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**Exploring the implications of the influence of organisational culture on work-life balance practices: evidence from Nigerian medical doctors**

Journal:	<i>Personnel Review</i>
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Keywords:	Work-Life Balance (WLB), Organisational Culture, Nigerian medical doctors
Methodologies:	Qualitative

## Exploring the Implications of the Influence of Organisational Culture on Work-life Balance Practices: Evidence from Nigerian Medical Doctors

### Abstract

**Purpose** - Whilst significant evidence of western work-life balance (WLB) challenges exists, studies that explore Sub-Saharan Africa (SSA) are scarce. This article explores how organisational culture in Nigerian medical organisations influences doctors' WLB and examines the implications of supportive and unsupportive cultures on doctors' WLB.

**Methodology** - The paper uses qualitative data gleaned from semi-structured interviews of 60 medical doctors across the six geo-political zones of Nigeria in order to elicit WLB challenges within the context of organisational culture.

**Findings** - The findings show that organisational culture strongly influences employees' abilities to use WLB policies. Unsupportive culture resulting from a lack of support from managers, supervisors, and colleagues together with long working hours influenced by shift-work patterns, a required physical presence in the workplace, and organisational time expectations exacerbate the challenges that Nigerian medical doctors face in coping with work demands and non-work related responsibilities. Our findings emphasise how ICT and institutions also influence WLB.

**Originality/value** - The paper addresses the under-researched SSA context of WLB and emphasises how human resource management policies and practices are influenced by the complex interaction of organisational, cultural, and institutional settings.

**Keywords:** Work-life balance practices, organisational culture, Nigerian medical doctors.

## Introduction

Balancing work related demands and non-work related obligations has become a global issue (Mohd Noor, Stanton and Young, 2009). There have been several studies on work-life balance (WLB) undertaken for western countries such as: Kinnunen and Mauno (1998) in Finland; Dikkers, van Engen and Vinkenburg (2010) for the Netherlands; Voyandoff (2004) for the US; de Luis Carnicer et al. (2004) in Spain; Dex and Bond (2005) in the UK; Fub et al. (2008) in Germany; and Russell, O'Connell and McGinnity (2009) in Ireland. Some noted studies in Asia have also illuminated our understanding of WLB (Ueda, 2012; Xiao and Cooke, 2012). The unified theme of their studies was to find ways by which employees could balance their work demands and non-work related responsibilities without conflict (Guest, 2001). However, despite the plethora of studies, WLB is yet to receive the much needed attention in Africa (Mordi, Mmieh and Ojo, 2013).

Countries in Sub-Saharan Africa (SSA) represent a neglected and little understood area of inquiry. This study encapsulates the unique socio-cultural, less egalitarian, and collectivistic perspectives from SSA. WLB in western, industrialised countries may not necessarily reflect all issues in SSA accurately (Epie and Ituma, 2014). Besides, scholars have called for country-specific studies in Africa and other non-western nations in order to broaden our understanding of the challenges employees face in balancing work and non-work related obligations in other parts of the world (Gartner, 1995; Kitching and Woldie, 2004).

A review of studies undertaken in the western context revealed a relationship between WLB, organisational effectiveness, and organisational performance (Eby et al., 2005; Beauregard and Henry, 2009; Cegarra-navarro et al., 2015). However, the relationship between WLB and organisational culture has not yet been adequately explored. This study employs a country-

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3 specific SSA context in order to explore the interrelationship between WLB and organisational  
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5 culture among Nigerian medical doctors.  
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9 This article examines the prevalent culture in Nigerian medical organisations and the factors that  
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11 constrain doctors' abilities to use WLB policies. The implications of a supportive or  
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13 unsupportive culture on doctors' work and non-work lives are also explored. The rest of the  
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15 paper is organised as follows: Firstly, we contextualise WLB, which is followed by a discussion  
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17 on doctors' WLB. Secondly, we discuss organisational culture and professional culture. Thirdly,  
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19 we outline the research context, which is then followed by the methodology section. Then, we  
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21 present the findings and then discuss their implications. Finally, we draw conclusions.  
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### 26 **Work-life Balance in Context**

27  
28 The debate about WLB is linked to the search for employee flexibility (Zeytinoglu et al., 2009),  
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30 which has been fuelled by several factors such as the need and push for a round-the-clock  
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32 business hours (Tan and Klaasen, 2007; Torrington, Hall and Taylor, 2008), demographic and  
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34 social changes (Sharma and Mishra, 2013), changes in the labour market (Cegarra-Leiva,  
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36 Sauchez-Vidal and Cagarra-Navarro, 2012), the increase in the number of dual-earner families  
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38 (Cegarra-Leiva et al., 2012), and the current economic situation that requires most families to  
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40 increase their financial power (Walker, Wang and Redmond, 2008). WLB, however, means  
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42 different things to different people (Lockwood, 2003). The concept recognises the multiple roles  
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44 of paid work and the non-work related responsibilities of employees, which often affect each  
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46 other (Kalliath and Brough, 2008). WLB means an employee's ability to successfully negotiate  
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48 work related and family commitments, as well as other non-work responsibilities and activities  
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50 (Parkes and Langford, 2008; Kesting and Harris, 2009; Wheatley, 2012). The purpose of WLB  
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52 policies is to adjust employees' work schedules in order to find a balance between their paid  
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3 work and other non-work related responsibilities (Pillinger, 2002). The term “work-life balance”  
4 has replaced the terms “work-family balance” (Hudson Resourcing, 2005), “work-family  
5 facilitation” (Rotondo and Kincaid, 2008) and “work-family synergy” (Beutell and Wittig-  
6 Berman, 2008). This replacement is due to the fact that WLB is more inclusive of employees’  
7 work related and non-work related activities (Lyness and Judiesch, 2014). The importance of an  
8 effective balance between employees’ work demands and non-work commitments cannot be  
9 overlooked (Liechty and Anderson, 2007). Carlson et al. (2008) noted that facilitating WLB can  
10 provide an organisation with a competitive advantage. WLB also reduces work-family conflict  
11 (Frone, 2003), promotes work-family enrichment (Mishra, Gupta and Bhatnagar, 2014) and  
12 helps organisations to attract and retain high-quality employees (Murphy and Doherty, 2011).  
13 High self-esteem, job satisfaction and an overall sense of harmony in life have been identified as  
14 indicators of successful WLB (Clarke, Kosh and Hill, 2004).  
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32 Working hours are a significant factor in achieving and managing WLB (Mubeen and Rashidi,  
33 2014). This is because excessive working hours can create imbalances which negatively affect  
34 employees’ personal and social lives (Bielby, 1992). There is growing evidence that patterns of  
35 long working hours without flexibility results in poor WLB (Othman, Yusof and Osman, 2009;  
36 Walter, 2012). These patterns of work without flexibility turn households upside down (Bamford  
37 and Bamford, 2008) and expose doctors to high risks of making sequential mistakes (Dembe,  
38 Delbos and Erickson, 2009). However, literature acknowledges that flexible working patterns  
39 will only enhance WLB (Vandeweyer and Glorieux, 2008).  
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52 Literature also emphasises the importance of formal and informal support in the realisation of  
53 WLB. Scholars have argued that management, supervisor and co-worker support are also  
54 essential for WLB (Ayman and Antani, 2008; Maxwell and McDougall, 2004; Ferguson et al.,  
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3 2012). Management support reflects the extent to which the wellbeing and socioemotional needs  
4 are met to enhance WLB (Eisenberger et al., 1986; Behson, 2002) and supervisor support  
5 involves general expressions of concern by supervisors that is intended to enhance employee  
6 well-being (House, 1981).  
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### 12 13 **Doctors' Work-life Balance**

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15 Over the years, issues pertaining to medical doctors' WLB have generated significant  
16 discussions among academics and practitioners (Lowenstein, 2003; Thielst, 2005; Wise et al.,  
17 2007). This could be because doctors find it hard to separate work from their personal lives  
18 (Sibert, 2011). Sibert recognised the value and importance of doctors' WLB, but also believed  
19 that the requirement of physical presence in the hospital and the high intensity work environment  
20 appear incompatible with WLB principles. Medical doctors are people who constantly juggle  
21 work and family responsibilities (Thielst, 2005). According to Thielst (2005), this often leaves  
22 medical practitioners vulnerable to stress and conflicts between home and work. A heavy  
23 workload means they have less time and energy available for their family and other non-work  
24 related activities (Swanson, Power and Simpson, 1998). Thielst (2005) found that doctors'  
25 commitment to their work keeps them away from their spouses/partners to the extent that most of  
26 them regard their job as their "first love" and give less time to non-work related and family  
27 related responsibilities. Therefore, patterns of work without flexibility turn households upside  
28 down (Bamford and Bamford, 2008) and present doctors with a high degree of burnout and a  
29 feeling of exhaustion and depersonalisation (Deary et al., 1996).  
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52 There have been few notable studies on the WLB of female doctors from western perspectives.  
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54 Women continue to maintain the majority of the domestic and caring responsibilities (Crompton  
55 and Lyonette, 2011; Walsh, 2013). Women's WLB has, in some cases, benefitted from strong  
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3 professional bodies such as the British Medical Association (BMA). This has been possible  
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5 because medicine is a principally public sector occupation. BMA has successfully (for both male  
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7 and female doctors) negotiated the reduction of the long hours for which doctors work  
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9 (Crompton and Lyonette, 2011). Pas, Peters and Doorewaard (2011) noted in their study of  
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11 Dutch female doctors that offering family-friendly HR practices such as flexible working hours  
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13 gives scope for improving WLB. As a result, they suggested an appropriate interaction between  
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15 HR practices and organisational culture as a key to realising the best HR outcomes.  
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### 20 **Understanding Organisational Culture**

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22 Culture is a collective programming of the mind that distinguishes members of one group from  
23  
24 another (Hofstede, 1991). Organisational culture can therefore be defined as a “deep and  
25  
26 complex part of an organisation that can strongly influence organisational members” (Choi and  
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28 Scott, 2008, p. 34). It can also be viewed as the relationship between employer and employee  
29  
30 which is influenced by workplace traditions and regulations (Sackman, 2006). For Schein  
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32 (2010), organisational culture reflects widely shared values and assumptions that are deeply  
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34 rooted in an organisation, which members learn over an extended period as they solve problems.  
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40 Employees (doctors) working in medical organisations work for longer hours than other  
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42 professions which often affects ability to make time for non-work activities (Wilson et al. 2007).  
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44 Most organisations have now embraced the culture of long working hours, which is considered a  
45  
46 prerequisite of organisational commitment (Mubeen and Rashidi, 2014). Employees should have  
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48 control over how, when and where their daily work is carried out (Anxo, Boulin and Fagan,  
49  
50 2006), which is otherwise known as work-life balance (Kesting and Harris, 2009). This gives rise  
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52 to the issue of work-life culture (Holt and Thaulow, 1996; Thompson, Beauvais and Lyness,  
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54 1999). For Thompson, Beauvais and Lyness (1999, p. 394), “work-family culture is the shared  
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3 assumptions, beliefs, and values on the extent to which an organisation supports and values  
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5 integrating employees' work and family lives". This definition focuses on work and family life  
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7 and ignores other non-work related activities. Bond (2004, p. 3), however, extends this definition  
8  
9 to include other non-work related activities by defining work-life culture as "an organisation's  
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11 support and valuing of the integration of employees' work and non-work lives." A work-life  
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13 culture is developed when employees receive organisational support for managing their work-life  
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15 responsibilities (Wu et al., 2011). Overall, the success of WLB initiatives depends on the nature  
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17 of the prevailing culture of an organisation.  
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23 It is essential to note the relationship between organisational culture and professional culture.  
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25 Professional culture dictates not only tasks and social norms but also defines the entire work  
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27 environment, including what makes sense and how things are done. The medical profession  
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29 involves a great deal of professional responsibilities and duties besides the actual role of treating  
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31 patients (such as professional beliefs, professional rules and regulations, professional ethics, the  
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33 Hippocratic Oath, and societal expectations) which conflate and form their values, beliefs, basic  
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35 assumptions, shared perceptions, and practices upon which the profession's culture is strongly  
36  
37 built. Professional culture is a subculture of organisational culture, but it is strong and dominant;  
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39 and often referred to by doctors as their organisational culture (Montgomery et al., 2011; Scott et  
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41 al., 2003). Hence, the relationship between professional culture and organisational culture is not  
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43 in conflict, rather it is mutually interwoven. In medicine, however, organisational culture is a  
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45 good representation of professional culture (Helmreich and Merritt, 1988) and will be treated as  
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47 synonymous to professional culture in this study.  
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54 Wheatley (2012) studied dual earner couples (with managerial, professional, or associate  
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56 professional occupations) in the UK and observed that work-group cultures prevent employees,  
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3 especially women, from achieving WLB. Employees may experience long hours in response to  
4 professional work-group cultures which often engenders undesirable consequences, especially  
5 for working mothers (Wheatley, 2012). Bond (2004) found that unsupportive organisational  
6 culture promotes WLC among UK employees in the financial sector. Previous studies indicate  
7 that organisational culture is a critical factor for achieving WLB (Lewis, 1997; Lewis, 2001;  
8 Thompson et al., 1999).  
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### 17 18 **The Research Context**

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20 Nigeria is a West African country with a population of over 180 million people and over 250  
21 diverse ethnic groups (CIA World Fact Book, 2015). The workforce is estimated to be 51.33  
22 million and the unemployment rate to be 23.9% (CIA World Fact Book, 2011). The Nigerian  
23 health sector comprised of private and government/public hospitals. The Medical and Dental  
24 Council of Nigeria (MDCN) regulates its affairs. According to the Human Resources for Health  
25 (HRH) Fact Sheet (2010), Nigeria has the largest base of health workers in Africa; with 55,375  
26 doctors practising in different parts of the country. This makes Nigeria a unique research context.  
27  
28 The health sector has been chosen as the empirical focus because it allows the evaluation of the  
29 relationship between medical professional culture and doctors' WLB. As far back as 35 years  
30 ago, the Nigerian health sector was reported to be so under-staffed that there were only  
31 approximately 500 doctors available for 1 million Nigerians (Bower and Purcell, 1978).  
32  
33 Recently, the President of the Nigerian Medical Association (NMA) suggested that Nigeria has  
34 71,740 medical and dental practitioners and they are listed on the register of the MDCN  
35 (Muanya, 2013), out of which only approximately 27,000 are practising in Nigeria. The dearth of  
36 doctors in Nigeria is further aggravated by the issue of doctors migrating to wealthier nations in  
37 order to further their careers and thereby improve their economic and social situations (Healy  
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3 and Oikelome, 2007). For instance, more than 8,893 doctors migrated from Nigeria to countries  
4 like the UK, the US, Ireland, South Africa, the West Indies, Germany, Poland, and other  
5 countries between 2005 and 2007 (HRH Fact Sheet, 2010). This continuous migration of doctors  
6 has led to a situation in which there are only 600 paediatricians to care for its over 40 million  
7 population of children compared to the UK that has over 5,000 paediatricians for 20 million  
8 children (Ovuorie, 2013). This perhaps explains the high infant mortality rate in Nigeria, which  
9 stands at 73 deaths/1,000 live births (CIA World Fact Book, 2015). The shortage of medical  
10 doctors remains a problem for Nigeria and this influences the level of doctors' workloads which  
11 in turn leads to long working hours for doctors.  
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## 25 **Methodology**

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27 WLB in the context of SSA has been underexplored, so we adopt a qualitative approach to data  
28 collection and analyses. A qualitative research approach is deemed ideal because of its strength  
29 in providing rich insights into issues of importance (Cassell, 2009). The study draws on  
30 interpretive-constructivist and constructivist-phenomenologist traditions which highlight  
31 individual experiences (Guba and Lincoln, 1994). This methodological position provides  
32 researchers with an in-depth understanding of this under-studied phenomenon (Cresswell, 2008),  
33 and will eventually lead to the discovery of richly detailed accounts of individual experiences  
34 (Fassinger, 2001). Several qualitative studies have also adopted this approach among different  
35 professional groups in different environments (Hennequin, 2007; Ituma et al., 2011). In addition,  
36 a case study approach has been employed in order to give the researchers the chance to explore  
37 employees' daily activities, experiences, and views on the subject matter (Cresswell, 2008). A  
38 qualitative method creates an interactive process between literature and evidence which helps to  
39 understand representativeness across a wider range of circumstances (Ciao, 2011). For the  
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3 purpose of fair representation, medical doctors working in different hospitals across the six-geo-  
4 political zones of Nigeria were interviewed for the study. Data was collected from 60 medical  
5 doctors (33 male, 27 female) in public and private hospitals with an age composition ranging  
6 from 36-54 years. This was achieved through semi-structured interviewing. The researchers  
7 opted for the method of semi-structured interviews because of its strengths in revealing  
8 important and often hidden facts about human and organisational behaviour (Qu and Dumay,  
9 2011).

10  
11 Participants were solicited through the MDCN, which is an umbrella association for medical  
12 doctors. Sampling later developed into snowballing. Participants were asked the same questions  
13 at different times and locations in order to reduce any chance of bias. All participants passed the  
14 eligibility criteria as they were registered with the MDCN. Specifically, the participants were  
15 asked the following research questions: (a) What is the prevalent culture in your organisation?  
16 (b) What are the factors that constrain you from using WLB policies and practices in your  
17 organisation and would you say these factors are part of your organisational culture? (c) What  
18 are the implications of a supportive or unsupportive culture on your work and non-work lives? It  
19 should be noted, however, that pseudonyms have been used to represent the names of hospitals  
20 in this study in order to fulfil the promise of confidentiality made to the sources of the primary  
21 data. Consent forms were presented to the participants at the start of every interview stating the  
22 purpose of the study. Participants were informed of their right to participate or not to participate  
23 and that they could withdraw from participation at any stage of the interview process. All of the  
24 interviews were conducted in English and they lasted between 20-60 minutes. All of the  
25 interviews were electronically recorded with the permission of the participants in order to  
26 capture the participants' words verbatim. Furthermore, the recordings can help to identify what  
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3 might have been missed during the interview so that supplementary interviews could be  
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5 conducted where relevant. After interviewing 48 participants, it was perceived that emerging  
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7 themes were recurrent and it would be unlikely that further data collection would uncover new  
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9 themes. In order to improve the reliability of the interviews and to ensure that no important  
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11 themes had been left uncovered, a further 12 “confirmatory” interviews were conducted,  
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13 therefore 60 interviews in total were undertaken. The findings of the 12 additional interviews  
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15 corroborated the themes found in the previous 48 interviews and there were no new emerging  
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17 themes. This means that we have reached a point at which Glaser and Strauss (1967, p. 61)  
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19 referred to as “theoretical saturation”.

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22 After the transcription, the researchers meticulously went back to the beginning of the recording  
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24 and followed through every word to ensure that the transcribed version of the interviews exactly  
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26 matched the recorded version. After a narrative summary for the interviews had been drafted,  
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28 open coding (the identification of key points and objectives that seemed to be significant to the  
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30 data) was applied (Boeije, 2005). At this stage, the emphasis was on the researchers’ ability to  
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32 question the meaning of particular words or phrases and to think carefully about their meaning  
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34 and interpretations (Corbin and Strauss, 2008). The researchers then grouped the first set of  
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36 codes into categories according to their common codes. Through the combination of codes that  
37  
38 had similar underlying ideas, two dominant themes and eight sub-themes emerged (see Table 1).  
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40 The researchers did not impose coding categories a priori; rather the researchers remained open  
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42 to surprising insights by allowing the categories to emerge from the data in order not to miss any  
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44 important themes. Although the researchers considered labelling the categories to be accurate  
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46 and reflective of the meanings of the participants’ feelings about their WLB and organisational  
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48 cultures, the researchers recognised that this is an inherently subjective exercise; given that one  
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“cannot escape background preconceptions embedded in the language and life of their authors” (Gill and Johnson, 1997, p. 144). The categories were then marked with different colours in order to facilitate analysis of the data and a thematic map was drawn. The main categories were further fine-tuned by frequent comparisons until a representative overview was achieved. For the exploratory nature of this study, data-driven thematic analysis was employed. The application of thematic analysis was based on the guide given by Braun and Clarke (2006) and the steps in data analysis were based on Corbin and Strauss’s (2008) recommendation. Emerging themes from the data became the categories for analysis (prearranged enigmas were verified twice in order to ensure reliability) and investigator triangulation (Polit and Beck, 2004) was applied.

## Findings

Emerging themes, subthemes, and illustrative extracts are presented in Table 1. Long working hours and organisational culture emerge as the main themes

**Table 1 Emerging themes with illustrative extracts**

Themes	Sub-themes	Illustrative Extracts
Long Working Hours	Shift Work Patterns	The medical professional culture requires doctors to work shift patterns; it could be a day or a night shift with no exception for weekends and public holidays...
	Required Physical Presence in the Hospital	This is a medical profession and not another profession where you can telework or work from home...as a doctor, I need to be physically present in the hospital at all times of my shift...
	Organisational Time Expectations	The OTE in the medical profession is high... ..the number of hours we put in matter for the patients’ care, medical research, doctors’ image, and promotions...
Organisational Culture	Management Support	As a senior surgeon and a member of the hospital management, I do not expect any doctor to complain about not being allowed to use work-life balance policies, this is medicine...
	Supervisors’ Support	My supervisor will not hear of work-life balance...My supervisor is very strict and does not care about what happens to your life outside work. It is all about work...Do I have supervisor support in using WLB policies at work? The answer is no, not in this profession.
		The way some of my colleagues look at me anytime I demand for working hours flexibility is nauseating, in

	Colleagues or Co-workers' Support	fact, it is a shame...I have suffered, in the past, abuse and insinuations from my colleagues because I always use work-life balance policies.
	Supportive Culture	Really nice... I am allowed two hours off every day... This flexibility is amazing; it allows peace to reign again in my marriage and keeps me very sharp and focused at work.
	Unsupportive Culture	I'm considering migrating to countries like the UK, the US, or Canada; where medical doctors enjoy some flexibility... I really am not happy with this situation. It's affecting me, my health, and my family life.

### Researchers' Findings 2015

#### Long Working Hours

An overwhelming percentage of doctors (99%) said that the culture of their organisations requires them to work for long and unsociable hours. Participants described how long working hours (which they described as being part of the medical professional culture) constrained their choice and use of WLB policies and practices. They spoke of how they usually work between 12 to 36 hours in one shift. In fact, no participant reported working a shift of less than 12 hours in one day or working less than 72 hours in one week. Some Doctors reported working as much as 94 hours in one week. The following statements typify the participants' shared views and experiences:

*I work for unbelievably long hours (which include nights, weekends and sometimes during public holidays) to look after the patients and for my training. I started this shift at 8am yesterday and I will finish by 12pm this afternoon (that is 14 hours in one go), and it will continue like that for the next five days. Even though lack of enough manpower is a contributory factor, yet the job requires that I work for long hours; it is the tradition, the culture. Yes, it can be a very serious barrier to work-life balance but the culture comes along with being a medical doctor and it has been like that for ages (Surgeon, Metro UTH).*

*Working for long hours is an ancient tradition of the medical profession. It is affecting my family life and preventing me from attending to other important issues. But, it is needed for the patients' care, medical research, and doctors' training. For instance, I am part of the medical team that is working on the new malaria vaccine and this research is taking up a lot of my time. Sometimes I don't go home for three days. Yes, it is that demanding and it is part of the medical professional culture (Epidemiologist, Met UTH).*

*Working for long hours is an integral part of the medical profession (in this part of the world). I spend more time in the hospital than I spend at home with my family. I remember we were told in*

1  
2  
3 *the medical school upon graduation that we should see the hospital as our second home because*  
4 *we will spend the majority of our working life in the hospital. That is the culture (General*  
5 *Practitioner, Goth Hospital).*  
6

7  
8 The above statements indicate that doctors have been trained to accept long working hours as an  
9  
10 embedded culture of the medical profession. Participants affirmed that the culture comes along  
11  
12 with being doctors. Sadly, this has a negative influence on doctors' ability to use WLB policies.  
13

### 14 **Shift Work Patterns**

15  
16 The second ubiquitous culture in the Nigerian medical sector identified by the participants is the  
17  
18 prevalence of shift work patterns, which include night and weekend shifts. Participants, most  
19  
20 especially female doctors who had young children, expressed their difficulties in coping with  
21  
22 shift work patterns, especially night shifts. A participant said:  
23

24  
25 *The medical professional culture requires doctors to work shift patterns; it could be a day or a*  
26 *night shift with no exception for weekends and public holidays...the night shift is the one I dread*  
27 *the most; it is like fighting against nature, it is bad for my health and keeps me away from my*  
28 *children (Gynaecologist, Hic Hospital).*  
29

30  
31 Other participants said:  
32

33  
34  
35 *As a single mother, whenever I am on the night shift my children suffer because I usually leave*  
36 *them with a neighbour whose way of life differs from mine, but that is the only option I have for*  
37 *now...I have applied for permanent leave from night duty, but the head of my unit said there is a*  
38 *shortage of staff and that my request cannot be granted (Immunologist, Lox Hospital).*  
39

40  
41 *Yes, it is part of the job...we work all hours of the day and all days of the week...In doing so,*  
42 *shift patterns (which include days, nights and weekends) come in...nearly everybody hates it*  
43 *because of its negative consequences on our health, family, and general lives. In fact, it is now*  
44 *threatening my marriage (Dermatologist, Metro UTH).*  
45

46  
47 Participants voiced their dissatisfaction about shift working patterns (especially night shifts). The  
48  
49 participant above and a few others felt that shift working patterns were threatening the survival  
50  
51 of their marriage.  
52

### 53 **The Required Physical Presence in the Hospital**



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3 A required physical presence in the hospital is another culture found to be prevalent within the  
4  
5 profession. This study reveals that physical presence in the hospital at all times of doctors'  
6  
7 working hours is one of the tenets of the medical profession; it is essential for doctors' training  
8  
9 and medical research and is paramount to patients' care and safety. This culture, however, has  
10  
11 been found to pose a great impediment to doctors' adoption of WLB policies and practices. The  
12  
13 following quotations typify the participants' shared views:  
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16  
17  
18 *Any doctor who wishes to advance in his/her career must spend more time in the hospital than*  
19  
20 *he/she spends at home or somewhere else attending to non-work related issues...the medical*  
21  
22 *profession is so much aligned with the culture of being at work at all times or what some call*  
23  
24 *"presenteeism". The number of hours a doctor spends in the hospital speaks volumes of his/her*  
25  
26 *seriousness and commitment about his/her job. This is the nature of the medical profession*  
27  
28 *(General Practitioner, Pym Hospital).*

29  
30 *This is a medical profession and not another profession where you can telework or work from*  
31  
32 *home...as a doctor, I need to be physically present in the hospital at all times of my shift...aside*  
33  
34 *from the fact that it is required for the patients' health and care, the number of hours a doctor*  
35  
36 *spends in the hospital matter for his/her career progression and his/her image as a committed*  
37  
38 *doctor...In this part of the world, you will be tagged as lazy, unserious and a non-committed*  
39  
40 *doctor if you are not always present at work. Yes, it is part of medical professional culture*  
41  
42 *(Obstetrician, Flex Hospital).*

43  
44 Having established the prevalent culture in Nigerian health organisations, participants were  
45  
46 asked about the factors that constrain their use of WLB policies and practices and whether such  
47  
48 factors form a part of their organisational culture. The following themes were found to be  
49  
50 typical: management support, supervisors' support, colleagues or co-workers' support and  
51  
52 organisational time expectations (OTE). These themes (according to the participants) prevent  
53  
54 them from using WLB policies and they are part of the medical professional culture.  
55  
56

### 57 **Organisational Time Expectations**

58  
59 OTE is concerned with the number of hours that employees are required to devote to working or  
60  
work related activities. OTE is relatively high in Nigerian healthcare organisations. This is  
because healthcare organisations are committed to patient care, medical research, and doctors'

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2  
3 training (resident doctors). This means that doctors are expected to stay in the hospital for long  
4  
5 periods of time. The following views were typical among the participants:  
6  
7

8 *The culture of the medical profession requires that doctors put in more hours in the hospital. The*  
9 *time expectation is high...yes it affects our non-work lives, but that is the culture of the medical*  
10 *profession (Neurologist, Gross-Health Hospital).*  
11

12 *The OTE in the medical profession is high...as doctors, we are required to be physically present*  
13 *in the hospital at all times and we have to stay there for long hours...the number of hours we put*  
14 *in matter for the patients' care, medical research, doctors' image, and promotions...that is the*  
15 *culture and it has been like that for ages (Optician, Standard-Health Clinic).*  
16  
17

18  
19  
20 This means that the medical profession (in Nigeria) is notorious for high OTE, which  
21  
22 participants described as part of the medical professional culture. This is antithetical to the  
23  
24 principles of WLB and constrains doctors' ability to subscribe to related policies.  
25  
26

### 27 28 **Management Support**

29  
30 This is the support that employees receive from management in order to ease the competing and  
31  
32 contradictory responsibilities of work obligations and non-work related duties. Eisenberger et al.  
33  
34 (2002) described it as the degree to which management cares about its employees' well-being  
35  
36 and contribution to the organisation and therefore allows them to use WLB polices. WLB begins  
37  
38 at management level, since they are responsible for formulating policies and creating awareness  
39  
40 thereof. In Nigerian healthcare organisations, hospital managers are not supportive of doctors  
41  
42 using WLB. In fact, doctors who complain of a lack of WLB policies or frequently request to use  
43  
44 them are perceived as being lazy and unserious. When asked about managerial support, the  
45  
46 following responses were typical:  
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51  
52 *I requested for flexibility in my working hours to care for my sick parent...after a series of*  
53 *meetings at the unit level, I was summoned by the Chief Medical Director and he advised me to*  
54 *find someone to look after my parent...as you can imagine, I was devastated and had a terrible*  
55 *time at work over that period...the management are not supportive of me to balance my work*  
56 *demands and non-work related activities (Gynaecologist, Hart Hospital).*  
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*As a senior surgeon and a member of the hospital management, I do not expect any doctor to complain about not being allowed to use work-life balance policies, this is medicine...I think doctors should be more concerned about patients' care and medical research which will facilitate their career progression. I am not being personal...it is the culture in medicine (Senior Surgeon, Tower Hospital).*

The statement from the Senior Surgeon (also a member of the hospital management team) clearly shows the management's attitude towards WLB. Typically, management teams in various hospitals in Nigerian healthcare organisations have not shown support for WLB policies and practices.

### **Supervisors' Support**

Supervisors' support is an important determinant of doctors' ability to use WLB policies and practices. The majority of the participants, however, described the attitude of their supervisors towards WLB as "unsupportive". A participant told of the fear that usually overwhelms her and prevents her from asking her supervisor about using WLB policies:

*Anytime I need to use any work-life balance policies, maybe I need to close earlier or quickly take a few hours off to attend to particular family issues; I am always put off by the fear of approaching the unit head (who is like my supervisor). She once told me to consider a change of career if I so much desire work-life balance. "This is medicine" she said (Dermatologist, Yes Hospital).*

The above quotation demonstrates a hierarchical culture, which creates a power distance between employees and their supervisors/line managers in Nigeria. In fact, many employees treat their supervisors/line managers as "mini gods", as they realise that their careers depend on having good relationships with them. Other participants relate their supervisors' attitudes toward using WLB policies as follows:

*My supervisor will not hear of work-life balance. I'm not even sure whether there is anything like work-life balance policies in this hospital. Doctors don't talk about it. My supervisor is very strict and does not care about what happens to your life outside work. It is all about work. Even to get the legal annual leave is not easy. For sure, you can't get more than a week at a go...we do not have enough manpower (Dermatologist, Trafalgar Hospital).*

1  
2  
3 *I don't have the privilege of any supervisors' support for using work-life balance policies. This is*  
4 *medicine; the story is entirely different here. My supervisor does not expect me to ask to use*  
5 *WLB policies because of the negative effects that it will have on the patients' care. My*  
6 *application for two weeks' sick leave was declined because we have a shortage of staff and my*  
7 *position could not be covered. Do I have supervisor support in using WLB policies at work? The*  
8 *answer is no, not in this profession (Surgeon, Red Hospital). (90% of participants shared this*  
9 *view).*  
10

11  
12 The majority of supervisors in Nigerian hospitals are inclined towards the traditionally ingrained  
13 culture of the medical profession, thus they exercise inflexibility in terms of WLB policies. High  
14 power distance also makes employees apprehensive about asking to use WLB policies.  
15  
16

### 17 18 19 20 **Colleagues or Co-workers' Support**

21  
22 While there were widely shared views about management and supervisors' negative attitudes  
23 towards WLB policies and practices, participants also voiced their concerns about the lack of  
24 support from colleagues. Some related their experiences with colleagues which a participant  
25 described as a "shame". She said:  
26  
27

28  
29 *The way some of my colleagues look at me anytime I demand for working hours flexibility is*  
30 *nauseating, in fact, it is a shame (Psychiatrist, Lily Hospital).*  
31

32  
33 Doctors related how they had suffered abuse and insinuations from their colleagues because they  
34 use or used WLB policies. The following quotations typify their shared experiences:  
35  
36

37  
38 *From my experience, the support you get from your colleagues depends on how frequently you*  
39 *use work-life balance policies...shortage of staff is an issue that most hospitals are struggling to*  
40 *cope with; when one doctor is absent, the workload is shouldered by his/her colleagues at work*  
41 *which they actually don't mind doing it once in a while...but they tend to resent and sometimes*  
42 *revolt against their colleagues who persistently use work-life balance policies...I have seen this*  
43 *happen on several occasions (Surgeon, Spring Hospital)*  
44

45  
46 *I have suffered, in the past, abuse and insinuations from my colleagues because I always use*  
47 *work-life balance policies. My situation then demands that I use those policies but some of my*  
48 *colleagues believe I was lazy and always revolt against my using those policies (Dentist, State*  
49 *Hospital).*  
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3 An experienced participant who is nearing retirement said that the lack of support from co-  
4  
5 workers is part of the medical profession in Nigeria. She said that she had experienced it  
6  
7 throughout her career in different hospitals and suggested a change in attitude.  
8  
9

10  
11 *I think it is part of the medical professional culture. I have worked in different hospitals across*  
12 *the country for over 25 years now. Colleagues don't actually support each other in using work-*  
13 *life balance policies because there will be too much to do at work when a colleague is absent. I*  
14 *think this attitude has to change (Gynaecologist, Well Hospital).*  
15  
16

17  
18 The findings show that doctors complain about their colleagues who often use WLB policies  
19  
20 because they will have to stand in for their absent co-workers. Colleagues, whose workloads  
21  
22 increase as a result thereof, become less sympathetic to or supportive of those doctors who use  
23  
24 WLB policies; particularly when they have to cover them on a regular basis.  
25  
26

### 27 **Supportive Culture**

28  
29 The few participants who have been privileged to use WLB shared their experiences as follows:  
30  
31

32  
33 *Really nice...my manager is a kind woman. She granted my request to be exempted from night*  
34 *shifts and allows me a great deal of flexibility in terms of when I start my shift. This allows peace*  
35 *to reign again in my marriage and keeps me very sharp and focused at work (Surgeon, Niger*  
36 *Hospital).*  
37

38  
39 *I am allowed two hours off every day. One hour in the morning to drop off my children at school*  
40 *and one hour to pick them in the afternoon before coming back to clinic to finish my shift. But,*  
41 *instead of closing at five, I close at seven to make up for the two hours. This flexibility is*  
42 *amazing; it makes my life easier and I am very happy with my life and my job (Dermatologist,*  
43 *Keen Hospital).*  
44

45  
46 The above quotations illustrate that culture that is supportive of WLB offers doctors the  
47  
48 opportunity to balance work demands and non-work related responsibilities. WLB practices keep  
49  
50 them focused. This shows that a supportive culture is an important factor in doctors' ability to  
51  
52 function well as doctors and good members of their families.  
53

### 54 **Unsupportive Culture**

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2  
3 An overwhelming majority of the doctors interviewed emphasised that the medical professional  
4 culture and other factors (as discussed above) prevent them from using WLB policies. Unhappy  
5 doctors are unlikely to perform to the best of their abilities. One participant said:  
6  
7  
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9

10  
11 *Medical professional culture is so rigid that it has little or no cushion for flexibility. I really am*  
12 *not happy with this situation. It's affecting me, my health, and my family life. Many colleagues*  
13 *(especially women) have quit for family reasons; at least, I can count 8 of them in the last three*  
14 *years (Gynaecologist, Sky Hospital).*  
15

16 Another participant said:  
17

18  
19 *To me, I am still doing this job because I don't have alternatives...seriously, I'm considering*  
20 *migrating to countries like the UK, the US, or Canada; where medical doctors enjoy some*  
21 *flexibility and of course, better pay...I've got no time for my family, no time to go to church, I*  
22 *cannot even remember the last time I visited my parents, let alone socialise...I mean, its suicidal*  
23 *(Immunologist, Care Clinic)*  
24

25 These statements highlight the serious implications of a culture that is unsupportive of WLB  
26 policies. The accounts of the interviewed doctors portrayed the influence of organisational  
27 culture on employees' ability to use WLB policies.  
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### 33 **Discussion**

34  
35 This article examined the influence of organisational culture on WLB policies and practices. We  
36 analysed the relationship between the prevalent culture in Nigerian healthcare organisations and  
37 its influence on the adoption (by doctors) of WLB policies and practices. The issue of long  
38 working hours has been a dominant feature of the medical profession (Walsh, 2013); however, in  
39 the Nigerian context, the reported 94 hours per week, for example, is excessive. In practice, this  
40 exceeds acceptable standards (Lee, McCann and Messenger, 2007). In the context of the medical  
41 profession in Nigeria, the suggestion that working for long hours translates to loyalty and  
42 commitment is embedded in healthcare organisations' cultures and agrees with findings by  
43 Wheatley (2012) that, in a western setting, employees may experience long hours of work as a  
44 result of professional work-group cultures. Therefore, there is the need for some form of external  
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3 influence to investigate this culture in order to increase the potential for achieving WLB. In the  
4  
5 EU, Australia, and Singapore, for example, doctors may not work over 48 hours in one week  
6  
7  
8 (Bamford and Bamford, 2008; British Medical Association News, 2007; Lai-Ching and Kam-  
9  
10 Wah, 2012). Our findings lead us to conclude that the medical profession in Nigeria is does not  
11  
12 sufficiently value WLB in order to negotiate favourable working hours as shown in the case of  
13  
14 the UK by Crompton and Lyonette (2011). In addition, the absence of employment laws relating  
15  
16 to working hours and working time directives also has implications for doctors' WLB. However,  
17  
18 even if the Nigerian medical association were sufficiently strong it would be challenging to  
19  
20 negotiate more suitable working hours within the constraint of the reported shortage of doctors  
21  
22 (Ovuorie, 2013) that arises from few locally trained doctors and brain drain. Our findings align  
23  
24 with studies by Wheatley (2012) that professional work-group cultures prevent employees,  
25  
26 especially women, from achieving WLB. Whilst this is not specific to the medical profession, in  
27  
28 the Nigerian context no attempt has been made to incorporate family-friendly HR practices (Pas  
29  
30 et al., 2011). In addition, male participation in domestic and caring responsibilities has not  
31  
32 reached the same levels in Nigeria compared to western countries and, therefore, female doctors  
33  
34 in Nigeria struggle even more than men to achieve WLB. Societal expectations about the role of  
35  
36 a woman make it difficult for Nigerian mothers with careers and young children to enjoy  
37  
38 adequate WLB. Note that in the Nigerian context, the underutilisation of ICT worsens the  
39  
40 adoption WLB of medical professionals. Unfortunately, most Nigerian organisations continue to  
41  
42 measure productivity in terms of employees' physical presence at work (Adisa, Mordi and  
43  
44 Mordi, 2014). Although the literature emphasises that organisational culture is a critical factor in  
45  
46 achieving WLB (Lewis, 1997; Lewis, 2001, Thompson et al., 1999), the findings in this study,  
47  
48 however, demonstrate that medical organisational culture does not support WLB. The Nigerian  
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3 government and management within the hospitals have failed to enact policies to address the  
4 issues and appear to prefer employee silence on WLB issues. For instance, on several occasions  
5 during medical sector industrial disputes on unsupportive culture, weak infrastructures and WLB  
6 related issues, the Nigerian government have frequently deployed coercive tactics threatening to  
7 sack doctors (Ige, 2016; Omofoye, 2016). The posture of the government and management in  
8 Nigerian hospitals is in stark contrast to the British experience in which there is a broad  
9 legislation that address WLB issues (Bamford and Bamford, 2008; British Medical Association  
10 News, 2007). Since most organisations in Nigeria in general and the medical practice in  
11 particular have not developed the organisational cultures required to enhance the appropriate  
12 interaction between HR practices and organisational culture as suggested by Pas et al. (2011), the  
13 challenge of achieving WLB is exacerbated. This implies that, whilst the government has failed  
14 to institute and implement national working time directives, the medical associations have also  
15 failed to strongly influence the status quo. This is adversely affecting the WLB of Nigerian  
16 workers, specifically medical doctors. This emphasises that good HR practice requires strong  
17 professional bodies and state-led policies.  
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39 The findings in this study also agree with Bond (2004) in that unsupportive organisational  
40 culture promotes WLC. This study found that fellow doctors do not support colleagues who use  
41 WLB policies. This phenomenon is connected to the critical shortage of medical doctors in  
42 Nigeria (Ovuorie, 2013) and the emigration of a considerable number of Nigerian-trained doctors  
43 to high-income, developed nations (Eastwood et al., 2005). Our research evidence, in terms of  
44 the effect of organisational culture on WLB, is context-specific and may interact with cultural  
45 and institutional norms. This has implications for WLB and related theories. The empirical  
46 evidence gathered in this study indicates that authority figures (managers and supervisors) appear  
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3 to ignore the effect of WLB on productivity. However, employees tend to be more productive  
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5 when they are provided with HR policies that promote WLB (Beauregard and Henry, 2009). The  
6  
7 appropriate interaction between HR practices and organisational culture, as suggested by Pas et  
8  
9 al. (2011), to realise HR outcomes such as WLB and productivity are missing and we suggest  
10  
11 that this is exacerbated by the absence of support of state and professional bodies. Social  
12  
13 exchange theory (Blau, 1964) emphasises that maintaining a reciprocally supportive relationship  
14  
15 enhances organisational attachment and productivity (Shore et al., 2006). Our findings suggest  
16  
17 that the culture of Nigerian healthcare organisations does not support WLB because such  
18  
19 organisations fail to appreciate the essential links of WLB with productivity. Although Sibert  
20  
21 (2011) argued that, in general, whoever desires WLB should not seek to become a medical  
22  
23 doctor, our findings raise context-specific questions about whether WLB is achievable for  
24  
25 medical doctors in general and whether the situation is exacerbated in developing countries;  
26  
27 where the institutional, organisational, and national cultures are at variance with the very practice  
28  
29 of WLB.  
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### 37 **Research Implications**

38  
39 Since the Nigerian state and the Nigerian Medical Association's (NMA) support in terms of  
40  
41 encouraging the required interaction between HR practices and organisational culture is absent,  
42  
43 research needs to be undertaken into how WLB can be enhanced. Research needs to capture how  
44  
45 effective WLB may be implemented in a developing country in which the state and professional  
46  
47 arrangements do not necessarily support WLB. Can the professional bodies influence the state to  
48  
49 change human HR and, indeed, organisational culture? If the absence of institutional  
50  
51 arrangements such as those that relate to the implementation of working time directives prevents  
52  
53 the implementation of effective WLB policies and practices, then what can professional bodies  
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3 do about it? How can such professional bodies influence the expectations of employers and  
4  
5 employees in terms of both national and organisational cultures and how do these affect WLB  
6  
7 policies and practices? Can organisations themselves work towards changing perceptions about  
8  
9 WLB? Therefore, if the WLB issues in developing countries, such as those in SSA, are to be  
10  
11 understood then future studies should explore the interactions between HR practices, national  
12  
13 and organisational cultures and institutional influences. Our research has limitations for  
14  
15 generalisability in the developing country, SSA and Nigerian context, since we focus on one  
16  
17 sector in one country. There is the need to conduct similar studies in other developing countries  
18  
19 in SSA in particular to evaluate if the findings resonate across the sub-region. In addition, it is  
20  
21 important to conduct similar studies (in SSA) that examine and compare gender as well as other  
22  
23 professional groups such as the study of Crompton and Lyonette (2011) who compared women's  
24  
25 success and work-life adaptations in the accountancy and medical professions in Britain.  
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### 32 **Practice Implications**

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34 Starting from an individual level, institutional, cultural and attitudinal change on the part of  
35  
36 management and employees (doctors) in Nigerian healthcare organisations in terms of working  
37  
38 hours and WLB need to change because of the possible realisation of HR outcomes and  
39  
40 productivity gains. This resonates with Gamble, Lewis and Rapoport's (2006, p. 54) argument  
41  
42 that a "change in individual's mind-sets and orientations can be an impetus for changes in their  
43  
44 own working practices and can perhaps contribute to wider organisational change". The NMA  
45  
46 and, indeed, other relevant professional bodies should seek to influence national policy in terms  
47  
48 of working arrangements that incorporate WLB policies and practices. This would inevitably  
49  
50 influence organisational culture. The introduction of a Nigerian Working Time Act would  
51  
52 regulate working hours as in other developed countries. However, that would not be sufficient if  
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3 the NMA does not get involved by incorporating the specifics of the Nigerian medical  
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5 profession. In addition, in terms of assisting the state to improve employment laws and working  
6  
7 practices, the professional bodies could organise training programmes for supervisors, managers,  
8  
9 and employees to improve appreciation of WLB and its link with productivity and organisational  
10  
11 outcomes. This could lead to individual organisations arranging similar training programmes.  
12  
13 Since our findings also show that the shortage of employees affects support for WLB, more  
14  
15 could be done in terms of HR planning at state, institutional, and organisational levels.  
16  
17 Healthcare organisations, therefore, need to make a concerted effort towards developing a  
18  
19 professional culture that seeks to encourage WLB. Furthermore, those who are responsible for  
20  
21 human resource management (HRM) must ensure the implementation and monitoring of WLB  
22  
23 initiatives. This would lead to good WLB with consequent well-being and satisfaction, which  
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25 would increase employee morale and high performance (Hammer et al., 2011; Butts et al., 2013;  
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27 McCarthy et al., 2013) and productivity.  
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### 34 35 **Conclusion**

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37 The focus of this article has been to explore the influence of organisational culture on WLB  
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39 practices using Nigerian medical doctors as a case study. Long working hours (strongly  
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41 influenced by shift working patterns, a required physical presence at work at all times of one's  
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43 shift, and organisational time expectation) were found to influence doctors' abilities to use WLB  
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45 policies. This is compounded by the medical organisational culture, which is characterised by a  
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47 lack of support from managers, supervisors, and colleagues. We found that the medical  
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49 professional culture (which is also the organisational culture) perpetuates long working hours,  
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51 which adversely influences WLB policies and practices. Our findings exemplify the importance  
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53 of institutional arrangements that would ensure the adherence to working time directives in  
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3 developing countries in order to improve employees' WLB. Our findings also complement the  
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6 existent literature on this subject to emphasise that the limited use of ICT leads to a high demand  
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8 for the physical presence of medical practitioners at work with consequent organisational time  
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10 expectations, resulting in a lack of WLB for employees. Whilst it is evident that the medical  
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12 profession across the world places enormous demands on medical doctors, this article contributes  
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14 to the relevant literature in order to emphasise that, in developing countries in general and  
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16 specifically the Sub-Saharan Africa, societal culture, organisational culture and institutional  
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18 arrangements have a great influence on the adoption and utilisation of WLB policies and  
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20 practices. In a wider sense, HRM requires a nuanced, country-specific approach that appreciates  
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22 that HRM policies and practices are influenced by distinct organisational, cultural, and  
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24 institutional settings. Although our findings give an essential country-specific context of WLB  
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26 for the medical profession, future studies could explore multi-sector and multi-country studies in  
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28 Sub-Saharan Africa. Future research also needs to evaluate the effect of cross-national cultural  
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30 variation on WLB policies and practices.  
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