrial harmony among public sector workers. Employees who perceived fairness in organizational processes demonstrated greater job satisfaction and lower conflict levels.

The World Health Organization (2023) emphasized that collaborative practice and equitable workforce management are essential for improving health system performance and achieving universal health coverage.

Overall, previous studies consistently identify leadership, communication, organizational justice, professional rivalry, remuneration, and working conditions as major determinants of industrial harmony and organizational effectiveness.

Identified Knowledge Gap

Although numerous studies have examined industrial relations, labour disputes, and interprofessional conflict within healthcare organizations, several important gaps remain.

First, most previous studies have focused on nationwide industrial actions or specific professional groups such as physicians or nurses, with limited attention to multidisciplinary healthcare professionals working together within tertiary healthcare institutions.

Second, existing Nigerian studies have largely adopted quantitative approaches, providing limited insight into the lived experiences, perceptions, and contextual factors influencing industrial disharmony. A qualitative approach is therefore necessary to obtain an in-depth understanding of these issues.

Third, few empirical studies have specifically investigated the organizational, managerial, interpersonal, and professional factors responsible for industrial disharmony in tertiary healthcare institutions in Bayelsa State. Consequently, evidence-based strategies tailored to the unique context of these institutions remain limited.

This study addresses these gaps by employing a qualitative research approach to explore the experiences and perceptions of healthcare professionals regarding the factors responsible for industrial disharmony in tertiary healthcare institutions in Bayelsa State.

METHODS AND MATERIALS

Research Design

This study adopted a qualitative descriptive research design using semi-structured, in-depth interviews. A qualitative descriptive approach was considered appropriate because the study sought to explore healthcare professionals' perceptions, experiences, and interpretations of the factors contributing to industrial disharmony within tertiary healthcare institutions. Unlike quantitative approaches that emphasize measurement and hypothesis testing, qualitative research enables an in-depth understanding of complex social phenomena from the perspectives of participants (Creswell & Poth, 2018).

The qualitative descriptive design is particularly suitable when researchers aim to obtain straightforward accounts of participants' experiences in their natural settings while remaining close to the data (Colorafi & Evans, 2016). Industrial disharmony is influenced by organizational culture, leadership practices, interpersonal relationships, professional identity, and institutional policies—factors that are best understood through participants lived experiences and narratives rather than numerical indicators.

Semi-structured interviews were selected because they provide flexibility to explore emerging issues while ensuring that all participants address key aspects of the research objectives. This approach allows participants to describe their experiences in their own words while enabling the researcher to probe for clarification and richer explanations (Braun & Clarke, 2022).

The study was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) to enhance transparency and methodological rigor in reporting the study (Tong et al., 2007).

Study Setting

The study was conducted in tertiary healthcare institutions in Bayelsa State, Nigeria. These institutions serve as referral centres for specialized healthcare services within the Niger Delta region and provide clinical care, teaching, and research. The study focused on institutions where multidisciplinary healthcare professionals work collaboratively in delivering comprehensive healthcare services.

The institutions comprise professionals from various disciplines, including physicians, nurses, pharmacists, medical laboratory scientists, radiographers, physiotherapists, health information management professionals, dentists, and other allied healthcare workers. Their multidisciplinary nature provides an appropriate context for examining the organizational, professional, managerial, and interpersonal factors responsible for industrial disharmony.
Healthcare delivery within these institutions is characterized by high patient volume, complex clinical services, resource constraints, and frequent interaction among professionals from different disciplines. These contextual characteristics make the study setting particularly suitable for exploring industrial relations and workplace harmony.

Participants and Sampling

Study Population

The study population comprised healthcare professionals employed in selected tertiary healthcare institutions in Bayelsa State. Participants were drawn from different professional groups to ensure a comprehensive understanding of industrial disharmony across disciplines.

The target participants included:

- Medical doctors
- Nurses
- Pharmacists
- Medical Laboratory Scientists
- Health Information Management professionals
- Radiographers
- Physiotherapists
- Other allied healthcare professionals
- Administrative personnel directly involved in healthcare management
- Labour union representatives and departmental heads where applicable

Including participants from multiple professional groups enhanced the diversity of perspectives and strengthened the credibility of the findings.

Sampling Technique

A purposive sampling strategy was employed to recruit participants who possessed rich knowledge and direct experience relating to industrial relations within the study institutions. Purposive sampling is widely recommended in qualitative research because it facilitates the

selection of information-rich participants capable of providing detailed insights into the phenomenon under investigation (Patton, 2015).

To maximize variation in experiences, maximum variation purposive sampling was adopted. Participants were selected based on professional cadre, years of work experience, administrative responsibilities, and involvement in industrial relations. This approach enhanced the breadth of perspectives represented in the study.

Sample Size

A total of 90 healthcare professionals participated in the interviews. While qualitative research does not prescribe statistically determined sample sizes, the adequacy of the sample was justified using the concept of information power, which suggests that the more relevant information participants possess in relation to the study aim, the fewer participants are required, whereas broader study aims involving heterogeneous populations may require larger samples (Malterud et al., 2016).

The relatively large sample reflected the multidisciplinary nature of the study and ensured representation across the various healthcare professions. Recruitment continued until data saturation was achieved, that is, the point at which additional interviews no longer generated substantially new themes or insights (Hennink et al., 2019).

Inclusion Criteria

Participants were eligible if they:

- Were healthcare professionals employed in the selected tertiary healthcare institutions.
- Had worked in the institution for at least one year.
- Had experience relating to organizational relationships or industrial issues.
- We are willing to participate voluntarily.
- Provided written informed consent.

Exclusion Criteria

Healthcare professionals who were on leave during data collection, newly employed staff with less than one year of service, temporary staff, interns, and those who declined participation were excluded from the study.

Development of the Interview Guide

Data were collected using a semi-structured interview guide developed after an extensive review of literature on industrial relations, organizational justice, interprofessional collaboration, workplace conflict, and healthcare management. The interview questions were

aligned with the study objectives and informed by the Social Identity Theory and Organizational Justice Theory.

The interview guide consisted of open-ended questions exploring:

- Participants' understanding of industrial harmony and industrial disharmony.
- Perceived organizational factors contributing to industrial disharmony.
- Professional rivalry and interprofessional relationships.
- Leadership and management practices.
- Communication and conflict management.
- Working conditions and employee welfare.
- Perceived consequences of industrial disharmony.
- Strategies for promoting industrial harmony.

To ensure content validity, the interview guide was reviewed by experts in Health Information Management, qualitative research, healthcare management, and organizational behaviour. Suggestions from the reviewers were incorporated before commencement of data collection.

The interview guide was pilot-tested among a small group of healthcare professionals outside the study sites to assess clarity, relevance, sequencing, and comprehensibility of the questions. Minor revisions were made based on participant feedback.

Data Collection Procedures

Data collection was conducted through face-to-face semi-structured interviews between the researcher and participants. Prior to each interview, participants received detailed information regarding the study objectives, voluntary nature of participation, confidentiality measures, and their right to withdraw without penalty.

Written informed consent was obtained before commencing the interviews. With participants' permission, interviews were audio-recorded to ensure accurate capture of responses. Field notes were also maintained to document non-verbal expressions, contextual observations, and the researcher's reflections.

Each interview lasted approximately 45–60 minutes, depending on participants' availability and depth of responses. Interviews were conducted in private locations within the institutions to ensure confidentiality and minimize interruptions.

Data collection continued until thematic saturation was achieved, whereby no substantially new themes emerged from subsequent interviews.

Data Analysis

The interview recordings were transcribed verbatim immediately after each interview. The transcripts were compared with the audio recordings to ensure accuracy before analysis.

The data were analyzed using Braun and Clarke's (2022) six-phase thematic analysis, which involved:

1. Familiarization with the data.
2. Generation of initial codes.
3. Searching for themes.
4. Reviewing themes.
5. Defining and naming themes.
6. Producing the final report.

Coding was performed manually, with repeated reading of transcripts to identify recurring ideas, patterns, and relationships. Similar codes were grouped into categories, which were subsequently synthesized into overarching themes representing the participants' perceptions of industrial disharmony. Direct quotations from participants were used to support the identified themes and enhance the authenticity of the findings.

Trustworthiness of the Study

To enhance methodological rigor, the study adopted the four criteria proposed by Yvonna Lincoln and Egon Guba for establishing trustworthiness in qualitative research.

Credibility: Credibility was ensured through prolonged engagement with participants, purposive sampling of information-rich participants, member checking, peer debriefing, and triangulation of professional perspectives.

Dependability: Dependability was achieved by maintaining a detailed audit trail documenting methodological decisions, interview procedures, coding processes, and analytical decisions. This enables other researchers to assess the consistency of the research process.

Confirmability: Confirmability was enhanced through reflexive journaling, documentation of analytical decisions, and preservation of interview transcripts, coding frameworks, and field notes. Peer review of coding further minimized researcher bias.

Transferability**:** Transferability was promoted through rich descriptions of the study setting, participant characteristics, sampling procedures, and contextual factors, enabling readers to assess the applicability of the findings to similar healthcare environments.

Ethical Considerations

Ethical approval for the study was obtained from the appropriate Health Research Ethics Committee before commencement of data collection. Administrative permission was also secured from the management of the participating tertiary healthcare institutions.

Participation was entirely voluntary. Participants received written and verbal information regarding the study objectives, procedures, potential benefits, and their rights as research participants. Written informed consent was obtained before each interview.

Participants were assured of confidentiality and anonymity. Personal identifiers were removed from transcripts, and pseudonyms or participant codes (e.g., P01, P02) were used during analysis and reporting. Audio recordings, transcripts, and field notes were securely stored in password-protected electronic files and locked cabinets accessible only to the research team.

Participants were informed of their right to decline answering any question or withdraw from the study at any stage without adverse consequences. The study complied with the ethical principles of respect for persons, beneficence, non-maleficence, justice, and confidentiality as articulated in internationally accepted research ethics guidelines.

RESULTS

Presentation and Analysis of Research Questions

Research Question One:

What is the extent of industrial disharmony among healthcare professionals in tertiary hospitals?

Findings from participants across the two selected tertiary hospitals revealed that industrial disharmony is perceived as a persistent and multi-dimensional challenge within the healthcare system. Respondents indicated that disharmony manifests in several operational and relational dimensions, including communication breakdown, professional rivalry, and fragmented teamwork.

Participants consistently associated industrial disharmony with delays in patients' access to care, inefficiencies in service delivery, and increased risk of clinical errors such as medication and prescription mistakes. It was further revealed that inter-professional disagreements often result in disrupted hospital services, particularly during industrial actions or informal work slowdowns, sometimes with severe consequences for patient outcomes.

In addition, respondents noted that industrial disharmony weakens organizational productivity by diverting attention away from patient-centered care toward internal conflicts.

It also fosters hostility, reduces cooperation among healthcare teams, and undermines psychological safety within the workplace.

Overall, the data suggest that industrial disharmony is not an isolated occurrence but a systemic issue embedded within daily hospital operations, affecting both service quality and staff relationships.

Research Question Two:

How does industrial disharmony among healthcare professionals affect the quality of care rendered to patients?

Responses to this question reflected mixed perceptions among healthcare workers. While some respondents claimed that industrial disharmony is minimal or "normalized" within their facilities, others described it as an underlying "cold war" that subtly influences service delivery.

Several participants stated that professional rivalry and lack of teamwork negatively affect coordinated care, particularly in cases requiring multidisciplinary collaboration. Some respondents, however, perceived that such conflicts do not always directly disrupt services, as professionals often maintain functional boundaries to sustain service delivery.

Despite these differing views, a dominant theme emerged indicating that industrial disharmony contributes to reduced efficiency, weakened collaboration, and occasional delays in patient management. Respondents acknowledged that even when not openly expressed, underlying tensions among professionals affect communication flow, decision-making, and continuity of care.

The findings therefore suggest that industrial disharmony has both visible and invisible effects on healthcare quality, influencing not only service outcomes but also the interpersonal dynamics that sustain patient care.

Research Question Three:

To what extent are management and government engaged in addressing industrial disharmony among healthcare professionals?

Findings indicate limited and inconsistent engagement from both management and government authorities in addressing industrial disharmony. Many respondents expressed dissatisfaction with the level of institutional response to professional conflicts and workplace grievances.

Some participants reflected sentiments of professional undervaluation and lack of recognition, while others emphasized strong professional identity and perceived superiority

within the healthcare hierarchy. These expressions revealed underlying inter-professional tensions that are insufficiently addressed by institutional leadership.

The data suggest that management intervention in conflict resolution is often reactive rather than proactive. Participants indicated that conflicts are frequently allowed to escalate before being addressed, thereby weakening trust in leadership structures.

Furthermore, the responses demonstrate that professional identity politics and hierarchical perceptions continue to shape inter-professional relationships, with limited mediation from management to foster collaboration and equity.

Research Question Four

What factors are responsible for industrial disharmony among healthcare professionals?

The findings revealed multiple interconnected factors contributing to industrial disharmony in tertiary healthcare institutions. These include structural, organizational, professional, and socio-cultural determinants.

Key factors identified by respondents include:

- Lack of equal professional representation in decision-making processes
- Autocratic or domineering leadership styles
- Encroachment into professional roles and responsibilities
- Appointment of non-professionals to head clinical departments
- Poor recognition of certain health professions
- Salary disparities and unequal allowances among professional groups
- Perceived professional superiority and rivalry
- Tribalism and interpersonal/ethnic conflicts
- Inadequate infrastructure, equipment, and logistics
- Poor working environment and resource constraints
- Self-interest and internal workforce competition
- Political interference and “settlement syndrome” in union leadership
- Lack of inter-professional consultation in policy formulation
- Weak adherence to professional ethics
- Repeated systemic neglect of staff welfare and motivation structures

These findings indicate that industrial disharmony is driven by both systemic inequalities and interpersonal dynamics within healthcare institutions. The interaction of poor governance

structures, resource limitations, and professional competition creates an environment conducive to conflict escalation.

DISCUSSION OF FINDINGS

The findings of this study reveal that industrial disharmony among healthcare professionals in tertiary hospitals in Bayelsa State is a significant and multidimensional challenge that adversely affects healthcare delivery, organizational efficiency, and professional relationships. The study established that industrial disharmony manifests through delayed healthcare access, communication breakdown, medication errors, reduced productivity, and disruption of hospital services. These findings align with Johansen (2012), who emphasized that workplace conflict in healthcare settings undermines efficiency and compromises patient care outcomes. Similarly, Vivar (2006) noted that strained interpersonal relationships among healthcare professionals contribute significantly to workplace stress and reduced service effectiveness.

Furthermore, the study revealed that industrial disharmony negatively affects psychological well-being and promotes hostile workplace environments. This is consistent with Leonard, Graham, and Bonacum (2004), who reported that poor teamwork and communication failures are major contributors to clinical errors and compromised patient safety. De Dreu and Weingart (2003) also confirmed that workplace conflict reduces group performance and organizational effectiveness.

Findings also showed that some healthcare professionals normalize conflict within hospital environments, viewing it as an unavoidable aspect of professional interaction. This supports Reeves, Lewin, Espin, and Zwarenstein (2011), who argued that weak inter-professional collaboration is a persistent barrier to effective healthcare delivery.

Additionally, expressions of professional superiority and dominance observed in the study align with Social Identity Theory (Tajfel & Turner, 1979), which explains how group identification can lead to in-group favoritism and inter-group conflict. Similar findings were reported by Bolaji (2018), who observed that professional rivalry significantly contributes to industrial disputes within Nigeria's health sector.

The study further identified poor leadership, unequal representation, salary disparities, inadequate resources, and weak policy implementation as key drivers of industrial disharmony. These findings corroborate Adeogun (2001), who identified structural inequality and poor leadership as major causes of conflict in Nigerian healthcare institutions. Guidroz, Wang, and Perez (2012) also emphasized that unclear roles and poor communication significantly increase workplace conflict.

Finally, the findings suggest that management and government interventions in resolving industrial disharmony remain inadequate. This supports Al-Hamdan, Nussera, and Masa'deh (2016), who stressed that effective leadership and proactive conflict management are essential for sustaining harmony in healthcare organizations.

SUMMARY OF FINDINGS

In summary, the study reveals that industrial disharmony among healthcare professionals in tertiary hospitals in Bayelsa State is widespread and influenced by structural inequality, leadership challenges, professional rivalry, and inadequate resource allocation. The phenomenon significantly affects teamwork, service delivery, patient outcomes, and organizational productivity.

CONCLUSION

This study has demonstrated that industrial disharmony remains a persistent and complex challenge within tertiary healthcare institutions in Bayelsa State. Although many healthcare professionals indicated that open industrial disputes are not frequent in their respective hospitals, the findings revealed the existence of underlying tensions characterized by professional rivalry, unequal recognition, communication barriers, and strained interpersonal relationships. These subtle forms of conflict often create an atmosphere of mistrust that weakens collaboration and ultimately affects the quality of healthcare delivery.

The study further showed that industrial disharmony is not merely a labour relations issue but a broader organizational problem with significant implications for patient care, employee well-being, and institutional performance. When healthcare professionals work in an environment marked by poor communication, perceived injustice, leadership bias, or competition for professional dominance, teamwork becomes difficult to sustain. Since modern healthcare depends on the coordinated efforts of multidisciplinary teams, any breakdown in collaboration can negatively influence clinical decision-making, patient safety, and service efficiency.

A major contribution of this study is the identification of the organizational and systemic factors that continue to fuel industrial disharmony in tertiary healthcare institutions. Participants consistently highlighted issues such as unequal professional representation in leadership, salary disparities, inadequate recognition of some professional groups, poor working conditions, ineffective communication, limited participation in decision-making, and weak conflict management structures. These findings suggest that industrial disharmony is

deeply rooted in organizational policies and institutional culture rather than in individual differences alone.

The findings also emphasize the important role of hospital management and government in fostering harmonious workplace relationships. Healthcare institutions where leadership promotes fairness, transparency, inclusiveness, and mutual respect are more likely to experience stronger teamwork, higher staff morale, improved job satisfaction, and better patient outcomes. Conversely, when employees perceive discrimination, exclusion, or inequity, workplace tensions are likely to persist and may eventually escalate into industrial disputes.

Overall, this study concludes that achieving sustainable industrial harmony requires more than resolving conflicts after they occur. It demands deliberate investment in inclusive leadership, equitable human resource policies, effective communication, inter-professional collaboration, and proactive conflict management. Building a culture of respect and shared responsibility among healthcare professionals is essential for improving healthcare quality, enhancing employee satisfaction, and strengthening the performance of tertiary healthcare institutions in Bayelsa State and Nigeria as a whole.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations are proposed to improve industrial relations and strengthen collaborative healthcare practice in tertiary healthcare institutions.

1. Promote Inclusive and Equitable Leadership: Hospital leadership should be guided by the principles of fairness, competence, transparency, and inclusiveness. Leadership positions should be accessible to all qualified healthcare professionals based on merit rather than professional affiliation. Creating equal opportunities for leadership will help reduce perceptions of marginalization and strengthen trust among professional groups.

2. Strengthen Inter-professional Collaboration: Healthcare institutions should intentionally promote a culture of teamwork by encouraging regular multidisciplinary meetings, joint clinical decision-making, collaborative ward rounds, and shared professional responsibilities. Continuous interaction among healthcare professionals will improve mutual understanding, reduce professional rivalry, and enhance the quality of patient care.

3. Establish Effective Conflict Prevention and Resolution Mechanisms: Rather than waiting for disagreements to escalate into industrial actions, hospital management should establish structured systems for identifying and resolving workplace conflicts at an early stage.

Dedicated conflict resolution committees, mediation services, and confidential grievance channels should be strengthened to encourage constructive dialogue and peaceful resolution of disputes.

4. Ensure Equity in Human Resource Management: Government and hospital management should review existing policies on remuneration, promotion, welfare, and career progression to ensure that all healthcare professionals are treated fairly and equitably. Transparent and consistent human resource practices will reduce feelings of discrimination and promote stronger organizational commitment.

5. Invest in Leadership Development: Healthcare administrators should receive continuous training in transformational leadership, emotional intelligence, communication, negotiation, and conflict management. Leaders who possess these competencies are better equipped to manage diverse healthcare teams and create supportive work environments that promote collaboration rather than competition.

6. Encourage Open Communication and Employee Participation: Management should create regular opportunities for healthcare professionals to participate in institutional decision-making. Open communication channels, staff consultative meetings, and feedback mechanisms should be strengthened so that employees feel heard, respected, and actively involved in matters affecting their work and professional practice.

7. Improve Working Conditions and Resource Availability: Government should continue to invest in healthcare infrastructure by providing adequate equipment, essential medical supplies, and sufficient human resources. A supportive working environment not only improves employee morale but also reduces frustration and workplace tensions that may contribute to industrial disharmony.

8. Promote Mutual Respect Across Healthcare Professions: Professional regulatory bodies and healthcare institutions should strengthen initiatives that encourage respect for the unique contributions of every healthcare profession. Continuous professional development programmes should include training on inter-professional education, collaborative practice, professional ethics, and respectful workplace behaviour. Recognizing the complementary roles of different healthcare professionals will help reduce unhealthy competition and foster stronger teamwork.

9. Prioritize Employee Well-being: Healthcare organizations should implement staff wellness programmes that address occupational stress, burnout, and psychological well-being. Providing access to counselling services, mental health support, and employee assistance programmes can improve staff resilience, job satisfaction, and overall workplace harmony.

10. Monitor Industrial Relations Regularly: Hospital management should routinely assess workplace climate, staff satisfaction, and inter-professional relationships through periodic surveys, staff engagement forums, and organizational assessments. Early identification of emerging issues will enable timely interventions before conflicts become deeply rooted or escalate into industrial disputes.

11. Strengthen Collaboration Between Government and Professional Associations: Government, hospital management, labour unions, and professional associations should maintain regular dialogue through institutionalized consultative platforms. Continuous engagement will encourage mutual understanding, build trust among stakeholders, and facilitate the development of policies that reflect the interests of the entire healthcare workforce rather than individual professional groups.

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Conflict of interest

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