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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии

საქართველოს სამედიცინო სიახლენი

GEORGIAN MEDICAL NEWS

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GMN: Georgian Medical News is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

GMN: Медицинские новости Грузии - ежемесячный рецензируемый научный журнал, издаётся Редакционной коллегией с 1994 года на русском и английском языках в целях поддержки медицинской науки и улучшения здравоохранения. В журнале публикуются оригинальные научные статьи в области медицины, биологии и фармации, статьи обзорного характера, научные сообщения, новости медицины и здравоохранения. Журнал индексируется в MEDLINE, отражён в базе данных SCOPUS, PubMed и ВИНИТИ РАН. Полнотекстовые статьи журнала доступны через БД EBSCO.

GMN: Georgian Medical News – საქართველოს სამედიცინო სიახლენი – არის ყოველთვიური სამეცნიერო სამედიცინო რეცენზირებადი ჟურნალი, გამოიცემა 1994 წლიდან, წარმოადგენს სარედაქციო კოლეგიისა და აშშ-ის მეცნიერების, განათლების, ინდუსტრიის, ხელოვნებისა და ბუნებისმეტყველების საერთაშორისო აკადემიის ერთობლივ გამოცემას. GMN-ში რუსულ და ინგლისურ ენებზე ქვეყნდება ექსპერიმენტული, თეორიული და პრაქტიკული ხასიათის ორიგინალური სამეცნიერო სტატიები მედიცინის, ბიოლოგიისა და ფარმაციის სფეროში, მიმოხილვითი ხასიათის სტატიები.

ჟურნალი ინდექსირებულია MEDLINE-ის საერთაშორისო სისტემაში, ასახულია SCOPUS-ის, PubMed-ის და ВИНИТИ РАН-ის მონაცემთა ბაზებში. სტატიების სრული ტექსტი ხელმისაწვდომია EBSCO-ს მონაცემთა ბაზებიდან.

WEBSITE

www.geomednews.com

К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через **полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра**. Используемый компьютерный шрифт для текста на русском и английском языках - **Times New Roman** (**Кириллица**), для текста на грузинском языке следует использовать **AcadNusx.** Размер шрифта - **12**. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применявшиеся методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. **Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи**. Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста **в tiff формате**.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.

8. При оформлении и направлении статей в журнал МНГ просим авторов соблюдать правила, изложенные в «Единых требованиях к рукописям, представляемым в биомедицинские журналы», принятых Международным комитетом редакторов медицинских журналов - http://www.spinesurgery.ru/files/publish.pdf и http://www.nlm.nih.gov/bsd/uniform_requirements.html
В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректура авторам не высылается, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

При нарушении указанных правил статьи не рассматриваются.

REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or compu-ter-printed on a single side of standard typing paper, with the left margin of **3** centimeters width, and **1.5** spacing between the lines, typeface - **Times New Roman** (**Cyrillic**), print size - **12** (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. **Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles.** Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author's name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in **tiff format**.

Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.

8. Please follow guidance offered to authors by The International Committee of Medical Journal Editors guidance in its Uniform Requirements for Manuscripts Submitted to Biomedical Journals publication available online at: http://www.nlm.nih.gov/bsd/uniform_requirements.html
http://www.icmje.org/urm_full.pdf
In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title "References". All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author's original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

Articles that Fail to Meet the Aforementioned Requirements are not Assigned to be Reviewed.

ავტორთა საყურადღებოდ!

რედაქციაში სტატიის წარმოდგენისას საჭიროა დავიცვათ შემდეგი წესები:

1. სტატია უნდა წარმოადგინოთ 2 ცალად, რუსულ ან ინგლისურ ენებზე,დაბეჭდილი სტანდარტული ფურცლის 1 გვერდზე, 3 სმ სიგანის მარცხენა ველისა და სტრიქონებს შორის 1,5 ინტერვალის დაცვით. გამოყენებული კომპიუტერული შრიფტი რუსულ და ინგლისურენოვან ტექსტებში - **Times New Roman (Кириллица)**, ხოლო ქართულენოვან ტექსტში საჭიროა გამოვიყენოთ **AcadNusx.** შრიფტის ზომა – 12. სტატიას თან უნდა ახლდეს CD სტატიით.

2. სტატიის მოცულობა არ უნდა შეადგენდეს 10 გვერდზე ნაკლებს და 20 გვერდზე მეტს ლიტერატურის სიის და რეზიუმეების (ინგლისურ, რუსულ და ქართულ ენებზე) ჩათვლით.

3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემაჯამებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრამების ფოტოასლები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალების შეღებვის ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფჩხილებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

აღნიშნული წესების დარღვევის შემთხვევაში სტატიები არ განიხილება.

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CONFLICTS DURING THE COVID-19 PANDEMIC IN ARMENIA: A STUDY OF MEDICAL FACILITIES

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Abstract.

The Covid-19 pandemic represented a profound disruption to the stability of Armenian society. Key areas of public life and social relations were significantly affected. The daily lives of citizens were critically disrupted, and Armenia's healthcare system was burdened with the unforeseen effects of the pandemic. The disease imposed significant challenges on hospitals and medical staff. The crisis environment facilitated the emergence and intensification of conflicts, exacerbating an already difficult situation. Our goal is to identify the root causes, aspects, process, and practices applied in overcoming conflicts within medical institutions of Armenia during the pandemic. In-depth interviews were conducted with chief physicians of Armenian hospitals. The collected material was subjected to thematic analysis. The causes of conflicts have been identified as work and emotional overload, insufficient resources, insufficient reward, organizational contradictions, medical and sanitary norms, parties to conflicts: patients, relatives of patients, other structures, higher instances and coping practices - informal anti-conflict communications adopted by self-organization, adaptation.

Key words. COVID-19, Pandemic, Armenia, conflicts, healthcare, medical facilities.

Introduction.

Conflict and collisions are intrinsic to modern societies, serving as fundamental elements that shape societal dynamics [1]. It can be argued that conflicts are among the most crucial ontological underpinnings of society, guiding its evolution and ensuring its existence [2]. Social dynamics are inherently complex and multifaceted [3]. The ongoing competitive struggle for advantageous positions, whether current or prospective, creates a fertile ground for the continuous emergence of various conflicts [4]. Factors such as limited resources, stressful situations, divergent viewpoints, individual personality traits, and deficiencies in communication and mutual respect within society, etc., can all precipitate conflict [5,6]. The modern world is far from homogeneous [7,8]. In its highly diverse structural landscape, boundaries are crossed among social institutions, operational infrastructures [9,10]. With their structural, functional, and organizational characteristics, these serve as carriers and reproducers of the full spectrum of conflicts [11,12]. While summarizing a definitive and competitive list of social institutions and structures based on their nature of conflict may be challenging, the healthcare system, encompassing individual medical facilities and specific countrywide healthcare institutions, undeniably occupies significant positions in such analyses [13-16].

Healthcare facilities operate within the multidimensional environment of the institutional organization of societies and are part of the complex and multifaceted relations of the state, government, funding funds and organizations, as well as external decision-making structures [17-19]. Ultimately, the function of healthcare facilities is to deliver medical services to the population. These relations and interactions are characterized by contradictions, conflicts, and conflict generation [20-23]. Such a situation can hinder the effective organization of health services, leading to negative and undesirable consequences in the future [24]. Intra-hospital and multi-level conflicts encompass subordinate conflicts between higher and lower-ranking groups, interpersonal conflicts among employees at the same level, structural conflicts between different departments, and conflicts between administration and staff, as well as between management and employees [25-28]. Some research suggests that work overload is a primary cause of conflicts [29]. It exists within a generally stressful environment that negatively affects employees [30]. For staff's representatives, the basis of labor disputes and conflicts is financial, followed by social and unfair reward [31-33]. Simultaneously, insufficient education, limited experience, and a lack of skills acquired through professional relationships and communication contribute to conflicts between direct management, senior physicians, and junior staff, including nursing personnel [34,35]. A notable source of conflict is the idealization of the medical mission. The reality of the profession and the daily work often falls short of the idealized expectations and dreams of newcomers. A significant source of conflict arises from the gap between the idealized image of the medical profession and the realities of daily work. This tension is exacerbated by insufficient management competence among mid-level and administrative leaders, particularly during urgent decision-making, where unclear or contradictory directives are common [36]. Lower-level staff often face bureaucratic obstacles and conflicting instructions, leading to frustration and ethical dilemmas in choosing appropriate treatment strategies [37]. Conflicts also emerge when actual clinical practice diverges from formal policies and regulations. In these situations, clear, consistent, and multidirectional communication is essential; without it, collaborative relationships and decision-making processes rapidly erode.

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The problem of moral dilemmas is an enduring aspect of the medical profession [38-42]. It becomes prominent in professional relations, especially in traditional, community-oriented societies, where the imperative of belonging to community and family groups can strongly override formal medical rationality [43].

Conflicts arise from resource scarcity [44]. We can talk about time and ineffective time management [45]. The material, technical, territorial capabilities, as well as the quality of personnel of medical facilities serving the broad masses of society are insufficient.

The frequency, intensity, and manifestations of conflicts depend on the nature of hospitals and healthcare facilities [44]. Conflicts occur more frequently and are more widespread in specialized hospitals than in general hospitals. The situation is similar in private hospitals, where staff and administration engage with numerous additional parties and collaborative partners. Additionally, the volume of patients and the flow within hospitals contribute to the emergence of conflicts [25].

Conflicts arise from emotional strain and mental burnout. Continuous emotional strain and inability to cope are definitely causes of mental burnout [45-48]. Emotional overload and productive strain result from a conflict-generating work-life balance that undermines formal obligations [49]. The workplace and professional mission become undesirable and unpleasant, often accompanied by debilitating depression [50]. Consequently, the physician may be reduced to merely functioning as a technical tool [51,52]. The situation impacts the attitude towards the patient. The latter is dehumanized, objectified [53-56].

Conflicts escalate into direct confrontations and manifest as physical violence. Nursing and emergency personnel become victims of both physical and verbal violence. Here, patients and their relatives are on the opposing side. The uncertain and frightening future, the pain of loss, the gap between expectations and reality, the feelings of injustice, abandonment, indifference to oneself prompt them to resort to aggressive attack [57-60].

The emergence of the COVID-19 pandemic in late 2019, which rapidly spread worldwide from early 2020, posed an unprecedented challenge, impacting humanity, societies economies, and social institutions [61-67]. First of all, the pandemic had its most significant negative impact on the healthcare system, disrupting its stable, established, and effective course of operation [68,69]. As a litmus test for the institutional modernization of societies, it clearly exposed the gaps and unpreparedness of healthcare system [70]. Even in advanced societies, the critical shortage of essential resources was undeniable. The supply chains for essential medical equipment for care and treatment, medicine were disrupted [71]. Many parties responsible for the health and well-being of societies clashed over resources, including hospitals with their administrative and medical staff, organizational links of the anti-pandemic struggle, countries' governments and infrastructures, etc. Hospital staff are burdened with an extraordinary workload [72,73]. The relentless death toll, the severe and unpredictable course of the disease, prolonged irreversible isolation, emotional strain, depression, mental burnout, aggressive demands of patients and their relatives created the best, fertile ground for conflicts, the origin and unwanted course of violence [74-76]. The situation is further complicated in hospitals and departments not directly involved in COVID-19 care. These facilities are operating under crisis conditions, while absorbing the additional workload from COVID-19-hospitals. The critical aspects of healthcare delivery, such as preventive medicine, routine screenings, and care for patients with chronic and infectious diseases, were disrupted as facilities shifted their focus to managing COVID-19 patients. This shift not only strained healthcare infrastructure but also affected patient care for non-COVID-19-related diseases, leading to deferred treatments and surgeries, exacerbating health outcomes for many [77,78]. The situation is unfamiliar. Breakdowns in communication and differing decision-making processes among healthcare teams exacerbated tensions within medical facilities. Disagreements among healthcare providers regarding treatment protocols, resource allocation, and patient management underscored the challenges of coordinating care during a global health crisis [79,80].

In the peak stages of the pandemic, the issue of insurmountable imbalance between family and work obligations of the staff was particularly pronounced, as employees of intensive care units were separated from their families for months [81]. Here is a conflict causing emotional overstrain. In addition to physical overload, the staff faced constant threat of infection and death, along with the immense pressure of ongoing moral decisions. Mental health issues among healthcare workers became increasingly prevalent during the pandemic, with a significant proportion reporting anxiety, depression, and burnout [82]. Conflict within medical facilities intensified during the pandemic largely due to strict infection control policies, particularly visitation restrictions. The prohibition of relatives from seeing patients generated ethical tension and emotional distress among families, patients, and healthcare providers. Additionally, compliance with measures such as mask use, distancing, and quarantine further strained patient–physician interactions and heightened psycho-emotional stress in clinical settings [83].

The pandemic has triggered a surge of violence [84,85]. There is also violence directed at healthcare personnel with frontline workers, including medical and nursing staff, specialists in emergency departments and urgent care units, and emergency response teams being the primary victims battling under the most severe conditions to preserve life and health [86].

Armenia is experiencing the full spectrum of the pandemic's effects and consequences [87]. The healthcare system, including hospitals, medical facilities, and staff bears the brunt of the pandemic, as well as the burden of responding to the population's needs and rescue efforts. In Armenia, responsible agencies are implementing anti-pandemic measures and adapting peacetime healthcare practices to address the crisis [88]. A state of emergency was declared in March 2020 [89]. The first hospital in the Republic of Armenia was re-profiled as a full-service COVID-19 hospital, suspending all planned medical service functions for an unknown period of time [90]. By the end of 2020, the number of hospitals treating COVID-19 had surpassed ten. Most of these hospitals had only been partially re-profiled,

with COVID-service departments integrated into existing medical facilities. Their primary aim was to provide care for patients with conditions other than COVID-19, while also adapting to pandemic conditions by prioritizing the most critical cases. Meanwhile, efforts were actively focused on detecting and isolating infected individuals and maintaining quarantine measures. Testing of suspected patients was conducted around the clock. Reporting new cases and contacting persons for testing and quarantine were carried out daily. The large-scale application of anti-pandemic sanitary norms throughout the Republic, the constant mask-wearing, and social distancing were actively explored. Amid this challenging scenario, the primary healthcare units — the policlinics played a crucial role. Regional, state and public polyclinics, along with medical staff, not only carried out their regular duties but also served as the primary frontline in treating and providing healthcare, as well as facilitating pre-hospital referrals for large numbers of people infected with SARS-CoV-2 [91].

Despite these efforts, there remains a shortage of essential health and medical resources, along with organizational contradictions and problems, such as delays in COVID-19 testing results, heavy workloads for medical staff, poor coordination of patients with COVID-19 and ineffective COVID-19 management, unavailability of ambulances, insufficient hospital beds for COVID-19 patients, etc. Especially during the peak of the pandemic, the resources to fight against the COVID-19 pandemic were insufficient. According to 2020 data, hospitals of the Republic of Armenia had 12,871 beds [92]. According to the National Center for Disease Control and Prevention of the Ministry of Health of the Republic of Armenia, 449,357 cases of infection with COVID-19 have been officially registered in Armenia [93]. Several major peaks of the COVID-19 pandemic were recorded in Armenia. The first peak was recorded in July 2020, with 11,000 people hospitalized with COVID-19. The second peak was recorded in November 2020, which was the most critical period with over 20,000 people hospitalized. The third peak was recorded in April 2021 with 16,000 people hospitalized [94]. In addition to the global COVID-19 pandemic, Armenia faced the harrowing challenge of the second Artsakh War, also known as the 44-Day War. Thousands of wounded are removed from the front, the battlefield and the settlements under the deadly attack of the enemy, as well as from the border zone, and are transferred to the rear hospitals and civilian hospitals. Yerevan attempts to handle the most serious cases. This dual crisis put both the Armenian state and its people in the midst of two simultaneous battles. Like elsewhere, the frontline in the fight against the pandemic was the healthcare system, which had to combat the virus while also addressing the consequences of the armed conflict [95,96].

The staff faced unprecedented realities, necessitating new working conditions, personal and professional qualities, ideology, and behavioral patterns. The main problems faced by the healthcare system of the Republic of Armenia during the COVID-19 pandemic included a shortage of medical staff in hospitals (necessitating the use of students or interns for work), a lack of special courses, a lack of equipment, especially artificial respiration devices, a lack of computer tomography, and a shortage of medicine [97]. The medical institutions actively engaged in educating medical personnel, exchanging international experiences, discussing cases through consultations, and continuously improving the qualifications of staff serving in COVID-related roles. Such situations were highly undesirable due to a lack of trust in medical care. However, under normal conditions, the healthcare system in Armenia enjoyed considerable trust from the local population. This, in turn, serves as a major factor contributing to the limited accessibility of medical facilities [98]. Armenia's healthcare system faced unique challenges, primarily due to difficulties in implementing necessary measures in response to the evolving situation and the rigidity of concurrent laws. This situation forced medical facility managers and staff to make difficult decisions to use available resources effectively. A major contradiction arose when a patient's COVID-19 test was negative, yet hospitalization in the Republic of Armenia was only permitted for those with a positive test result. This created an ethical dilemma, especially in cases where patients exhibited COVID-19 symptoms despite a negative test result. Without hospitalization, these patients' conditions often worsened, putting medical staff in a controversial situation regarding whether to admit them or not. Another ethical dilemma occurred when a patient tested positive for COVID-19 but had only mild or very mild symptoms. In such cases, healthcare workers faced the challenge of deciding whether to hospitalize the patient, potentially occupying a bed that could be needed for someone in a more serious condition, thus risking the latter's access to necessary medical care due to bed shortages. In the medical facilities of the Republic of Armenia, there is no clear procedure for addressing conflicts with the medical staff, which complicates the prevention, resolution and management of conflict situations, leaving the resolution of conflicts to the discretion of healthcare workers. This research significantly contributes to identifying and describing the conflicts that arose in the medical facilities of the Republic of Armenia during the Covid-19 pandemic, both throughout Armenia and in the regions of the Republic of Armenia, improving patient care outcomes amidst crises.

The pandemic exacerbates the challenges faced by hospitals and related organizations, increasing their workload, the staff emotional strain, and overall pressure. This creates an ideal environment for contradictions and conflicts, influencing both their origins and their development. Thus, the analytical focus of this work is on healthcare in hospitals during the pandemic, examining conflicts that emerge during treatment, their underlying causes, and the aspects, peculiarities, and strategies for addressing and resolving these issues.

This research is unique, no similar research has been conducted in Armenia before.

Methodology.

We conducted in-depth interviews with chief physicians from hospitals and primary healthcare centers in Yerevan (the capital city), as well as regional centers across the Republic of Armenia. Out of 19 interviews, we covered hospitals that were fully re-profiled (5), partially re-profiled (9), and non-profiled (2), as well as primary healthcare centers (3). The in-depth interviews revealed various aspects of the problem, including the origins

of conflicts during medical interventions and healthcare, the involved parties, the progression of these conflicts, and their unique resolutions. The qualitative data collected were analyzed through thematic analyses. Expressions regarding the causes of the conflict, involved parties, coping practices, etc. were categorized and organized into distinct analytical themes.

Fully re-profiled hospital that had previously offered general or specialized healthcare services to the population of Yerevan and regions had their mission altered during the pandemic. They have been re-profiled to focus exclusively on treating COVID-19 and caring for related patients. These hospitals now focus exclusively on treating COVID-19 and caring for related patients. They were selected as research units because their medical staff faced unprecedented challenges. Working on the front lines under immense stress, they adopted innovative therapeutic, caregiving, and organizational approaches to manage the crisis. They experienced significant mental and emotional strain, including moral dilemmas of life and death, and encountered various conflicts that are of particular interest to us.

Partially re-profiled hospitals were those that established separate, isolated departments with dedicated entrances and internal infrastructures specifically for the treatment and care of COVID-19 patients. The rest of the hospitals continued to maintain their pre-COVID functions. Researching these hospitals is valuable because their staff not only took on new and complex responsibilities but also continued to fulfill their existing roles under crisis conditions. It is likely that the professional and official workload of the medical staff increased significantly, making it important to identify the specific nature of conflicts emerging under these circumstances.

Not re-profiled hospitals were those that maintained their pre-pandemic functions throughout the pandemic and did not provide COVID-19 treatment or care. These hospitals likely faced unique challenges during the pandemic, as they experienced an influx of regular patients from re-profiled and partially re-profiled hospitals, which increased their local workload. This, in turn, likely led to an increase in conflicts and contradictions.

Primary healthcare centers play a crucial role in disease prevention, diagnosis, ambulatory care, and providing on-site treatment through emergency admissions and home visits. Essentially, primary healthcare centers serve as primary providers of healthcare for the public. During the pandemic, they also took on the responsibility of managing COVID-19 cases. Physicians and medical staff at these centers are involved in diagnosing, referring, and treating COVID-19 patients. The unique challenges of providing healthcare in crisis conditions create additional problems and contradictions, potentially leading to localized conflicts.

Conducting in-depth interviews with general practitioners is valuable because they possess extensive knowledge about health interventions, organizational strategies, and practices. They can offer a thorough account of conflicts and tensions involving hospital staff, patients, their families, and other responsible or supervisory entities.

Research Geography: To ensure nationwide coverage, we conducted the research across various regions of Armenia. This included the northern regions of Shirak and Lori, the southern regions of Vayots Dzor and Syunik, as well as the central areas near Yerevan and the capital city itself. These locations were chosen because they included the hospitals and primary healthcare centers of primary interest for the study.

Chronology of Research: The field phase of the research was conducted from February 2022 to March 2023.

Restrictions: During the field phase, it became evident that chief physicians — the key informants perceived and evaluated the crisis reality and its conflicts differently depending on their positions, roles, and the specifics of their working relationships. Consequently, perspectives of other staff members — such as middle managers, physicians at various levels and departments, nurses, and others were not assessed in this study. It's likely that higher administrative management was officially evasive on many organizational and moral issues, particularly those involving alternative viewpoints.

Participants of the in-depth interviews were informed about the research objectives and methods beforehand and provided their consent for the processing and publication of the recorded materials and conversation content.

Main Findings.

The research findings somewhat reflect the experiences of medical institutions facing conflict during the pandemic crisis in other countries. However, we also identified distinct Armenian characteristics of conflicts in medical facilities, including their origins, involved parties, processes, social contexts, and the approaches used to address and resolve them within healthcare facilities.

The Armenian healthcare system was primarily focused on the urgent need to save infected individuals. As a result, conflicts and issues within hospitals emerged as an inevitable consequence of this focus.

The analytical results of the research reveal a range of conflicts and clashes within medical facilities. We will present these findings in a comprehensive manner, using analytically homogeneous themes derived from unique coding.

Theme 1: Causes of Conflicts.

Work Overload:

The pandemic and its associated challenges significantly increased the workload across all staff levels, with a particularly pronounced impact on specialists in emergency medical care and rehabilitation departments. This issue is especially relevant for hospitals in Yerevan and the regions that have been fully and partially re-profiled.

The disease was new, unfamiliar, and deadly, requiring a unique approach, specialized interventions, and intensive adaptation. The chief physician of a partially re-profiled hospital reports:

"…it was something unexpected for everyone, and no one was ready for the changes that had to be made..."

Chief Physician of Partially Re-Profiled Hospital, Yerevan.

During the initial phase of the disease's spread, particularly in the first few months, physicians and staff lacked the necessary experience and knowledge. They had to learn during pandemic, which required significant time and effort. The patient influx was unprecedented, and the disease itself proved to be unpredictable.

Specialists were on duty continuously for weeks, and at times even for months, working in isolated departments.

Emotional Overload:

Death, the fear of death, and the distressing symptoms of oxygen deprivation were inherent aspects of the disease. Both physicians and others were at risk of infection and death. Additionally, family members of the medical staff who contracted the virus were also at risk and required care. Physicians also faced aggressive demands from patients' relatives. The situation was exacerbated by formal investigations into controversial cases and supervisory interventions. This overload involved not only physical strain but also intense emotional stress, impacting the mental well-being of the healthcare team.

"…People are not made of stone. Everyone has their own feelings, and conflicts were inevitable…"

Chief Physician of Fully Re-Profiled Hospital, Yerevan

The head of the intensive care unit at a fully re-profiled hospital complained that the constant noise from the continuously operating equipment was unbearable for him. Strangely, it persisted even during moments of rest, including at home, far from the hospital and patients.

Insufficiency of Resources:

Resource scarcity was one of the most significant challenges of the pandemic. There was a shortage of staff, including medical specialists, nurses, and support personnel. The issue was addressed through various measures. For instance, hospitals that were fully re-profiled experienced a significant increase in their workloads. First aid physicians, such as resuscitators, pulmonologists, and radiologists, were recruited to handle the surge. Other specialists, including general practitioners, cardiologists, gastroenterologists, and even orthopedists were retrained and redirected to assist in the fight against COVID-19. Additionally, medical students volunteered to support the COVID-19 hospitals and wards. There was a lack of essential knowledge. The continuous and ever-increasing influx of patients, particularly severe cases, disrupted effective training and specialization. Disagreements over alternative therapeutic approaches and patient care strategies, along with mistakes and errors by current staff, were major sources of conflict. The COVID-19 pandemic required advanced technical equipment for intensive care units in hospitals. In Armenia, there was an urgent need for oxygen-supplying ventilators, which could have saved many lives. The chief physician of a partially re-profiled hospital described how they had to connect a single ventilator to the most critically ill patient individually, or use the same device at reduced capacity for several patients simultaneously. During the initial and peak periods of the disease, there was a shortage of beds. For instance, patients from Yerevan were placed in neighboring cities, leading to complaints and dissatisfaction from both patients and their families. This situation led to conflicts with hospital representatives, emergency services, and other responsible entities. Essential medications were in short supply, and obtaining them was neither straightforward nor easy. The administration had to engage in intense competition and struggle to secure these crucial resources.

"... The import of Remdesivir into Armenia was insufficient; although 2000 ampoules were requested, only 300 were provided. Through significant efforts, persuasion, and intense negotiation, we managed to increase the supply from 300 to just over 500 for critical and urgent cases."

Chief Physician of Partially Re-Profiled Hospital, Yerevan

The issue of work overload was evident in non-reprofiled hospitals as well. The full and partial re-profiling of certain hospitals led to patient transfers to other facilities, which consequently increased their workload. In Yerevan, the situation was particularly striking. The 'Sent Grigor Lusavorich' multi-disciplinary hospital with nearly 1,000 beds and over 20 specialized departments and clinics, fully transited to serving only COVID-19 patients. This shift meant that urgent care for other patients had to be handled by different facilities.

The surviving and still operational primary healthcare facilities from the Soviet era (policlinics) played a crucial role in the fight against the COVID-19 pandemic. Their primary mission includes ambulatory treatment, disease prevention, and diagnostics for large segments of the population. As a result, these centers assumed significant responsibilities for anti-pandemic measures, diagnostics, and treatment. Regional physicians, already overwhelmed with their regular duties, were also tasked with handling COVID-19 cases. The influx of suspected and confirmed COVID-19 patients to regional primary healthcare centers created a high-risk environment. With a high volume of visitors, the medical staff faced immense pressure, and long queues led to impatience and tension among patients, creating a breeding ground for conflicts. This situation caused conflicts between staff and various departments, leading to verbal disputes and communication problems.

"...Conflicts with physicians and others persisted, including over work-related and organizational issues. Verbal complaints were common and everyone, including myself, expressed dissatisfaction and tension…"

Chief Physician of Policlinic, Yerevan

Inadequate Reward:

Work overload was also a significant issue in partially re-profiled hospitals. In addition to their COVID-19 responsibilities, these hospitals continued to handle their regular, non-COVID duties. This situation created a risk where patients in internal medicine, surgical, and other departments could potentially infect healthcare staff, jeopardizing their health, safety, and healthcare delivery. Unfortunately, despite the increased workload, these hospitals did not provide additional compensation, unlike the COVID-19-specific hospitals and wards.

"…There was also a problem with financing. Perhaps they did not received as much financing as the COVID departments…"

Chief Physician of Fully Re-Profiled Hospital, Region.

Many attempts to address the problem went unanswered, leaving the resulting conflicts unresolved. As is often the case, the issue was only resolved once the general situation was overcome.

"… Unfortunately, the issue of inadequate financing for regular departments operating in critical conditions with overloading, both during and especially after the pandemic, remained unresolved despite direct appeals, exchanges, and negotiations."

Chief Physician of Fully Re-Profiled Hospital, Yerevan.

There was no official justification for the lack of additional pay, leading to feelings of exploitation and social injustice. This dissatisfaction resulted in ongoing clashes and conflicts with the administration. Many staff members chose to refuse additional but urgent responsibilities. Despite the attempts to escalate the issue to higher authorities and draw attention from relevant bodies, these efforts proved ineffective.

"... As you might expect, I escalated the issue of financing... I even wrote to the Minister, then called the Accounting Department of the Ministry and inquired about this money...but they never provided an explanation. The State Health Agency of the Ministry of Health of the Republic of Armenia responded cynically, stating: "This is not a COVID hospital; you should not have had Covid patients there, you should not have treated Covid patients, why did you treat them?" How can I explain that patients cannot choose the diseases they contract? How can I instruct ordinary patients to wait until we have finished treating all Covid patients?"

Chief Physician of Fully Re-Profiled Hospital, Yerevan

Contradictions in Crisis Work Organization:

The pandemic crisis involved more than just immediate treatment and care. Multifaceted contradictions and insufficient resources led to the clashes and conflicts previously discussed. The adaptation of the health system, including both hospitals and primary healthcare centers, to the crisis proved to be challenging. New legal regulations and instructions often conflicted with the reality on the ground. This situation created additional organizational tensions, as anti-pandemic measures conflicted with labor rights and legal guarantees for staff, creating tensions among medical workers who relied on their legal protection.

Fully re-profiled hospitals, emergency medical services, and resuscitation departments, focusing on protective and security priorities, excluded vulnerable medical staff, including the elderly and those with health issues. The staff roster was reorganized to prioritize specialists and positions critical to managing the pandemic. This reorganization was perceived as unfair and dishonest, particularly when experienced physicians were sidelined. This led to prolonged conflicts with hospital administration. In many cases, it was technically impossible for these temporarily removed staff to return, as their previous positions no longer existed or had changed.

"... Legal job lists were changed with shifting to COVID services. Some left without knowing about these legal changes. Attempts to inform them were met with disinterest regarding reassignment...".

Chief Physician of Fully Re-Profiled Hospital, Yerevan

Anti-Pandemic Sanitary Norms:

The health consequences of the COVID-19 pandemic were unprecedented in the last century. The measures taken to combat the pandemic were equally unprecedented, with nearly the entire global population experiencing home isolation and movement restrictions. Alongside these measures, mask wearing and enhanced sanitation practices became mandatory. These protocols were especially prioritized in hospitals, COVID-19 treatment centers, emergency medical services, and intensive care units.

The necessity of these norms is clear and undeniable. However, even medical staff did not always adhere to them consistently. This incompatibility led to conflicts and disputes among hospital administrations, regulatory bodies, and staff members. The constant use of anti-virus protective gear — such as clothing, gloves, masks, and face shields — proved to be challenging. Many medical professionals found that these protective measures hindered their effectiveness and made their work uncomfortable. Exhaustion and disrupted mental balance became common, with frontline physicians and nurses feeling increasingly overwhelmed. In the face of these challenges, the dilemma of balancing protective measures with the demands of crisis management often tilted in favor of operational efficiency and comfort. This was particularly evident in non-reprofiled hospitals, where restrictions were generally less stringent.

COVID-19 Dissidence:

Soon after the pandemic began, major pharmaceutical companies introduced a range of vaccines to the public. The rapid development and deployment of these vaccines, however, were met with suspicion and sparked conspiracy theories. The emergence of COVID-19 dissidence was notable, even among medical professionals who are typically considered authoritative figures in the field. Mandatory vaccination regulations were rapidly introduced to fight against the pandemic. However, these requirements conflicted with the personal views, beliefs, and even the professional philosophies of some physicians. This led to significant debates, conflicts, and clashes within the medical community.

"…Yes, some employees refused to get vaccinated due to a lack of trust and fear of potential side effects. I consistently advocated and instructed for immediate vaccination as soon as it became available. Despite encountering opposition and counter-propaganda, I stressed the importance of vaccination. In addressing medical workers involved in counter-propaganda, I highlighted the negative impact of such actions. Ultimately, those who were hesitant, realized that there was no harm from vaccination, despite the occasional post-vaccination complications that were typical of any medication."

Chief Physician of Non-Profiled Hospital, Region.

Party to the Conflict:

During the pandemic, numerous conflicts and clashes emerged involving various parties, including medical personnel at different levels. These disputes encompassed subordinate conflicts, disagreements over resource redistribution between administration and related bodies, and more. Notably, clashes between healthcare providers and patients, as well as their relatives, were particularly prominent within this context.

Conflicts with Patients:

In even the most advanced societies, the disease resulted in numerous deaths. The media broadcast harrowing images — corpses, refrigerated morgues, deserted cities, exhausted physicians, and bleak prospects for swift recovery and crisis resolution, which sparked public panic. These images exacerbated the already dire situation for patients in hospitals, COVID-19 treatment centers, and intensive care units. Death appeared to be ever-present; patients who were once recovering and hopeful could succumb to the illness overnight. Patients

faced isolation, separated from their loved ones and familiar, safe environments, with an uncertain and frightening future ahead. Under such conditions, it was unrealistic to expect patients to remain rational and calm. Instead, patients often exhibited restlessness, impatience, and heightened demands. Medical care was often perceived as inadequate. Patients and their relatives demanded better hospital conditions, more stringent infection control measures, and private rooms for isolation. In response, the progression of the disease and oxygen deprivation due to lung damage led to distorted perceptions of reality and occasionally resulted in inappropriate or aggressive behavior.

"…Patients consistently exhibited inappropriate behavior due to a variety of encephalopathy, including hypoxia and toxic conditions. Observations have underscored the impact of the virus on the brain leading to behavioral disorders, even in the absence of overt signs of hypoxia or toxicity."

Chief Physician of Fully Re-Profiled Hospital, Yerevan.

Although these situations may not represent rational, ongoing conflicts, they were widespread issues that exacerbated and further strained an already challenging environment. Addressing these clashes required medical staff to develop new skills, including enhanced communication abilities, and to allocate additional time, physical and emotional resources.

"… I cannot speak about actual conflicts. There were no conflicts with patients; the disease caused severe encephalopathy, leading to episodes of inappropriate behavior. I recall a critically ill patient waking up at night and demanding to be allowed to go home. What can the staff do? Should they fulfill the request, of course not…"

Chief Physician of Partially Re-Profiled Hospital, Yerevan.

Conflicts with Friends and Relatives of Patients:

Before delving into the specifics of the conflict, it is important to understand the social and institutional context in which it emerged and developed. The healthcare system in Armenia, particularly in the capital and the regions, has long been characterized by gaps and contradictions in its institutional modernization. These issues have led to established practices where patients' relatives and friends play a significant role in their care.

In Armenia, the term "Patient Owner" reflects this traditional practice. This person assumes various institutional responsibilities traditionally managed by the hospital. They are responsible for providing own quality food for the patient, finding and obtaining necessary medications, and ensuring consistent care through regular visits and supportive interactions. This role often involves navigating conflicts and cooperating with medical staff to ensure the patient's well-being. All these traditional practices were either disrupted or prohibited during the pandemic. The inability to provide direct care and monitor one's own patient firsthand led to public distrust. Concerns about what was happening behind the closed doors of the hospital grew, leading to heightened skepticism and uncertainty.

"…Unfortunately, physicians have encountered disrespect and negative opinions about COVID centers and treatment provided. Our professional capabilities and abilities were called into question. Patients began to question our practices and procedures more frequently in the clinic already with a negative predisposition... Friends and relatives initially reacted negatively…"

Chief Physician of Fully Re-Profiled Hospital, Yerevan.

Public panic and the relentless spread of rumors regarding the incompetence and indifference of hospitals and medical staff intensified suspicion and increased demands from relatives and friends. There was a pervasive belief that essential and adequate care was often lacking, leading to perceptions of neglect towards patients.

"... The patient's relatives expressed dissatisfaction, seeing that the hospital was resistant to any intervention and participation on their part. They believed that their patient was treated only when they actively participated in it. Meeting, calls, explanations were required to inform and prove that the patient was receiving necessary care and medicine worth 300-350 US dollars daily, but mistrust continue to persist. I recall a case when a relative said that our words and evidences were worth nothing as long as the patient permanently called and demanded something necessary."

Chief Physician of Partially Re-Profiled Hospital, Yerevan.

In an atmosphere of mistrust, the impossibility of directly controlling and caring for a relative, even under pandemic critical conditions led to the most undesirable and perhaps even dangerous decisions, and further steps. Relatives rejected the services of one or another hospital, insisting on transferring the patient to a more suitable place in this regard.

"…The situation occasionally spiraled out of control, particularly during tense moments. Relatives, friends, and acquaintances of patients often attempted to "rescue" their loved ones from what they perceived as the "incompetence" of medical professionals. They resorted to aggressive tactics, including direct threats or promises of imminent violence, demanding the patient's discharge to transfer them to a different hospital or to arrange better care".

Chief Physician of Partially Re-Profiled Hospital, Yerevan.

Community and family networks are both strong and effective in Armenian society, both in the capital and the regions. Amid the widespread mistrust, public anxiety, and panic, influential figures, such as prominent community members and mediators became involved in conflicts with hospitals and medical staff. They often attempted to leverage their power to secure the discharge of patients from provided medical care and arrange alternative treatment and care.

"… There were numerous calls, demands, and even threats directed at the medical staff. Healthcare professionals witnessed and sometimes directly faced instances of physical violence, including fights and altercations in reception areas. We all participated in resisting and addressing these challenges as they emerged, involving everyone from security guards to fellow officers, and the police. We faced these challenges together..."

Chief Physician of Fully Re-Profiled Hospital, Yerevan.

The situation was particularly challenging in the regions and local communities, where community ties and family networks are exceptionally strong and active. Local medical staff is deeply integrated into these networks. Resisting the pressure exerted through these community connections proved to be extremely

difficult, almost impossible, even when the issue was rooted in professional and scientific medical rationality. Physicians often found themselves compelled to compromise, bending or breaking established regulations and norms to maintain community solidarity, preserve their local standing, and uphold their reputation as good colleagues and friends.

"We resided in a small town where everyone knew each other. Requests to visit the patient, or to temporarily leave them to attend funerals and other important events were indeed situational decisions, but they were made. The alternative was often less clear or less acceptable."

Chief Physician of Fully Re-Profiled Hospital, Region.

The most emotionally and physically intense conflicts with relatives and friends of patients emerged while waiting for the patients to die and after their death. Such behavior from relatives is comprehensible. They are in shock and bewildered, often exhibiting significant aggression. Relatives demand explanations and present their arguments. Statements by physicians and the department that everything was done correctly, and that the death was inevitable seemed unconvincing. This behavior, along with other factors, is driven by the uncertainty and mistrust stemming from the complete isolation of patients. This is compounded by the perceived lack of applied resuscitation knowledge and the absence of clear, logical explanations in such situations.

"...Relatives often failed to recognize that physicians worked tirelessly day and night, sacrificing their personal well-being, and continuing to fight for patients, instead, some of them placed blame on the medical staff."

Chief Physician of Fully Re-Profiled Hospital, Yerevan.

Relatives often perceived medical steps and practices as intentional physical violence inflicted by the medical staff. They pointed to visible marks on the body, such as bruises and hematomas, which were caused by the disease and medical interventions, as evidence of mistreatment.

"…We were accused of physical violence in the hospital and intensive care unit. Relatives claimed that we restrained the patient and caused harm instead of providing care. Explaining to nervous and angry relatives that immobilization was necessary to prevent further harm, such as breaking medical devices, tearing off tubes, and removing the oxygen masks due to the patient's impaired consciousness from encephalopathic brain damage, was incredibly challenging."

Chief Physician of the Fully Re-Profiled Hospital, Yerevan.

The conflict with friends and relatives was further fueled by a decision from the Ministry of Health of the Republic of Armenia. According to this decision, the sorting triage centers and COVID hospitals only admitted patients with positive initial test results. However, it later became known that the disease could progress even with a negative test result. This led to anger among patients and their families and resulted in various conflicts, confrontations, and attempts at intervention.

"… We, as physicians, struggled to explain to the anxious and distressed relatives of patients that the decision regarding hospitalization was beyond our control. The triage center was responsible for these decisions, even when a patient had a positive test result…".

Chief Physician of the Policlinics, Region.

Conflicts with Other Responsible Structures:

Anti-pandemic measures, as well as the organization, direction, and control of internal medicine interventions, were centrally managed. Hospitals and medical facilities had limited decision-making authority. The responsibility for patient referral and placement rested with the patient sorting center, also known as the triage center of the Ministry of Health of the Republic of Armenia, which was established for this purpose. This central structure aimed to allocate patients to appropriate COVID centers based on the severity of their condition. However, there were issues with the accuracy of information provided by the triage center regarding the capabilities of hospitals. This sometimes led to discrepancies between the information provided and the actual situation on the ground. As a result, patients often experienced conflicts and delays due to friction between hospital administration, the triage center, patients and their families, and ambulance services. Consequently, patients frequently found themselves being transferred to available beds in different cities.

Conflicts with Senior Healthcare Leadership:

It is important to note that the primary interlocutors in this study were chief physicians of hospitals, representing top management. Given their positions, it is unlikely that we would obtain a fully candid and comprehensive account of all contradictions and conflicts. Nonetheless, from the limited information available, it was evident that conflicts persisted over the allocation of medical resources to hospitals and departments, as well as related organizational and governmental practices.

Overcoming conflicts.

Anti-Conflict Peace-Oriented Communications:

It was obvious that the state and consequently the healthcare system were poorly prepared for the crisis, which was reflected in legal norms and measures that did not correspond to the actual realities. The responses lacked systematic organization and proposed solutions exhibited a bottom-up approach which while promoting flexibility, led to conflicts. The organizational, functional approaches towards conflict prevention, de-escalation and final resolutions were mainly based on informal discussions, direct negotiations, both collective and private. A common applied approach was conflict adaptation, which instead of direct intervention assumed the possible extinguishment or at best the freezing of the conflict. This adaptive strategy, while effective, has highlighted systemic weaknesses, raising the need for a more comprehensive and proactive approach to crisis management in the future. Any organizational, care, or communicative practices, including those related to conflict management were continually refined and improved as experience and knowledge accumulated.

"…At the beginning, we encountered many challenges for the first time and had to work very hard, under the strain of forces, but now we have already gained experience. If a similar situation arises in the future, we will be better organized and more experienced. We will know more effectively how to manage from the outset, what actions to take and where to allocate resources."

Chief Physician of the Partially Re-profiled Hospital, Yerevan.

The critical adaptive re-socialization of medical facilities occurred through establishing a reciprocal channel of effective communication between physicians and patients. In practice, communicative isolation contradicted the prevailing conditions. Despite limitations, the staff and department established intra-hospital communication and connections with relatives, which helped overcoming conflicts relied on traditional methods and self-organization. Although this required additional resources, time, and skills, it was important for fostering a stable relationship, creating calmness, and building trust.

"…From my personal perspective as a leader I undertook extensive explanatory work, outlining potential problems that might arise and discussing possible solutions."

Chief Physician of the Partially Re-Profiled Hospital, Region.

The medical staff, responsible physicians, and hospital management were often compelled to navigate conflicts and confrontations with patients' relatives to ensure effective intervention, maintain operational efficiency, and ultimately save the patient breach, weaken, and manipulate existing regulations and formal restrictions.

"... At least, we showed the patient to his relative, calming him down and assuring that the patient was indeed doing well..."

Chief Physician of the Partially Re-Profiled Hospital, Yerevan.

To improve the overall situation, enhance efficiency, and effectively manage and resolve conflicts, it was essential to provide the medical staff with encouragement and psychological support.

Thus, the 44-Day Artsakh War had a profound impact not only on the material but also on the moral aspects of the relationships and work practices of the medical staff. Additional vigilance, tenacity, dedication, and responsibility were imperative. While the ongoing pandemic presented significant challenges, it did not overshadow the primary goal of supplying medicine to the front.

"…I consistently communicated with everyone, emphasizing the importance of teamwork. I stressed that this was a collective effort, and that we needed to remain steadfast in our positions. If our guys guard the border, then this becomes our border and our post. We must always be vigilant and collected...".

Chief Physician of Non-Reprofiled Hospital.

Discussion.

The COVID-19 pandemic was unprecedented, especially for our seemingly peaceful era, where such shocks and tragedies seemed relegated to the past, distant from today's developed societies and humanity in general. The pandemic caught the world by surprise, exposing the vulnerabilities of what we had believed to be a well-developed and nearly omnipotent medical system. We thought only a few unsolvable problems remained, which would soon be overcome. However, a new disease emerged in a remote corner of the world, one that many of us could hardly pronounce. Initially dismissed as another minor outbreak, it quickly proved otherwise.

The disease's development and progression were both unpredictable and deadly. The number of victims and the death toll increased daily, and within months of the first cases, the entire world found itself in a pandemic crisis. Harsh anti-pandemic measures swept the globe, plunging humanity into apocalyptic horror. Even the most advanced healthcare systems found themselves helpless and unprepared. Essential resources seemed perpetually lacking — physicians, medical assistants, knowledge, skills, technical equipment, medicine, time, human resources — all in short supply as patients flooded in and deaths set new, grim records.

In Armenia, as in many other places, healthcare institutions on the front lines faced these challenges. Under immense stress, peacetime healthcare system was urgently transformed into critical care units. This environment was ripe for multifaceted conflicts and clashes. The workload was overwhelming. In critical isolation, risking their lives and health, and straining family relationships, healthcare professionals worked tirelessly, fulfilling their duties without counting shifts. Anti-epidemic gear was quickly exhausted. The choice was to use ineffective equipment or rely on luck. Emotional strain was unprecedented. Patients and their relatives were additional stressors, mistrusting physicians and the overall situation. Furthermore, the concept of the "patient owner" identified warrants more explicit emphasis, as it represents a culturally specific dynamic that extends beyond the general anxiety associated with visitation restrictions reported in other countries. In the Armenian context, family members traditionally assume an active caregiving role—preparing food, administering medications, and maintaining continuous presence at the bedside. Pandemic isolation policies abruptly removed this role, not only disrupting practical support mechanisms but also challenging deeply embedded cultural expectations regarding responsibility for the patient's wellbeing. This disruption generated mistrust, emotional distress, and in some cases escalated into confrontational attempts to "rescue" patients from hospitals. Therefore, the "patient owner" phenomenon illustrates a qualitative cultural divergence that is central to understanding the intensity and forms of conflict observed during the pandemic. Effective collaboration within the health management system was challenging, as its components often failed to align. Managerial decisions and directives, untested and inexperienced led to conflict. Inadequate Compensation" in case of "non-COVID" patients should be more explicitly framed as a structural driver of conflict rather than only a workload-related stressor. In partially repurposed hospitals, staff who were not officially designated as "COVID teams" nonetheless experienced substantial increases in clinical duties due to staff shortages, bed overflow, and patient acuity. However, the absence of proportional financial compensation, combined with the Ministry's dismissive stance (e.g., "Why did you treat COVID patients?"), was perceived by workers as organizational injustice. This perception did not merely produce dissatisfaction; it triggered ethical conflict, demoralization, and erosion of institutional trust. Highlighting this dynamic demonstrates how compensation policies intersected with moral responsibility and professional identity, becoming a catalyst for both interpersonal tension and systemic distrust within the healthcare environment.

The crisis was further complicated by the Artsakh War, which brought countless wounded in need of treatment and care. Many specialists were at the front line, prioritizing the

liberation struggle for the motherland. The reference to the Artsakh War as a motivational frame ("This is our border") should be interpreted not as a structural conflict resolution mechanism, but rather as a short-term morale-boosting narrative that temporarily unified staff around a shared symbolic purpose. While this framing helped reduce emotional resistance and fostered a sense of collective duty during peak crisis, it did not address underlying organizational tensions or structural sources of conflict. Therefore, in the discussion, we clarify that this strategy functioned primarily as a transient coping mechanism rather than a sustainable conflict management approach. Every action, event, intervention, and tactic was shaped, validated, and realized through ongoing painful experiences, both defeats and victories. This was especially true for conflict management. While healthcare interventions often draw from years of medical experience, even with unknown diseases, conflict management is not typically within a physician's purview. Yet, conflicts can undermine the effectiveness of medical aid. This crisis was a severe test, an unprecedented and tragic experience.

Is this experience sufficient for future crises? What is needed to turn it into productive capital? First, research should accumulate multifaceted human experience and institutionalize it within the new social education of medicine. Medicine and care must integrate this experience. However, in conflicts, collisions, and other organizational problems, delays and indifference are evident.

Critical management and conflict management are essential skills. Current passive traditional approaches are insufficient, especially in traditional societies. There is a need for professional quality, in-depth reflection, multidimensional standardization of situations, and the establishment of mechanisms for overcoming and resolving conflicts.

The conflicts observed in the healthcare system during the pandemic were influenced not only by clinical uncertainty and emotional strain but also by systemic coordination challenges. Interview data demonstrated that hospitals frequently operated with limited guidance while simultaneously facing surges of critically ill patients. Resource allocation was uneven across institutions, and communication with central management and triage centers was often delayed, inconsistent, or unclear. As a result, hospital directors were required to make rapid autonomous decisions, redistribute internal resources, and adapt administrative structures under conditions of uncertainty. These systemic inefficiencies shaped the escalation of conflict, as frontline staff perceived inconsistencies in support and decision-making processes. Therefore, the conflict patterns identified in this study reflect not abstract structural forces but the concrete impacts of fragmented coordination, inequitable resource distribution, and limited crisis management frameworks.

Limitations.

The primary limitation of this study is that interviews were conducted exclusively with hospital directors. This sampling approach may introduce bias, as directors are responsible for maintaining institutional stability, public reputation, and administrative coherence. Consequently, they may have minimized or reframed accounts of internal disagreements with senior leadership or inconsistencies in decision-making processes. As a result, the findings may not fully capture the perspectives of frontline staff, mid-level managers, or clinical personnel who directly experienced operational challenges and interpersonal conflicts. Therefore, the interpretation of results should be approached with caution, acknowledging that the data reflect organizational leadership viewpoints rather than the broader spectrum of staff experiences.

Conclusion.

The pandemic crisis has undoubtedly served as a significant basis for the medical care framework in Armenia, highlighting the origins and evolution of multifaceted conflicts within medical and healthcare institutions. A fundamental cause of these conflicts is the physical and emotional overload brought about by the crisis and appropriate managerial approaches. Conflicts emerged due to the inadequacy of essential resources necessary for effective treatment and care, including effective human resources, knowledge, skills, technical equipment, and medications. The contradictions between local management approaches and the current reality, which emerged alongside the crisis, also led to conflicts. For individual representatives of medical staff, the additional and dangerous workload, coupled with consistently insufficient rewards, was unacceptable. Anti-pandemic conditions and the imperative of vaccination were perceived as contradictory by some staff, causing conflicts between the administration and subordinates. It should be noted that these conflicts were not only diverse but also multifaceted. The primary opposing sides in the conflict were the patients and their relatives. For the patients, contradictions and tension stemmed from the unique progression of the disease, while for their relatives, the conflict emerged from an atmosphere of growing fear and mistrust. Organizational and functional conflicts also surrounded hospital administration, other structures responsible for public health in Armenia, and top health management of Armenia. An analysis of key conflict management practices reveals that the bodies and individuals responsible for healthcare were unprepared and inexperienced even in conflict resolution. The findings indicate that institutional conflict during the pandemic extended beyond shortages of resources and staff. A central contributing factor was the absence of formal dispute resolution and communication mechanisms within healthcare organizations, which forced personnel to rely on informal negotiation, personal networks, and ad-hoc adaptations. This dependence on interpersonal problem-solving, rather than structured conflict management systems, not only increased emotional strain but also deepened perceptions of organizational injustice and vulnerability. Strengthening transparent, standardized conflict resolution frameworks is therefore essential for enhancing institutional resilience and protecting healthcare workers in future crisis conditions. Traditional approaches to resolving conflicts that emerged in parallel to the provision of medical services relied on adaptive tactics and direct interactions aimed at calming both staff and patients. Coping strategies and effective practices were also emerged during critical life experience.

Statement of Ethics.

The research was approved by the Ethics Committee of

Yerevan State Medical University named after Mkhitar Heratsi and adheres to the norms of the Declaration of Helsinki.

Declaration of Competing Interest.

The authors declare that there are no conflicts of interest.

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