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IMPLICATIONS OF INTERPERSONAL CONFLICT FOR PHYSICIANS' TASK PERFORMANCE: WORKPLACE DEVIANCE AS A MEDIATOR



SINTA 2

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ABSTRACT

Medical environments frequently encounter interpersonal tensions that influence clinical effectiveness and may shape how physicians carry out their tasks. Grounded in Social Exchange Theory and Conservation of Resources Theory, this study examines the link between interpersonal conflict and physicians' task performance by considering workplace deviance as a mediating mechanism. Using a cross-sectional design and surveyed a population of physicians in various healthcare facilities in Surabaya. Using purposive sampling than collected data from 150 respondents via an online, self-administered structured questionnaire. The data were analyzed with PLS-SEM. The measurement model met all reliability and validity criteria, and the structural model demonstrated significant explanatory and predictive power. The findings indicate that conflict can actually enhance performance when it is managed as task-focused disagreement within a framework of strong professional controls. In contrast, deviant behaviors consistently undermine performance. Furthermore, workplace deviance partially mediated the relationship between conflict and performance. Based on these findings, the study offers practical solutions for healthcare organizations in Indonesia. Include implementing effective conflict management, providing communication training, and consistently enforcing a code of ethics to harness potential benefits of task-related conflict.

Keywords: interpersonal conflict; workplace deviance; task performance; healthcare management; physicians.

INTRODUCTION

Workplace conflict is an unavoidable organizational reality, particularly in healthcare environments characterized by high work pressure and stringent accuracy demands. In healthcare settings, physicians often occupy a central decision-making role in clinical teams, requiring them to shoulder heavier workloads; such as simultaneously providing competent clinical care while coordinating with nurses, pharmacists, laboratory staff, and other service managers. However, interprofessional collaboration does not always proceed harmoniously. Yusoff et al. (2023), highlight that workplace violence and hostility toward primary care staff or healthcare workers, whether verbal, physical, or psychological have become a growing global concern with serious implications for staff well-being and performance. Reinforcing this phenomenon, Zeng et al. (2025) reported that 44.3% of primary care physicians in Chengdu, China, experienced at least one episode of workplace violence in the past year

(emotional abuse, threats, physical assault, sexual harassment) from coworkers, patients, or patients' families. While workplace violence represents an extreme manifestation, this study focuses on everyday interpersonal conflict among physicians and coworkers that can shape how tasks are executed in clinical teams. These findings underscore the need for formal preparation of healthcare workers to recognize, de-escalate, and manage workplace conflict and violence.

In Indonesia, empirical evidence indicates that conflicts among physicians and coworkers are often triggered by workload pressure and stress, differences in clinical judgments and role expectations, as well as knowledge limitations such as restricted training and weak team communication (Dewi et al., 2025; Kusuma et al., 2021; Rina et al., 2019). These conditions are exacerbated by administrative burdens, referral systems, seemingly overlapping government programs, drug supply issues, and asymmetries between senior and junior physicians. Although comprehensive national statistics are limited, field evidence shows that interpersonal conflict is not merely a psychological inconvenience but has direct implications for service quality, work effectiveness, and patient satisfaction. In short, conflict in clinical organizations is not a peripheral issue but resides at the intersection of professional identity, coordination, and safety.

Interpersonal conflict warrants special attention because it can trigger various adverse effects. Recent studies show that inter-individual conflict can reduce task focus, increase emotional strain, and heighten the likelihood of deviant behavior (Abunemeh, 2024; Beenish Khan & Amir Azam, 2022). For physicians working shifts in emergency departments (ED), delivery rooms, or Intensive Care Units (ICUs) requiring complex management, prolonged conflict can trigger frustration, cognitive fatigue, and ultimately job burnout. Ben Natan (2025), Cullati et al. (2019), and Lewis (2023) argue that conflict among healthcare workers contributes to medical errors and undermines the accuracy of clinical decision-making. Consistent with this, Qiu et al. (2025) also documented strong associations between interpersonal conflict, emotional exhaustion, and psychological distress among healthcare workers.

Within Indonesia's health system, workload and stress have been linked to deteriorating team functioning and declining performance. Rauf et al. (2020) found that communication accounted for 63.3% of the main causes of conflict among nurses at Haji Public Hospital Makassar. Ineffectively managed conflict impedes teamwork and reduces productivity and job satisfaction, thus emphasizing the need for early detection and structured conflict management to build a conducive work environment. Rina et al. (2019) further reported that workload and interpersonal conflict significantly suppress nursing performance. At the system level, the implementation of National Health Insurance (JKN) adds complex administrative demands that can burden doctor-patient relationships and service smoothness (Ekawati & Claramita, 2021). Consequently, conflict arises not only from clinical disagreements but also from workload allocation, seniority dynamics, and cross-professional communication barriers.

In modern organizational studies, task performance is a key indicator of human resource productivity and effectiveness. In healthcare, physician task performance is a key productivity indicator, encompassing diagnostic accuracy, treatment appropriateness, adherence to standard operating procedures (SOPs), interprofessional coordination (Claramita et al., 2020), and competence indicators (Krijgsheld et al., 2022). When interpersonal conflict arises, physicians' cognitive and emotional resources are divided between task execution and

efforts to repair relationships or respond to conflict, with subsequent consequences for impaired performance quality and patient safety. Zhang et al. (2021) and Roth et al. (2024) argue that conflict redistributes psychological resources within medical teams and can ultimately weaken clinical performance, meaning in medical contexts, conflict is not just about interpersonal relationships, but a systemic problem threatening service quality through the mechanism of depleting the team's cognitive resources.

This dynamic can be understood through the lens of Social Exchange Theory (Blau, 2017), where unfair or unpleasant interactions create relational imbalance and can trigger negative reciprocity. In healthcare organizations, physicians who feel undervalued or treated unfairly by colleagues, whether intentionally or not, may reduce the quality of task performance, visible through slow documentation, cursory procedures, or diminished initiative to coordinate across professional boundaries. The primary pathway linking conflict to performance decline is workplace deviance, conscious behavior violating organizational norms and potentially harming the institution or its members (Calderwood et al., 2021). Combined multi-wave and multi-source evidence in Kundi et al. (2023), research provides high confidence that deviance indeed serves as the mechanism connecting conflict to performance, not merely coincidence or methodological bias. Deviance mediates the negative effect of interpersonal conflict on task performance (Kundi et al., 2023). In hospitals, deviance can include delaying tasks, passive resistance to supervisory instructions, or restricting communication to selected colleagues. McCarthy et al. (2021), showed that unresolved conflict increases the likelihood of such behaviors, which in turn suppress productivity and service quality. Kundi & Badar (2021); see also Kundi et al. (2023) provided further evidence that workplace deviance significantly transmits the impact of conflict onto task performance. However, most of this evidence comes from business or administrative contexts; physician-specific settings, where responsibilities directly affect patient lives and professional ethics are stringent, remain understudied.

Nevertheless, not all conflict is harmful. When managed functionally, conflict can stimulate scientific knowledge transfer and strengthen team decisions (Walker & Daniels, 2019). Therefore, distinguishing constructive task conflict (differences in viewpoints about clinical work) from destructive relationship conflict (personal tension, disrespect, behavior) becomes crucial. Under conditions of psychological safety and strong collaborative norms, task-focused disagreement can prompt evidence clarification, problem clarity, peer collaboration, and tighter coordination that ultimately improves task performance (Fairchild et al., 2025; Kumar, 2025). Conversely, without such conditions, conflict tends to evolve into hostility, emotional tension, and counterproductive behavior. In practice, poorly handled conflict increases burnout, erodes job satisfaction, decreases organizational compliance, fuels turnover intention, and degrades clinical decision quality, with documented links to diagnostic and procedural errors (Lee et al., 2024).

Despite the growing global literature, important gaps remain for the Indonesian context. First, many studies aggregate "health workers" without distinguishing physicians as a professional group with distinct authority, responsibilities, and coordination demands. Second, few investigations explicitly test workplace deviance as a mediating mechanism between conflict and physician task performance. Third, contextual features of Indonesia's health system. Bureaucracy, human resource shortages, and administrative pressure amplified by the National Health Insurance program remains underrepresented in mainstream discourse. Finally, evidence from Sub-Saharan Africa shows that conflict impact is not uniform; for

instance, in Ugandan general hospitals, workplace conflict did not significantly predict performance after leadership, culture, and resources were accounted for (Atwiine et al., 2024), aligning with broader findings that job resources moderate leadership effects, culture shapes retention, and values-based leadership and working conditions can enhance service performance (Margaret & Isaac, 2025; Mayende & Musenze, 2018; Mutumba et al., 2025; Shumba et al., 2017). It is evident that leadership is not a magical solution—its effectiveness highly depends on a supportive resource ecosystem. In healthcare contexts, this explains why excellent leaders in resource-poor hospitals may not achieve significant results. These mixed findings demonstrate that context and controls matter, raising a critical question for Indonesian clinical organizations: under what conditions does conflict harm or help physician performance, and through which behavioral channels?

To address these gaps, this study focuses on physicians in Indonesian healthcare facilities and pursues three objectives: (i) to test the relationship between interpersonal conflict (IC) and physician task performance (TP) within a clinical governance environment; (ii) to examine the relationships between IC and workplace deviance (WP), and between WP and TP, as behavioral mechanisms linking conflict to performance; and (iii) to assess whether WP mediates the relationship between IC and TP (complementary or competitive), thereby clarifying when and how conflict affects performance in medical teams.

The research is expected to contribute to (a) theory by testing deviance as a behavioral conduit between conflict and performance in a setting with strong professional controls; (b) contextual understanding by situating Indonesian features SOPs, accreditation, electronic medical record systems' (EMR) visibility, and hierarchical teams within contemporary conflict theory; and (c) practice by generating actionable implications for conflict management training, physician communication, and micro-governance mechanisms that detect and reduce deviance (e.g., documentation lag dashboards, closed-loop compliance checks).

Interpersonal conflict refers to perceived incompatibilities or disagreements between physicians and coworkers regarding work-related issues (task or relationship). Deviant workplace behavior refers to voluntary behavior that violates significant organizational norms and, in doing so, threatens the well-being of an organization, its members, or both (Atwiine et al., 2024; Robinson & Bennett, 1995). In hospital environments, this could include acts like intentionally delaying documentation, bypassing safety checks, or selectively communicating with specific team members. Physician task performance encompasses documentation completeness, diagnostic consistency, treatment appropriateness, adherence to SOPs, interprofessional coordination (Claramita et al., 2020), and competence indicators (Krijgheld et al., 2022). Although the quality of healthcare outcomes received by patients is shaped by many factors, task performance (of physicians) remains a proximal indicator. A direct measure of clinical processes controllable by physicians before final patient outcomes are visible and is manageable (monitorable, evaluable, and improvable) managerially in daily clinical work.

Based on the literature, this research framework positions Interpersonal Conflict (IC) as the exogenous variable, Task Performance (TP) as the endogenous variable, and Workplace Deviance (WP) as the mediator. The model acknowledges two possibilities observed in previous research: (i) conflict can decrease performance directly (through strain) and indirectly (through deviance), yet under specific boundary conditions, especially when conflict is strictly task-focused within psychologically safe teams, where the conflict type is task conflict (debate about the best way to handle patients), not relationship conflict (personal

conflict), and where there is psychological safety, team members feel safe expressing opinions without fear of humiliation or punishment. (ii) conflict may be neutral or even beneficial by promoting evidence examination and coordination. Evidence examination means conflict forces the team to review evidence, checklists, and guideline usage more meticulously, and coordination means differences of opinion actually clarify roles and enhance communication among professionals.

Social Exchange Theory (SET) explains that workplace interactions shape reciprocity expectations; unfavorable exchanges can reduce cooperation and increase withdrawal or counterproductive responses (Blau, 2017). In healthcare organizations, however, reciprocity is shaped by strong professional norms, peer visibility, and reputational stakes. Clinical governance mechanisms (e.g., SOPs, case discussions, audits, and professional committees), which the reputational and procedural consequences of misconduct. Under such conditions, interpersonal friction may be more likely to trigger self-regulation and compliance than retaliatory deviance. Evidence from Indonesian organizational settings also highlights the centrality of relational mechanisms: empowering leadership can improve employee performance through increased trust in managers, supporting the practical relevance of reciprocity and trust pathways in shaping behavior.

Conservation of Resources (COR) theory complements this view by proposing that interpersonal conflict threatens key resources such as time, cognitive focus, emotional energy, and professional standing (Hobfoll, 1989). When resources are threatened, individuals tend to prioritize loss-avoidance strategies. In high-stakes clinical settings, deviant behavior (e.g., delaying documentation, bypassing safety checks, or withholding information) entails disproportionate risks because actions are traceable, auditable, and sanctionable. Thus, COR suggests that conflict may prompt physicians to conserve resources by adhering more strictly to routines and formal procedures, thereby reducing workplace deviance.

At the same time, interpersonal conflict is not uniformly detrimental. When disagreements remain task-focused rather than personal, conflict can stimulate deeper evidence scrutiny, clarify role expectations, and strengthen coordination, which may enhance task performance. A supportive interpersonal climate is critical for this constructive pathway; evidence from Indonesian organizations indicates that interpersonal trust facilitates knowledge sharing and is associated with higher job satisfaction, conditions that are consistent with productive information exchange rather than interpersonal hostility (Noerchoidah et al., 2022; Sudiyani & Rihayana, 2025). Integrating SET and COR, this study proposes that in governance-rich healthcare organizations, interpersonal conflict may improve physician task performance directly and indirectly by suppressing workplace deviance, whereas workplace deviance is expected to consistently undermine performance.

Based on the theoretical arguments above, the following hypotheses are formulated:

- H₁.** Interpersonal conflict is negatively associated with physician task performance.
- H₂.** Interpersonal conflict is positively associated with workplace deviance.
- H₃.** Workplace deviance is negatively associated with physician task performance.
- H₄.** Workplace deviance mediates the relationship between interpersonal conflict and task performance.

Data analysis in this study uses PLS-SEM to test the proposed model because (i) the study emphasizes prediction and explanation of variance in TP and WP rather than global goodness-of-fit; (ii) the model includes a mediation mechanism (WP) with several latent constructs and indicators, for which PLS-SEM is highly suitable for complex paths and non-

normally distributed data; (iii) this approach is robust with moderate sample sizes and allows assessment of out-of-sample predictive relevance (e.g., PLSpredict/Q²); and (iv) it facilitates simultaneous evaluation of measurement quality (reliability, convergent/discriminant validity) and structural relationships without imposing strict multivariate normality assumptions. These features align with this study's objective to quantify explanatory and predictive power in a clinically realistic, governance-rich environment.

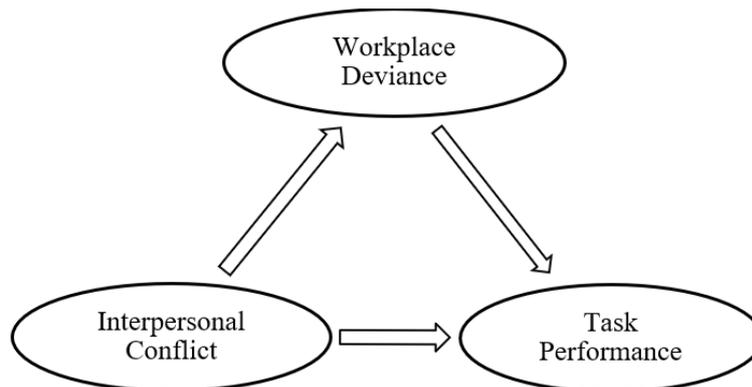


Figure 1. Conceptual Framework

Source: Author, 2026

The next section details the methods, measures, and analytical strategy. We then present the results, followed by a discussion that interprets the relationships between IC and TP, IC and WP, and WP and TP, as well as the mediation mechanism, within the context of Indonesian clinical governance. The paper concludes by outlining practical and theoretical implications for leaders and policymakers, study limitations, and directions for future research.

METHODS

This study employed a quantitative approach with a cross-sectional research design conducted in Surabaya, East Java. The research setting encompasses the city's diverse healthcare ecosystem, which includes 63 public health centers (*puskesmas*) and three major public hospitals (Type B)(Health Ministry of Indonesia, 2023). Physicians were recruited purposively from within this ecosystem through online surveys distributed via professional networks and associations. This approach ensured that respondents came from a variety of organizational settings such as public hospitals, private hospitals of different classes, and *puskesmas* to capture relevant variations in organizational forms, patient care processes, and workload characteristics. This variation is expected to provide a comprehensive picture of interpersonal conflict dynamics across different types of healthcare organizations.

The population and target of this research included general practitioners and specialists actively engaged in clinical practice at the selected facilities during the research period from January to July 2025. The established inclusion criteria comprised a minimum of one year of work at the relevant institution and active involvement in multidisciplinary medical teams, while physicians who refused participation, did not complete the questionnaire, or were on extended leave were excluded from the study. A purposive sampling strategy was applied to

recruit physicians whose profiles aligned with the research objective, ensuring representation from different facility types (public hospitals, private hospitals, and *puskesmas*) and a mix of general practitioners and specialists. While the exact distribution across each specific facility was not recorded, the sample aimed to reflect the diversity of clinical settings in Surabaya.

Sample size determination referred to general PLS-SEM guidelines recommended by Hair et al. (2019), Hair et al. (2021), and Kock & Hadaya (2018) with the minimum sample size set at approximately 5–10 times the number of indicators. The final reflective measurement model retained 18 indicators that consisting of five for Interpersonal Conflict (IC), seven for Workplace Deviance (WP), and six for Task Performance (TP). Implying a desired sample range of approximately 90–180 observations. Overall, 150 complete responses were obtained that met these guidelines and supported stable parameter estimation in the analysis. A response rate of 75% from 200 distributed questionnaires indicated adequate participation for further analysis.

Primary data were collected using self-administered closed questionnaires with a five-point Likert scale (from strongly disagree to strongly agree) distributed through online platforms. The instruments were adapted from standard sources and contextualized to the daily practice of physicians in Indonesian healthcare organizations. Interpersonal Conflict (IC) was measured using five questionnaire items capturing the frequency and intensity of perceived conflictual interactions with coworkers and other clinicians, referencing previous works while ensuring relevance to clinical teams. Although labeled as interpersonal conflict, the IC items were phrased to capture task-focused disagreements (e.g., differences in clinical judgments/procedures) rather than interpersonal hostility. Therefore, the measured IC in this study is conceptually closer to task conflict than relationship conflict. Workplace Deviance (WP) initially included ten indicators of deviant behavior developed through preliminary studies; however, through initial measurement screening with exploratory factor analysis, three items with outer loadings below 0.70 (WP3, WP5, WP7) were eliminated, leaving seven indicators for the final model (adapted primarily and related work behavior scales). Workplace deviance (WP) was operationalized as self-reported frequency/endorsement of behaviors that intentionally deviate from expected professional/organizational standards. All WP items were coded so that higher scores indicate higher deviance. If any items were positively worded (compliance-oriented), they were reverse-coded prior to analysis to ensure directional consistency across indicators. Task Performance (TP) was measured with six indicators, emphasizing the ability to complete assigned tasks, maintain service quality, and adhere to clinical and administrative procedures. Secondary sources (indexed journal articles and academic books) were used to confirm construct definitions and adapt item wording to suit the medical profession.

Initial data screening ensured questionnaire completeness for the variables of interest, enabling analysis without imputation. The PLS-SEM approach was chosen as it does not assume multivariate normality and is suitable for complex models with moderate sample sizes, although collinearity among predictors was still examined using the variance inflation factor (VIF) with a threshold of 3.3 to avoid bias in path estimates. Given the reflective model specification, measurement evaluation was conducted by examining indicator reliability (outer loading with target ≥ 0.70), internal consistency reliability (Cronbach's alpha and composite reliability ≥ 0.70), and convergent validity (average variance extracted/AVE ≥ 0.50). Discriminant validity was assessed using the heterotrait-monotrait (HTMT) ratio with conservative (< 0.85) and liberal (< 0.90) thresholds, and cross-checked using the Fornell-

Larcker criterion (square root of AVE exceeding inter-construct correlations). Where relevant, the Dijkstra-Henseler rho (ρ_A) was also inspected to supplement evidence of internal consistency.

Structural relationships among IC, WP, and TP were tested using nonparametric bootstrapping with 5000 subsamples to obtain standard errors, t-values, and 95% confidence intervals for path coefficients. Structural model quality was assessed using the coefficient of determination (R^2) for endogenous constructs with interpretation of weak (>0.25), moderate (>0.50), and substantial (>0.75), local effect size (f^2) to quantify each predictor's contribution with categories of small (0.02), medium (0.15), large (0.35), and Stone-Geisser predictive Q^2 (through blindfolding) to evaluate out-of-sample predictive relevance with values >0 indicating predictive relevance. To enhance reporting transparency, the researchers reported a series of fit and discrepancy indices common in variance-based SEM, namely standardized root mean square residual ($SRMR < 0.08$), and supplementarily, normed fit index ($NFI > 0.90$) and discrepancy measures d_{ULS} and d_G with acknowledgment that these indices are complementary and do not replace the predictive orientation of PLS.

Three layers of quality control were applied in this study within the analytical workflow. First, monitoring multicollinearity at the outer and inner model levels with $VIF < 3.3$ to limit standard error inflation. Second, mitigating common method bias through questionnaire design with item mixing and variation of anchor points, and statistical examination through full collinearity VIF. Third, assessing the robustness of the hypothesized mediation (IC to WP to TP) not only through path significance but also through the magnitude of indirect effects and their confidence intervals, with consideration of variance accounted for (VAF) to categorize mediation types.

Participation was voluntary with implementation of informed consent explaining the right to withdraw without consequences, and data confidentiality was maintained through response anonymity, identity coding, and aggregate reporting of results. No personal identification data were collected, and responses were analyzed and reported in aggregate to maintain confidentiality. Data storage protocols followed electronic data protection standards with encryption and specific retention periods.

Overall, the methodological choices applied from sample design considering setting heterogeneity to data analysis with PLS-SEM were designed to produce findings that not only meet academic standards but are also relevant to the practical reality of physician work in Indonesia. Several methodological limitations are acknowledged, including the cross-sectional nature that limits causal inference and potential self-report bias despite mitigation efforts. This approach is expected to bridge the gap between methodological rigor and practical contextualization in healthcare management studies in Indonesia.

RESULTS AND DISCUSSION

The demographic composition of the study sample is presented in Table 1, detailing the distribution of respondents across key characteristics including sex and age categories. This comprehensive profiling establishes the foundational context for understanding the participant base upon which subsequent analyses of interpersonal conflict, workplace deviance, and task performance dynamics are constructed.

Table 1 presents the demographic profile of the 150 physician respondents. The sample comprised 102 males (68%) and 48 females (32%), with a gender ratio of approximately 2:1. In terms of age distribution, 82 respondents (55%) were in the 46-60 years

cohort, while 68 respondents (45%) were in the 30-45 years cohort. The majority of respondents were thus senior clinicians, a factor that may influence the study's dynamics related to professional conflict and performance.

Table 1. Respondent Characteristics of Physician Respondents (N = 150)

Characteristic	Category	Number of Respondent	Percentage
Sex	Male	102	68%
	Female	48	32%
	Total	150	100%
Age	30 – 45 years	68	45%
	46 – 60 years	82	55%
	Total	150	100%

Source: Data processed, 2025

Table 2 presents the outer loadings of the reflective indicators for all constructs. All loading values exceed the recommended threshold of 0.70, demonstrating satisfactory indicator reliability (Hair et al., 2021). The strong loadings (ranging from 0.740 to 0.956) indicate that all items are adequate measures of their respective latent constructs and that the measurement model possesses good convergent validity at the indicator level.

Table 2. Outer Loading for the Reflective Measurement Model

Construct	Indicator	Outer loadings
Interpersonal Conflict	IC1 <- IC	0.945
	IC2 <- IC	0.956
	IC3 <- IC	0.910
	IC4 <- IC	0.918
	IC5 <- IC	0.881
Task Performance	TP1 <- TP	0.761
	TP2 <- TP	0.896
	TP3 <- TP	0.882
	TP4 <- TP	0.771
	TP5 <- TP	0.759
	TP6 <- TP	0.794
Workplace Deviance	WP1 <- WP	0.852
	WP10 <- WP	0.789
	WP2 <- WP	0.801
	WP4 <- WP	0.773
	WP6 <- WP	0.768
	WP8 <- WP	0.838
	WP9 <- WP	0.740

Source: Data processed, 2025

Table 3 presents the results for assessing the measurement model's internal consistency reliability and convergent validity. All constructs demonstrate excellent reliability, with Composite Reliability (ρ_c) values exceeding 0.90, surpassing the recommended threshold of 0.70. Similarly, Cronbach's Alpha and ρ_A (ρ_A) for all constructs are above 0.89, further confirming the high internal consistency of the measures. For convergent validity, all

constructs meet the requirement as their Average Variance Extracted (AVE) values are above 0.50. This indicates that more than 50% of the variance in the indicators is explained by their respective latent constructs, confirming that the measures well-represent their intended theoretical concepts.

Table 3. Internal Consistency Reliability and Convergent Validity of the Measurement Model (Cronbach's Alpha, rho_A, Composite Reliability, and AVE)

	Cronbach's Alpha	Composite reliability (rho_a)	Composite reliability (rho_c)	Average variance extracted (AVE)
Interpersonal Conflict	0.956	0.962	0.966	0.851
Task Performance	0.896	0.902	0.921	0.660
Workplace Deviance	0.903	0.904	0.923	0.633

Source: Data processed, 2025

The discriminant validity of the constructs was assessed using both the Heterotrait-Monotrait (HTMT) ratio and the Fornell-Larcker criterion. As shown in Table 4, all HTMT values are below the conservative threshold of 0.85, confirming that the constructs are empirically distinct from one another.

Table 4. Discriminant Validity Assessment Using the Heterotrait-Monotrait (HTMT) Ratio

	Interpersonal Conflict	Task Performance	Workplace Deviance
Interpersonal Conflict			
Task Performance	0.681		
Workplace Deviance	0.660	0.778	

Source: Data processed, 2025

Furthermore, the Fornell-Larcker criterion was also satisfied, as shown in Table 5. The square root of the Average Variance Extracted (AVE) for each construct (diagonal values) was greater than its correlations with all other constructs (off-diagonal values). This result provides additional evidence of discriminant validity, confirming that the three constructs measure distinct phenomena.

Table 5. Discriminant Validity Assessment Using the Fornell-Larcker Criterion

Construct	Interpersonal Conflict	Task Performance	Workplace Deviance
Interpersonal Conflict	0.922	0.632	-0.621
Task Performance	0.632	0.812	-0.707
Workplace Deviance	-0.621	-0.707	0.795

Note: Diagonal elements (in bold) represent the square root of the AVE.

Source: Data processed, 2025

The results from both tests collectively affirm that Interpersonal Conflict, Task Performance, and Workplace Deviance are distinct constructs, thereby supporting the structural and conceptual validity of the measurement model.

The reflective measurement model was evaluated for reliability and validity, and it met all standard quality criteria. As shown in Table 2, all outer loadings exceeded 0.70,

confirming adequate indicator reliability. Internal consistency was established with Cronbach's Alpha and Composite Reliability values above 0.70 for all constructs, while convergent validity was satisfied as all Average Variance Extracted (AVE) values were greater than 0.50 see Table 3.

Discriminant validity was verified through multiple tests. All Heterotrait-Monotrait (HTMT) ratios were below the 0.90 threshold shown in Table 4, and the Fornell-Larcker criterion was met, with the square root of each construct's AVE being greater than its correlations with other constructs at Table 5. Finally, cross-loading analysis was conducted to further verify discriminant validity at the indicator level.

Cross-loading analysis was conducted to further verify discriminant validity at the indicator level. As presented in Table 6, each indicator's loading on its associated construct is higher than its cross-loadings on all other constructs. For instance, indicator IC1 loads highest on Interpersonal Conflict (0.945) compared to Task Performance (0.654) and Workplace Deviance (-0.585). This pattern holds for all indicators.

Table 6. Cross-Loadings of Indicators Across Constructs (Indicator-Level Discriminant Validity Check)

	Interpersonal Conflict	Task Performance	Workplace Deviance
IC1	0.945	0.654	-0.585
IC2	0.956	0.585	-0.644
IC3	0.910	0.551	-0.514
IC4	0.918	0.586	-0.637
IC5	0.881	0.531	-0.456
TP1	0.488	0.761	-0.605
TP2	0.516	0.896	-0.666
TP3	0.530	0.882	-0.607
TP4	0.439	0.771	-0.416
TP5	0.607	0.759	-0.488
TP6	0.494	0.794	-0.622
WP1	-0.591	-0.572	0.852
WP10	-0.396	-0.594	0.789
WP2	-0.509	-0.495	0.801
WP4	-0.454	-0.572	0.773
WP6	-0.499	-0.544	0.768
WP8	-0.491	-0.599	0.838
WP9	-0.502	-0.561	0.740

Source: Data processed, 2025

The structural model shows moderate explanatory power for Task Performance and weak-to-moderate explanatory power for Workplace Deviance (Table 7–8). Specifically, the model explains 56.1% of the variance in TP ($R^2 = 0.561$) and 38.5% of the variance in WP ($R^2 = 0.385$). Predictive relevance was examined using PLSpredict with 10 folds (Table 9). Both endogenous constructs yielded positive Q^2_{predict} values (TP = 0.388; WP = 0.367), indicating that the model has out-of-sample predictive relevance.

Table 7. R Square (R²) and Adjusted R Square (R² Adjusted) for Endogenous Constructs in the Structural Model

Construct	R ²	R ² Adjusted
TP	0.561	0.555
WP	0.385	0.381

Source: Data processed, 2025

Following Hair et al. (2019), $R^2 \geq 0.75$ = substantial, ≥ 0.50 = moderate, ≥ 0.25 = weak. TP shows $R^2 = 0.561$ (moderate): 56.1% of TP variance is explained by IC and WP ($p < 0.001$). WP shows $R^2 = 0.385$ (weak-to-moderate): 38.5% of WP variance is explained by IC ($p < 0.001$). The adjusted R^2 values, which account for model complexity and sample size, are only marginally lower than the R^2 values. This minimal difference suggests that the model is robust and not overfitted, confirming the stability and generalizability of the explanatory power.

The model's predictive relevance was assessed using the PLSpredict procedure with 10 folds. As shown in Table 8, both endogenous constructs yielded positive Q^2_{predict} values, which confirms that the model possesses out-of-sample predictive power. The Q^2_{predict} value for Task Performance (TP) was 0.388, and for Workplace Deviance (WP) it was 0.367.

Table 8. Predictive Relevance (Q^2_{predict}) and Prediction Errors

	Q^2_{predict}	RMSE	MAE
TP	0.388	0.801	0.540
WP	0.367	0.819	0.522

Source: Data processed, 2025

The prediction errors, as indicated by the Root Mean Square Error (RMSE) and Mean Absolute Error (MAE) values, fall within a moderate range. Collectively, these results demonstrate the model's meaningful predictive capability, thereby bolstering its external validity and practical utility.

The hypothesized structural relationships were tested using bootstrapping with 5,000 subsamples. As presented in Table 9, all three direct paths in the model are statistically significant ($T > 1.96$; $p < 0.05$), confirming the proposed relationships.

Table 9. Structural Path Estimates of Direct Relationships in the Hypothesized Model

	Original sample (O)	Sample mean (M)	Standard deviation (STDEV)	T statistics (O/STDEV)	P values
IC -> TP	0.315	0.299	0.093	3.380	0.001
IC -> WP	-0.621	-0.631	0.061	10.235	0.000
WP -> TP	-0.512	-0.533	0.087	5.891	0.000

Source: Data processed, 2025

Table 10. Coefficients and Hypothesis Testing Results for Direct Effects (Path Coefficients, t-values, and p-values)

Relation	Original Sample (O)	T Statistics	P Values	Interpretation
IC → TP	0.315	3.380	0.001	Significant, positive
IC → WP	-0.621	10.235	0.000	Significant, negative
WP → TP	-0.512	5.891	0.000	Significant, negative

Source: Data processed, 2025

The positive and significant path from Interpersonal Conflict to Task Performance (IC to TP: $\beta = 0.315$; $p = 0.001$) suggests that, within the controlled professional environment of healthcare settings, conflict may function as constructive task conflict that ultimately enhances performance through rigorous clinical debate and information scrutiny. Conversely, the strong negative relationship between Interpersonal Conflict and Workplace Deviance (IC to WP: $\beta = -0.621$; $p < 0.001$) indicates that higher levels of conflict are associated with reduced deviant behavior. This counterintuitive finding aligns with the "discipline-locked context effect," where organizational controls and professional norms become activated during conflict episodes, thereby suppressing deviant responses.

The significant negative path from Workplace Deviance to Task Performance (WP to TP: $\beta = -0.512$; $p < 0.001$) confirms that deviant behaviors consistently undermine physicians' task performance, regardless of the conflict context.

The pattern of these relationships, specifically, the negative IC to WP path combined with the negative WP to TP path establishes the foundation for a complementary mediation effect, where the indirect effect of conflict on performance through reduced deviance is positive ($\beta_{ind} = 0.318$). Structural Model Assessment: Hypothesis Testing Summary.

The results of the structural model analysis and hypothesis testing are presented in Table 11. All three direct paths in the model are statistically significant, though with unexpected directional relationships for two hypotheses.

Table 11. Structural Model Results (Direct Effects): Estimates, t-values, and p-values

	Original sample (O)	Sample mean (M)	Standard deviation (STDEV)	T statistics ((O/STDEV))	P values
IC -> TP	0.315	0.299	0.093	3.380	0.001
IC -> WP	-0.621	-0.631	0.061	10.235	0.000
WP -> TP	-0.512	-0.533	0.087	5.891	0.000

Source: Data processed, 2025

Contrary to the initial hypotheses but consistent with the discipline-locked context of healthcare organizations, interpersonal conflict shows a significant positive relationship with task performance (IC to TP: $\beta = 0.315$; $p = 0.001$), leading to the rejection of H_1 . Similarly, interpersonal conflict demonstrates a strong negative association with workplace deviance (IC to WP: $\beta = -0.621$; $p < 0.001$), resulting in the rejection of H_2 .

The significant negative relationship between workplace deviance and task performance (WP to TP: $\beta = -0.512$; $p < 0.001$) confirms the detrimental effect of deviant behaviors on performance. Most importantly, the mediation hypothesis (H_4) is supported, with a significant positive indirect effect ($\beta_{ind} = 0.318$; $p < 0.001$). This complementary mediation occurs because both constituent paths (IC to WP and WP to TP) are negative, resulting in a

positive indirect effect that reinforces the direct positive effect of conflict on performance. The overall model demonstrates moderate explanatory power, accounting for 56.1% of the variance in task performance ($R^2 = 0.561$) and 38.5% of the variance in workplace deviance ($R^2 = 0.385$).

The results of the bootstrapping analysis confirm that all structural paths in the model are statistically significant, as evidenced by 95% confidence intervals that do not include zero. The path coefficients, their confidence intervals, and the model's explanatory power are summarized below.

Table 12. Bootstrapped 95% Confidence Intervals for Structural Path Estimates

Relationship	Original sample (O)	Sample mean (M)	2.5%	97.5%
IC -> TP	0.315	0.299	0.120	0.479
IC -> WP	-0.621	-0.631	-0.750	-0.513
WP -> TP	-0.512	-0.533	-0.696	-0.362

Source: Data processed, 2025

The effects of IC on WP ($\beta = -0.621$; 95% CI $[-0.750, -0.513]$) is entirely negative, stable and significant, implying that higher interpersonal conflict is associated with lower workplace deviance. The effects of WP on TP ($\beta = -0.512$; 95% CI $[-0.696, -0.362]$) is also entirely negative, stable and significant, confirming workplace deviance has a significant negative effect on task performance. The effects of IC on TP ($\beta = 0.315$; 95% CI $[0.120, 0.479]$) is positive and significant. Because all CIs exclude zero, the structural paths are precise and robust, supporting the interpretation that WP mediates the effects of IC to TP relationship. A positive effect of IC on TP association can arise when conflict is predominantly task conflict and the organization maintains strong psychological safety and collaborative norms.

The model demonstrates substantial explanatory power, explaining 56.1% of the variance in Task Performance (TP) and 38.5% of the variance in Workplace Deviance (WP). Furthermore, the model exhibits strong out-of-sample predictive relevance, as indicated by the positive Q^2 predict values for both TP ($Q^2 = 0.388$) and WP ($Q^2 = 0.367$). The pattern of results specifically, a significant negative effect of IC on WP and a significant negative effect of WP on TP supports the interpretation that Workplace Deviance acts as a mediator in the relationship between Interpersonal Conflict and Task Performance. The positive direct effect from IC on TP suggests a complex relationship, potentially indicating that the conflict measured is more task-oriented and occurs within a context of strong collaborative norms. The mediation test result ($\beta_{\text{indirect}} = 0.318$, $p < 0.001$) confirms that Workplace Deviance (WP) significantly mediates the relationship between Interpersonal Conflict (IC) and Task Performance (TP). Given that both the direct effect (IC to TP) and the indirect effect are significant, this establishes a partial mediation.

Table 14. Indirect Effect and Mediation Test Results (IC \rightarrow WP \rightarrow TP)

	Original sample (O)	Sample mean (M)	Standard deviation (STDEV)	T statistics (O/STDEV)	P values
IC -> WP -> TP	0.318	0.338	0.071	4.499	0.000

Source: Data processed, 2025

The overall model explains a substantial portion of the variance in the endogenous constructs, with R^2 values of 0.561 for Task Performance (TP) and 0.385 for Workplace Deviance (WP). The model's practical credibility is strengthened by its out-of-sample predictive relevance, as indicated by positive Q^2 predict values for both TP (0.388) and WP (0.367).

These findings directly address the three objectives of this study. First, the positive and significant IC on TP path ($\beta = 0.315$) confirms that interpersonal conflict does not invariably harm physicians' task performance. When conflict stays focused on clinical (task) substance, it functions as a cognitive stimulus, sharpening diagnostic reasoning and strengthening interprofessional coordination. Second, the negative IC on WP and WP on TP paths reveal a key behavioral mechanism among physicians: in tightly supervised clinical environments, conflict triggers greater procedural compliance and work visibility, thereby suppressing deviance and protecting performance. Third, the significant indirect effect supports a model of complementary mediation, showing that conflict enhances performance both directly and indirectly by channeling team energy into disciplined processes while reducing the space for deviant behavior. This coherent framework lays the groundwork for a detailed examination of each pathway.

The positive and significant IC on TP path ($\beta = 0.315$) indicates that interpersonal conflict (IC) exerts a meaningful effect on physicians' task performance (TP). This positive coefficient shows that interpersonal conflict in medical workplaces is not always detrimental; under certain conditions it can stimulate better task execution. A plausible explanation lies in the presence of task conflict, distinct from relationship conflict, where disagreements about patient management prompt physicians to work more meticulously, prepare stronger clinical arguments, and improve decision quality. As reported by (de Wit et al., 2012), task conflict does not necessarily become harmful and can even benefit performance, provided it does not spill over into relationship conflict and occurs within a climate that supports open discussion. This positive direction aligns with literature showing that task conflict can enhance performance when it is kept distinct from relationship conflict and is supported by psychological safety and collaborative norms. In such contexts, clinical disagreement drives tighter diagnostic reasoning, guideline review, and coordination, thereby improving task performance (de Wit et al., 2012; Ilies et al., 2011).

The interpretation of these findings has a strong theoretical basis from two perspectives. First, consistent with Conflict Management Theory (Abunemeh, 2024), conflict can be beneficial when managed functionally. Through proper identification and regulation by enriching information diversity, clarifying medical assumptions, and opening constructive dialogue spaces, thus improving decision quality. Second, from the perspective of Social Exchange Theory (Blau, 2017), challenging interactions trigger positive reciprocity through increased effort, careful data presentation, and willingness to mutually validate clinical findings, serving as a social investment to preserve professional reputation and trust. The consistency of this finding is reinforced by empirical evidence in medical settings showing that task conflict can improve diagnostic accuracy when accompanied by effective communication clarification, confirmation, and two-way feedback and correction mechanisms (de Wit et al., 2012; Ilies et al., 2011). Thus, the positive coefficient in this study is not anomalous but reflects the reality of clinical practice operating within established systemic boundaries and professional norms.

The negative and significant IC on WP coefficient ($\beta = -0.621$) suggests that, in the clinical settings studied, higher interpersonal conflict is associated with lower workplace deviance. Rather than interpreting this as a universal reversal of the conflict–deviance relationship, the finding is more plausibly explained by the governance characteristics of healthcare organizations. Clinical work is embedded in strong professional norms, high peer visibility, and formal accountability mechanisms (e.g., SOPs, case discussions, audits, and committee oversight). These mechanisms can increase the perceived costs of deviant responses during periods of interpersonal friction, thereby encouraging greater self-regulation and procedural compliance.

The predominance of senior physicians in the sample may help explain this pattern. From Social Exchange Theory (Blau, 2017), senior physicians tend to place greater value on professional reputation, collegial trust, and long-term relational capital. In situations of interpersonal tension, they may therefore be more likely to respond with behaviors that signal professionalism such as adhering more closely to procedures and maintaining performance rather than engaging in deviant acts that could harm professional standing and working relationships. This interpretation is consistent with the idea that individuals invest in cooperative conduct when future reciprocity and reputational returns are salient (Cropanzano & Mitchell, 2005).

In parallel, Conservation of Resources Theory (Hobfoll, 1989), provides a complementary explanation. Interpersonal conflict can be experienced as a threat to key resources (time, emotional energy, cognitive focus, and professional standing). When resource loss is salient, individuals tend to adopt loss-minimizing strategies. In governance-rich clinical environments, deviant behaviors are comparatively high-risk because they can be traced through documentation systems, audits, and peer review. Under these conditions, stricter adherence to routines and SOPs may represent a lower risk strategy that both conserves resources and reduces exposure to sanctions. Taken together, SET and COR converge on a consistent implication in this setting: when reputational stakes and accountability are salient, conflict may be associated with tighter procedural compliance rather than increased deviance. This pattern stands in contrast to evidence in non-medical sectors where interpersonal conflict more consistently predicts higher deviance from Kundi et al. (2023). The difference may reflect contextual variation in professional control and accountability. In many general organizational settings, emerging conflict is not always counterbalanced by tightly institutionalized oversight, which may leave more opportunity for counterproductive reactions to manifest as deviant behavior.

By contrast, healthcare organizations typically operate under formalized governance structures that heighten observability and accountability, including routine case review processes, audit trails, and committee-based oversight. Under such conditions, the perceived costs of deviance during conflict episodes may increase, which can dampen the likelihood of deviant responses. Accordingly, the present findings should be interpreted as specifying plausible boundary conditions, particularly governance strength and professional control, under which the conflict deviance relationship may differ from patterns reported in non-medical contexts.

The strong negative WP on TP path ($\beta = -0.512$; $p < 0.001$) indicates that workplace deviance is associated with lower physician task performance. This is consistent with the view that deviations from expected professional and organizational standards can disrupt workflow reliability, information continuity, and coordination in team-based clinical work. In practice,

several forms of everyday deviance may plausibly contribute to performance impairment. First, delayed documentation can weaken the timeliness of clinical information, complicate coordination, and increase rework for other team members. Second, withholding or delaying important updates can reduce shared situational awareness, particularly in fast-moving clinical contexts. Third, selective or incomplete communication can weaken closed-loop communication and reduce coordination quality. Collectively, these behaviors are consistent with the negative association observed between deviance and task performance in this sample. Finally, the significant indirect effect IC on WP on TP ($\beta = 0.318$) indicates complementary partial mediation. Because both IC on WP and WP on TP are negative, the indirect pathway is positive, suggesting that conflict is associated with higher performance partly through its association with reduced deviance. Substantively, this pattern is most consistent with an interpretation in which conflict episodes increase procedural visibility and accountability, thereby constraining deviant responses and supporting task execution. However, to avoid overgeneralization, this interpretation should be bounded to contexts where governance mechanisms are strong and where interpersonal conflict is predominantly task-focused rather than relationally hostile. Under these conditions, conflict may be more likely to be channeled into structured review, procedural adherence, and performance protective behaviors, while workplace deviance remains consistently detrimental to task performance.

This study has several limitations. First, the cross sectional design restricts causal inference and does not establish temporal ordering among interpersonal conflict, workplace deviance, and task performance. Second, the use of self reported measures collected from a single survey source may introduce common method variance and social desirability bias, particularly for deviance-related items. Third, the purposive sampling strategy and the focus on physicians in Surabaya may limit generalizability to other regions and health systems. In addition, because the distribution of respondents across facility types was not recorded in sufficient detail, the study cannot rigorously test whether structural relationships differ across public hospitals, private hospitals, and *puskesmas*. Finally, the conflict measure likely captures a blend of task focused disagreement (clinical/procedural differences) and affect-laden interpersonal tension; future work should explicitly separate task conflict from relationship conflict to improve construct clarity.

Despite these limitations, several results support analytic credibility within the study scope. The measurement model demonstrated satisfactory indicator reliability and convergent/discriminant validity, the structural paths were supported by bootstrapped confidence intervals excluding zero, and the model showed meaningful explanatory and out of sample predictive relevance for the endogenous constructs (R^2 and Q^2_{predict}). These points should be interpreted as evidence of internal consistency in this dataset, not as proof of causal mechanisms.

The findings suggest actionable implications for clinical governance and team functioning. First, healthcare organizations should provide structured training that helps clinicians distinguish task conflict from relationship conflict, use neutral clinical language, and escalate disagreements into data based discussion rather than personal attribution. Second, routine forums (e.g., daily huddles, case discussions, morbidity mortality reviews where appropriate) can be formalized to channel disagreements into structured review, guideline alignment, and role clarification. Third, a psychologically safe incident reporting and response process should be strengthened so destructive behaviors can be addressed promptly and fairly, with clear follow-up pathways involving supervisory and professional committees. Fourth,

organizations can reduce opportunities for everyday deviance by increasing procedural visibility through simple monitoring systems (e.g., documentation timeliness indicators, closed-loop communication checks) paired with feedback and coaching rather than punitive escalation as the default.

This study contributes to the conflict performance literature by suggesting that governance strength and professional accountability may function as boundary conditions that shape how conflict relates to deviance and performance in healthcare teams. In governance-rich environments, the perceived costs of deviance (auditability, peer visibility, reputational stakes) may discourage counterproductive responses during conflict episodes, making procedural compliance more likely. This does not overturn prior findings from non-medical settings; rather, it refines them by specifying contextual conditions under which conflict-related reactions may differ.

Future studies should (i) use longitudinal or time-lagged designs to better examine temporal ordering and mediation mechanisms; (ii) incorporate multi-source data (e.g., supervisor ratings, peer reports, objective documentation metrics) to reduce single-source bias in deviance and performance measurement; (iii) conduct qualitative or mixed-method studies to clarify how clinicians interpret “conflict” and how governance mechanisms operate in daily practice; and (iv) compare sites with varying governance strength to test whether the conflict deviance relationship changes systematically across contexts.

CONCLUSIONS

In this sample of physicians, workplace deviance was consistently associated with lower task performance, while interpersonal conflict showed a pattern consistent with context-dependent dynamics in governance-rich clinical environments. These findings suggest that conflict is not uniformly detrimental; its implications may depend on how disagreement is structured, observed, and managed within professional accountability systems. Strengthening governance routines, psychological safety, and communication discipline remains central to protecting task performance and minimizing deviance in team-based clinical work.

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