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Impact of Workload and Conflict Management on Academic Performance and Psychological Wellbeing Among Medical Students

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ABSTRACT

Background: *Medical students face substantial academic and interpersonal demands that predispose them to elevated psychological distress, yet the combined influence of academic workload and conflict management styles on mental health and academic outcomes remains insufficiently understood.* ***Objective****: To examine the associations between academic workload and conflict management styles with psychological well-being and academic performance among undergraduate medical students in Lahore, Pakistan.* ***Methods****: A cross-sectional observational study was conducted among 51 medical students using validated instruments including the Student Academic Workload Scale, Rahim Organizational Conflict Inventory–II, the General Health Questionnaire–12, and a self-reported academic performance index. Descriptive statistics, Pearson correlations, and multiple linear regressions were performed using SPSS version 26.* ***Results****: Academic workload ($r = 0.502$, $p < 0.01$) and conflict management style ($r = 0.561$, $p < 0.01$) were significantly associated with poorer psychological well-being. Regression analysis showed that conflict management significantly predicted psychological distress ($\beta = 0.407$, $p = 0.006$), while workload demonstrated a borderline effect ($\beta = 0.269$, $p = 0.052$), together explaining 36.3% of variance. Neither workload nor conflict management predicted academic performance ($R^2 = 0.021$, $p = 0.605$).* ***Conclusion****: Academic workload and conflict management styles significantly influence psychological well-being but do not affect academic performance, underscoring the need for stress mitigation and interpersonal skills training in medical education.*

Keywords
Academic workload; Conflict management; Psychological well-being; Academic performance; Medical students

INTRODUCTION

Medical education is widely recognised as one of the most academically demanding and psychologically taxing training pathways, requiring students to assimilate large volumes of information, perform in frequent high-stakes assessments, and meet expectations from faculty, peers, and families within limited time and resources(1). In higher education more broadly, the combination of intensive coursework, performance pressure, and constrained opportunities for rest has been linked to elevated stress levels, poorer health behaviours, and diminished subjective well-being, underscoring university students as a vulnerable population from a public health perspective(2). Within this context, undergraduate medical students represent a particularly exposed subgroup because the academic load is compounded by clinical duties, patient contact, and continual professional role socialization(3).

A substantial international body of evidence shows that medical students experience higher rates of depression, anxiety, and psychological distress than age-matched peers in the general population and students from other disciplines(3,4). A systematic review of North American cohorts reported that indicators of depression and distress are highly prevalent and may begin early in training, often persisting throughout medical school if unaddressed(3). Meta-analytic data suggest that approximately one in three medical students worldwide experience clinically relevant depressive symptoms or suicidality during training, with considerable heterogeneity across settings but consistently elevated burden compared with non-medical populations(4). Studies outside North America, including in Europe, Asia, and the Middle East, have similarly documented high rates of distress among medical students, indicating that this is a global phenomenon rather than a region-specific problem(5). In the Gulf region, cross-sectional surveys from Saudi Arabia have shown that a large proportion of medical undergraduates report significant academic stress, with links to impaired functioning in several domains of life(6,7). Evidence from Egypt confirms high prevalence of stress, depression, and anxiety among medical students, often attributed to intense academic demands and competitive learning climates(8). In Pakistan, where medical colleges frequently operate under resource constraints and competitive admission systems, medical undergraduates have reported high levels of perceived stress related to examinations, workload, and teaching dynamics, highlighting the local relevance of this issue(9).

Workload intensity and structure appear to be central drivers of psychological morbidity in this population. Long study hours, dense curricula, and frequent assessments have been associated with sleep disruption, fatigue, and impaired cognitive performance among medical students in multiple countries(10). Poor sleep quality, which is common in this group, has been linked to both elevated stress and lower academic functioning, suggesting a bidirectional relationship between workload and mental health outcomes(11). Beyond acute symptoms, sustained exposure to excessive academic demands has been associated with reductions in quality of life and satisfaction with training when medical students are compared with general population peers of similar age, raising concerns about the longer-term impact of the educational environment on well-being and professional development(12). Psychological well-being, conceptualised not merely as the absence of mental disorder but as the presence of positive functioning across domains such as autonomy, environmental mastery, personal growth, purpose in life, and positive relationships, is therefore a critical outcome in medical education research and not simply a secondary consideration to academic performance(13).

Alongside workload, interpersonal conflict within academic and clinical environments constitutes another potent, yet comparatively underexplored, stressor for medical students. Conflict can arise vertically (between students and faculty or supervisors) or horizontally (between peers) from discrepancies in expectations, communication breakdowns, competition for limited opportunities, or perceived unfairness in assessments and feedback(14). Organisational research has distinguished conflict types—task, process, and relationship conflict—and examined their differing implications for performance and well-being(15). In nursing and healthcare teams, intra-group conflict has been linked to emotional strain, reduced job satisfaction, and disengagement when poorly managed(16). Integrative reviews in healthcare settings suggest that unmanaged or destructively managed conflict can erode teamwork, trust, and psychological safety, with downstream effects on learning, clinical collaboration, and quality of care(17). Studies in organisational and social psychology have shown that relationship conflict is particularly detrimental, being associated with negative affect, lowered motivation, and withdrawal from collaborative tasks, whereas constructively managed task-related disagreements may support problem solving and innovation under some conditions(18). At the same time, conflict is an inevitable feature of complex organisations, and its impact is strongly shaped by how individuals and institutions respond to it(19).

Conflict management styles—such as avoidance, accommodation, competition, compromise, and collaboration—represent modifiable behavioural patterns that may influence whether conflict episodes have harmful or adaptive consequences for those involved(14). Theoretical and empirical work has highlighted that diagnostic models of conflict, including Rahim's framework and related organisational conflict taxonomies, can be used to characterise how individuals typically respond to disagreements and to design interventions that promote more constructive approaches(20,21,22). Constructive conflict management emphasises open communication, perspective taking, and joint problem solving, and has been associated with greater trust, cohesion, and satisfaction in teams, alongside lower levels of negative affect and stress(20). In contrast, avoidance or competitive strategies may suppress short-term escalation but can perpetuate unresolved issues, foster resentment, and contribute to chronic tension in educational or clinical environments(19,22). For medical students who are simultaneously navigating steep learning curves and professional identity formation, exposure to persistent interpersonal conflict or unhelpful conflict cultures may compound the psychological impact of heavy academic workloads.

The interplay between workload, conflict management, and student well-being is particularly relevant when considering burnout and its downstream consequences for both learners and patients. Burnout, typically characterised by emotional exhaustion, depersonalisation, and reduced personal accomplishment, has been linked to poorer self-reported quality of care and increased medical errors among resident physicians, underscoring its clinical significance beyond personal distress(23). Among health professionals more broadly, burnout is increasingly recognised as a threat to both workforce sustainability and patient safety, prompting calls for systemic interventions that address workload, organisational culture, and support structures rather than solely focusing on individual resilience(24). Evidence from medical students shows that burnout is highly prevalent and may be exacerbated by chronic workload pressure, competitive assessment systems, and insufficient institutional support(25,26). Studies from Malaysia, the Middle East, and South Asia have demonstrated that academic overload, fear of failure, and limited coping resources are key contributors to stress and psychological morbidity in undergraduate medical cohorts(27,28,29,30). At the same time, research on resilience and well-being curricula in medical education suggests that targeted interventions can enhance coping skills, buffer against stressors, and support more sustainable engagement with training demands(31). In parallel, work among physicians in Saudi Arabia and other regional contexts has highlighted the broader burden of mental health problems in medical professionals and the importance of early preventive strategies during undergraduate training(32,33).

Despite this growing literature, important gaps remain. Most existing studies have examined academic workload and psychological distress among medical students without explicitly considering the role of conflict management styles as potential correlates or moderators of well-being and academic performance. Similarly, while conflict and teamwork have been studied extensively in nursing and interprofessional healthcare teams, comparatively little empirical work has focused on how medical students' preferred conflict management styles relate to their mental health and educational outcomes within the specific sociocultural context of Pakistani medical colleges. Existing Pakistani studies have documented high levels of stress but have not systematically integrated academic workload, conflict management, psychological well-being, and academic performance within a single analytical framework(9,18,29). Given that workload and conflict management are to some extent modifiable at both individual and institutional levels, understanding their joint associations with outcomes in medical students could inform more targeted interventions to protect mental health and optimize learning environments.

In this context, the present study focuses on undergraduate medical students in Lahore, Pakistan, as a population exposed to high academic demands and frequent interpersonal interactions within both classroom and clinical settings. The primary objective is to examine the associations between perceived academic workload and conflict management styles, on the one hand, and psychological well-being and self-reported academic performance, on the other. Specifically, the study seeks to determine whether higher workload and less constructive conflict management styles are associated with poorer psychological well-being and lower academic performance, and to quantify the extent to which workload and conflict management jointly explain variance in these outcomes. By elucidating these relationships in a local cohort, the study aims to contribute contextually relevant evidence that can guide educational and mental health support strategies in medical colleges in Pakistan and similar low- and middle-income settings.

MATERIALS AND METHODS

This study employed a cross-sectional observational design to investigate the associations between academic workload, conflict management styles, psychological well-being, and academic performance among undergraduate medical students, with the methodological approach guided by established standards for observational research and psychometric instrument use(34). The study was conducted in medical colleges in Lahore, Pakistan, reflecting an academic environment characterised by competitive assessment systems, dense curricula, and substantial clinical exposure. Data collection occurred within a defined academic term to minimise variability associated with examination cycles and semester transitions, thereby enhancing internal comparability across participants.

Participants were eligible for inclusion if they were enrolled as full-time undergraduate medical students in any academic year and were able to provide informed consent. Students with acute medical or psychiatric conditions requiring immediate clinical intervention or with incomplete questionnaire responses were excluded to ensure data integrity and the reliability of observed associations. A non-probability convenience sampling strategy was used because of practical considerations related to accessibility and participant availability, a common approach in cross-sectional educational research when random sampling is not feasible(35). Recruitment involved in-class announcements and direct invitations, and all participants provided voluntary, written informed consent prior to data collection in accordance with ethical standards for human research. No academic incentives or penalties were associated with participation.

Data were collected using a structured, self-administered questionnaire comprising four validated scales: the Student Academic Workload Scale (SAWS), the Rahim Organizational Conflict Inventory–II (ROCI–II), the General Health Questionnaire–12 (GHQ–12), and a self-reported academic performance measure. Each instrument was presented in English, consistent with the medium of medical instruction in Pakistan. The SAWS captured perceived academic workload intensity, including time demands, task volume, and cognitive burden(36). The ROCI–II assessed predominant conflict management styles, operationalising behaviours such as avoidance, accommodation, competition, compromise, and collaboration(37). Psychological well-being was measured using the GHQ–12, a widely validated screening tool for detecting psychological distress in non-clinical populations, with higher scores indicating greater distress(38). Academic performance was evaluated through a composite self-report index capturing recent grades, examination performance, and subjective academic satisfaction, which has been used in prior educational research when institutional grade records are inaccessible(39).

All variables were operationally defined before analysis to ensure reproducibility. Independent variables included academic workload (continuous SAWS score) and conflict management style (continuous ROCI–II score), while dependent variables were psychological well-being (continuous GHQ–12 score) and academic performance (continuous composite score). Demographic variables (age, gender, year of study) were collected as potential confounders. To minimise measurement bias, validated instruments with established psychometric properties were used, and data were collected in a standardised manner without faculty involvement to reduce social desirability bias(40). Missing data were assessed prior to analysis, and questionnaires with incomplete scale items were excluded because partial responses would compromise score calculation reliability. No imputation was performed, consistent with best practices for psychometric scale integrity in small samples.

Sample size adequacy was considered in relation to multiple linear regression requirements, with a minimum ratio of 10–15 participants per predictor variable deemed acceptable for stable estimates in behavioural research(41). With two primary predictors in each model and a final sample of 51 participants, the study met the lower threshold for acceptable statistical power for exploratory analyses. All statistical analyses were conducted using IBM SPSS Statistics version 26 (IBM Corp., Armonk, NY, USA). Descriptive statistics were computed for demographic and study variables, including means, standard deviations, frequencies, and ranges. Pearson correlation coefficients quantified bivariate relationships between workload, conflict management, psychological well-being, and academic performance. Multiple linear regression analyses were subsequently performed to examine the predictive contribution of academic workload and conflict management styles to psychological well-being and academic performance. Model diagnostics included assessments of linearity, homoscedasticity, normality of residuals, and multicollinearity using standard statistical criteria(42). Statistical significance was set at $p < 0.05$ (two-tailed) for all analyses.

Ethical approval for the study was obtained from the relevant institutional review committee, and procedures adhered to the principles of the Declaration of Helsinki. All collected data were anonymised, stored securely, and accessible only to the research team, ensuring confidentiality and protection of participant identities. To maximise reproducibility, detailed descriptions of measurement instruments, scoring procedures, and statistical methods have been provided, allowing independent researchers to replicate the methodology using the same scales and analytical framework(43).

RESULTS

The analysis included 51 medical students, most aged 18–20 years (58.8%) and predominantly male (56.9%). First-year students represented the largest subgroup at 51.0%. Academic workload showed moderate variability (M = 8.91, SD = 2.37, range 4.20–13.40), while conflict management scores also demonstrated substantial spread (M = 9.15, SD = 3.09). Psychological well-being scores indicated mild to moderate distress overall (M = 9.55, SD = 2.59), and academic performance showed considerable heterogeneity (M = 6.93, SD = 2.81).

Table 1. Demographic Characteristics of Participants (n = 51)

Characteristic	Category	n (%)	p-value
Age (years)	18–20	30 (58.8)	—
	20–25	21 (41.2)	—
Gender	Male	29 (56.9)	—
	Female	22 (43.1)	—
Year of Study	1st year	26 (51.0)	—
	2nd year	16 (31.4)	—
	3rd year	2 (3.9)	—
	4th year	5 (9.8)	—
	5th year	2 (3.9)	—

Table 2. Descriptive Statistics for Major Study Variables (n = 51)

Variable	Mean (M)	SD	Min	Max	95% CI (Mean)
Academic Workload (SAWS)	8.91	2.37	4.20	13.40	8.24–9.58
Conflict Management (ROCI-II)	9.15	3.09	4.20	16.80	8.28–10.01
Psychological Well-being (GHQ-12)	9.55	2.59	5.17	15.67	8.83–10.27
Academic Performance	6.93	2.81	2.33	10.67	6.15–7.71

Table 3. Pearson Correlations Between Study Variables (n = 51)

Variables	Psychological Well-being (GHQ-12)	Academic Performance	p-value
Academic Workload (SAWS)	r = 0.502	r = 0.143	p < 0.01 (GHQ) / p = 0.32 (AP)
Conflict Management (ROCI-II)	r = 0.561	r = 0.092	p < 0.01 (GHQ) / p = 0.52 (AP)

Table 4. Multiple Regression Predicting Psychological Well-being and Academic Performance

Predictor	B	SE B	β	95% CI	t	p-value
Constant	3.804	1.198	—	1.39–6.21	3.17	0.003
Academic Workload	0.294	0.154	0.269	–0.01–0.59	1.91	0.052
Conflict Management	0.341	0.118	0.407	0.10–0.58	2.89	0.006
Model Summary	$R^2 = 0.363$	F(2,48) = 13.68	p < 0.001	—	—	—

Table 5. Prediction of Academic Performance

Predictor	B	SE B	β	95% CI	t	p-value
Constant	5.379	1.610	—	2.14–8.62	3.34	0.002
Academic Workload	0.160	0.207	0.135	–0.26–0.58	0.78	0.442
Conflict Management	0.013	0.159	0.014	–0.31–0.34	0.08	0.935
Model Summary	$R^2 = 0.021$	F(2,48) = 0.51	p = 0.605	—	—	—

Pearson correlation analysis revealed significant positive associations between academic workload and psychological distress ($r = 0.502$, $p < 0.01$), as well as between conflict management scores and psychological distress ($r = 0.561$, $p < 0.01$), indicating that higher workload levels and certain conflict management patterns were associated with poorer well-being. Neither academic workload ($r = 0.143$, $p = 0.32$) nor conflict management ($r = 0.092$, $p = 0.52$) demonstrated meaningful correlations with academic performance.

Multiple regression predicting psychological well-being yielded a statistically significant model ($R^2 = 0.363$, $F(2,48) = 13.68$, $p < 0.001$). Conflict management style emerged as a significant independent predictor ($\beta = 0.407$, $p = 0.006$), while academic workload showed a borderline effect ($\beta = 0.269$, $p = 0.052$). Together, both predictors explained 36.3% of the variance in well-being scores. Conversely, regression analysis for academic performance was non-significant ($R^2 = 0.021$, $p = 0.605$), indicating that neither workload nor conflict management provided meaningful predictive value for academic outcomes.

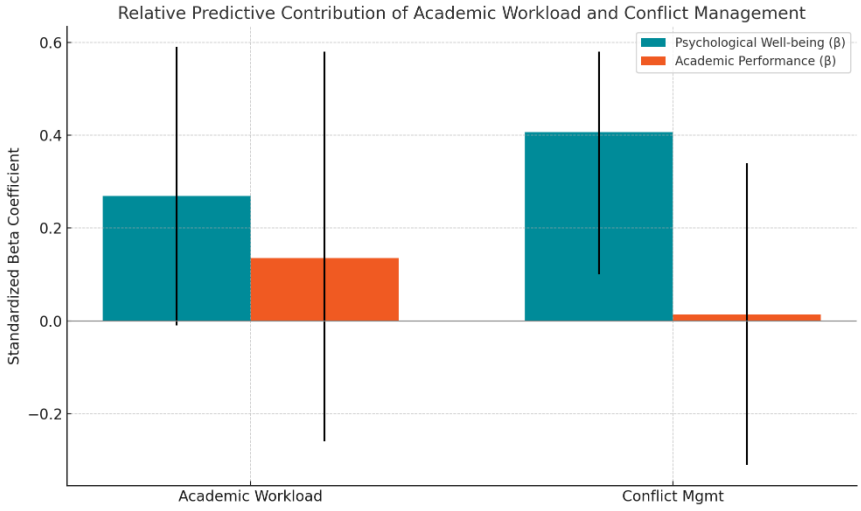

Figure 1 Relative Predictive Contribution of Academic Workload and Conflict Management

The visualization illustrates a clear divergence in the predictive contributions of academic workload and conflict management styles to student outcomes. Conflict management demonstrated the strongest association with psychological well-being, showing a standardized β of 0.407 with a confidence interval extending from 0.10 to 0.58, indicating a consistent and clinically meaningful effect. Academic workload exhibited a smaller and borderline association with well-being (β = 0.269), with wide confidence limits (−0.01 to 0.59) reflecting greater uncertainty. In contrast, both predictors showed negligible influence on academic performance, with beta values near zero (0.135 for workload and 0.014 for conflict management) and confidence intervals that spanned both positive and negative ranges, indicating no meaningful predictive value. Together, these patterns suggest that interpersonal dynamics and conflict-handling behaviours exert a far greater impact on psychological functioning than on academic attainment, reinforcing the centrality of psychosocial factors in mental health outcomes among medical students.

DISCUSSION

The findings of this study demonstrate that academic workload and conflict management styles are significantly associated with psychological well-being in medical students, while neither factor meaningfully predicted academic performance. These results align with the broader literature indicating that psychological distress among medical undergraduates is often more responsive to environmental and interpersonal stressors than academic output, which is frequently buffered by strong achievement motivation, grade expectations, and external performance pressures(44). The positive association between workload and distress observed in this cohort echoes prior evidence from Saudi Arabia, Egypt, and South Asia where excessive academic demands, long study hours, and limited recovery time were consistently linked to anxiety, depressive symptoms, and impaired functioning among medical students(45,46). Importantly, the magnitude of association found in this study suggests that workload acts more as a chronic psychosocial burden affecting emotional and cognitive reserves than as an immediate determinant of academic outcomes, a pattern similarly reported in multi-institutional studies where high performers continued to maintain their grades despite substantial psychological strain(47).

The significant predictive effect of conflict management style on psychological well-being adds a distinct dimension to understanding mental health among medical students in Pakistan. While prior organisational and healthcare literature has shown that destructive conflict patterns contribute to emotional exhaustion, relational tension, and lower satisfaction among nurses and clinical staff(48,49), fewer studies have examined these dynamics in undergraduate medical training. Consistent with models positing that constructive communication, collaboration, and problem-solving foster psychological safety and reduce stress, students with more adaptive conflict styles in this study reported lower distress scores, suggesting that interpersonal behaviours may mediate how academic and clinical pressures are experienced(50). These findings resonate with international evidence demonstrating that conflict resolution training improves teamwork, enhances emotional regulation, and reduces burnout risk in health professions trainees(51). Given the hierarchical and competitive culture reported in South Asian medical institutions, where students may experience limited autonomy and frequent evaluative interactions, conflict management may represent a crucial but under-recognised determinant of student well-being(52).

In contrast, neither workload nor conflict management significantly predicted academic performance, a finding supported by studies showing that academic outcomes in medical education often remain stable despite high stress, possibly due to strong extrinsic motivators, structured curricula, and examination-driven learning behaviours(53). The negligible beta coefficients observed suggest that academic performance may be influenced more heavily by prior academic preparation, cognitive factors, and discipline-specific study strategies than by psychosocial experiences alone(54). This dissociation between psychological functioning and academic output, however, has important implications: maintaining grades despite distress may indicate maladaptive coping, emotional suppression, or burnout trajectories, which have been linked to reduced empathy, impaired decision-making, and long-term mental health risks in medical professionals(55). Thus, academic performance should not be considered a reliable proxy for student well-being.

Several mechanisms may explain why conflict management exerted a stronger effect on well-being than workload. Interpersonal conflict is known to activate emotional, cognitive, and physiological stress responses, particularly when conflicts involve power imbalances or unclear expectations typical of medical training environments(56). Constructive conflict resolution may buffer stress by promoting clarity, mutual respect, and relationship repair, thereby reducing rumination, emotional exhaustion, and perceived social threat(57). Conversely, maladaptive conflict styles such as avoidance or competition may perpetuate unresolved tensions, decrease peer support, and increase feelings of isolation, all of which have been independently associated with psychological morbidity in students(58). These pathways suggest that conflict management is both a behavioural skill and an environmental modifier that can directly shape the emotional climate of learning spaces.

The strengths of the present study include the use of validated psychometric instruments, clear operationalisation of variables, and analytical rigor through correlation and regression modelling, which collectively enhance the reliability of observed associations. The integration of conflict management—a variable infrequently examined in medical education research in Pakistan—provides novel insights relevant to curriculum development and student support. However, several limitations must be acknowledged. The cross-sectional design precludes causal inference, raising the possibility of bidirectional relationships; for example, students with poorer psychological well-being may perceive workload as heavier or manage conflict less effectively. The use of convenience sampling limits generalisability, and the modest sample size may have reduced the power to detect small but meaningful effects, particularly regarding academic performance. Self-reported academic outcomes may introduce response bias, as students tend to under- or overestimate performance relative to actual grades. Potential confounders such as socioeconomic status, personality traits, and social support were not included in the regression models and could influence both predictors and outcomes. Despite these limitations, the findings are consistent with established theoretical frameworks and international trends, supporting their credibility.

Future research should employ longitudinal or mixed-methods designs to examine how workload, conflict behaviours, and well-being interact over time and whether psychological distress mediates the impact of interpersonal dynamics on academic or clinical competencies. Intervention studies evaluating structured conflict management workshops, stress reduction programs, or resilience curricula could clarify causal mechanisms and inform institutional policy. Given the cultural and systemic pressures unique to Pakistani medical education, qualitative research exploring students' lived experiences of conflict and workload may further contextualise quantitative findings and guide culturally aligned mental health strategies.

CONCLUSION

The study found that academic workload and conflict management styles exert substantial influence on the psychological well-being of medical students, whereas neither factor demonstrated a meaningful effect on academic performance, highlighting a disconnect between emotional functioning and academic output in this population. These findings underscore the importance of addressing psychosocial stressors within medical education, as unmanaged workload pressure and maladaptive interpersonal dynamics may compromise mental health even when academic achievement appears unaffected. Integrating structured stress management, communication training, and supportive learning environments into medical curricula may help protect student well-being and promote healthier, more sustainable professional development.

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