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**The Inter-relationship between work life balance and  
Organisational Culture: an Empirical Study of  
Nigerian Health Sector**

*A Thesis Submitted for the Degree of Doctor of Philosophy*

*By*

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## **Abstract**

This exploratory study examines the relationship between the work-life balance and organisational culture of medical doctors and nurses in Nigeria. There has been an overwhelming majority of work-life balance studies undertaken in Western countries. This leaves Africa, most notably Nigeria, an understudied area of investigations. In order to achieve this objective, this study applies a qualitative research method. Semi-structured qualitative interviews were carried out with 62 medical doctors and 29 nurses across the six geopolitical zones of Nigeria. Drawing on the data collected, this thesis makes two important contributions to this field of research. Empirically, the study enhances the work-life balance database most especially in the specific context of Nigeria, by revealing that the traditional culture of Nigerian health organisations has an enormous influence on the employees' abilities to use work-life balance policies and practices. In other words, there is an overarching relationship between organisational culture and the use of work-life balance policies and practices by doctors and nurses in the Nigerian health sector. The findings also reveal that Nigerian doctors and nurses struggle to cope with the demanding nature of their jobs and their aspirations to fulfil their non-work responsibilities. Theoretically, the study identifies an important shift in the construct and application of border theory. Border theory explains how employees negotiate their daily movements across work and family domains, but fails to recognise that family is by no means the only non-work duty that is important to employees. Also, border theory does not deal with factors that determine employees' movements across the border. These shortcomings are alarming, especially now that Generation X employees (workers born after 1963) prefer work arrangements that also cater for their non-work duties and responsibilities. Following these shortcomings, and with the data collected, a work-life border control model was developed. Practically, the developed model (work-life border control model) extends work-life border theory by incorporating other non-

working live activities including familial duties and outlines factors that determine employees' movement across the border. Also, the findings of this study provide a valuable insight into the reality of work-life balance practices in Nigeria. This study thus provides an important and timely understanding about the working and non-working lives of Nigerian doctors and nurses and provides feasible and practicable recommendations for the relevant authorities.

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## **Glossary**

**AHWO**- African Health Workforce Observatory

**AU**- African Union

**BCF**- Bill Clinton Foundations

**BGF**- Bill Gate Foundations

**BTA**- British Technical Assistance

**CIA**- Central Intelligent Agency

**EU**- European Union

**HRD**- Human Resource Development

**HRM**- Human Resource Management

**ICN**- International Council of Nurse

**JCF**- Jimmy Carter Foundations

**MDCN**- Medical and Dental Council of Nigeria

**NANMN**- National Association of Nurses and Midwifery of Nigeria

**NBS**- National Bureau of Statistic

**NCH**- National Council of Health

**NEA**- Nigerian Employment Act

**NECA**- The Nigerian Employers' Consultative Association

**NLA**- Nigerian Labour Act

**NLC**- Nigerian Labour Congress

**NMA**- Nigerian Medical Association

**NMB**- Nigerian Manpower Board

**NMWA**- National Minimum Wage Act

**UN**- United Nations

**UNICEF**- United Nations Children’s Fund

**NSWCD**- National Salaries and Wages Commission Decree

**OC**- Organisational Culture

**OECD**- Organisation for Economic Cooperation and Development

**PH**- Private Hospitals

**USAID**- United State Agency for International Development

**UTH**- University Teaching Hospitals

**WBICA**- Wages Board and the Industrial Council Act

**WFB**- Work-Family Balance

**WFC**- Work-Family Conflict

**WHO**- World Health Organisation

**WLB**- Work-Life Balance

**WLBCM**- Work-Life Border Control Model

**WLC**- Work-Life Conflict

**WLI**- Work-Life Integration

## **Dedication**

To my late mother, for her unwavering and dedicated efforts toward my education and well-being. Dear mum, your son has yet again added another feather to his cap. I will be forever grateful to you. To my late dad, for his valuable words of wisdom, encouragement, kind support and prayers. May Allah forgive your sins and bless your place of rest. I cannot thank you both enough, May Allah reward you abundantly. To my wife, Oyin and my son, Shasili, for their endurance, love and support. I love you both.

Toyin Ajibade Adisa  
2015

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## **Declaration**

I hereby declare that this thesis is written by myself for the purpose of PhD degree at Brunel University, London and has not been previously submitted for any other degree or qualification to any other academic institution. I confirm that this study is wholly my own work, and that all information in this study has been obtained and presented in accordance with academic rules and ethical conduct.

Toyin Ajibade Adisa  
2015



## Publications Associated with the Thesis

The following papers are outputs based on the research conducted during my PhD study:

- Adisa, T. A. and Mordi, C. (2015). Understanding the good and bad effects of information technology devices on employees' work-life balance: An exploratory study of Nigerian Employees. Accepted for the British Academy of Management Conference in Portsmouth.
- Adisa, T. A., Mordi, C., and Mordi, T. (2014). The Challenges and Realities of Work-Family Balance among Nigerian Female Doctors and Nurses. *Economic Insight-Trends and Challenges*, 3, 3, 23-37.
- Adisa, T. A. and Mordi, C. Exploring the implications of the influence of organisational culture on work-life balance practices: evidence from Nigerian medical doctors (Under review).

## **Chapter One**

### **Introduction to the Study**

The purpose of this exploratory study is to examine the interrelationship between work-life balance and organisational culture for Nigerian medical doctors and nurses. The concept of work-life balance is not novel. Although the idea emanated from western countries in which several studies have been undertaken on work-life balance: Kinnunen and Mauno (1998) in Finland; Dikkers, van Engen and Vinckenburg (2010) for the Netherlands; Voyandoff (2004) for the US; de Luis Carnicer, Sánchez, Pérez and Jiménez (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; and even as far as Asia (Malik, Saleem and Ahmad 2010; Ueda, 2012; Xiao and Cooke, 2012) to mention but a few. However, work-life balance is yet to receive the desired attention in Africa from the government and all other stakeholders as in Europe and the US (Mordi, Mmieh, and Ojo, 2013). Furthermore, the quest to balance workplace demands and non-work related obligations by workers and academics is now a global issue (Mohd Noor, Stanton and Young, 2009).

The need to undertake empirical studies on work-life balance in Africa, especially in Nigeria, due to its socio-economic environment, national and family cultural differences has become essential. Furthermore, a stereotypical and homogeneous view and classification that WLB is the same as or similar across various nations of the world is erroneous (Adisa, Mordi and Mordi, 2014). The work-life balance situation in western industrialised countries is not an accurate reflection of the position in Africa, especially in Nigeria (Epie and Ituma, 2014).

Therefore, it is imperative to gain a purposeful insight into how Nigerian workers combine obligations of their work and non-work lives and the challenges that come with it. To that

extend, this thesis focuses on work-life balance in Nigeria by examining the interrelationship between work-life balance and the organisational culture of Nigeria medical doctors and nurses. In addition, scholars have intensified the call for country-specific studies in Africa and other non-western nations (Gartner, 1995; Kitching and Woldie, 2004) in order to provide insights and broaden our understanding of the challenges that confront employees while they try to balance their work and non-work lives obligations in other parts of the world.

Thus, this study provides a country-specific study to bridge this research gap and increases the conventional database of work-life balance literature in Africa. It is important to note that the occupational distribution of Nigerians as people is conjectural (Epie, 2011). The terms and conditions of employment in the private and public sectors (except for wages and salaries) are regulated by the government by the Nigerian Employment Act 1971 and 1974, which does not provide for work-life balance policies (Epie, 2006). Nigeria is influenced by the British system in terms of the government's exercise of limited regulations for employers. This allows employers a myriad scope of opportunities to design and adopt work-life balance policies that would suit them (Den Dulk, 2005). Furthermore, it is widely acknowledged that medical doctors and nurses all over the world work under pressure and experience significant work-life conflict and/ or work-life balance challenges (Heiligers and Hingstman, 2000; Walsh, 2013). The health care sector around the world has been charged to be more proactive and focus on intense policy scrutiny because of the many challenges with which they are confronted (Townsend, Lawrence and Wilkinson, 2013). This study, thus, researches doctors and nurses specifically because their professions are identified with a specialised knowledge base and desire to achieve work-life balance. This chapter presents the background of the research objectives, research questions, the

statement of the research problem and justification for the study. Finally, it provides an overview for the subsequent chapters which will vividly spell out the structure of the thesis.

## **1.1 Background of the Study**

The issue of work-life balance has been around for more than eight decades and its discussion still continues (Lockwood 2003). This can be attributed to an increase in interest in how employees juggle work related obligations and non-work related responsibilities (Wheatley, 2012). Sirajunisa and Panchanatham (2010) and Rehman and Roomi (2012) argue that women, rather than men, should be the subject of discussion in relation to WLB practices in the workplace. This, according to these authors, is attributed to the multi-purpose nature of women with the responsibilities of looking after children and the general household activities (Maxwell, 2008).

On the contrary, McIntosh (2013) argues that the need for effective WLB policies and practices in the work environment should not be considered in terms of gender. Moreover, it is a fact that WLB is crucial for success in today's competitive business world (Osoian, Lazar and Ratiu, 2011). This view is consistent with that of Kesting and Harris (2009), who identified that WLB has advantages, since it offers employees freedom of choice and some degree of control over when, how and where they carry out their daily work responsibilities. The debate about work-life balance can be traced back to the 1930s among the employees of W. K. Kellogg Company (Lockwood, 2003). Sequentially, this continued throughout the 1960s when Rapoport and his colleague researched how work and family were related to each other in agrarian society (Rapoport and Rapoport, 1965).

In the 1970s, the interdependence of work and family was highlighted by Rosabeth Kanter (Kanter, 1977). The discussions continued through the 1980s using ethical ideology as a factor in

achieving balance between employee's work and non-work life (Forsyth, 1980). However, in the 1990s, the nature of work and the autonomy presented to workers to schedule their work related and non-work related commitments remained the theme of work-life balance (Lambeth, 1990). In the past few decades, organisations around the world have witnessed some changes to their internal and external operations and environments. The reasons range from the massive influx of women into the labour force to the drastic economic downturn of 2008 (which drove many companies into oblivion) and a rise in the number of the aged population and more. These have had continuum effects and have driven many of them to change their functions, strategies, human resources management (HRM) policies, and manage their cultural norms and differences more effectively (Fard, Rostamy and Taghiloo, 2009; Karjalainen, 2010). In the efforts to adapt to the new ways of organisational management, organisational culture became relevant and essential to the survival of organisations (Hofstede, 1998).

Organisational culture, on the other hand, is the pattern of shared values and beliefs that help employees to understand an organisation's functions and provide them with the norms and the acceptable behaviours in the organisation (Ramachandran, Chong and Ismail, 2011). There is a growing view that using WLB policies, in some organisations, automatically has a negative effect on some aspects of employees' working life. For example, some organisations see employees who sign up to WLB policies as bad members of the organisation (McDonald, Bradley and Brown, 2008). Such a view reinforces an organisational culture which is unsupportive of WLB policies and practices (Beauregard and Henry, 2009). Furthermore, it has been argued that an ingrained organisational culture, if antithetical to the principles of WLB, could constrain the successful use of work-life balance policies (Ammons and Markham, 2004; Othman, Yusof and Osman, 2009; Walter, 2012). Note that this thesis is guided by border theory,

which explains how employees negotiate between work and non-work domains to attain a balance. Border theory has been chosen because of its usefulness in conceptualising WLB. Also, border theory is effective in identifying and addressing the constituents of work and the rest of employee's life which other theories fail to address (Clark, 2001).

## **1.2 Research Objectives**

As mentioned above, this thesis sets out to investigate the interrelationship between work-life balance and organisational culture for Nigerian doctors and nurses. Specifically, the main objectives are:

- (a) To critically examine the notions of WLB for doctors and nurses in the Nigerian health sector:
- (b) To assess the range and scope of work-life balance initiatives in the Nigerian health sector:
- (c) To evaluate the perceptions of doctors and nurses towards work-life balance initiatives and organisational culture in Nigeria:
- (d) To assess the organisational culture and determine whether the prevalent culture allows work-life balance: and
- (e) To identify the forces helping or constraining to shape the choices of WLB practices in the Nigerian health sector.

## **1.3 Research Questions**

This research hopes to achieve its aim by answering the following questions:

- (a) How do doctors and nurses define work-life balance in the Nigerian health sector?

(b) What is the range and use of work-life balance policies and practices in the Nigerian health sector, and how are these WLB initiatives being used in Nigerian hospitals?

(c) What sort of culture is prevalent in the Nigerian health sector and what is the perception of doctors and nurses towards such culture and does the prevalent culture allow work life balance?

(d) What factors constrain or help shape the choices of work-life balance practices and policies which exist in the Nigerian health sector?

(e) What is the perceived impact of work-life balance and organisational culture on the attitude and performance of doctors and nurses?

#### **1.4 Research Problem**

Different studies have emphasised the benefits of work-life balance policies to both employers and employees, irrespective of the working environment (Lim et al., 2012; Wheatley, 2012; McManus, 2009). However, the saying that work-life balance is a western phenomenon no longer exists, even though most work-life balance studies are undertaken in the western countries (Rehman and Roomi, 2012). Recently, scholars and researchers have joined in the discussions of WLB in Nigeria (Mordi, Mmieh and Ojo, 2013; Epie, 2006, 2011; Okonkwo, 2012). It is nonetheless still important that more empirical studies about WLB are undertaken in Nigeria to (a) examine the reality of work-life balance among the Nigerian labour force, and (b) to bridge the enormous research gap that exists in that aspect of knowledge.

Furthermore, the studies undertaken by Mordi and Ojo (2011), Mordi et al. (2013), Epie (2006, 2009, 2011), Akanji (2012), Okonkwo (2012), Alutu and Ogbe (2007) and some other research works provide an insight of WLB in Nigeria. However, they do not include the health sector, which is the umbrella sector for the Nigerian medical doctors and nurses. The Nigerian health sector has its own uniqueness in terms of its environment, functionality and employees' needs

and requirements. A stereotypical classification of the Nigerian employees' work-life balance is, therefore, not appropriate. There is a need for more empirical studies to widen the publicity and close the academic gap concerning the social realities of WLB policies and practices in Nigeria. Also, such studies would assist in unravelling the interrelationship between work-life balance and organisational culture in the Nigerian health sector.

### **1.5 Justification for the Study**

Work-life balance appears to be a relatively new concept within Nigeria. In comparison to the UK government that launched work-life balance initiatives in 2000 and 2003, the Nigerian government barely has any supportive policy or WLB programmes for Nigerian workers (Adisa, Mordi and Mordi, 2014). The work-life balance campaign flagged by the UK government accords employees the right to request flexible working arrangements, especially working parents (Levin-Epstein, 2005). This is one of the many programmes embarked on by the UK government to promote a strong business case for family-friendly policies and flexible working practices, the sign of government that supports work-life balance (Chatrakul Na Ayudhya, 2009).

Furthermore, in the present context of a globalised economy, further studies on work-life balance and what enhances or hinders its effectiveness are crucial to the field. As a result, this empirical study is paramount because it is perhaps the first research to look at how and to what extent organisational culture impacts employees' work-life balance in Nigeria. It also provides a unique contribution to the literature and to the existing knowledge in WLB studies. This study is useful because it contributes immensely to academic, business and organisational researches and serves as a significant value for policymakers, hospital management and medical practitioners. It will also add value to the limited information which exists for multinational corporations already operating in Nigeria or wishing to set up business in Nigeria. Also, it will be beneficial to



Nigerian doctors, nurses and all other stakeholders (including the Federal Ministry of Health) and the Nigerian government towards developing effective work-life balance policies and programmes that will benefit the government, employers and employees.

## **1.6 Research Framework**

This study is guided by border theory as propounded by Clark (2000) and further develops on the theory to realise the fundamental objectives of this study. Border theory expounds how employees negotiate between their work and family domains, and the border that exists between them to attain balance (Clark, 2000). Border theory has been chosen as a conceptual framework for this study because it has an array of advantages for conceptualising WLB (Gurney, 2010). Also, border theory identifies and addresses the constituents of work and family domains which other theories fail to address (Clark, 2001). However, as the gale of globalisation and organisational restructuring of the 21<sup>st</sup> century enveloped the world, the non-work domain's activities cease to be confined to home/family duties. Employees' non-work related duties and responsibilities, opportunities and interests now expand beyond the home/family sphere; there are many other activities in the non-work domain which are equally important as family duties (Osoian, Lazar and Ratiu, 2011); Chan, 2008). This shift in duties, choices and interests requires a model that will encompass not only home/family duties, but all other non-work related activities/duties that are equally important to employees. Thus, by using data collected among Nigerians doctors and nurses, work-life border control model was developed. This resonates with Ransome's (2007, p. 374) argument that "it is rather important to use an established theory and concepts as a basis to develop a new one". The work-life border control model explains the forces that determine employees' movements across the border.

## **1.7 Research Methodology**

The study uses an in-depth qualitative research design. Qualitative research method has been chosen for this study because it builds an understanding of how participants make sense of and decipher things. It also appreciates context rather than controls it and exploits human potential to analyse and interpret. In addition, it provides accurate, comprehensive and descriptive foundations. The qualitative research method provides rich insights into issues of great importance that will benefit both management practitioners and researchers (Cassell, 2009). However, the research instruments used are semi-structured interviews and telephone interviews (Cachia and Millward, 2011; Rowley, 2012). This method helps the researcher to integrate the findings of the study into a coherent conclusion which gives the research work credibility.

## **1.8 Research Structure and Content**

The structure of this study is as follows: This section provides an overview of the thesis and content in a sequential order. The thesis is divided into chapters for unambiguous understanding and clarity. Chapter One contains the introduction, background of the study and the research objectives. This is followed by research questions, a statement of the research problem, justification for the research, the research framework, research methodology and, of course, the research structure section which are all contained in Chapter One. Chapter Two explains the concept of flexibility, types of flexibility, a review of WLB literature, the origin of work-life balance, the relationship between work and life, work-life balance policies and the drivers, merits and criticisms of WLB. Chapter Two also discusses the barriers of work-life balance and work-life conflict.

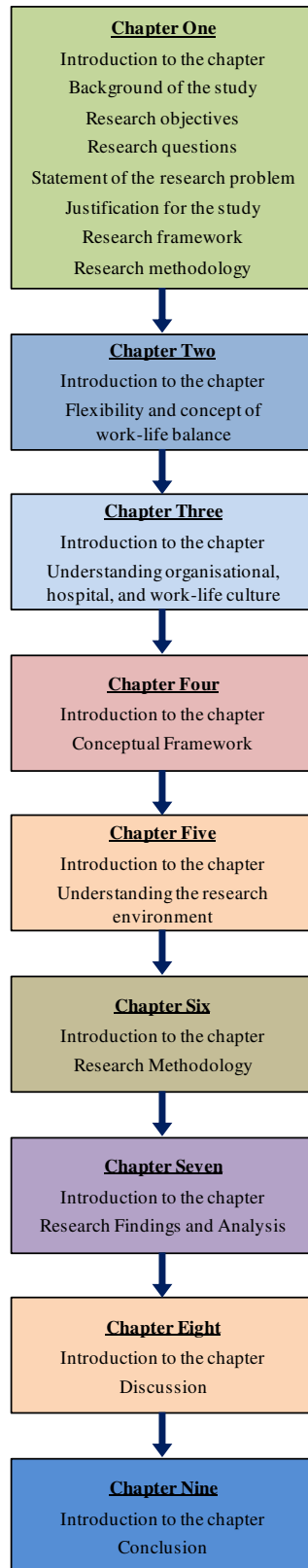
Chapter Three examines organisational culture, its relationship with organisational climate, cultural perspectives, types of culture, levels of culture and their interactions, the hospital

organisational culture and work-life culture. The conceptual framework for the study (border theory) and the newly developed work-life border control model will be discussed in Chapter Four. Chapter Five presents the research context including a brief history of Nigeria, a history of medicine and nursing in Nigeria, various healthcare plans in Nigeria, the present state of the Nigerian health sector, the Nigerian labour market and the activities of different trade unions. Chapter Five also discusses work-life balance among doctors and nurses and the outlook of work-life balance in Nigeria. Subsequently, Chapter Six presents the research methodology. Chapters Seven, Eight, and Nine analyse the following: the key research findings, the process of discussing data collection and interpretation, the implications of the findings, conclusions, the study overview, an overview of the research findings and discussion, possible suggestions for future research work, recommendations, contribution to knowledge and personal reflection.

## **1.9 Conclusion**

This study examines the interrelationship between work-life balance and organisational culture among Nigerian doctors and nurses. This chapter presented the foundation and highlighted the details and procedures to be followed to achieve the research aims. The chapter introduced the background of the study, the research objectives, research questions and a statement of the research problem. The chapter included justification for the research, research framework, a brief description of research methodology and the research structure. This thesis makes both theoretical and managerial contribution to and will broaden the existing knowledge of work-life balance and human resource development (HRD). The thesis is, therefore, broken down into a nine chapter document, which will be beneficial to academics, practitioners, government and policymakers. The next chapter provides a literature review.

**Figure 1 the Research Structure and Content**



## **Chapter Two**

### **Literature Review on Work-Life Balance**

#### **2.0 Introduction**

This chapter presents flexibility in the context of the study discussion. Employers' flexibility will be discussed, after which the types thereof will be examined. The chapter also discusses employees' flexibility otherwise known as work-life balance. Different strands of work-life balance include the definitions and drivers of work-life balance, the relationship between work and life, the merit of work-life balance, barriers preventing work-life balance, criticisms about work-life balance and work-life conflict are examined. This will facilitate good illustrations and understanding of the research. It is essential to note that this study is about employees' flexibility otherwise known as work-life balance. However, the study provides a brief discussion on employers' flexibility to better understand employees' flexibility (work-life balance). Therefore, while numerical and financial flexibility, functional and structural flexibility, vertical and horizontal flexibility provide employers with choice and control over the usage of manpower in an organisation, employees' flexibility (work-life balance) provides employees with control over when, where and how organisational tasks are undertaken.

#### **2.1 Flexibility in Context**

The theoretical undertone of flexibility offers employers and employees a locus of control over the time and places in which they work, but in reality, the potential benefits of flexibility are still far from being fully and optimally used by both employers and employees (Bernier, 2014). Flexibility is often appreciated as "considering its opposites – inflexibility, rigidity, stiffness and the like", all of which carry negative meaning (Redman and Wilkinson, 2009, p. 495). Therefore,

flexibility is important and cannot be overlooked in the value-laden discourses on employees' work life (Furaker, Hakansson and Karlsson, 2007).

The concept of flexibility was introduced in the 1970s by Doeringer and Piore, but was popularised by Atkinson in the 1980s (Armstrong, 2012). It is defined by Redman and Wilkinson (2009, p. 495) as a “quality by which an entity adapts itself to a change in the demands made upon it”. According to Standing (1999, p. 81), “when someone calls on workers or employers to be flexible, it usually means he wants them to make concessions”. Mandelbaum (1978) examines flexibility from the perspective of a change in circumstances and response from both employers and employees. He defines it as ability to respond swiftly to changes in circumstances. However, Jonsson (2007, p. 31) describes it more elaborately as “the propensity of an actor or system to exhibit variation in activities or states which is correlated with some other variation and desirable in view of this variation”. All definitions of flexibility recognise the propensity and ability to change as the situation demands (Armstrong, 2012; Atkinson and Hall, 2011).

In social science, the word “flexibility” has various meanings (Furaker, Hakansson and Karlsson, 2007). It is used in the following ways: in the development of capital society (Aglieta, 1979), in industrial relations (Wood, 1989), selection of a new system for production and markets (Piore and Sabel, 1984) and in the labour market, for flexible firms and flexible employees (Atkinson and Meager, 1986). It should be noted there are two types of flexibility; employee and employer flexibility (Verdu-Jover, Gomez-Gras and Llorens-Montes, 2008). Employer flexibility is the type of flexibility whereby the employer can use and deploy workers as the situation requires and for its sole benefit (Hartmann and De Grahl, 2011).

Employer flexibility includes both formal and informal workplace policies driven by production goals, customer needs and other organisational requirements (Wheatley, 2012). The lofty aims of this flexibility, however, are to improve the use of employees' skills and capacities, increase productivity and reduce employment costs, thus improving operational effectiveness (Armstrong, 2012). Flexibility also enables organisations to control employees' time and efforts efficiently so that employees' are only at work when they are needed and so that employees are focused and committed to achieving organisational goals (Torrington et al., 2011; Atkinson and Hall, 2011). Murphy and Doherty (2011, p. 254) succinctly stated as follows: "employer flexibility helps to improve the employer efficiency and also aid them to respond to economic conditions by identifying the need to 'pull' in and 'push' out labour depending on the point in the economic cycle". On the other hand, employees' flexibility, otherwise known as work-life balance, is driven by employees' needs and preferences (Wheatley, 2012).

## **2.2 Types of Employers' Flexibility**

There are different types of employers' flexibility, depending on researcher's aims, which differ from one researcher to the other (Atkinson and Meager, 1986; Boyer, 1987; Sayer and Walker, 1992). For this study, however, four types of employers' flexibility will be briefly discussed.

### **2.2.1 Numerical Flexibility**

This type of flexibility allows organisations to respond quickly to its environment in terms of the numbers of employees' needed (Torrington et al., 2011). It is an organisational responsibility to adjust the number of employees and hours worked in order to cut overhead costs and maximise profit (Redman and Wilkinson, 2009, p. 497). However, numerical flexibility enables organisations to reduce or expand workforce quickly and cheaply; replacing the traditional permanent and full-time positions with short-term contract staff, rolling contract staff, out workers, and so on (Torrington, Hall and Taylor, 2008). The rationale behind the numerical

flexibility is that it allows organisations to employ the right number of employees needed at a particular time for tasks (Murphy and Doherty, 2011). It saves overhead and operational costs by bringing the right number of people to meet the business demands (Beardwell and Claydon, 2010).

### **2.2.2 Functional and Temporal Flexibility**

Functional flexibility is the process that gives the employee the “ability to undertake a variety of tasks rather than specialising in one particular area” (Torrington et al., 2011). This type of flexibility originated in the manufacturing industry whereby organisations sought to break the barriers that existed within crafts trades and those who worked in production and other units of the company. Functional flexibility was then introduced to enable workers in one department to work in another department of the same organisation (Reilly, 2001). According to Murphy and Doherty (2011), functional flexibility allows employees to be redeployed quickly and smoothly between activities and tasks within the same organisation.

However, this may require multi-skilled workers who possess and can apply a number of skills (Armstrong, 2010). It is an organisational responsibility to match the skills profiles of its workforce to the changing pattern of needs (Redman and Wilkinson, 2009), while temporal flexibility is when an employee works a different pattern of hours in order to meet business demands and employees’ needs. Temporal flexibility is on the rise especially among retailers that open for longer hours (Torrington et al., 2011). Examples of temporal flexibility include: part-time working, job-sharing, flexitime, and career break, zero hours contract, voluntary reduced hours, flexible working week, and term-time working (Humphreys, Fleming and O’Donnell, 2000; Reilly, 2001).



### **2.2.3 Financial and Structural Flexibility**

Financial flexibility “provides for pay levels to reflect the state of supply and demand in the external labour market” (Murphy and Doherty, 2011, p. 254). It supports the use of flexible payment systems which facilitate either functional or numerical flexibility (Armstrong, 2012). Financial flexibility links rewards closely with individual or organisational performance including incentives such as performance-related pay (Brewster, Sparrow and Vernon, 2011). Structural flexibility is when core employees are supplemented by peripheral employees (e.g. part-time workers, employees on short-term contracts and sub-contracted workers) saving hugely on operational costs (Armstrong, 2012).

### **2.2.4 Vertical and Horizontal Flexibility**

Vertical flexibility is when an employee gains the capacity and ability to work in place of both senior and junior colleagues within the organisation’s hierarchy. Horizontal flexibility is when employees become multi-skilled, so that they can work in other departments within the organisation (Torrington, Hall and Taylor, 2008, Torrington et al., 2011). The discussion about flexibility often begins with the employer and the notion of what is required for smooth business operations to meet fluctuations in demand. Sometimes employers take advantage of the structure of taxation concerned with employment and employers’ social insurance contributions (Brewster et al., 2010).

Furthermore, all the aforementioned concepts of flexibility are employers’ types of flexibility which they use to twist and turn employees’ skills and time to achieve organisational goals (Redman and Wilkinson, 2009). However, the increasing yearning for employees’ flexibility to accommodate their work and non-work responsibilities eventually gives birth to the concept of work-life balance (Brewster et al., 2010; Murphy and Doherty, 2011). Flexibility in this context

is not about employer demands for flexibility in scheduling work; rather, it is about providing the employees with some sort of control and flexibility over the place and time in which they work, which is the precept of work-life balance (Atkinson and Hall, 2011).

### **2.3 Origin of Work-Life Balance**

Work-life balance has existed as early as the 1930s, before the Second World War. Introducing reduced working hours (using four shifts of six hours instead of the usual three daily shifts of eight hours) in W. K. Kellogg Company resulted in improved employee morale and productivity (Lockwood, 2003). However, the academic concept of work-life balance can be traced back to 1960s, when Rapoport and Rapoport researched how work and family were closely related to each other in agrarian society. They also investigated how the industrial revolution of the late 18<sup>th</sup> and early 19<sup>th</sup> centuries created divisions between work and personal life (Rapoport and Rapoport, 1965). Although, their research covered a limited scope of work-life balance because it did not relate work to its impact on other aspects of life (Naithani, 2010a and 2010b).

In the 1970s, however, Kanter (1977) highlighted aspects of family life that affect work and aspects of work that affect family life (Naithani, 2010b). She describes work and family as separate worlds in her classic treatise on the relationship between work and family (Kanter, 1977). During the same period, Pleck also analysed the concept of work-family life as being a collection of male work role, female work role, male family role and female family role (Pleck, 1977). The discussions continued throughout the 1980s using “taxonomy ethical ideology” as a factor in achieving balance between employee’s work and non-work life (Forsyth, 1980, p. 176). During the period between 1960 and the 1970s, employers viewed work-life issues as exclusively affecting women; who struggled with the demands of their job and raising children (Bird, 2006). The nature of work and employees’ dilemma to combine their work related and

non-work related commitments remained the theme of work-life balance in the 1990s (Lambert, 1990). The 1990s saw the rise of the view that work-life balance is an issue for everyone – women, men, couples, singles, parents and non-parents (Bird, 2006).

In the last two decades, the intensification of work caused by economic uncertainty, organisational restructuring and increasing business competition has proliferated the discussions of work-life balance (Hughes and Bozionelos, 2007). However, at this early stage in the 21<sup>st</sup> century, there is glaring evidence that the value of work is changing and there continues to be room for personal interests, environment and family obligations aside from work commitments. These issues continue to keep the debates and discussions about work-life balance alive (Torrington, Hall and Taylor, 2008). Work-life balance continues to generate interest and support from organisations and governments across European countries (Maxwell, 2008), the US and even in far Eastern countries such as Japan (Torrington et al., 2008). Lately, African nations such as Nigeria have also opened their interest in the discussions and benefits of work-life balance (Mordi, Mmieh and Ojo, 2013; Adisa, Mordi and Mordi, 2014).

#### **2.4 The Concept of Work-Life Balance**

The diction of work-life balance has become a crucial feature of most debates within government, among practitioners, and academics. The key message of these debates is the need for good work-life balance (Eikhof, Warhurst and Haunschild, 2007) which is vital to employees' lives and employers' businesses (Naithani, 2010). However, despite the extensive usage of the term "work-life balance", the concept is not as easy to understand as it appears (Koubova and Buchko, 2013). It is important to emphasise that the concept of work-life balance has abruptly ceased to be a western phenomenon, even though the majority of studies on work-life balance do focus on western context (Rehman and Roomi, 2012).

The 21<sup>st</sup> century is an era confronted with a change in the value of work, economic uncertainty and organisational restructuring (Torrington et al., 2008). This makes organisations press for unalloyed commitment and higher productivity from their employees (Naithani, 2010; Hughes and Bozionelos, 2007). Many people now work for long hours, feel more pressure in their jobs and at home. They struggle to maintain a healthy balance in their lives which makes work and non-work aspects of their life to collide and become difficult to maintain. Consequently, the number of employees who are going through work-life conflict is on the rise (Redman and Wilkinson, 2009). The concept of work-life balance, hence, is paramount (Parris, Vickers and Wilkes 2008). Several definitions of work-life balance will advance knowledge of the subject.

Gregory and Milner (2009, p. 2) describe work-life balance as “practices which allow employees some flexibility and autonomy to negotiate their time and presence in the workplace”. They further explain that work-life balance practices become a reality when work-life balance initiatives are designed and duly implemented. According to Wheatley (2012, p. 815), work-life balance “is the ability of individuals, regardless of age, or gender, to combine work and household responsibilities successfully”. Caven and Raiden (2010, p. 533) define work-life balance as individual’s ability to maintain a satisfactory equilibrium between work and non-work life obligations. Noon and Blyton (2007, p. 356) emphasised that work-life balance “is the individual ability to pursue their work and non-work lives successfully, without undue pressures from one undermining the satisfactory experience of other”.

For Greenhaus, Collins and Shaw (2003), work-life balance “is the extent to which an individual engages in and equally satisfied with his or her work role and family role consisting three parts of work-family balance”. These are time balance (equal time devoted to work and family), involvement balance (equal involvement in work and family) and satisfaction balance (equal

satisfaction with work and family). Greenhaus et al. (2003) defined work-life balance in relation to the three abovementioned components of work-family balance, thereby restricting their meaning of 'family' as the only aspect of employee's non-work life. Perhaps the meaning given by Simons is more definitive. He succinctly describes work-life balance as a "means of bringing work, whether done on the job or at home, and leisure time into balance to live life to its fullest. It does not mean that you spend half of your life working and half of it playing; instead, it means balancing the two to achieve harmony in physical, emotional, and spiritual health" (Simons, 2012, p. 25).

The term work-life balance means different things to different people; it depends on the context in which it is used (Lockwood, 2003). It is the employees' "ability to negotiate successfully their work and family commitments and other non-work responsibilities and activities" (Parkes and Langford, 2008, p. 267). This definition of work-life balance includes employees' other responsibilities and activities aside from family commitments. It recognises employees' desires to find a healthier rhythm and, therefore, a more satisfying balance between their roles and responsibilities, irrespective of their marital or parental status (Parkes and Langford, 2008). Work-life balance policies are targeted at fine-tuning work schedules so that employees, regardless of their age, gender or race can find a balance that will help them combine work and other responsibilities and aspirations without rancour (Pillinger, 2002).

It is, however, pertinent to note that work-life balance does not mean allotting an equal amount of energy and time to both work related and non-work related life responsibilities (Osoian, Lazar and Ratiu, 2011). It means "allowing employees some degree of flexibility over when, where and how they do their work" (Kesting and Harris, 2009, p. 47). Work Foundation (2003) declared that work-life balance is about "workers achieving a satisfactory equilibrium between their work

and non-work life activities, which include parental responsibilities, caring duties and other activities and interests”. However, several researchers have raised issues with the definition of work-life balance in relation to what is work, life and balance and how the three components integrate. Wheatley (2012) expounds that the “word” work mentioned in the context of work-life balance connotes paid and unpaid work carried out for an employer. “Life” in the same context refers to non-work related activities which Lowry and Moskos (2008) describe as “free time spent in leisure activities and family time”.

For Clutterbuck (2003, p. 8), the word “work” in the context of work-life balance means “the time and energy which an employee contracted to expend in return for a reward, usually financial, to a third party while life is the antithesis of work”. Guest (2001, p. 8) argues that “life” mean “the rest of life after work”. Parris et al., (2008, p. 105) argue that the customary use of the word “balance”, which gives “equal weight to work and non-work activities is misnomer”. Clark (2000) defines balance as satisfaction and healthy functioning at work and home, with minimum role conflict. Clarke, Koch and Hill (2004) argued that the word balance in the term work-life balance should not be seen as giving equal time and energy to paid and non-paid roles, but, in its broad sense, it is a satisfactory equilibrium between work related and non-work related roles.

## **2.5 The Relationship between Work and Life**

Eikhof et al. (2007) aver the need to recognise the relationship between work and life in assessing and understanding the concept. The relationship between work and life is worth discussing especially now that the interconnectivity between working adults who have responsibility for dependent children and elderly relatives at home is at a growing pace (Brannen et al., 1994). The word work in the term work-life balance refers to the time and energy which an employee is contracted to expend for a reward, usually financial, to a third party (Clutterbuck,

2003). For Wheatley (2012), work refers to paid and unpaid work carried out for an employer. It is presumed that the work has negative and debilitating effects on life (Eikhof et al., 2007), most especially those aspects of work that technology has permitted to creep into aspects of life; for example, checking emails at home can cause work-life imbalance (Waller and Ragsdell, 2012).

The pressure of work, according to Guest (2001) (especially with the current and recent advances in information technology) has been intensified in terms of workload and work/non-work boundaries. Sophisticated technology has changed the way in which work is done all over the world (Tennakoon, da Silveira and Taras, 2013; Berkowsky, 2013). The days in which typewriters stayed back in the office and its operators went home (or the office phone and computers were table-bound in the office) are long gone. Nowadays, the acts and methods of carrying out daily work is no longer limited to a particular place or time (Duxbury and Smart, 2011), making the boundaries between work and life porous.

The latest technology such as mobile devices including laptops, cell phones (iPhones, BlackBerrys and smart phones), iPads, pagers, portable digital assistants and other integrated wireless devices and use of super-fast internet (Duxbury and Smart, 2011) have technically demolished the boundaries that separate the domains of work and life. These devices allow employees to work anywhere and at any time of the day and/or night (Pica and Kakihara, 2003; Towers et al., 2006). It is pertinent to note that these advance technologies have profoundly shifted the perceptions and understanding of the work and life constructs, especially within the western milieu (Golden and Geisler, 2007). They have rendered Kahn et al's (1964) work on the separation of work and home roles, in terms of time and space, practically invalid.

The nature of work has changed (Wheatley, Hardill and Green, 2008). Therefore, the relationship between work and life is more interwoven than before; work has now crept into life and vice-

versa. Russell (2005, p. 1065) explains as follows: “given increasing technology and globalisation of work, instead of having more simplified lives, people are often ‘on call’ at work 24/7. They work anywhere at any time...this makes the lines between work, family and other life issues more blurred than ever before”. Guest (2001) notes that the demands of work dominate non-work life, resulting in work-life imbalance. Similarly, Lazar, Osoian and Ratiu, (2010) also highlight the relationship between work and non-work life in their study and relate how work-life balance initiatives and practices impact employees’ performance in an organisation.

## **2.6 The Drivers of Work-Life Balance**

The invasiveness of paid work in people’s lives for both men and women is evident and can no longer be ignored. Gamble, Lewis and Rapoport (2006) argue that this invasiveness can divert employees’ time and energy from other equally important aspects of life and cause imbalance in their work and non-work lives. Furthermore, the 21<sup>st</sup> century is enmeshed in a series of challenges and technological breakthroughs which have altered the mode of business operations; thus creating lots of imbalance between employees’ work and non-work lives. Work-life balance has never been as widely discussed as it has been in this century. Several factors are responsible for the intercontinental discussions related to work-life balance. The first factor is that there is now a 24/7 economy that requires most businesses to stay operational for 24 hours a day and 7 days a week (Torrington, Hall and Taylor, 2008).

According to Tan and Klaasen (2007, p. 702), the concept of the 24/7 environment is “an environment in which there are possibilities for multiple temporal rhythms, multiple functions, and various activities to coexist and interact within a finite space”. Consumer demands affect the culture of the 24/7 economy (Tan and Klaasen, 2007). The implication of this is that businesses must operate outside the traditional 9am-5pm traditional structure. Employees must be alert and



available during the day and at night, at weekends and even on bank holidays in order to cater for their customers' needs and this expansion of the required working hours will consequently affect their non-work lives (Houston, 2005). The nature of work has changed, increasing the number of discussions about the need for employees to be flexible, adaptable, and team-working and having individual responsibility at work (Wheatley, Hardill and Green, 2008). Another factor which is part of the discussions about work-life balance is demographic and social change (Sharma and Mishra, 2013) which has resulted in the influx of women entering the labour force (Jones, Burke and Westman, 2006). The National Council of Women's Organisations in 2003 estimated that 63% of women with children under the age of six and 78% of women with children aged between 6 and 17 are employed (Quesenberry, Trauth and Morgan, 2006).

However, the increased participation of women in the labour force (Rehman and Roomi, 2012) poses big challenges for women in terms of managing their work related obligations and duties at home (Guendouzi, 2006; Shelton, 2006). This reflects an enormous pressure for employees to maintain their work related and non-work related obligations (Baral and Bhargava, 2012). There are also changes in the labour market (Cegarra-Leiva, Sauchez-Vidal and Cagarra-Navarro, 2012) that have resulted in increased numbers of organisations in the service sector (Ahuja, 2002) which require employees to work shift patterns and stay longer at work in different time zones and frequently interact with customers (Baral and Bhargava, 2012). This blurs the line between the work related and non-work related aspects of employees' lives.

The economic uncertainty which lasted for over twenty years (Hughes and Bozionelos, 2007) and eventually resulted in economic downturn in 2008 caused a substantial intensification of workloads, organisational restructuring, and fierce competition in global business (Millward, Bryson and Forth, 2000; Green, 2001). To respond to these developments, employers demand

unalloyed commitment and higher quality performance from their employees, which means employees must work for longer hours and put work before their personal lives (Simpson, 2000; Perrons, 2003). This makes work-life balance a key subject for discussion (Hughes and Bozionelos, 2007).

Another driver of work-life balance is the increasing numbers of dual-earner families (Cegarra-Leiva et al., 2012). Achieving work-life balance is somewhat difficult in families in which both partners are in paid employment (Wheatley, 2012). The current economic situation requires most families to increase their financial power (Walker et al., 2008) which is one reason why most couples now engage in paid work; thereby destroying the traditional notion of men being the breadwinners and women the home carers (Houston, 2005). According to Jones, Burke and Westman (2006), women no longer sit at home; they are now part of the norm rather than the exception. The demographical change of the aging workforce has prompted employers to develop a range of work-life balance policies and initiatives that allow older employees who wish to work or remain in work to choose part-time and different shift patterns that suit them (Torrington, Hall and Taylor, 2008).

The growing deterioration of the quality of home and community life (Guest 2001) which result from the enormous pressure on employees to be more productive and innovative (Alutu and Ogbe, 2007) have also increased general talks about work-life balance. Younger generations are not ready to work as their parents; they desire flexibility, greater control and many influences in the mode and structure of their works and future prospects (Byrne, 2005). All these factors have raised brows and increased talks about employees' flexibility otherwise known as work-life balance.

## **2.7 Work-Life Balance Policies and the Merits of Work-Life Balance**

Empirical studies have identified a panoply of work-life balance policies designed to provide support to both employees and employers (Bailey, 1991; Blair-Loy and Wharton, 2002; Berg, Kalleberg and Appelbaum, 2003). However, Morgan and Milliken (1992) argue that there are three types of work-life balance policies formulated to help employees balance their work and family or non-work responsibilities; provision of carer arrangements, alternative work arrangements and off-site working arrangements. Similarly, Glass and Finley (2002) also identified three categories of work-life balance policies: parental leave, alternative work arrangements and employer-supported childcare.

Comprehensively, work-life balance policies include all flexible work arrangements that provide employees some control over where, when and how their work related duties are carried out. These flexible work arrangements include: part-time working, flexible work schedules, carers arrangements, carer facilities, offsite arrangements, accrued days off, time off, job sharing, annualised hours, teleworking, compressed working weeks, family leave and employee assistance programmes (Bilal, Zia-ur-Rehman and Raza, 2010; Yuile et al., 2012). Other such policies include: parental leave, allowances to cover childcare costs, work and family incentives and social support for children and parents (Den Dulk and Doorne-Huiskes, 2010; Den Dulk, Groeneveld and Bram, 2014). All of the aforementioned work-life balance policies provide work-life respite for employees and improve organisational attachment and productivity.

The advantages of an effective balance by employees (men and women) between the demands of the workplace and aspirations of non-work related commitments are of crucial importance and advantageous to both employers and employees (Liechty and Anderson, 2007). As Carlson et al. (2008) noted, work-life balance provides organisations with a competitive advantage in the

marketplace, it reduces work-family conflict, promotes work-family enrichment and also helps in attracting and retaining high-quality employees. There are different work-life balance policies, but flexitime is becoming an increasingly popular work-life balance policy. It allows employees to define their core working hours and makes the start and finish work time flexible (O'Brien and Hayden, 2008).

Research has shown that implementing work-life balance policies in an organisation increases motivation and job satisfaction among employees, significantly improves employees' morale and organisational commitment and increases employees' energy level on the job and productivity (Bilal, Zia-ur-Rehman and Raza, 2010; Hill, Hawkins and Miller, 1996; Kurland and Bailey, 1999). Eaton (2003), for instance, supports this premise. In his study of 463 professional and technical employees, it was found that provision of work-life balance policies and practices improved their commitments. Furthermore, some have argued that work-life balance helps to assuage work-life conflicts, which significantly improves employees' performance (Kumari, 2012). Allen and Meyer (1990) also support this argument.

Grover and Crooker (1995) also found that flexible working hours, parental leave, childcare information and financial assistance with childcare significantly increases organisational commitment. They also reported that employees who have access to and are able to use work-life balance policies whenever the need arises are unlikely to quit their job, thereby reducing the rate of turnover (Grover and Crooker, 1995). Kenexa Research Institute (2007) and Rahman, Naqvi and Ramay (2008) agree with Grover and Crooker. Conversely, dissatisfaction may provoke absenteeism, high rate of staff turnover and possibly affect employees' performance (Okpara, 2004).

Research has indicated that employees who have work-life balance are less likely to suffer from stress and other stress-related illnesses (Lazar, Osoian and Ratiu, 2010). Undoubtedly, work-life balance is advantageous to both employers and employees (Schneider, Ruppenthal and Hauser, 2006; Kozjek, Tomazevic and Stare, 2014). All work-life balance policies are aimed at assisting employees to balance their work related and non-work related demands, which then leads to enhanced employee productivity and significant business improvements (Beauregard and Henry, 2009). This can be interpreted using social exchange theory (Blau, 1964). Social exchange theory emphasises the notion of reciprocity for keeping and maintaining social relationships such that the employee who engages in reciprocally supportive relationships is better at work in organisational attachment and productivity (Shore et al., 2006). According to Beauregard and Henry (2009), employees will be obliged to respond in kind through a positive attitude or behaviour when treated well by their organisations.

## **2.8 Barriers Affecting Work-Life Balance**

The term “work-life balance” is a relatively new concept that replaced “work-family balance” (Hudson Resourcing, 2005). The replacement arises from the fact that childcare and other familial duties are not the only important non-work related activities. Other activities that need to be balanced with work include education, travel, leisure, elderly care and personal development and so on (Osoian, Lazar and Ratiu, 2011). For this study, therefore, barriers affecting work-family balance, work-family harmony or work-life initiatives will all be regarded to as barriers affecting “work-life balance”. One of the barriers affecting work-life balance is high performance and high-commitment managerial practices designed to provide greater participation in decision-making and to increase the level of discretionary work efforts. It

impedes the successful implementation of work-life balance policies and practices (White et al., 2003).

Other barriers affecting work-life balance policies and practices include long working hours, organisational time expectation and demands and an unsupportive organisational culture. Organisations with a culture of long working hours will surely discourage employees from using work-life balance policies (Beauregard and Henry, 2009). As indicated by Bond (2004), an overarching organisational culture of long working hours nurtures stress and fatigue among employees and often disconnects them from other non-work related activities. The impact of working long hours on the well-being of the employee will be discussed in the analysis chapter. Unsupportive management, supervisors and co-workers are also barriers to successful implementation of work-life balance policies and practices (Bond, 2004). Management plays the crucial role of HRM decision-making which includes work-life balance decisions. They therefore become a barrier if their decision about employees' work-life balance is unfavourable (Hales, 2006; Purcell and Hutchinson, 2007). Thompson (2008, p. 223) describes supervisors as the "gatekeepers" of work-life balance programmes who determine whether employees use work-life balance policies or not (Lapierre et al., 2008 and Lapierre and Allen, 2006).

According to McDonald, Brown and Bradley (2005), resentful co-workers can make using work-life balance programs difficult. In the 1997 National Study of the Changing Workforce, 22% of respondents strongly agreed that they would resent work-life balance policies if they felt the systems would not benefit them. A further 16% also agreed that they would resent doing extra work occasionally to accommodate co-workers who need to attend to urgent personal or family related needs (Bond, Galinsky and Swanberg, 1998). A lack of work-life balance awareness is another barrier to work-life balance (Kodz et al., 1998; Lewis, Kagan and Heaton, 2000). For

instance, in a study of 945 employees carried out across six organisations, Yeandle et al. (2002) found that 50% of workers were oblivious of work-life balance policies offered by their organisations (McCarthy et al., 2009). Furthermore, some have argued that, even in a situation in which employees know of the work-life balance policies available to them, many are reluctant to use them for fear of being accused of having conflicting priorities and being seen as less committed (Berry and Rao, 1997; Pleck, 1993). Despite all the benefits of work-life balance policies, the aforementioned factors constrain employees from signing up to using such (McDonald, Brown and Bradley, 2005; Beauregard and Henry, 2009).

## **2.9 Work-Life Conflict**

Despite the visible and undeniable facts about the positive implications of work-life balance for both employees and employers (Ozbilgin et al., 2011), conflict between work related and non-work related roles of employees is still prevalent (Steyl and Koekemoer, 2011). Work-life conflict is perceived to be a negative phenomenon and it has long dominated the discussions about work-life balance (Eby et al., 2005). The term “work-life conflict” was first used in the late 1970s to describe the imbalance that occurs between an individual employee’s work and personal life (Idemobi and Akam, 2012). Work-life conflict occurs when one aspect of an employee’s life intrudes into another in a dysfunctional or excessive manner (Baldiga, 2005). According to Greenhaus and Beutell (1985, p. 77), “conflict is experienced when pressures arising in one role are incompatible with pressures arising in another role...participation in one role is made more difficult by virtue of participation in another role”. Work-life conflict is bi-directional; work-non-work conflict and non-work-work conflict (Gurney, 2010; Steyl and Koekemoer, 2011). Normally, people usually think the intrusion is only from work related to

non-work related spheres but Clutterbuck (2003) argues that there are instances in which the flow is the other way round.

Kargwell (2008) notes that work-life conflict is prominent among female employees who are most devoted to both work related and family related roles. Women are well known for combining productive and reproductive roles (Hammer and Thompson, 2003). The impact of this is the division of their time, attention and energy between work and domestic duties. This competition for time, attention, and energy (Gurney, 2010) often leads to “constant tension and perpetual conflict” (Barnett and Gareis, 2006, p. 210). There are several other non-work issues and activities equally important to employees. These activities often cause an interface with work obligations, yet work-family conflict have received so much attention from both organisations and researchers (Brough and Kalliath, 2009; Burke et al., 2011).

However, researchers have attributed the causes of conflict between work related and non-work related roles to the demographic and structural changes in family and workforce structures (Cavaleros, Van Vuuren and Visser, 2002; Geurts and Demerouti, 2003). The results in increased numbers of women and dual-earner families being part of the workforce (Stevens et al., 2007). There is an increase in the conflict between demands in work related and non-work related spheres; therefore, most employees’ daily chores at work stand at variance and become incompatible with their non-work related responsibilities (Jansen et al., 2004). Hence, the potential for conflict between employee’s work and non-work life (known as work-family conflict) increases (Byron, 2005; Mesmer-Magnus and Viswesvaran, 2005).

Research has indicated that demographic groups differ in their experiences of and interactions between work and family lives, which further deepens the work-life conflict (Rost and Mostert,



2007; Donald and Linington, 2008; De Klerk and Mostert, 2010; Steyl and Koekemoer, 2011). Furthermore, employees from different demographic groups have different working environments, different non-work activities, and attach different saliency to their individual private lives, all of which are contributory factors to the employees' work-life conflict (Nikandrou, Panayotopoulou and Apospori, 2008). In their study, Van Steenbergen and Ellemers (2009) contended that employees who experience less conflicts between their work related and non-work related roles are objectively healthier, maintain a higher level of punctuality and perform better at work.

This argument provides a strong business case for proper implementation of family-friendly work-life balance programmes in organisations (Brough and Kalliath, 2009). In this vein, Taylor, DelCampo and Blancero (2009) pointed out the importance of family-friendly policies in ameliorating work-life conflict among employees. Organisations are, therefore, encouraged to offer practical and family-friendly work-life balance programmes which will enable employees to conveniently discharge their work related and non-work related roles and also to lessen any conflict that may arise (Steyl and Koekemoer, 2011).

## **2.10 Criticisms of Work-Life Balance**

The concept of work-life balance is an important area of HRM known to have several meritorious advantages (McCarthy, Darcy and Grady, 2009); but it is not, however, without criticism. For instance, Pichler (2009) argues that the scale of measurement of work-life balance does not correlate in any relevant way with external criteria such as well-being which is subjective. This means that it is necessary to find the statistical equivalent of indicators and equal measurement properties across groups or countries (Steenkamp and Baumgartner, 1998). It is imperative to have in place high-quality measures in several constructs to be able to compare the

situation within and across countries (Pichler, 2009). Another criticism of work-life balance is the problem of analysing and determining what constitutes work, life and balance between employees' work and nonwork life. This may well be the reason that Guest (2001) described work-life balance as a misnomer.

### **2.11 Work-Life Balance among Doctors and Nurses**

Work-life balance for medical doctors has generated many discussions and concerns among academics and medical doctors themselves (Lowenstein, 2003; Thielst, 2005; Wise et al., 2007). This could be because doctors find it hard to separate work from their personal lives (Sibert, 2011). Sibert recognises the value and importance of having WLB, but also believes that the required physical presence at work and the intensity of the medical profession seem to be unsupportive of WLB policies. Medical doctors are people who on a daily basis juggle work related and family responsibilities (Thielst, 2005).

According to Thielst (2005), this often leaves medical practitioners vulnerable to stress and conflicts between home and work. A heavy workload means that they have less time and energy available for family related and other non-work related activities (Swanson, Power and Simpson, 1998). White, O'Connor and Garrett (1997, p. 325) argue that "doctors have suicide risk of about seventy-two percent higher than the general population," and that doctors are among the ten occupations with the highest risk of suicide. Thielst (2005) found that doctors' commitment to their work keeps them away from their spouses/partners to the extent that most of them regard their job as their "first love" and give less time to non-work related and family related responsibilities. Gerstel and Gross (1987, p. 350) concluded that "the patterns of work without flexibility have created difficulties for doctors in relation to their family lifestyles, and have sometimes led to either the complete breakdown of the family or their families have borne the

brunt of these imbalances”. The likelihood of errors with patient care should concern everyone, as long shifts expose doctors to the risks of making sequential mistakes, which could be dangerous to the lives of their patients (Dembe, Delbos and Erickson, 2009).

Other problems associated with long working hours include separating employees from their family, thereby stimulating work-family conflict (Othman, Yusof Osman, 2009). This leads doctors to feel exhausted, fatigued and rarely have time for family related or other non-work related activities (Wilson et al., 2007; Lasebikan and Oyetunde, 2012) and negatively affect the quality and quantity of sleep (Walter, 2012). These patterns of work without flexibility turn a household upside down (Bamford and Bamford, 2008) and present doctors with a high degree of burnout, exhaustion and depersonalisation (Deary et al., 1996). Their family related and other significant non-work related commitments take the strain of this imbalance (Johnson, 1991). Benligiray and Sonmez (2012) also found a positive, but weak relationship between organisational commitment and work-family conflict among doctors and nurses suggesting that the more committed they are to the hospital they work for, the more work-family conflict they experience. Therefore, it is plausible that doctors with families may find long-hours and shift work harder than those without a family.

The workplace experience of doctors and monitoring of their work differs across the world. The common theme seems to be that they work long hours and under pressure. In the UK, in reaction to the growing evidence brought to the fore by issues related to WLB, the maximum number of hours by law that can be worked each week by junior doctors has been cut down in accordance with guidance and law from the EU (Bamford and Bamford, 2008; British Medical Association News, 2007). For too long so much emphasis has been placed on how working for long hours is good and essential for the continuity of patients’ care, or doctors’ training (Bamford and

Bamford, 2008), with little consideration given to the effects of exhaustion and the potential risk of error that may quickly set in because of working for long hours (Thorpe, 2002; Rohrich, Persing and Phillips, 2003). However, work practice transformation must highlight and cater for the risk associated with enervation and not give weight to commitment to the act of long working hours (Gaba and Howard, 2002). Similarly, in the UK, Walsh (2013) assesses whether female hospital doctors are at greater risk of burnout and more likely to terminate their employment than male hospital doctors. The research suggests that female doctors are more likely to experience job burnout than male doctors. The converse is likely to be true in Nigeria as it seems medical practitioners stay on despite these difficulties (Adisa, Mordi and Mordi, 2014).

In addition, in Nigeria there is an acute shortage of medical doctors, which consequently increased their workload and working hours, as well as other consequences. 35 years ago, the Nigerian health sector was reported to be so under-staffed that there were just about 500 doctors available for one million Nigerians (Bower and Purcell, 1978). Recently, the President of the Nigerian Medical Association (NMA) (Muanya, 2013) suggested that Nigeria has 71,740 medical and dental practitioners and they are listed on the register of the Medical and Dental Council of Nigeria (MDCN) out of which only approximately 27, 000 are practising in Nigeria. According to the Human Resources for Health (HRH) Fact Sheet (2010) in the Africa Health Workforce Observatory, Nigeria has one of the largest health workforce in Africa, with 55, 375 doctors practising in different parts of the country. This means that just one doctor is available for 6,187 Nigerians, based on a population of 167,000, 000.

The challenges of doctors are also reflected in the nursing profession. Nursing services are crucial for the management of patients' care in hospitals, but a shortage of nurses appears to be a global problem in every states (Nelson and Tarpey, 2010). This would perhaps explain why the

demand for nurses is on the rise (Neates, 2010). Nurses are always scheduled to provide constant, endless care for patients. As a result, they work in shift patterns and for non-standard hours. Because of this and other factors (such as the inability of nurses to influence their shift patterns) attaining and maintaining work-life balance is somewhat rare for nurses. In Nigeria, nurses are confronted with massive challenges of balancing their work and nonwork, especially their family life (Adisa, Mordi and Mordi, 2014). It is therefore safe to say that work-life balance for nurses is problematic.

## **2.12 The Outlook of Work-Life Balance in Nigeria**

Nigeria is a West African coastal country made up of 36 states with a diverse ethnic grouping of over 250 ethnic groups (Epie, 2011; Mordi and Ojo, 2011). The country is also the most populous African country with over 177, 000, 000 people (CIA World Fact Book, 2014). The Nigerian workforce is estimated to be 52.5 million within which the division of occupations is as follows: service sector - 20% (1999 estimate); the agricultural sector - 70%, while the industry sector is only 10% (2011 estimate CIA World Fact Book, 2014). The Nigerian Labour Act 1974 stipulates that daily hours of work are to be fixed by mutual agreement or collective bargaining. All of these and other conditions of labour are contained in section 13 (1) (3) (7) and (18) thereof. According to Idemobi and Akam (2012), Nigerian employees are now more concerned about their work-family life than they have ever been. This is because employees, most especially those in the public sector, are persistently complaining about the line between their work and non-work time that have become increasingly blurred. Even though Nigeria is a male-dominated society (Mordi et al., 2010), the social changes witnessed over the last three decades have gradually reduced the traditional family structure of men being the breadwinners and women being the homemakers (Barling and Sorenson, 1997; Powell and Greenhaus, 2006).

Because of this change, Nigerian women now shuffle household, caring and family duties with paid work to help the family meet its financial obligations (Okonkwo, 2012), making work-life balance an issue for both male and female Nigerian employees (Alutu and Ogbe, 2007).

Even though work-life balance has ceased to be exclusively a western phenomenon, work-life balance policies and practices are still not firmly rooted in an African (especially a Nigerian) setting. It is clear that the western countries, especially the US in which most work-life balance studies were carried out, are well-developed with strong corporate governance, government commitment to citizens' welfare and the rule of law and a high level of wealth (Aguilera and Jackson, 2003). At present, drawing on institutional theory, companies, and employees operating in different national settings are more likely to be open to different elements and factors which are bound to affect their organisational and managerial practices (Scott, 2008; Lee, Chang and Kim, 2011). Country-specific analysis is essential because the country's distinctive history and socio-economic environment can define the behaviour of individuals and companies operating in that country (Epie and Ituma, 2014). For instance, Nigeria is a male-dominated society (Mordi et al., 2013), with a collectivist culture whereby every individual is tied to his family or groups (Omololu, 1997).

Nigerian women in employment on either a full-time or part-time basis are still expected to be active in their domestic duties of tidying the home, cooking for the family, doing laundry and caring for the children and the elderly family members (Okonkwo, 2012). In Nigeria, less egalitarian society, work related roles for women are a secondary issue to their domestic and maternal roles. This is not the case in an egalitarian society such as the US, where a woman's self-image is attached to her career and not her home or family (Agassi, 1982; Lieblich, 1993). Additionally, the occupational distribution of Nigerians as a people is conjectural (Epie, 2011)

and terms and conditions of employment in the private and public sectors(except for wages and salaries) are regulated by the government through the Nigerian Employment Acts of 1971and 1974 which do not provide for family-friendly policies (Epie, 2006). Nigeria’s unemployment rate stands at 21% (CIA World Fact Book, 2012) which makes the labour market somehow crowded. A result of this is that employers may design and dictate what work-life balance policies are available to employees (Epie, 2011). Nigeria is influenced by the British system whereby the government exercises limited regulations for employers (Epie, 2011). This allows employers a myriad scope of opportunities to create and adopt work-family policies that suit them (den Dulk, 2005). Furthermore, the Nigerian Supreme Court, which is the highest of the judicial institutions, has repeatedly ruled that collective agreements are enforceable only when their terms and conditions are incorporated into every employee’s contract of employment (Epie and Ituma, 2014, p. 62).

Organisations in western countries have recorded a high level of success in their adoption and implementation of work-life balance policies; while in Nigeria, only a minute number of organisations have shown an interest in such policies and many others remain indifferent (Epie, 2006, 2010). This resonates with Mordi and Ojo’s (2011) argument that Nigerian employees’ work-life balance policies have received infinitesimal attention compared to their counterparts in western countries. In addition, some have argued that the “absence of government provisions, like infrastructural facilities, stimulates the creation of work-life programmes in organisations” (Poelmans and Caligiuri, 2008, p. 40). In this vein, Fred-Adegbulugbe (2010) argues that the lack of stable and efficient infrastructural facilities is a major barrier affecting work-life balance in Nigeria, portraying the work-life balance outlook in a different format to what is obtainable elsewhere in the world.

According to Epie (2010), working in Nigerian big cities is stressful; traffic problems that keep workers for hours on the road on a daily basis. Fred-Adegbulugbe (2010) cited an example of Lagos city in which traffic is chaotic. Employees leave their homes very early in the morning to beat the bad traffic and will not return home, mostly, until midnight - when all of the members of their households (especially the children) have gone to sleep. Guest (2001) questioned the fast declining quality of the concepts of home and community. Epie (2011, p. 13) also notes that the “face time” attitude which equates physical presence with commitment is still prevalent at all levels of management in Nigeria. Undoubtedly, Nigeria is still far behind in the formulation, adoption, and implementation of work-life balance policies and practices and cannot be compared to countries like the US, the UK or even South Africa (Fred-Adegbulugbe, 2010).

### **2.13 Conclusion**

This chapter provided a critical review of the literature on the subject of work-life balance. The review of various studies revealed two type of flexibility: employer and employee flexibility. Employer flexibility includes tools used by organisations to achieve organisational aims and objectives. On the other hand, employee flexibility (otherwise known as work-life balance) advocates a healthy balance between an employee’s work and nonwork life. There are other terms such as work-family balance, work-life integration and work-life harmonisation. However, work-life balance is a more inclusive term. The literature, most importantly, revealed that the overwhelming majority of all work-life balance studies were carried out in the western countries and only a limited number of literature has been found to be devoted to the African continent. This suggests a need for more empirical studies to be undertaken in an African context to gain insight into employees’ WLB in that part of the world. This study provides a basis for developing a model that extends the knowledge-base on work-life border theory. The next



chapter presents the extant literature on the subject of organisational culture, which will conclude the literature review aspect of this thesis.

## **Chapter Three**

### **Understanding Organisational Culture**

#### **3.0 Introduction**

This chapter presents an exposition of the concept of organisational culture. To understand organisational culture in relation to work-life balance, this chapter reviews literature on the concept of organisational culture in order to establish a context from which to study its relationship with work-life balance practices and policies within an organisation. The previous chapter explored the review of literature on the subject of work-life balance, this chapter, however, completes the discussions by analysing all the important strands of organisational culture. The chapter also examines hospital culture and work-life culture. It is important to note that this chapter, in relation to the three levels of culture, explains the relationship between organisational culture and work-life balance. This is done by explaining the influence of organisational culture on the usage of work-life balance policies and practices. Furthermore, for the purpose of this study, professional culture will be referred to as organisational culture. This is because doctors and nurses regard and adopt their professional culture as their organisational culture.

#### **3.1 Organisational Culture**

The last few decades have witnessed changes around the world in terms of the operation and the internal and external environments of organisations. The reasons for these changes range from globalisation and a change in employees' needs, to the hostile economic downturn that crippled the world's economy, among others. The aftermath of all of these changes drove many organisations to change their functions, HRM strategies and manage their cultural differences and diversity more effectively. Hence, all organisations (whether public or private) must be

adaptive in this rapid changing environment if they aspire to continue their businesses (Fard, Rostamy and Taghiloo, 2009; Karjalainen, 2010). An organisation's culture, which is an essential, influential factor in analysing organisations in different contexts (Dauber, Fink and Yolles, 2012) has been relevant in the survival or death of organisations (Hofstede, 1998).

Organisational culture is a significant driving force of business. It reflects the way tasks are realised, how goals are set and how employees are guided toward achieving organisational goals (Stare, 2011). The study of organisational culture is not a recent phenomenon (Mohanty and Rath, 2012), its origin is traceable to the 1930s (the Hawthorne studies of the Western Electric Company in Chicago, Illinois) (Warner and Low, 1947). Some theorists on organisational culture even believe that the concept of organisational culture has been around as early as 431 BCE. The focus of studying organisational culture, however, is to recognise and move away from the mechanistic perceptions of organisations associated with Fredrick W. Taylor's concept of scientific management known as "Taylorism" (Mannion, 2008). Subsequently, culture within an organisation was explored further in the 1950s and 1960s, mainly at Harvard University and at Britain's Tavistock Institute. During this period, job satisfaction and informal interactions among a small group of factory workers were explored (Jacques, 1951; Roy, 1960). The debate continued until the 1980s, when the likes of Bakers and Hofstede contributed theoretically to the study of organisational culture (Bakers, 1980; Hofstede, 1980). Since then, the concept of organisational culture has become visible and has emerged as one of the themes in organisational research (Mohanty and Rath, 2012). The 1990s was an era in which organisations were in search of organisational excellence and needed to focus on their culture (Jordan, 1994). However, the 21<sup>st</sup> century presents organisational culture practitioners with potential answers for mainstream organisational research (Jung et al., 2009).

Organisational culture remains a significant predictor of organisational effectiveness in organisational studies. Theorists and scholars in social science literature have developed different definitions of organisational culture, and each definition is founded on the proponent's research interest (Ji-Young, Yom and Ruggiero, 2011). However, from a theoretical point of view, organisational culture refers to "a broad and complex part of an organisation that can actively affect and influence organisational members" (Choi and Scott, 2008, p. 34). It can be viewed as the embodiment of the relationship between the employer and employee as influenced and regulated by workplace regulations within the framework of legislation. Hence, organisational culture represents the customary and established way of thinking and doing things and the unique configuration of norms, values, beliefs and ways of behaving (Barney, 1986). This partly resonates with Edgar Schein's definition of organisational culture, even though Schein's approach to organisational culture is more observational and clinical. For Schein, organisational culture means widely shared values and assumptions rooted in an organisation (Schein, 2010).

Ramachandran, Chong and Ismail, (2011) define organisational culture as a pattern of shared values and beliefs that help individuals understand organisation's functions and provide them with the norm for the behaviour in the organisation. This definition follows the work of Deshpande, Farley and Webster, Jr. (1993) who reviewed over a hundred studies on organisational culture. This study has considered more than one definition of organisational culture, because a single definition of organisational culture cannot represent the dynamic characteristics and patterns of culture of many organisations. Note that there is variance in cultural inclinations among organisations. This means that, while some organisations are culturally tied together because they have a shared history or a relevant intense experience, some

have no overarching cultural similitude because they share no history or any such experience (Schein, 2010).

According to Schein, (1985, p. 48), “Whether we are taking the point of view of the total organisation attempting to operate in a complex environment or the point of view of the individual trying to learn to be productive and satisfied in an occupation or organisation...we cannot escape having to analyse at some point the cultural forces involved. Once we demystify the concept of culture and learn to analyse its dynamics, it will aid us enormously in understanding both organisational and individual-level phenomena”. The culture of a group, however, is a pattern of shared basic assumptions learned over a period of time, as that group solves its problems of internal integration and external environment then pass on to new members as the correct and valid way to perceive, think and feel. Similarly, culture as an abstraction creates powerful organisational and social forces. Cultural forces explain phenomena, puzzles and frustrating experiences in social and organisational life (Schein, 1985, 2010). When an organisation has a strong culture, it becomes more efficient than when it has a weak, incongruent and disjointed culture. Organisational culture provides a “framework for using conceptual work to improve organisational effectiveness” (Mohanty and Rath, 2012, p. 65), which implies that, when an organisation has a resilient culture, it becomes more effective (Schein, 2010).

Cultural clashes are an inevitable aspect of organisational life and, most of the time, resolving those rifts and fictions can be tasking and difficult. However, cultural fluency is the application of respect, empathy, flexibility, patience, interest, curiosity, openness, a willingness to suspend judgement, tolerance for ambiguity and a sense of humour in order to resolve clashes among employees (Stanford, 2010). Since cultural clashes are part of organisational life, cultural fluency

is, therefore, the “instrument with which clashes are resolved and dissolved” (Stanford, 2010, p. 154). Organisational culture is a controversial area of study, and it is difficult to change. However, periodic checks and improvement of organisational culture helps in making organisations more competitive and helps in revitalising organisations (Mohanty and Rath, 2012).

### **3.2 Organisational Culture and Organisational Climate**

Over the years, the terms “organisational culture” and “organisational climate” have been used interchangeably and in different ways, notwithstanding the diverse definitions thereof. The terms organisational culture, organisational climate, managerial climate, organisational atmosphere and management culture are, often, accepted as interchangeable terms (Mahal, 2009). The study and usage of the term gained prominence in the 1960s and 1970s (Mahal, 2009). During this period, much research, which triggered several debates and academic discussions, was undertaken on the concept of organisational climate (Guldenmud, 2000).

However, in the 1980s, interest in the term “organisational culture” flourished and eventually replaced the term “organisational climate” in the study of organisational theory (Hale, 2000), making organisational culture “a derivative of organisational climate” (Karassavidou and Glaveli, 2011, p. 221). Organisational climate refers to the perceived quality of an organisation’s internal environment (Oke, 2006). It is a set of lay down perceptions shared by employees who work in the same organisation (Pena-Suarez et al., 2013) in relation to features such as autonomy, trust, cohesiveness, support, recognition, innovation and fairness, people interactions and structural aspects of the organisation (Carlucci and Schiuma, 2012).

The concept of organisational climate, according to Merriam-Webster (2004), has four distinct attributes thought to promote job satisfaction and increase motivation at individual and organisational levels. Organisational climate could be (1) a supportive climate, (2) a climate of risk-taking, (3) a climate of cohesiveness, and (4) a climate with the motivation to achieve. These enable an organisational climate to provide a context for studying organisational behaviour (Pena-Suarez et al., 2013), which enhances the exploration of individual and group behaviour (Asif, 2011). On the other hand, organisational culture describes the attitudes, experiences, beliefs and values of an organisation (Al-Omari, Tineh and Khasawneh, 2013). For Tahilramani (2013), it is a precious asset that money cannot purchase and a decisive factor that can make or break an organisation.

According to Schein (1985, 1992, 2010), organisational culture helps to increase competition, globalisation, mergers, acquisition, alliances and various workforce developments; it improves the efficiency, quality and speed of designing, manufacturing and delivery of products and services. As a comprehensive concept that encompasses belief, ideology, custom, norm, tradition, knowledge and technology, organisational culture is an essential factor that influences the behaviour of an organisation and its members (Park and Kim, 2009). It is important to note that, even though there is a relationship between organisational culture and organisational climate, the two are different concepts (Oke, 2006; Mahal, 2009). While organisational culture sets out organisational norms and expectations regarding how people behave and how things are done within an organisation (Kagaari, 2011), organisational climate reflects “employees perceptions of, and emotional responses to, the characteristics of their work environment” (Khetarpal, 2010, p. 77). Furthermore, both organisational culture and organisational climate are powerful enough to influence attitudes in the workplace (Mahal, 2009). The two concepts deal

with organisations and their variables and appear to be reciprocally related (McMurray, 2003; Karassavidou and Glaveli, 2011).

Organisational climate is seen as an empiricist substitute for organisational culture because organisational climate is viewed as a quantifiable concept whereas organisational culture is qualitative and less tangible. Hence, although organisational culture and climate share several overlapping attributes, the difference between them is not great (McMurray, 2003). It is safe to conclude, therefore, that the organisational culture and organisational climate of an organisation are significant variables powerful which are enough to raise employees' motivation and dictate norms that bind the organisation (Mahal, 2009). Furthermore, recognising organisational culture and climate as “distinct but interlinked and inseparable terms reinforces the fact that culture is not a set of inseparable variables but a series of complex, dynamic, interactive and pervasive ecosystems” (Stanford, 2010, p. 15).

### **3.3 Types of Culture**

Culture has been a vital and viable term to understand human societies and groups for a long time (Schein, 1996). It permeates every aspect of human life and separates humanity from the rest of nature (Whiten et al., 2011). Organisational culture is the amalgamation of values that give rise to behaviour (Chernatony and Cottam, 2008). Over the past three decades, culture has been widely acceptable as a way of understanding human nature, with each aspect of organisational culture as an important environmental condition affecting the system and its subsystem (Ehlers, 2009). Attempts by scholars to categorise different cultures have been beneficial because they provide broad overviews of variations that exist between cultures (Oke, 2006).



Various organisations, public or private, often develop their inherent culture to influence organisational operations (Fard, Rostamy and Taghiloo, 2009). According to Schein (1990), organisational culture comprises two layers: visible and invisible characteristics. The visible layer includes building, clothing, and modes of behaviour, regulations, myths, stories, language and rites, while the invisible layer includes common values, norms, faith and the assumptions of organisational members (Fard, Rostamy and Taghiloo, 2009). According to Hellringel and Slocum (1994), organisational culture can be classified into four different categories: bureaucratic culture, competitive culture, participative culture and learning culture. Bureaucratic culture is characterised by a low level of adaptation to the environment and a low level of internal integration (Hellringel and Slocum, 1994). This culture is inflexible with rigid controls, power and centralised decision-making.

Competitive culture is a culture with a high level of adaptation to the environmental and low level of internal integration. This culture “promotes weak cultural identity and contracts relations between employees and the organisation” (Fard et al., 2009, p. 54). Participative culture has a moderate level of adaptation to the environmental with a high level of internal integration. Participative culture has a tendency for stability, confidence and loyalty of employees and a high level of societal acceptance. Finally, learning culture has a high environmental adaptation and high internal integration. Learning culture is characterised by a complex and sensitive competitive environment. It encourages learning, innovation and creativity (Fard et al., 2009).

Several researchers have also come up with different classifications for organisational culture (Hartmann et al., 2009) such as group culture, entrepreneurial culture, hierarchical culture and rational culture. Hofstede (1991) classified it as follows: process oriented and result oriented culture; employee/job oriented culture, parochial/professional culture, open/closed systems, tight

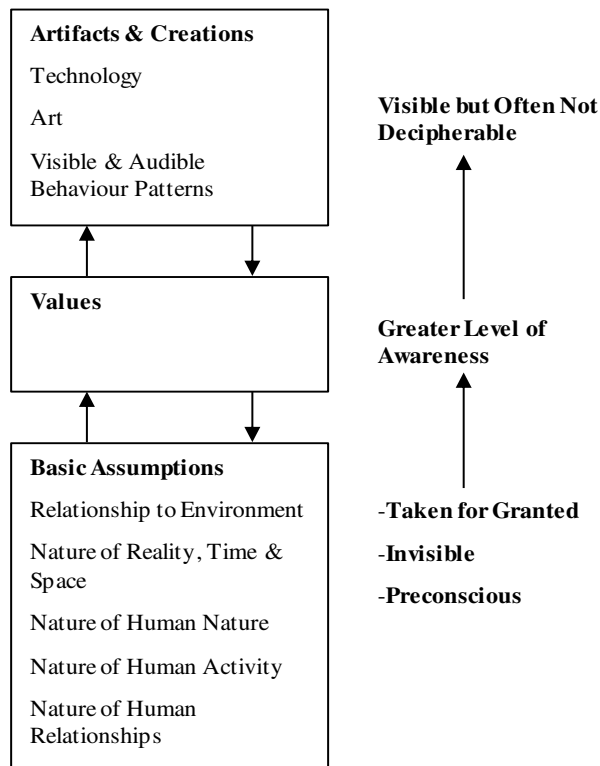
formal control/loss control and normative/pragmatic culture. Mahal (2009) categorised culture into constructive and defensive cultures. Hence, these different classifications reflect the structural views of an organisation and the diverse underlying principles inherent within an organisation (Oke, 2006).

### **3.4 Levels of Culture and their Interactions**

Edgar Schein's model is widely regarded as one of the most well-known conceptualisations of organisational culture (Harris and Ogbonna, 2002). The model is influential in the study of culture as it is one of the few structured and insightful ways to understand organisational phenomenon (Heracleous, 2001). Schein (2010) proposes three fundamental levels at which culture can be analysed. These levels range from the visible, tangible and overt manifestations to the deeply embedded, unconscious and basic assumptions, which Schein described as the essence of culture. The model is not only one of the most cited cultural models in recent times, but it is also a model that serves as a high abstraction and reduces complexity (Dauber, Fink and Yolles, 2012). According to Schein (1984, 2010), the basic underlying assumptions are the core of an organisation's culture, espoused beliefs and values form the next level and artefacts form the surface aspect of the organisational culture. Schein upholds that culture should be scrutinised at the level of deeply held basic assumptions that members of an organisation share (Kong, 2003). He also contends that cultures are historically established structures, stored in the organisational members in an almost unconscious realm, which offer direction and meaning for man's relationships with nature, reality and humans (Schein, 1984, 1985, 1992, 2010). Meanwhile, the artefacts are considered as materialised expressions of the values and basic assumptions (Kong, 2003). Schein (2010), therefore, argues that, unless someone probes into the affairs of an organisation, certain things like the artefacts, values and norms of the organisation will not be

understood. Furthermore, if properly explored, there are elements within basic assumptions that will enlighten the essence of culture.

**Figure 2 The Levels of Culture and their Interactions**



**Adapted From Schein (1984, p. 4)**

Edgar Schein uses three levels of organisational culture, as shown in the diagram above. The first level of culture is “artefacts” which comprises obvious organisational processes and different artefacts (Reiman and Oedewald, 2002). Artefacts are visible, audible, touchable and identifiable in the organisation (Testa and Sipe, 2011). They include “the visible products, such as the building, the physical environment, language, technology, artistic creations, styles, manner of dressing and addressing, myths, the organisation’s published values and observable rituals”

(Schein, 2010, p. 23). Artefacts are easy to spot, but their meanings and interpretations are ambiguous and difficult to understand (Ramachandran et al., 2011).

For instance, when one enters an organisation, one observes and feels its artefacts; but the observer can only describe what he/she sees, feels or hears about the organisation. Only the members of the organisation know the actual meaning of what he or she sees, feels or hears (Schein, 1984, 2010). The interpretation and meaning of the artefacts require practical research and a clear understanding of the internal dynamics of the culture (Frontiera, 2009; Schein, 1990).

Beneath the artefact level are espoused beliefs and values which are conscious strategies, goals and philosophies (Schein, 1985, 2010). Members of the organisation learn collectively and create belief systems (Testa and Sipe, 2011). These are also obvious in an organisation, but they do not always reflect the organisation's ordinary mode of operations (Reiman and Oedewald, 2002). The first stage of this model is visible and audible, but ambiguous and practically meaningless to an outsider. However, the outsider become knowledgeable of the artefacts if a member of the organisation analyses "the espoused values, the norms, and the rules that provide the everyday operating principles" by which the members are guided (Schein, 2010, p. 25).

Most of the time, espoused beliefs and values are non-discussable assumptions supported by articulated sets of beliefs, norms and operating rules of behaviour shared by the members of the organisation (Ramachandran et al., 2011). Espoused beliefs and values are also explicitly articulated, and they are the normative and moral functions of guiding organisational members on how to deal with key occurrences. These beliefs and values are so abstract that they can be contradictory and often leave large areas of behaviour unexplained (Schein, 1985, 1990, 2010). The last level of Schein's model of organisational culture is the primary assumptions. "To

understand the organisational pattern and get a deeper understanding of the artefacts, and the espoused beliefs and values requires a critical understanding of the organisational category of the basic assumptions” (Schein, 2010, p. 27). The basic underlying assumptions refer to the members’ unique solutions to the problems that relate to the organisation’s external adaptation and internal integration. These solutions gradually become stronger and self-evident assumptions that cannot be questioned (Reiman and Oedewald, 2002).

According to Schein, the basic underlying assumptions are not debatable; they are issues which have been taken for granted over the years and shared by every member of the organisation (Schein, 2010; Ramachandran et al., 2011). The basic underlying assumptions are not challengeable and are difficult to change. In fact, “if basic assumptions come to be firmly held in an organisation, members will find behaviour based on any other premise inconceivable” (Schein, 2010, p. 28). Culture at this level provides an organisation’s members with basic identity and defines the values that provide self-esteem (Schultz and Hatch, 2005). Schein’s approach to organisational culture provides a better understanding of why organisations behave in the ways they do (Oke, 2006) and uncovers the underlying structure of reality within an organisation (Kong, 2003).

However, assumptions are taken for granted and they are constructed in such a way that they are neither conscious nor questionable (Fleury, 2009). Schein in “Organisational culture and leadership” (2010), suggests two broad categories of organisational culture at the deepest levels of assumptions. The first category of assumptions includes assumptions about external adaptation issues and assumptions about managing internal integration. Assumptions about external adaptation means the different issues a group encountered that ultimately determine the survival of the group in the environment.

According to Schein, a part of a group environment is enacted in the sense that prior cultural experience predisposes group members to perceive the situation in a particular way and even to control the environment (to a certain degree). Hence, there will be environmental issues, such as weather, natural circumstances, availability of economic resources and political upheavals which are clearly beyond the control of the group and that could determine the fate of the group (Schein, 1984, 2010). Assumptions about managing internal integration refer to the group internal affairs which tend toward the group's growth, operations, creating a common language, defining group boundaries, creating norms of trust, intimacy, friendship and love; defining rewards and methods of punishments and the management of its internal relationships (Schein, 2010).

The second category of assumptions is classified into five dimensions. The first dimension is the organisation's relationship to its environment and the view of itself in relation to its environment. This includes the culture's basic assumptions about the actions of humans regarding their environment and what the culture's basic assumptions about the right and proper forms of human relationships are (Schein, 2010). According to Schein (1985, p. 87), "the organisational counterpart in this core assumption is the group's view of its relationship to its defined and perceived environment within the larger host culture. Does this group see itself as capable of dominating or changing its environment?; Does it assume that it must coexist in and harmonise with its environment by developing its proper niche, or does it assume that it must subjugate itself to its environment and take whatever niche is possible?".

The assumptions about the environment should not only deal with dominance and submission alone but must also consider areas of focus and signs from the environment which have been ignored (Oke, 2006). The next dimension is the nature of reality and truth, which deals with the

question of what is real and how to determine or discover what is real. These assumptions inform members of the group how to determine and interpret information and show them when they have enough of that information. The truth, at this level, may not be shared; hence, members must have a consensus on whose experience to trust (Schein, 1984, 1985). The third dimension is human nature. This assumption is often expressed in terms of how workers and managers are viewed. It queries the group's basic instincts, the inhuman behaviours, whether humans are lazy, anterior pro-organisation (or somewhere in between) self-centred, hardworking and/or committed (Schein, 1985, 2010). This leads to different organisational solutions, stringent control, or empowering management behaviour (Oke, 2006). The "Doing-Orientation" is linked with (a) the assumption that life can be controlled and manipulated, (b) a pragmatic orientation toward reality and (c) a belief in human perfectibility. Schein suggests that the proper thing for people to do is to take control of their environment and their fate. The "Doing-Orientation" focuses on the task, efficiency, and discovery. An organisation driven by this assumption will grow and dominate the market in which it operates (Schein, 2010)

The other aspect is the "Being-Orientation". This correlates closely with the assumption that nature is powerful, and humanity is subservient to it. This orientation is flawed because one cannot influence or dictate to nature, rather we must take whatever situation with which we are presented. According to Schein, "an organisation operating with regards to this orientation looks for a niche in their environment that allows them to survive and they try to adapt to external realities" (Schein, 2010, p. 147). There is also the "Being-in-Becoming Orientation" in between the two aforementioned extremes. This refers to the idea that an individual must achieve harmony with nature and accomplish a perfect union with their environment (Schein, 2010). It underscores the development of all aspects of the self as an integrated whole (Oke, 2006; Schein,

2010). The last dimension of assumptions is the nature of human relationships. All of the previous assumptions deal with the group's relationship with the external environment; however, this assumption deals more with the organisation itself and the internal climate it creates for its members. These assumptions include assumptions about the right way for people to engage with each other, how to distribute power and love, and so on (Schein, 1997, 2010). This model is relevant and useful to this study because of its ability to depict different levels of organisational culture and their interactions with organisational variables and uncover the underlying structure of reality within the organisation (Siew-Huat, 2003). The model also provides the social glue that gives organisations coherence, identity, and direction (Lok, Rhodes and Westwood, 2011).

### **3.5 The Nexus between Organisational Culture and Professional Culture**

Culture is comprised of a multifaceted framework within which individuals and groups function (Helmreich and Merritt, 1998). This attribute of culture applies to both organisational culture and professional culture. It is important to understand the similarity between these two cultures. Just like an organisation, a profession is a group of people who share values, attitudes (Helmreich and Merritt, 1988), norms and assumptions (Schein, 2010) and social ideals and beliefs among its members (Janus and Browning, 2014).

Organisations differ in their components and skills. Some organisations employ different types of professionals, while some organisations are predominantly non-professional in their type and therefore employ few specialist professionals. The number and the importance of professionals working within an organisation will determine how organisational culture and professionalism will affect each other (Bloor and Dawson, 1994). Professional culture is a collective programming of the minds of occupational groups (Herkenhoff, 2010) which specifies the behaviour that is proper and acceptable by each profession (Boyatzis, 1982).



Professional culture dictates not only tasks and social norms at work but also defines the entire work environment, including what makes sense and how things are done in a professional group. Even though professional culture is often classified as subculture of national or organisational culture (Hofstede, 1980; Scott et al., 2003), rather it is strong, distinct and influential (Helmreich and Merritt, 1998) and often overrides organisational culture and becomes dominant. This always happens in organisations dominated by professional employees (Bloor and Dawson, 1994). According to Ott (1989, p. 80), a “culture of organisations dominated by a profession will be partially determined by that professional culture”. However, the professional culture of medicine is an essential part of the medical system (Scott et al., 2003) and strong that it is dominant in health organisation and often regarded as the culture of the organisation (Montgomery et al., 2009; Scott, 2003). The medical profession involves a great deal of professional responsibilities and duties besides the actual role of treating patients (such as professional beliefs, professional rules and regulations, professional ethics, the Hippocratic Oath and societal expectations) which conflate and form their values, beliefs, basic assumptions, shared perceptions and practices upon which the profession’s culture is strongly built.

However, a professional culture is a subculture of organisational culture but it is strong, dominant and often referred to by health professionals as their organisational culture. Furthermore, a study by Bloor and Dawson (1994) suggests that professional culture is similar to organisational culture if it exists within an historical context and professional environment, which shape their operating practices and professional codes, beliefs, values, and ceremonies. Professional culture provides cultural values and practices absorbed into the culture of an organisation. Therefore the relationship between professional culture and organisational culture is not conflicting but rather mutually interwoven. In medicine, however, organisational culture is

a good representation of professional culture. Organisational culture will be treated as synonymous to professional culture in this study.

### **3.6 Hospital Organisational Culture**

Organisational culture is an organisation's operational process and shared values, which represent the norms that guide the attitudes and behaviour of the people within an organisation (Tong et al., 2013). An organisational culture is not a labelled product which tells us all about how it works, nor is it a set of discrete elements that can be easily manipulated (Stanford, 2010). Instead, organisational culture is a pattern of shared basic assumptions learned by members of an organisation, and which has worked well enough to be valid and to be taught to new members as the correct and valid way to perceive, think, and feel (Schein, 2010). However, a hospital is an organisation or a work environment that assembles a group of professionals, each with its own specialised body of knowledge and interests and own values and norms. A hospital's organisational culture is not homogeneous; it is a complex institution with multiple and conflicting goals (Karassavidou and Glaveli, 2011). Hospitals vary in culture (Speroff et al., 2011); they are multicultural organisations with different subcultures within distinct professional and occupational groups, divisions and teams working together (Karassavidou and Glaveli, 2011). This resonates with Morgan and Ogbonna's work, which describes organisational culture as "an amalgamation of many cultures and it is the interactions of these cultures (subcultures) that influence the emerging pattern of values that is commonly described as organisational culture" (Morgan and Ogbonna, 2008, pp. 41-42).

Most literature on organisational culture has not been matched by a parallel assessment of organisational culture in a hospital setting. Limited attention has been paid to the environs of healthcare and how it may influence prominent individuals such as doctors and nurses and even

the organisational outcomes (Rathert, Ishqaidef and May, 2009; Montgomery et al., 2011). Furthermore, hospital culture is woven around patient care, and doctors' training and this requires doctors and nurses to work for longer hours to ensure that patients receive excellent care. Little or no consideration is given to weariness and fallibility that may quickly arise because of tiredness (Gaba and Howard, 2002; Morgan and Ogbonna, 2008; Montgomery et al., 2011). This phenomenon is identified as one factor that makes work and non-work life of health care workers difficult for them to control (Tailby, 2005). Healthy or unhealthy, this study will confirm that working for long hours, and the required constant physical presence in the hospital are strong cultures firmly part of the medical practice in Nigeria. This culture reflects the philosophy prevalent in the Nigerian medical sector and plays a pivotal role in the work-life balance of Nigerian doctors and nurses.

Notably, there is a shift of organisational culture within hospitals from inter-professional models of care to the traditional ethos of being patient-centred (Khokher, Bourgeault and Sainsaulieu, 2009). That is, hospital culture is now centred on patient care and safety rather than on employees' work and non-work lives and obligations and how they manage themselves. Undoubtedly, this has a significant effect on the functionality and effectiveness of doctors and the way they attend to patients (Montgomery et al., 2011). This perhaps explains why increased attention is given to hospital culture as an important determinant of quality of care (Rabbani et al., 2009). The highly demanding nature of providing healthcare services means that work-related stress, burnout and anxiety are at a high level among doctors and nurses as compared with other occupations (Montgomery et al., 2011). The percentage of doctors and nurses who have a high level of work-related stress is remarkably high (Swanson, et al., 1998). Hospitals have, therefore, have been advised to inculcate a culture that will improve the quality of patient

safety and care, and that will also protect the well-being of doctors and nurses who provide this care (Montgomery et al., 2011).

### **3.7 Work-Life Culture**

Work-life balance is a prominent buzzword in today's management practice and theory. The key issues in the increasingly extensive debates and discussions surrounding work-life balance are working hours and work intensification, competitive pressure in the job market, the changing work related and family related values and the increasing focus of women towards their career. However, organisations are expected to have systems in place that will enable employees to work efficiently and integrate their work related obligations and non-work related responsibilities (Kaiser et al., 2011). Work-life balance policies and practices enhance “organisational structural and provide cultural/relational support for employees' work and personal life”. Work-life balance is about helping employees to better manage their work and non-work lives (Kossek, Lewis and Hammer, 2010). With effective work-life balance policies in place, employees can reconcile the demands of work and non-work lives (Lewis and Gruyere, 2011). Furthermore, organisations can implement various work-life balance initiatives that may help employees find a desirable balance between their work related and non-work related responsibilities (Osoian, Lazar and Ratiu, 2011). The success of work-life balance initiatives depends on the prevailing culture of an organisation.

An overwhelming number of scholars agree that organisational culture is a transmitted phenomenon, which comprises of different visible (conscious) and invisible (subconscious) deep cognitive, behavioural and emotional aspects (Sackman, 2006; Martin, 2002). These aspects are responsible for what happens or does not happen in an organisation (Kossek et al., 2005). However, work-life culture often refers to work-family culture in the literature (Holt and

Thaulow, 1996; Thompson, Beauvais and Lyness, 1999). According to Thompson, Beauvais and Lyness (1999, p. 394), “work-family culture is the shared assumptions, beliefs and values regarding the extent to which an organisation supports and values the integration of employees’ work and family lives”. This definition focuses on work and family life and ignores other non-work activities. However, Bond (2004, p. 3) extends this definition to include other non-work life activities by defining work-life culture as “an organisation’s support and valuing of integrating employees” work and non-work lives. The culture of an organisation can inhibit or support WLB practices that will help employees balance their work related and non-work related obligations and reduce work-life conflicts to a microscopic level (Friedman, 1990; Catanzaro, Moore and Marshall, 2010). A work-life culture is developed when employees receive warmth support from their management/supervisors toward managing their work-life responsibilities with fewer career consequences and less time demands (that is less organisation time expectation) (Wu et al., 2011). A supportive work-life culture is connected with employees’ exertion in balancing work and non-work obligations (Foley et al., 2006). Hence, by collecting and analysing data, this study identifies five key factors that could enhance or constrain the use of work-life balance in an organisation. They are organisational culture, management/supervisor support, co-workers support, willingness to cross the border and organisational time expectation. These factors are so important that if they are negatively ingrained in the culture of an organisation, achieving work-life balance in such an organisation will be impossible. The four factors will be adequately dealt with in the next chapter.

### **3.8 Conclusion**

This chapter provided an exposition of organisational culture. To understand this concept and to make sense of the subject under investigation, Schein’s levels of culture and interactions were

thoroughly examined. This provided a better understanding of why organisations behave in the ways they do and uncovered the underlying structure of reality within an organisation. The chapter, however, noted and discussed the relationship between professional and organisational culture and clarified the use of the two terms. Furthermore, the chapter examined hospital culture and work-life culture. The next chapter presents the research framework.

## **Chapter Four**

### **Conceptualising Border Theory**

#### **4.0 Introduction**

This study is guided by border theory. This chapter presents border theory as propounded by Clark (2000) and develops on the theory to realise the fundamental objectives of this study. Note from the start that the term “work-life balance” has replaced the concept of work-family balance and other names (Hudson Resourcing, 2005) which is one of the reasons for the birth of the work-life border control model. The replacement, however, became necessary because the term work-life balance is an all-encompassing and more inclusive term (Murphy and Doherty, 2011). Even though these terms are different in wording and sometimes in usage, yet they are similar in that they all recognise employees’ desires to find a healthier rhythm and a more satisfying balance between their work related and non-work related activities (Chan, 2008). In order to achieve the objectives of this research, work-family border theory is employed to illustrate how employees negotiate between work and non-work domains. Border theory exclusively deals with issues concerning employees’ work and family lives (Clark, 2000; Ashforth, Kreiner and Fugate, 2000). The study also examines various strands of border theory including segmentation and integration, flexibility and characteristics of boundaries. But because this study deals with employees’ work related and nonwork related activities, the study extends border theory to incorporate other non-work related duties and activities equally of great importance to employees (which are excluded in theory). It also expounds various factors/forces that determine employees’ movements across the border. This is done by introducing of work-life border control model

#### **4.1 Historical Evolution of Border Theory**

The historical evolution of border theory can be traced back to Zerubavel (1993, 1996) in his lumping and splitting classification of organisational frames and Nippert-Eng's (1996a, 1996b) work on "Home and Work: Negotiating boundaries Through Everyday life". Some argue that employees are classified into segmentors or integrators (Nippert-Eng, 1996a) and can be, at any point in time, actively engaged in mentally defining the boundaries (Naithani, 2010). Nippert-Eng's (1996a, 1996b) work aligns with Zerubavel's (1993, 1996) lumping and splitting classification of employees. According to Zerubavel (1993, 1996), people use heuristic methods of classification to organise physical and mental constructs by either lumping several categories into a single category or by "splitting" one mental category into distinct, separate entities. Zerubavel argues that lumping and splitting classifications are socially constructed, based on an individual identification process. Berg and Piszczek (2012, p. 3) stated succinctly: "the mental categorisations at the heart of boundary theory are influenced by broader social factors which cause individuals in the same social structures to create similar classification schemas".

Zerubavel (1993, 1996) posits that individuals carve islands of meaning out of reality and potentially form chunks of reality from the world and occurrences around them into classes. The islands of meaning are not part of nature; rather, they are clusters of things which are similar to one another within their circle of classification (Zerubavel, 1991, pp. 70-80). He further suggests that these islands are outcomes of active construction and that the processes of lumping and splitting (which he views from a sociological perspective) are at the heart of border theory (Zerubavel, 1997). He further identified the need for a comparative approach in social classification to identify different classification schemas across thoughts communities (Zerubavel, 1996).



However, Nippert-Eng (1996a, 1996b) broadened the discussion on border theory by applying the notion of cognitive, sociological classification to the work-family interface. In her work “Boundary Work”, she classified employees as segmentors or integrators (Nippert-Eng, 1996a). Segmentation happens “when the border between work and home is impregnable, while integration occurs when work and home are the same” (Nippert-Eng, 1996, pp. 567-568). Warhurst, Eikhof and Haunschild (2008, p. 10) stated logically, but more precisely, as follows: “Segmentors have two key rings...one for work keys, the other for house keys; integrators affix all keys to one key ring”. Nippert-Eng extrapolated border theory beyond a heuristic choice to a strategic choice (Berg and Piszczek, 2012) in which an employee’s boundary management plan includes those principles that he/she uses to organise and separate role demands and expectations into particular spheres (Kossek, Noe and DeMarr, 1999). For Nippert-Eng (1996a, 1996b), employees who prefer and engage themselves in a high overlap between the work and home domains are integrators while those who opt to keep work and home domain distinct are separators. Employees differ in their preferences, which often influence them in either separating or integrating work and family domains (Kossek, Noe and DeMarr, 1999).

It is imperative to understand that the notion of strategy was incorporated into border theory by Nippert-Eng (1996) in her conceptualisation of the border negotiation in which she represents employees as active role players rather than how they feature in the mental lumping and splitting roles. Consistent with Nippert-Eng’s position, mental categories of work and home can be managed by using three tools, namely: internalised cultural images of home and work, socially structural constraints on home and work, and personal practices within situational constraints. However, research has neglected the first two tools and embraced only the third one which

consequently narrows the possibility of understanding why and how employees segment or integrate their mental categorisations of home and work (Berg and Piszczek, 2012).

In the chronological evolvement of border theory, Nippert-Eng in “Home and Work” underscored the importance of Zerubavel’s social classification scheme in developing boundary theory; but, she developed it further. She argues that socio-structural forces act as constraints in boundary negotiation and influence the extent to which an employee is a separator or an integrator. However, even though she believes that employees cognitively construct the work and home domains, yet she maintains that individual thinking is nothing less than the embodiment of group thinking (Nippert-Eng, 1996). Nippert-Eng also stated that boundaries can be different in terms of the size of their conceptual territory and their sizes can change from time to time as employees change in their thinking and behaviours. She identified permeability as essential ease of transition from one mental category to another and as part of boundary model’s structure (Nippert-Eng, 1996, p. 280).

Undoubtedly, Nippert-Eng’s work made a significant step forward in the study of border theory; but her work does not deal with “how socio-structural forces are shaped by domestic institutions at higher and theoretical levels” (Berg and Piszczek, 2012, p. 5). Furthermore, Nippert-Eng’s work focuses mainly on only one aspect of life (home) while life or the non-work domain involves more than just the home (Warhurst, Eikhof and Haunschild, 2008; Osoian, Ratiu and Lazar, 2011). The insightful works of Perry-Jenkins, Repetti and Crouter (2000) and Bianchi and Milkie (2010) show the interrelationship between the work and home domains. They identified the structural factors that facilitate and impede employees’ efforts to integrate their different responsibilities, however, their studies extensively ignored the boundaries that exist between these two domains (Desrochers, Sargent and Hostetler, 2012).

In the same way, Ashforth, Kreiner and Fugate (2000) developed their study on the conceptualisations of characteristics of boundaries, while Clark (2000) propounded work/family theory. Her theory describes employees as border-crossers who travel between work and home domains separated by physical, temporal or psychological borders. This theory developed on the previous border theories on the basis that they did not sufficiently explain, predict or solve problems commonly faced by employees when balancing work and family responsibilities. However, Poelmans, O'Driscoll and Beham (2005) argued that previous border theories did not operate on the assumption that they are universally valid in all environments.

#### **4.2 Border Theory in Context**

The choice of border theory as a conceptual framework for this study is connected with the array of advantages of the theory including its ability to conceptualise work-life balance (Gurney, 2010). In addition, border theory identifies and addresses the constituents of work and family domains, which other theories fail to address (Clark, 2001). Furthermore, border theory clarifies how well employees stay on top of issues that determine stability and permits cognitive distortion of boundaries to create a defensible and subjective sense of balance (Guest, 2001).

The work of early researchers depicts that the work and family spheres are separate entities that operate independently (Pearsons and Bales, 1955). However, research on work and family in the 1970s and 1980s showed that activities in one domain affect the events in the other (Katz and Kahn, 1978). "Spillover theory" hypothesises that emotions and behaviours in one domain would transfer to the other domain. For instance, if an employee has had a frustrating day at work, that employee is more likely to carry the ruinous mood to the home, which will invariably affect the family domain and its members (Staines, 1980). "Compensation theory" postulates an inverse relationship between the domains in that what is lacking in one domain can be made up in the

other. Work may be undemanding but it is compensated for by familial or local community activities outside work (Guess, 2001). “Expansionist theory” postulates that satisfaction in one domain will aid satisfaction in the other domain (Barnett, 1999; Barnett and Hyde, 2001). Other theories include segmentation-integration theory (Nippert-Eng, 1996), instrumental theory (Greenhaus and Powell, 2006), conflict theory (Greenhaus and Beutell, 1985), role theory (Katz and Kahn, 1978) and conservation of resources theory (Grandey and Cropanzano, 1999; Poelmans et al., 2003). All of these theories attest to the fact that the work and non-work domains influence each other in that activities in one sphere affect the other. However, the majority of the theories did not sufficiently explain, predict or solve problems commonly faced by employees when balancing work and family responsibilities (Clark, 2000) and are not valid in all milieus (Poelmans, O’Driscoll and Beham, 2005). To remedy the shortcomings and criticisms of the earlier theories, Clark propounded the work/family border theory. According to Clark (2000), work and family are two asymmetric spheres with a penetrable or permeable boundary between them. Employees are border-crossers who make numerous trips across these two domains on a daily basis (Clark, 2000). For Clark, employees differ in border crossing.

The transition between the two domains may be easy or difficult depending on the similarity of some variables within the two spheres. In the domain in which the language and culture are similar, the change becomes easier. However, for others in which the language and the expected behaviour in the two domains are different, change is expected to be somewhat complicated (Kinnunen et al., 2005). Clark (2000) argues that borders between work and family life are temporal, spatial and psychologically permeable. According to Kalleberg (2008), the recent transformations in work and family life have triggered changes in paid work, and increase nonstandard and flexible work arrangements. These changes have blurred the boundaries that

separate work and family domains and have dramatically altered how the two spheres interact. Hence, work/family theory recognises these changes which traditional role segmentation, spillover and other theories inadequately analysed (Clark, 2000).

### **4.3 Segmentation and Integration**

Segmentation in border theory, suggests that the temporal and physical boundaries that exist between work and family roles help to create separate and distinct domains (Glavin and Schieman, 2011). According to Nippert-Eng (1996), segmentation takes place when the boundary between work and home is impregnable and allows no interference or interrelationship between the domains; one belongs to either work or home (Nippert-Eng, 1996). It implies that there are distinct clarifications and classifications of what belongs in which domain in order keep what belongs to each domain exclusively where it belongs and there is therefore no integration (Warhurst, Eikhof and Haunschild, 2008).

Integration allows for an amalgamation of domains. It means “no distinction exists between what belongs to work or home and where they are engaged” (Nippert-Eng, 1996, p. 567). This means that activities at home and work are fused together; no distinction exists between the two domains. Employees’ perceptions of boundary permeability and flexibility, to a large extent, determine the degree to which they integrate or segment work-life domains (Clark, 2000; Pederson and Lewis, 2012). This assertion is validated by Warhurst et al., (2008, p. 10): “segmentors keep two wall calendars: one at home, the other at work, with no overlapping contents. Integrators maintain just one pocket calendar”. However, the integration-segmentation distinction is “not a dichotomy, but a continuum in border theory” (Desrochers and Sargent, 2004, p. 41).

#### **4.4 Characteristics of Boundaries**

Boundaries are demarcations between work and family domains; they define the mark at which relevant or acceptable behaviours start and end (Clark, 2000). Ashforth (2001, p. 262) defined boundaries as “mental fences used to simplify...the environment”. Boundaries have been cited and used in many disciplines (Duxbury and Smart, 2011) to refer to the physical, emotional, temporal, cognitive and/or relative limit that defines entities as separate from one another (Ashforth, Kreiner and Fugate, 2001, p. 474). It is a gateway into the functions of domains (Mathews and Farrell, 2010, p. 330). A boundary separates domains from each other, but also promotes and or constrains how domains are connected and related (Kreiner et al., 2006).

Boundaries define the perimeters and the ranges of any domains (Kreiner, Hollensbe and Sheep, 2009) and they can become institutionalised to the point that they are hard to alter once they are socially shared (Zerubavel, 1991). This means that, once the activities around boundaries are ritualised among a particular crop of employees, then it becomes almost impossible to change what they have been used to. Any attempt to alter the boundary will bring about so much discomfort and ruckus. Boundaries could be physical, such as workplace or home. Boundaries also could be temporal, which dictate employees’ affairs such as the hours employees spend at work, when work is done and when (if at all) employees may attend to family issues. Psychological boundaries dictate when thinking, emotions and other behaviours are allowed (Clark, 2000, p. 756). Weak boundaries allow for a great deal of permeability and flexibility and facilitate balance between two similar domains, whereas strong borders are impermeable, inflexible and do not allow blending (especially when the domains are different (Kinnunen et al., 2005). Nippert-Eng (1996) and Clark (2000) postulate that work and home boundaries have two main characteristics: flexibility and permeability. Flexibility in this context refers to the

malleability of the boundary between two or more domains or the ability to expand or contract to accommodate the demands of another domain (Desrochers and Sargent, 2004). An employee can take full advantage of flexible working arrangements to attend to familial duty such as collecting children from school (Desrochers, Sargent and Hostetler, 2012). Clark (2000) expounds that the temporal border that separates work and home domains can be said to be highly flexible if individual employees may work at any time they request. The physical border is flexible if individual employees may choose the location in which they work. Similarly, an employee can think about work when they are at home and home when they are at work when the psychological border is flexible. Clark further argues that a highly flexible psychological border allows for a smooth and free flow of ideas, insights and emotions between the two domains of work and non-work. Flexibility answers the questions of where and when a role can be enacted (Sundaramurthy and Kreiner, 2008). “Permeability is the degree to which a position allows an employee to be physically located in the role’s domain but psychologically and/or behaviourally involved in another role (Ashforth, Kreiner and Fugate, 2000, p. 474)”. The permeability of any boundaries determines the extent of integration or segmentation of the content of the bound domains (Kreiner, Hollensbe and Sheep, 2009). An employee who can switch quickly from non-work related responsibilities to deal with work-related issues is considered to have a permeable boundary (Glavin and Schieman, 2011).

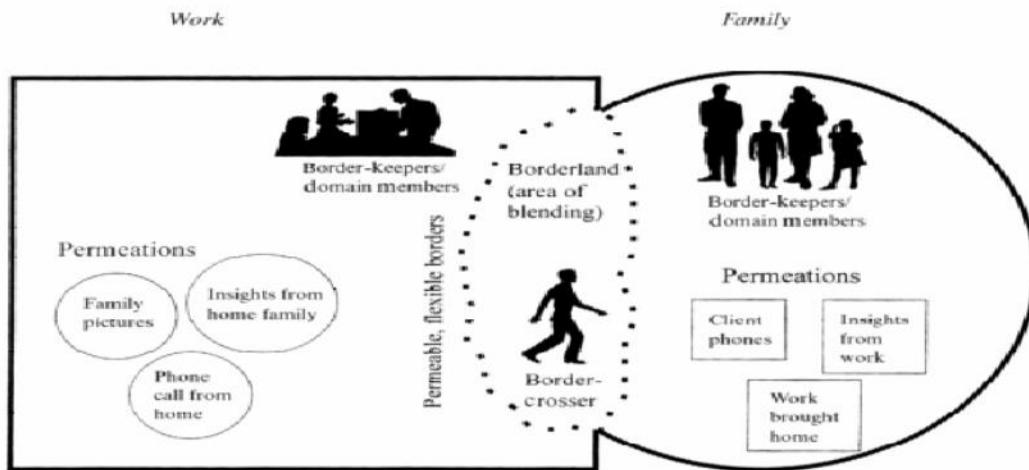
To attain and maintain balance, organisations usually amend domains and borders by introducing different work-family policies such as flex-time, flex-place and personal leave arrangements or by improving the supportiveness of the relationship between border-keepers (such as the relationship between supervisors or line managers and employees) (Kinnunen et al., 2005). However, when borders are modified, and changes eventually occur, organisations must

endeavour to change the domain's culture and values; which, mostly, are very difficult to do. Analogous changes will ensure that employees' workplaces are more flexible (just like their homes) in values and purpose (Clark, 2000). However, in a situation in which organisations provide flexible working arrangements only to suit their interest, disillusionment and unrealised expectations is always the outcome (Regan, 1994). It is therefore logical to state that, if it is not possible for an organisation to change its culture along with the employees' methods of working, then borders should be kept stable in both directions for employees to maintain balance (Clark, 2000; Kinnunen et al., 2005).

According to Clark (2000), interaction between the work and home domains largely depends on the strength of the borders that exist between them. For Clark (2000), blending occurs when there is a free flow of flexibility and permeability around the border. This means that the milieu around the border is no longer exclusive in terms of one particular sphere or the other, but punctiliously blends the two domains; hence this creates a borderland that belongs to neither of the two domains. This is an example of blending in Clark's (2000:757) words: "a man who worked at home selling insurance. He also had two sons in elementary school, one severely disabled pre-schooler and an infant. Though his wife was at home full-time, morning routine required both of their efforts. Blending typically occurred each morning as he began his work taking calls from clients while holding or feeding a child. Blending also occurs in family-run businesses, since family interactions are frequently also work interactions".



**Figure 3 Pictorial Representation of Work/Family Border Theory**



**Adapted from Clark (2000, p. 754).**

The two domains within border theory are work and home. Employees execute activities in these domains at different times and places (Clark, 2001). Border theory argues that the primary relationship between work and family systems is not emotional as previous theories (such as the spillover model, the compensation model, expansionist theory, etc.) claimed, but that it is more human. According to Clark (2000), in border theory, employees are border crossers who make daily and frequent journeys between the two spheres of the work and family domains. These employees dictate and shape the two domains, mould the borders between them and determine the employees' relationship within the two worlds and its members. The theory further posits that employees can shape their milieus just as the environs can also shape the employees; and it is these contradictions of “determining and being determined by these two dominions that make work/life balance a very challenging concept” (Clark, 2000, p. 748). According to Clark, individual employees manage and negotiate between the two spheres and the borders that exist between them in order to attain balance.

However, striking a balance between these two spheres somewhat varies among employees. It depends on their different purposes, statuses and cultures. It means that border-crossers often “modify their focus, goals and interpersonal style to fit the unique needs of each domain” (Clark, 2000, p. 751). As earlier mentioned, the word “balance” in the term work-life balance does not mean that an equal amount of time and energy is given to the different domains; rather, it means a satisfactory equilibrium between the two spheres (Osoian, Lazar and Ratiu, 2011), which often varies among individual employees (Guess, 2001) in differently organisational settings or even within the same organisational context. For instance, some employees may prefer to spend long hours at work, possibly because of the current stage in their career or their marital status as singles means that they have limited responsibilities outside of work. For others, staying longer at work is perceived as an imbalance because of the demands at home. This diversity in terms of what balance means for different employees was responsible for legislative and scholars’ actions to define “balance” more objectively (Guess, 2001).

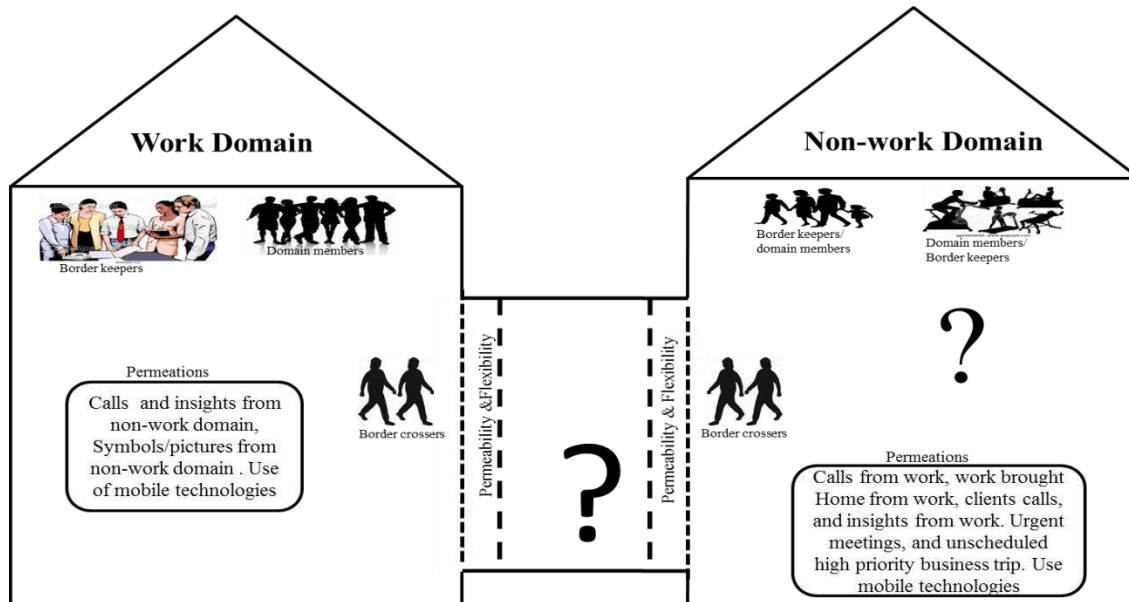
Another important proposition of border theory is that there are central and peripheral participants. These are relevant and important features for border-crossers; they make frequent transitions between work and family domains. This is because it augments their ability to adjust the border and the domains to suit their needs (Lave and Wegner, 1991; Clark, 2000). Kinnunen et al. (2005, p. 92) argue as follows: “the central participants in the domain (i. e. those who have influence in that domain because of their competence, affiliation with central members within the domain and their internalisation of the domain’s culture and values) have a good balance between work and family...the peripheral participants, that is, those who have less influence within the domain because they ignore domain values...and do not interact sufficiently with other central members within the domain (e. g. supervisors in the work domain and spouses in

the home domain)”. Some argue that identifying with membership of the spheres of work and non-work, home is imperative in managing borders and domains. Furthermore, when identification fails to occur or is lost, “employees lose balance, become frustrated, and have strained relationships with other members in the domain” (Clark, 2000, p. 760).

#### **4.5 Work-Life Border Control Model**

All studies on the subject of border theory are about work and home/ family domains (Nippert-Eng, 1996; Ashforth, Kreiner and Fugate, 2000; Clark, 2000). However, as the gale of globalisation and organisational restructuring of the 21<sup>st</sup> century enveloped the world, the non-work domain’s activities ceased to be confined to just home/familial duties. This assertion is further strengthened by the replacement of the term “work-family balance” with “work-life balance”. However, the need to develop a model that incorporates the factors that determine employees’ movements across the border, and all the activities that is important to the employees is, therefore, essential. This study, hence, used qualitative data collected from the Nigeria doctors and nurses to develop and test this model. Developing this model is in line with Ransome’s (2007, p. 374) argument that “it is rather important to use an established theory and concepts as a basis to develop new ones”. The diagram below is a skeletal representation of work-life border control model, showing that something is missing in the border area and the activities that make up the nonwork domain. However, the complete pictorial representation and discussion about the work-life border control model will be presented in the findings section in Chapter Seven.

**Figure 4 Skeletal Representation of Work-life Border Control Model**



#### **4.6 Conclusion**

This chapter presented the theoretical framework that guides this thesis. The novelty of this research is based on work/family border theory, which is the theoretical framework used to examine the interrelationship between work-life balance and organisational culture among Nigerian doctors and nurses. This theory explains how employees negotiate their daily movements across work and family domains. However, the theory failed to recognise that family is by no means the only non-work duty that matters to employees. Work/family border theory also did not expound factors that determine employees' movements across the border. The work-life border control model has been developed to cater for these shortcomings. The work-life border control model recognises every non-work activity that matters to employees and sets out factors that determine employees' movements across the border. This model provides a comprehensive and coherent understanding of a framework under which employees' movements from work to non-work domains can be studied, thus, providing a contribution that is

theoretically appealing for this study and for future studies. The next chapter presents a discussion about the research environment.

## **Chapter Five**

### **Medical Profession in Nigeria**

#### **5.0 Introduction**

This chapter presents a brief history of Nigeria, where this study has been carried out. The chapter further explores the history of medicine and various healthcare plans in Nigeria. Subsequently, the chapter presents the history of nursing in Nigeria, the current state of the Nigerian health sector, the Nigerian labour market and concludes the chapter with the activities of trade unions in Nigeria.

#### **5.1 Nigeria History**

A synopsis of the creation of the country will give a better understanding of the historical background of Nigeria. In 1900, the British government officially assumed full responsibility for the administration of the whole of what is now known as Nigeria from the Niger Company. This company is now known as Unilever Plc. The company is still around today but in a different capacity. However, the British protectorates were gradually established in the territory. In 1914, British colonial masters amalgamated the protectorates into one Nigeria, with its affairs entirely run by them (Falola and Heaton, 2008).

**Figure 5. Map of Nigeria**



**Adapted from CIA FACT BOOK 2015**

Nigeria is a land of many tribes, languages, different views and different people. The country ranges from the southern lowlands to the desert on the edge of the Sahara, through the cattle racing pastures to the mineral hills of the central Plateau down to the coasts and the swamps of the river delta. Nigeria is an area of 923 - 768 sq. km of which 910 - 768 sq. km is land locked and 13-000 sq. km is covered by water (CIA World Fact Book, 2014). In the early 1950s, notable Nigerians such as Jaja Wachuku, Funmilayo Ransome-Kuti, Obafemi Awolowo, Anthony Enahoro, Nnamdi Azikwe, Sir Ahmadu Bello, Sir Abubakar Tafawa Balewa and a host of others began discussions and negotiations with the UK for independence from colonial rule. On 1<sup>st</sup> October 1960, by an Act of the British Parliament, Nigeria became independent. A nation of thirty-five million people was born with three main regions: northern, western, and eastern regions; and Nigeria became an official member of the commonwealth nations (Sowunmi, 2014).

Unfortunately, independence did not halt the sufferings of the nation as the nationalists and the people had hoped. Instead, the ruling elites who assumed positions of authority after the

colonialists left became obsessed with power and eventually turned into rulers rather than leaders. They forgot the noble cause of building a united and prosperous nation and became notoriously corrupted and reckless (Agbibo, 2010). However, the military was watching all of these politicians and their activities from the side, as politicians engaged themselves in murder and brutality. The military became dissatisfied with the ugly situation and seized power from those reckless politicians in January 1966. They claimed that their actions were corrective taken in order to restore security and combat corruption; but, regrettably, they bequeathed to Nigeria a culture of corruption that will take a long time to remedy (Sowunmi, 2014).

In 1967, Nigeria officially dissociated itself from the remnant of the British colonial legacy by introducing the Nigerian Naira (Nigerian official currency) to replace the British pound. However, Nigerians have witnessed a longer period of military rule since its independence in 1960 and this is responsible for the country's economic problems (George, Amujo and Cornelius, 2012). The three years of civil war (which claimed over two million lives and properties worth several billions) of Naira is also a contributory factor to the economic situation. The prolonged military rule of twenty-eight years plays a crucial role in the Nigeria's present situation (Agbibo, 2012). The military government is the worst thing that has ever happened to Nigeria. The military nature of government has clogged and crippled the wheel of growth and development, damaged the rule of law, opened doors to corrupt practices, destroyed the economy and the value of Naira and steadily increased the rate of unemployment. Nigerians welcomed back democracy in 1999, but many Nigerians perceive the 1999-2007 civilian rules as an extension of military rule in another hue (Olorode, 2006).

Prior to the colonial era, Nigerians had a deep-rooted concept of the causes and cures for different illnesses and their management (Stanfield, 1995). Nigerians believed in many



superstitions; for instance, it is believed that enemies can use several forces such as witchcraft or evil spirits to harm a person. In some parts of Nigeria, a man who fights with his wife during planting season provokes the wrath of the god of fertility, which causes barrenness in the land and plagues it with epidemic diseases (Sneader, 2005). In another part of the country, it is thought that twins represent demons that must be killed to salvage the community from total ruin. It took the love and audacity of Mary Slessor, a Scottish missionary, to stop the practice of twin infanticide in Calabar, Nigeria. Epilepsy is considered as a visitation of the gods and it is infectious, while familial diseases are interpreted as a generational curse (Stanfield, 1995). Unfortunately, the Nigerians at that time did not understand the link that exists between the state of health and hygiene, the lack of which leads to microbial infections and organ failure; which is the reason why they sought solutions from odd sources (Sneader, 2005). Many diseases were believed to be spiritual and not amenable to conventional medical treatment; instead, they believed treatment modalities should be herbal preparations or concoctions. Sometimes, incantations were recited to appease or scare off evil forces or animal sacrifices to gods to placate them (Esho, 2006).

Another form of treatment which is believed to be effective by Nigerians is deliverance by the church priest or prayer warriors whereby; the patient is kept in the confinement of the church and individual prayers, fasting and supplications are carried out (Stanfield, 1995). Sometimes, the patient is taken to a flowing river for a special bath after which the individual is adorned in white robes to signify restoration of health and purity. Anecdotal reports suggest that missionaries only used healthcare facilities as tools for winning converts and expanding Christianity (Scott-Emuakpor, 2010). Nevertheless, a resounding tribute is due to the likes of the Roman Catholic Mission, the Church Missionary Society and the American Baptist Mission for bringing modern

medical services to Nigeria (Esho, 2006). The Church Missionary Society opened the first healthcare facility in Nigeria in 1880 in Obosi, then Onitsha and Ibadan in 1886 and Badagry in 1899 (Scott-Emuakpor, 2010). The first hospital in Nigeria was the Sacred Heart Hospital, built by the Roman Catholic Mission in Abeokuta in 1885. All of these hospitals rid Nigerians from all the archaic, non-scientific treatment methods and provided medical treatment based on scientific knowledge to the people.

Most Nigerians still believe that western medical treatments cannot cure certain illnesses (Sneader, 2005). This is because the basic concept of the traditional method is that all illnesses and deaths are caused by enemies, evil spirits or angered gods (Esho, 2006). The Church Missionary Society (CMS) educated the first two Nigerian doctors (Davies and Horton) before they proceeded to King's College London for the remainder of their medical education (Adeloye, 1974). There were 219 hospitals in Nigeria at the time of its independence in 1960; 118 were owned by Christian missionaries 101 were owned by the Nigerian government (Scott-Emuakpor, 2010).

At the turn of the century, however, just like in other African countries such as Gambia, Sierra Leone and Ghana (previously called Gold Coast), Nigerian medical services were controlled by the colonial office in London. They determined the services that were available and provided the workforce (Schram, 1971). However, all of this changed when control of the Nigerian medical service was transferred to the Nigerian regional governments between 1952 and 1954. Each of the regions established their ministries of health, and the Federal Ministry of Health in Lagos still regulates their affairs. The healthcare system, however, has changed over these years. These changes took place in training, management and the treatment of several diseases as well as therapeutic methods (Schram, 1971; Scott-Emuakpor, 2010).

## **5.2 Health Care Plans in Nigeria**

The first healthcare plan in Nigeria was the Colonial Development Plan from 1945 to 1955; this plan was known as the “Decade of Development”. It was designed by the British colonialists to provide healthcare services for the rapidly growing Nigerian population (Chuke, 1988). The second Colonial Development Plan was instituted for the period 1956 - 1962. However, following independence in 1960, the name changed from Colonial Development Plan to National Development Plan. The first National Development Plan was established from 1962 to 1968, the second from 1970 to 1975, the third from 1975 to 1980, the fourth from 1981 to 1985, and Nigeria’s Five Year Strategic Plan from 2004 to 2008 (Scott-Emuakpor, 2010). All of these plans were drafted to provide excellent medical services to Nigerians at all levels; but, unfortunately, the plans’ lofty objectives remained unachieved as hospital facilities and infrastructures were broken beyond repair and the workforce is still not large enough.

Interestingly, successive military governments have cited the poor state of healthcare services as contributing to the reasons for their interventions; but, sadly, the Nigerian Health Sector was not any better during their dictatorial reigns (Scott-Emuakpor, 2010). Today, there are 26 medical schools in Nigeria, and based on data obtained from the Medical and Dental Council of Nigeria, these medical schools produce between 2, 000 and 3, 000 medical doctors annually (MDCN, 2013). It is worth mentioning that the training of nurses in Nigeria began after the establishment of the Nursing Council of Nigeria, with training schools in Lagos, Ibadan, Kano and Aba; and, by 1954, 23 nurses graduated from the Kano school, 40 graduated from the Aba school and 71 graduated from the Ibadan school. Subsequently, there were 65 government nursing and midwifery training schools in Nigeria at the time of independence in 1960 (Scott-Emuakpor, 2010).

The roles played by some reputable international organisations were also of importance in developing the health services in Nigeria. These organisations include The World Bank, United State Agency for International Development (USAID), World Health Organisation (WHO), United Nations Children's Fund (UNICEF) and British Technical Assistance (BTA), among others. USAID and WHO launched a successful programme against smallpox and measles in 1967 and 1968 while UNICEF contributed immensely to projects aimed at controlling malaria and guinea worm. Today, these agencies, in collaboration with the US government and some notable private philanthropic organisations such as the Jimmy Carter Foundations (JCF), the Bill Gates Foundations (BGF), the Bill Clinton Foundations (BCF) and many more have not wavered in their efforts and support for various aspects of the Nigerian Health Sector.

The Nigerian population was approximately 35 million at the time of independence in 1960; it surged to 110 million 30 years thereafter and to nearly 170 million in 2013 (CIA World Fact Book, 2013). Nigeria is the most populous nation in Africa and the seventh most-populated country in the world. At least one out of every five black African is Nigerian (United Nations, 2013). It is, however, disheartening that the population continues to rise yearly without corresponding health facilities and manpower to accommodate the upsurge. Training of the required number of doctors is imperative for the health of millions of Nigerians and the doctors' work-life balance. For instance, it is estimated that there is a required ratio of one doctor for approximately 1, 500 to 2, 000 Nigerians. This means that there should be approximately 500 doctors per 1 million Nigerians (Bowers and Purcell, 1978). Following this calculation, the number of doctors required for the current population of 170 million Nigerians is around 340, 000 as opposed to the 35, 000 that are available, based on the data from the Nigerian Medical and Dental Council.

According to the CIA, World Fact Book (2013), there are 0.395 physicians (doctors) per 1, 000 Nigerians. This represents a massive shortage in the number of doctors available to Nigerians. The limited number of doctors available are given the enormous responsibility of looking after too many patients, which inevitably has a negative impact on their well-being and personal life. Furthermore, the nature of the medical profession, which requires total attention, devotion and concentration by medical practitioners (especially doctors and nurses) in order to fulfil their Hippocratic Oath, is not favourable to work-life balance. A number of academics (Swanson et al., 1998; Powel et al., 2009; Sibert, 2011) have supported this argument. Sibert (2011) argues that the part-time employment option is practicable in other professions but not for doctors. In light of the above discussions, Malu (2010) advises that more medical schools and provision of adequate facilities should be provided in order to meet the required workforce needed for the ever-growing Nigerian population.

### **5.3 Nursing in Nigeria**

Nursing, according to the International Council of Nurses (ICN, 2010), encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or healthy and in all settings. The history of nursing, like that of medicine, is dated to the mid-19<sup>th</sup> century when the “Mother of Professional Nursing”, Lady Florence Nightingale, started working on the battlefield with 38 other nurses and cared for the sick and injured men during the Crimean war in England (Ajibade, 2012). Lady Florence Nightingale was an English social reformer, statistician and the founder of modern nursing (Skretkowicz, 2010). Nursing is a dignified profession which accommodates every individual irrespective of their colour, religion, culture, gender, disability or illness, sexual orientation, nationality, political orientation, race or social status.

Traditionally, nursing used to be a matter for the family whereby mothers usually cared for their families. The year 1880, however, was a turning point for the profession when so many women (including religious leaders) became involved in patient care (Obadiya, 2011). During this period, various nursing training schools sprang up across Europe, with the first one established in 1836 by Parker Theoder Fliedner in Kavesworth Germany (through the influence of Lady Florence Nightingale) (Obadiya, 2011; Egenes, 2008). The first recognised movement and formal registration of nurses took place in 1882, The Royal British Nurses Council of Nurses was established in 1893, the British College of Nursing was founded in 1926 and the International Council of Nurses was established with its headquarters in Geneva, Switzerland and branches all over the world (Obadiya, 2011; Lesa and Dixon, 2007).

In Nigeria, however, the history of nursing can be traced back to the United Free Church of Scotland in Calabar in 1847. Mary Slessor later arrived in nursing the same town in 1876 and played a significant role in nursing which has been influential until the present day (Oguariri and Kabara, 2008). The British colonialists established the first nursing home in Ibadan and nursing spread through the entire country. The school of Nursing in Ibadan was established in 1949 and University College Hospital in Ibadan began training nurses in 1952 (Obadiya, 2011). Also in 1949, the Nursing Council of Nigeria was established to augment the efforts of various training bodies and set a standard for Nigerian nurses. By 1965, University College Hospital in Ibadan commenced degree programmes in nursing (Agbedia, 2012; Obadiya, 2011). The University of Nigeria in Enugu and the University of Ife (now Obafemi Awolowo University) followed suit by offering degrees in nursing in 1973. Currently, almost every state in Nigeria has one or more school of nursing and midwifery (Obadiya, 2011).

More institutions have been granted licence to award degrees in nursing and more private universities are doing the same. Prior to 1981, nursing in Nigeria was a vocation but the Industrial Arbitration Panel (IAP) of 1981 upgraded the status of nursing to a recognisable profession in its own right (Omofuma, 2007). However, nursing as a profession has undergone various changes and reforms over the years, in terms of situation, attitudes and the modes of healthcare delivery (Agbedia, 2012). There are four types of nursing: functional nursing, case nursing, primary care nursing and team nursing. However, care delivery nursing is the most prevalent in the Nigerian healthcare system, while the need to adopt other nursing care approaches has been brought to the fore in order to improve the quality of care (Agbedia, 2012). One of the challenges facing the nursing profession in Nigeria is that of a shortage of workforce (Ajibade, 2012).

According to WHO at the World Health Assembly (2004), most developed countries have approximately 1, 000 nurses per 100,000 people, while many developing countries (including Nigeria) have only 10 nurses per 100,000 citizens or even less (Obadiya, 2011). Obinna (2012) noted that there were only 136,000 registered nurses and midwives in Nigeria. This represents an acute shortage of healthcare workers in 2012. According to Agbedia (2012, p. 227), nursing in Nigeria is yet to recognise that nursing is both a profession and a business, influenced by the concept of supply and demand. While a lot of effort has been invested into the professional aspect of nursing, the business aspect is underestimate. The shortage of nursing teachers in Nigerian universities, reduced wages, condition of services and the lack of flexibility in nurses' working hours have been identified as factors of change that will improve and re-define nursing in Nigeria (Ojo, 2010; Agbedia, 2012).

#### **5.4 The Current State of the Nigeria Health Sector**

The economic development and productivity of any nation has been heavily based on the quality of healthcare available to its citizenry. To this extent, Nigerian economic problems are connected to the deplorable state of its healthcare system. The Nigerian healthcare system comprises the orthodox, the alternative and the traditional system of healthcare delivery (African Health Workforce Observatory (AHWO, 2008). The Nigerian healthcare status is indigent and is improving at a snail's in terms of key healthcare indicators. Nigeria is ranked among the nations with the highest child mortality rates. The Nigerian healthcare sector is characterised by both private and public hospitals with the Medical and Dental Council of Nigeria (MDCN) regulating its affairs. According to Human Resources for Health (HR Fact Sheet, 2010) in the Africa Health Workforce Observatory, Nigeria is one of the largest bases for healthcare workers in Africa with 55, 375 doctors practising in different parts of the country. However, this figure epitomises a drop of water in the ocean; it represents a massive shortage of doctors as over 170 million citizens are waiting for medical treatment.

This human resources crisis led to the formation of the National Human Resources Strategic Plan, which was approved by the National Council of Health (NCH) in 2007. The main objective of this project was to resolve the inequitable distribution and the shortage of medical staff (including doctors and nurses) in Nigeria. It is unfortunate that this plan has not been effective, as the shortage of healthcare workers still prevails. Furthermore, the exodus of Nigerian medical doctors leaving the country to practise in developed countries exacerbates the situation. Career advancement, better conditions of service and improved economic and social situations are the reasons for their departure (Healy and Oikelome, 2007). The rate at which doctors and nurses are migrating from Nigeria to foreign countries is alarming. Highly qualified nurses and doctors



have been involved in emigration to foreign countries (Raufu, 2002). For instance, there are over 8, 000 Nigerian doctors in the US and the UK alone, while only 27,000 are in Nigeria attending to over 170 million people (NMA, 2014; Enabulele, 2013). It is evident from these figures that the Nigerian medical sector is understaffed. The availability of doctors and nurses is far too small in proportion to the population and the few practising doctors and nurses are poorly distributed, mostly located in the urban and southern region of the country (World Health Organisation, 2008). The situation is, however, different in most western nations. For instance, Nigeria has only 600 paediatricians to care for its population of over 40 million children compared with the UK that has over 5, 000 paediatricians for 20 million children (Ovuorie, 2013).

The Nigerian healthcare sector is characterised by regional differences in health status, service delivery and availability of both human and material resources (AHWO, 2008). This dire situation is having a gruelling effect on the few doctors that are practising, as they are overworking themselves to cover for the shortage (Ovuorie, 2013). Furthermore, there is a correlation between the scarcity of doctors and other healthcare workers in Nigeria and the dearth of medical schools and approved schools of nursing and midwifery. For instance, there are only 26 accredited medical schools; 86 approved schools of nursing; 77 approved schools of midwifery; 12 medical laboratory schools, six schools of physiotherapy, five schools of radiography, nine schools of pharmacy, nineteen schools of pharmacy technology and only four schools of dental technology. These figures represent an acute shortage in relation to the Nigerian population of over 170 million and forces pressure on the few qualified doctors and other health workers available in the country.

Undoubtedly, this shortage of doctors and nurses causes the few professionals around to overwork themselves to cover for the shortage, which in turn results in burnout, long working

hours, poor quality of care and sometimes hostility towards colleagues and patients among doctors and nurses (Coker et al., 2012). This perhaps is the reason why the majority of doctors and nurses experience high level of work-life conflict.

### **5.5 The Nigerian Labour Market**

The labour market is a place in which human labour is traded and rewarded and a place in which supply and demand of labour intermingle. The labour-market brings about a systematic relationship between employees and employers (Wilton, 2010). The means of income in the labour market are salaries, wages and self-employed earnings. However, the extent to which an individual or household actively and productively participates in the labour market and how they are remunerated determines the status of both the individual and the household. This means that the outcomes of the labour market play a crucial role in determining the socio-economic status of individuals and households (Ogwumike et al., 2006). The labour market in developing countries such as Nigeria are characterised as having a high unemployment rate and a high level of informal sector employment wherein wages and condition of employment is inadequate and productivity are relatively low (Ogwumike et al., 2006).

However, to correct the imperfections that characterise labour markets, countries around the world (including Nigeria) have been urged to adopt a complex system of laws and institutions related to employment issues (Cok et al., 2009). It is safe to say that the hopeless reality of the current state of the Nigerian labour market, in which even the gainfully employed are hanging on the precipice of uncertainty, was never imagined by those Nigerians who witnessed the boom period of the Nigerian labour market approximately four decades ago (Asabor, 2012). This situation arose due to factors among which “skills mismatching” among Nigerian university graduates is.

According to Petters and Asuquo (2009), most Nigerian students graduated with degrees and certificates that do not match their skills and capabilities. Unemployment then sets in and the country's economy suffers. Oluyomi and Adedeji (2012, p. 90) define a skill as "the ability to perform a task to a pre-defined level of competence". Skills matter for earnings, but only if they are required for a particular job (Desjardins and Rubenson, 2011).

Broadly speaking, skills can be divided into two: transferable or generic skills used across different occupations; while vocational or technical skills are required to work in a particular occupation or occupational group (Oluyomi and Adedeji, 2012). However, "skill mismatch" means a gap or imbalance in skills, knowledge and competencies (Proctor and Dutta, 1995). It is a misallocation between the attributes and competencies of individuals seeking jobs and the qualities and competencies required by employers (Faberman and Mazumder, 2012). Other factors responsible for the capricious volatility in the Nigerian labour market as identified by the National Bureau of Statistics (NBS, 2010) include the three years of civil war in which millions of lives and properties were lost, the 28 years of military rule that destroyed the image and the economy of Nigeria and the tsunami of corruption and mismanagement which has now become the order of the day among the political elites and public office holders. All of these have hindered economic growth and increased the level of unemployment in Nigeria. NBS further attributes the causes of unemployment in Nigeria to include inadequate employment situations on both sectoral and national basis, which would allow for comprehensive and proper planning, policy formulation and design programmes for work.

The Nigerian labour market, just like in other developing countries, the labour market is characterised by heterogeneity and represents one of the sources of risk by which people fall into serious poverty. This is because job security in Nigeria is not guaranteed (Ogwumike et al.,

2006). As pointed out by Ogwumike, Adubi and Agba (2002), people who already have a job and those with no adequate skills are at risk if labour market shocks occur. According to Ogwumike et al. (2006) and the Nigerian Manpower Board (NMB, 1998), the self-employed and those in employment dominate the Nigerian labour market. The labour force stands at 53.83 million out of which 70% in agriculture; 10% work in the manufacturing sector while the remaining 20% is allocated to the service sector (CIA World Fact Book, 2014). The Nigerian unemployment rate stood at 23.9% in 2011 according to the CIA World Fact Book (2011).

### **5.6 Trade Union's Activities in the Nigerian Labour Market**

Okoroafor (1990) describes the Nigerian labour market as a composite market, which has a multitude of markets. The Nigerian labour market is dualistic, with formal and informal sectors. The formal sector composes salaried jobs in both the private and public sectors, while the informal sector comprises the urban, rural and intermediate sectors (Okigbo, 1991). The Nigerian labour market is relatively institutional. Government policies, unions and employers are often substituted for the traditional actions of the market forces as the significant factors in wage movements (Okoroafor, 1990). Furthermore, the market is “*market specific*” (that is, it is regional), highly immobile and politically focused (Okigbo, 1991). These features have caused perpetual disequilibrium in the Nigerian labour market (Okigbo, 1991; Aminu, 2010). However, the restoration of equilibrium in the Nigerian labour market is sluggish and precipitated by an increase in urban wages and a parallel rise in urban unemployment. This means that an increase in labour demand upsurges urban salaries and is likely to encourage migration, which worsens urban unemployment (Owioduokit, Adamgbe and Buno, 2009). Successive Nigerian governments since 1987 have channelled their efforts towards deregulation of the Nigerian markets and economy (Owioduokit, 2008). Deregulating a country's economy is tantamount to

privatisation, divestiture or marketization of the economy, which has no government involvement but rather allows for private participation in the country's economic activities (Godwin and Dagogo, 2011).

Furthermore, features of deregulation include an introduction of the market economy, increasing economic efficiency, the establishment of democracy and political freedom and increasing government revenue (Dhaji and Milanovic, 1991). Gbosi (1996, p. 46) argues that "deregulation does not mean a lack of control; rather it means a calculated process of removal or mitigation of restrictions that are obstacles that tend to reduce efficiency or competitive equities". Deregulation of the Nigerian economy since 1986 has pauperised a large percentage of the country's population (Godwin and Dagogo, 2011), even though the available data shows that the Nigerian unemployment rate has fallen marginally under deregulation as opposed to under regulation (Onwioduokit, Adamgbe and Buno, 2009).

It is important to note the contribution of various trade and labour unions toward the growth and sustenance of the Nigerian economy (Okolie, 2010). The history of trade unions in Nigeria can be traced back to the Trade Union Movement of 1912, when civil servants under the colonial government organised themselves into workers' representatives. This later metamorphosed into the Nigerian Civil Service Union, which subsequently became the platform on which workers in other sectors argued for the formation of trade unions before and after independence. Following the formation of trade unions, over 1, 000 other mushroom unions sprang up. The Nigerian military government of the late General Murtala Mohammed in 1977 commissioned a panel of inquiry into the formation of the trade unions and structured the policy of the unions. The end of 1977 saw the amalgamation of all unions into 42 unions. The Nigerian Labour Congress (NLC)

was formed and inaugurated in 1978, with all of the 42 unions under its umbrella with the legal backing of the Trade Union (Amendment) Decree 22 of 1978.

The 42 affiliated unions were reduced to 29 unions in 1989 and were still under the umbrella of the NLC. The creation of the NLC strengthened the bargaining power of the unions, but salaries and wages are still low and calls for pay rises often required strike action. The Nigerian Labour Act 1971 regulates the terms and conditions of employment, but wages come under the National Minimum Wage Act, the National Salaries and Wages Commission Decree, the Wages Board and the Industrial Council Act. Section 13(1) states that daily working hours are to be fixed by mutual agreement or by collective bargaining. Section 13(3) allows employees whose working hours are longer than six hours in one day to have a break of no less than one hour in total. In the same manner, Section 13(7) states that there must be one day of rest in a week while Section 18 allows employees working continually for twelve months an annual leave of at least six working days. In addition, women are entitled to twelve-week' maternity leave with no less than half pay (Epie, 2009). The Nigerian Employers' Consultative Association (NECA) is the central organisation of employers in the private sector. This association was founded to create organisations parallel to the industrial trade unions. Hence, NECA protects their members' interests, provides training services and information to its members and helps in developing HRM strategies. All trade unions in Nigeria have strived to ensure a standard culture in the labour market. They have engaged in a series of struggles with the government to negotiate better conditions of employment for Nigerian workers and resolve industrial disputes. Despite their efforts, there is still some structuring required among the trade unions operating in Nigeria (Okolie, 2010).

## **5.7 Conclusion**

Nigeria is the research context for this study. This chapter provided a brief history of Nigeria and the history of medicine in Nigeria. The chapter presented various healthcare plans that have been implanted in Nigeria and the important roles played by various reputable international organisations in developing healthcare services in Nigeria. The chapter noted the economic capacity of Nigeria as the biggest economy in Africa and one of the major oil-producing nations in the world, which has been not been felt in terms of the poor quality healthcare available to its citizens. The chapter also presented the Nigerian labour market and the activities of the labour unions. The chapter discussed various issues relevant to the research context, Nigeria. The next chapter presents the research methodology.

## **Chapter Six**

### **Research Methodology**

#### **6.0 Introduction**

This chapter presents the reflexive account of the research method. It clarifies the methodological approach that underpins this exploratory study and why such method has been chosen. The purpose of this study is to examine the relationship between work-life balance and organisational culture for medical doctors and nurses in Nigeria. After clarifying the research objectives, it is pertinent to decide on the research design (Blaikie, 2000). Research design is the blueprint for fulfilling the research objectives by answering the research questions. It guides the researcher in the sundry stages of the research (Cooper and Schindler, 2006; Frankfort-Nachmias and Nachmias, 2008) and provides a framework for the collection and analysis of data (Cameron and Price, 2009).

To achieve the research objective, this study adopts a qualitative approach. Face-to-face, semi-structured interviews were carried out among 62 medical doctors (32 male and 30 female) and 29 nurses (all female) at different times and places. Names of the hospitals have been written as pseudonyms wherever they appear throughout this study in order to fulfil the promise of confidentiality made with the management of the hospitals. The justification for the qualitative approach is that it builds understanding of how participants make sense of and decipher things; it appreciates context rather than controls it; it exploits human potential to analyse and interpret; and provides accurate, comprehensive and descriptive foundations. This chapter also addresses the practicalities in conducting this research and all the issues that emerged during the fieldwork process.



## **6.1 Research Design**

Research design has been described as the science and art of planning procedures for conducting studies in order to obtain the most valid findings. It provides the researcher with “a detailed plan that helps guide and focus individual research work” (Collis and Hussey, 2009, p. 111). The classic research design consists of four components: (a) comparison, which underlies the concepts of co-variation and correlation. It allows the researcher to express co-variation and it is required to demonstrate that two variables are correlated (b) manipulation, which helps the researcher in establishing the time order of events; (c) control, which enables the researcher to determine that the observed co-variation is non spurious; (d) generalisation, which is the extent to which the research findings can be applied to larger populations and different settings (Frankfort-Nachmias and Nachmias, 2008).

Management research is fast-becoming complex and is demanding new techniques for examining research problems, analysing data and explaining and clarifying social phenomena. Several researchers are concerned about the choice between quantitative and qualitative research methodology (Sobh and Perry, 2006; Jogulu and Pansiri, 2011). However, after due consideration of the research inquiry and the research’s cultural and organisational contexts, this study has employed the traditional qualitative research methodology, although, with a minute strand of quantitative analysis (such as tables and calculations in percentages). The use of the qualitative method in this study also includes the use of case study. This is necessary for both exploratory and explanatory properties in the study (Yin, 1984; Eisenhardt, 1989). The dominance of quantitative dichotomy in management studies has remained understandably the unquestioned method for exploring social and behavioural sciences since the twentieth century. Conversely, qualitative research methods launched themselves and attracted interest from

researchers in the mid to late 20th century as an alternative approach to the quantitative methods (Jogulu and Pansiri, 2011). The qualitative research method, however, did not gain momentum in some disciplines (such as psychology) until the 1980s and 1990s (Allwood, 2012).

## **6.2 Qualitative Research Method**

The qualitative research method has received overwhelming attention over the past decade in the disciplinary sub-fields that make-up management research (Johnson, et al., 2007; Devers, 2011). It has permeated all aspects of the management research field, ranging from the softer areas such as organisational analysis (Cassell and Symon, 2004), to the most quantitative areas of accounting and finance (Cassell et al., 2006). Qualitative research is often described as being in contrast to the quantitative research method, which dominates the body of scientific work undertaken in social sciences, including business analysis (Eriksson and Kovalainen, 2008). Hence, qualitative research can be considered a research strategy that usually emphasises words rather than numeric quantification in the collection and analysis of data (Bryman and Bell, 2011).

According to Hanson, Balmer and Giardino (2011, p. 375) “qualitative research draws on data in the form of words, images and observations, recorded as a written note, photographs, audiotapes, videotapes or drawings, which lend themselves to rich, thorough and detailed descriptions of complex behaviours, processes, relationships, settings and system”. This approach includes multiple methods (Sinkovics, Penz and Ghauri, 2008) and is characterised by the collection and analysis of textual data. Such data includes surveys, interviews, focus groups, conversational analysis, participant observation, ethnographies, case studies and by its emphasis on the context within which the study takes place (Olds, Moskal and Miller, 2005; Borrego, Douglas and Amelink, 2009).

The crucial rationales behind the use of qualitative research method are that: this method sets out to build understanding of how participants make sense of and decipher things; it appreciates context rather than controls it; it exploits human potential to analyse and interpret and provides accurate, comprehensive and descriptive foundations. Thus, it can provide rich insights into issues that are of great importance and this will benefit both management practitioners and researchers (Cassell, 2009). In addition, qualitative research is concerned with life as it is lived, activities as they unfold and situations as they occur in the day-to-day activities (Bryman and Bell, 2011). The philosophical framework, however, that usually informs qualitative research includes: (a) ethnography, which is the study of culture and the people who live in that culture; (b) phenomenology, which seeks to understand the meaning of someone's experience; and (c) grounded theory, which builds theory in a relatively unstudied area (Hanson et al., 2011, p. 376).

The choice and appropriateness of the qualitative research method as the methodological design for this thesis aligns with Eriksson and Kovalainen (2008). They claim that researchers are attracted to research problems that are compatible with the view of understanding the world around them and that they tend to choose and defend the methodology they are more familiar with on the platform of their prior knowledge. Qualitative research rarely follows a rigid and tightly woven plan, rather it sanctions inquiry into selected issues in great depth with careful attention to detail, and allows for flexibility in terms of data collection and analysis (Oke, 2006; Erikson and Kovalainen, 2008). For this study, semi-structured face-to-face interviews were used to collect data. The practicalities of the interview process will be explained in detail later in this chapter.

### **6.3 Interviews**

The popularity of interviews in qualitative research is overwhelming. Such an interview takes the form of an organised discourse arranged into a series of questions and answers. Traditionally, interviewer initiates the talk by asking questions, while the interviewee responds by providing answers (Eriksson and Kovalainen, 2008). In other words, interviews are purposeful discussions between two or more people (Saunders, Lewis and Thornhill, 2007) which are sought after in the relevant field of studies and ethnographic research (Qu and Dumay, 2011). Interviews are tools commonly employed to probe interviewees' notions, perceptions, attitudes, experiences and honest feelings about a particular topic or subject (Zhang and Wildemuth, 2009). Conducting interviews is, however, a demanding task, as it requires not only the use of various skills (such as intensive listening and judicious note taking) but also careful planning and sufficient preparation (Qu and Dumay, 2011).

The greatest value of interviews resides in the depth of detailed information that can be obtained there from. The interviewer can also record the situation and conditions of the meeting, and quickly come up with additional questions and obtain supplemental information through observation (Cameron and Price, 2009; Blumberg, Cooper and Schindler, 2011). It is fair to state that interviews are research vehicles (Eriksson and Kovalainen, 2008) that can produce incredibly rich and illuminating data with a natural process akin to having a conversation. The flexibility of the use of interviews allows for selection of venue wherein the interview can be conducted. Additionally, the interviewer can increase or reduce the participation rate by explaining the project and its value.

However, to obtain the interviewee's attention and cooperation, the interviewer must ensure that the interview is conducted in a conducive and relaxed environment (Hair Jr. et al., 2011).

Interviews are interactional processes, which could either be personal, face-to-face, in a group or by telephone (Cachia and Millward, 2011). Even though face-to-face semi-structured interviews are time-consuming and expensive, this study used personal interviews to uncover new clues and secure clearer, inclusive accounts based on reality and personal experience (Bryman and Burgess, 1994, 1999). Subsequently, telephone interviews were later used to cover research questions that later erupted in data analysis to make sure that the study would fulfil its objectives.

#### **6.4 Semi-Structured Interviews**

The use of interviews is a qualitative research method whereby the researcher or the interviewer is interested “in collecting facts, or gaining insights into or understanding of opinions, attitudes, experiences, processes, behaviours, or predictions of the interviewees” (Rowley, 2012, p. 261). However, based on the degree of structuring, interviews can be divided into three categories: structured interviews; unstructured interviews and semi-structured interviews (Fontana and Frey, 2005). Structured interviews are sometimes referred to as standardised interviews (Bryman and Bell, 2007). Such an interview would be a meeting wherein the interviewer would maintain and adhere to the pre-planned scripts which leaves room for little flexibility in the wording or structure of the questions (Eriksson and Kovalainen, 2008; Frankfort-Nachmias and Nachmias, 2008). All respondents would be asked the same questions with exactly the same wording (Blumberg et al., 2011). In an unstructured interview, the interviewer would suggest the question but leave it open to the respondents to discuss freely. The interviewer paradoxically has the free will to influence the questions (Cameron and Price, 2009).

The semi-structured interview lies in between structured and unstructured interviews and is widely used in business research (Cameron and Price, 2009). The process of semi-structured interviews “is flexible, accessible, intelligible and capable of disclosing relevant and often

hidden facts of human and organisational behaviour” (Qu and Dumay, 2011, p. 246). Semi-structured interviews are also called guided interviews because they usually start with specific questions but allow the participants to follow their thoughts (Blumberg et al., 2011). In a semi-structured interview, the interviewer has questions in the general form of an interview schedule, but is allowed to change the wording and the sequence of the interview questions (Bryman and Bell, 2007; Eriksson and Kovalainen, 2008; Bryman, 2012). This means that the researcher has before him a list of themes and questions to be covered and he may omit or even remove questions in the interview, as he deem necessary, to facilitate exploration of issues (Bryman and Bell, 2007; Eriksson and Kovalainen, 2008). The order of questions may vary depending on the flow of the conversation while additional questions may also be asked for deeper and better exploration of the subject (Saunders et al., 2007). Semi-structured interviews are often the most effective means of gathering information (Kvale and Brinkmann, 2009), because they have their basis in human conversations and enable the interviewees to provide responses conveniently in their terms. Both the interviewer and the interviewee participates in the process of the interview, producing questions and answers through a discourse of complex interpersonal conversation (Qu and Dumay, 2011).

### **6.5 Telephone Interviews**

Telephone is a widely accepted means of everyday communication in today’s business and corporate world. This medium of communication is less recognised in qualitative research as a means of data collection (Cachia and Millward, 2011). There is evidence that data obtained through telephone interviews is no less valid compared with data gathered from face-to-face structured, unstructured or semi-structured interviews (Smith, 2005; Glogowska, Young and Lockyer, 2011). This survey method has been recognised as an efficient and remarkable method

of obtaining data as far back as the 1960s (Simon, 1969). It has been reported that the number of telephone interviews, globally, has increased to about ninety percent (Ibsen and Ballweg, 2003). This represents significant usage of telephone interviews, and that such interviews assume a greater role as a method to obtaining data (Oke, 2006).

The widespread usage of telephone interviews has captured social researchers' attention as a new way of data collection. For Cachia and Millward (2011, p. 266), the use of semi-structured telephone interviews in qualitative data collection provides good quality textual data on a par with what would be obtained using a face-to-face interview. However, some researchers have argued that the time allowed for telephone interviews are shorter than face-to-face interviews (De Vaus, 1991; Wilson, Roe and Wright, 1998). In this study, all respondents were happy to relate their experiences and perceptions about the subject with no eagerness to terminate the call. The shortest telephone interview was 30 minutes. The notional time of 20 minutes set for every interview was exceeded. One of the interviews even lasted for an hour 32 two minutes, as the female respondent was enthusiastic to share her experience as she had worked in more than six hospitals across the country.

## **6.6 Data Collection and Analysis**

Data was obtained from both primary and secondary sources. The primary data was collected from medical doctors and nurses across the six geopolitical zones of Nigeria. Face-to-face, semi-structured interviews were carried out among 62 medical doctors (32 male, 30 female) and 29 nurses respectively at different places and times. Consent forms were presented at the start of every interview stating the purpose of the study and the benefits of participating in the interview. Participants were informed of their right to participate or not to participate and that they could end their participation at any stage of the interview process. Participants requested that their

names and the names of their workplaces should be kept anonymous and the researcher obliged to their requests.

The semi-structured face-to-face interviews were conducted at different paces and times. Most female doctors fixed times and venues conducive for them for the interviews and further flexibility in terms of the times and places of meetings were agreed upon and arranged to avoid attrition. Thankfully, an astonishing 91 respondents (62 doctors, 29 nurses) happily to shared their experienced of present and past issues concerning the research topic in their individual hospitals and personal lives. This resonates with Scott's (1997) argument that interviews help researchers to gain access to past events and what has changed over the years to run the organisation successfully. All the interviews were audio-taped with the permission of the respondents to capture the respondents' words verbatim. More so, the audiotapes help to identify what might have been missed out during the interview so that supplementary interviews could be conducted where relevant. The researcher also made observations or field note to provide a written account of what the researcher experienced, thought, heard and saw during the interviews and this therefore allowed for more details and depth to the study findings (Downes and Koekemoer, 2011). The observation notes and the tapes were carefully stored to ensure that data was not exposed to any form of exploitation (Burns and Grove, 1997; Creswell, 2007). Afterwards, the researcher personally transcribed the audio-taped voices and started the analysis. After the transcription, the researcher meticulously went back from the beginning of the recording and followed through every word to make sure the transcribed version exactly matched the audio-taped version. The researcher solely conducted the data collection and analysis without the support of a research assistant.



After a narrative summary for the interviews had been drafted, open coding (the identification of key points and objectives that seemed to be significant to the data) was applied (Boeije, 2005). At this stage, the emphasis was on the researcher's ability to question the meaning of particular words or phrases and to think carefully about their meaning and interpretations (Corbin and Strauss, 2008). The researcher then grouped the first set of codes into categories according to their common codes. 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 steps in data analysis from Corbin and Strauss (2008). Emerging themes from the data became the categories for analysis (prearranged enigmas were verified twice to ensure reliability) and investigator triangulation (Polit and Beck, 2004) was applied. To increase the reliability of the data, disconfirming evidence through purposive sampling was applied in order to offer a rival interpretation with cases that did not fit the researcher's interpretations.

Telephone interviews were conducted, at a later stage, with 10 medical doctors (five male, five female), and five nurses making a total of 62 medical doctors: 32 male, 30 female, and 29 nurses. The telephone interviews were conducted in order to cover research questions that later erupted in the data analysis to ensure that the study fulfils its objectives. The telephone interview technique was a success, as the researcher used the contacts of doctor and nurses he had in his research diary. These contacts were collected during the face-to-face semi-structured interviews. The telephone interviews lasted between 30 and 35 minutes, exceeding the 20 minutes notional time limit set for telephone interview. The telephone interviews, just like the face-to-face, semi-

structured interviews, were also recorded for clarity and in order to capture every single word verbatim.

In addition to the above, this study used secondary sources such as academic articles and journals, internet sources, newspapers and institutional documents. Likewise, information from the Nigerian Medical Association (NMA), the Medical and Dental Council of Nigeria (MDCN), the World Health Organisation (WHO), National Association of Nurses and Midwifery of Nigeria (NANMN) and the Central Intelligence Agency (CIA) was used. During the data analysis, however, the researcher read all the field notes to keep well-informed of all the contextual cues and clues.

### **6.7 Selection of Respondents**

Considering the myriad scope of the Nigerian health sector in which this study was carried out, selection of respondents needed to be undertaken carefully to capture the essence of the study. Therefore, stakeholder theory was adopted in selecting those that were interviewed. Stakeholders are groups or individuals who can affect, or are affected by, the strategic outcomes of an organisation (Jones and Wicks, 1999). The choice to use stakeholder theory was based on the fact that “stakeholders may reveal sensitive or private information about the organisation provided it will not be used to damage or disrepute the organisation’s interests and image” (Harrison, Bosse and Phillips, 2012, p. 151). Apart from the fact that stakeholder theory helps to identify key stakeholders in an organisation, the use of stakeholder theory and analysis thereof also helps to understand the relationship between behavioural patterns of organisations and the interest of some stakeholders (Husillos and Alvarez-Gil, 2008). Stakeholders of an organisation include its employees, managers, customers, suppliers and the company’s owners (this may be an individual(s), management, shareholders or partners) (Harrison et al., 2012). All of these groups

form an important part of the organisation (Reid, 2011). They can significantly influence or are crucial to the success of the organisation (Alpaslan, Green and Mitroff, 2009). The key stakeholders considered for this study are medical doctors and nurses. The government is the employer of doctors and nurses working in public or government hospitals. These hospitals are also known as University Teaching Hospitals (UTH) while private individuals are the employers of doctors and nurses working in private hospitals). Stakeholders also include trade unions and patients. Patients were not interviewed, but the heads of the trade union and their members were interviewed.

## **6.8 Reflexivity**

In social science, reflexivity is the concept used to explore and deal with the relationship between the researcher and the object under their study (Brannick and Coghlan, 2006). Reflexivity methodology is obscure and vague (Goldthorpe, 2000) and it requires the researcher to be conscious, critical and detailed during the enquiry process (Dupuis, 1999). This involvement includes deliberate and logical “self-meditation” (Dupuis, 1999). However, reflexivity suggests a complexification of thought and experience, or thinking about experience. It is related to reflection, but it is substantially more than a reflection. This implies that reflexivity brings about change in reflection through questioning the basis of the researcher interpretations (Hibbert, Coupland and MacIntosh, 2010).

For Ryan and Golden (2006), reflexivity involves honesty and openness about how, where and by whom the data was collected and treats the researcher as a participant in the dynamic interrelationship of the research process. This resonates with DeSouza’s (2004, p. 474) position on reflexivity that “reflexivity can be used in varying contexts and with different aims, to enhance the credibility and rigour of the research process as well as make transparent the

personality of the research”. The theoretical understanding of reflexivity is at the centre of a well-planned and properly executed research, because reflexivity helps the researcher to lighten up and reproduce closely what they see and know during the research process (Lloyd, 2009). Etherington (2004) posits that reflexivity provides the researcher with information about the contexts in which data was collected and also increases the researcher’s capacity to become involved in the experience under investigation (Hardy, Phillips and Clegg, 2001). Reflexivity is necessary for the researcher to recognise himself or herself and those involved in the research (Jones, Torres and Arminio, 2006).

Regarding this research, the researcher was careful in analysis and reflection, which are the two main characteristics of reflexive research (Alvesson and Skoldberg, 2000). Reflexivity was maintained throughout the data interpretation and analysis stage. Manthner and Doncet (2003) stress the importance of being reflexive in interpreting and analysing data. Fox, Martin, and Green, (2007) argue that reflexivity is part of the data dissemination process which helps the researcher to correctly understand the topic or issue under study and situate the research appropriately.

## **6.9 Reliability and Validity**

Reliability refers to the consistent measure of a concept (Bryman, 2012). It is the “extent to which, a measuring instrument contains variable errors, errors that appear inconsistently between observations” (Frankfort-Nachmias and Nachmias, 2008, p. 154). In other words, it means that reliability is when you or another researcher uses your evidence and obtains the same results (Maylor and Blackmon, 2005; Cameron and Price, 2009). It is the extent to which data collection techniques or analysis procedures will yield consistent findings (Saunders, Lewis and Thornhill, 2007). Reliability is concerned with consistency of measures (Bryman and Bell, 2011). If

measurement results are not reliable, it ultimately becomes difficult to test the hypothesis/hypotheses or to make reliable inferences about the relationships between variables (Ihantola and Kihn, 2011). Furthermore, “the best way of testing reliability is by replicating the same questions to the same respondent at different times and assessing correlation” (Gill and Johnson, 2010, p. 143).

Some have argued that there are four major threats to reliability. The first one is subject or participant error. It is the responsibility of the researcher to find the appropriate and more neutral time when the respondents are on high or low moments. The second threat is subject or participant bias wherein interviewees say what they feel their bosses would like or want them to say (Robson, 2002). Similarly, the third threat is observer error, this is common because of the structural weakness of the interview. However, the researcher could lessen this threat to reliability by introducing a strong structure in the interview schedule. The fourth and the last threat to reliability is observer bias, which occurs because of the various possible ways of interpreting replies (Robson, 2002).

Validity refers to the certainty and authenticity of the findings of the study, whether they are true and certain or not (Frankfort-Nachmias and Nachmias, 2008). “True” means that the research findings accurately reflect the situation and are “certain” in the sense that the research findings are supported by the evidence (Guion, Diehl and McDonald, 2011). In short, validity is based on how accurate the researcher has conducted their research (Maylor and Blackmon, 2005, p. 158; Cameron and Price, 2009). According to Bryman and Bell (2011, p. 42), validity “is the most important criterion of research. It is concerned with the integrity of the conclusions that are generated from the research”. There are different types of validity. Measurement or construct

validity deals with whether or not a measure devised for a concept reflects the concept intended to be represented (Bryman and Bell, 2011).

Internal validity is a crucial evaluation criterion for all deductive research. It is “the extent that the researcher can be confident that the designated causes have produced the observed effects” (Gill and Johnson, 2010, p. 77). Internal validity is concerned with whether the conclusion that incorporates causal relationship between two or more variables holds ground (Bryman and Bell, 2011). External validity is the extent to which the research findings can be generalised beyond the immediate sample of people from whom data has been collected (Gill and Johnson, 2010). This means results have external validity if the results can be generalised beyond the particular research context (Bryman and Bell, 2011; Ihantola and Kihn, 2011). Ecological validity is concerned with whether or not social scientific findings apply to people’s every day and natural social environments (Bryman and Bell, 2011).

For this study, however, triangulation was used to compare data to establish whether there is corroboration between the different sources used (Wiersma and Jurs, 2005). Triangulation is a process whereby a researcher employs more than one research method to investigate the same phenomenon (Grix, 2004). In triangulation, the researcher compared all the data collected from various sources to determine the similarities and/ or differences among them. Triangulation helps to overcome limitations of interview methods and enhances the validity and accuracy of the research findings and conclusions (Johnson and Duberley, 2000; Saunders, Lewis, and Thornhill, 2007). The triangulation table for this study is presented in Appendix 2.

## **6.10 Ethical Issues**

The reason for ethical considerations in social science research is to ensure that participants' interests and image are safeguarded (Hollway and Jeferson, 2000). The ethical problems involved in qualitative research are different and subtle compared to that of quantitative study. Virtually all hospitals (public and private) have ethical guidelines which must be strictly adhered to. All of them requested to know the purpose of the study, any possible encroachments on privacy, confidentiality, safety and moral issues, and so on (Flinders and Mills, 1993; Robson, 2002). The researcher asked the hospital management for its consent and the consent of its individual members and provided them with the purpose of the study and their rights to participate or not to and informed them of their right to withdraw at any stage of the interview with no problems. This resonates with Neuman's (2003) proposition that participants must give their consent and the researcher must inform them of their right to withdraw from the research at any stage of the process. This research conforms and complies with all of the appropriate ethical regulations, both at Brunel University and on the research field. Approval was sought from Brunel University's research ethical committee and approval was granted. This ensures that this research was conducted in an ethical manner. The ethical approval is presented in Appendix D.

## **6.11 Conclusion**

The aim of this chapter was to demonstrate the research methods used to collect and analyse data for this study. The qualitative research approach was deemed best to answer the research questions. The choice of qualitative research approach was based on the fact that qualitative research is concerned with life as it is lived, activities as they unfold and situations as they occur in the day-to-day course of life. However, 62 medical doctors (32 male, 30 female) and 29 nurses in the six geo-political zones across Nigeria were interviewed. This was done to ensure a fair

representation for the study. The interview was semi-structured, which allowed the researcher to change the wording and the sequence of the interview questions. Catch-up telephone interviews were also conducted to cover research questions that later emerged in data analysis to ensure the study fulfils its objectives. Data was coded and analysed using data-driven thematic analysis with no assistance of any computer programmes and ethical procedures were duly followed. The results of the 91 interviews are presented in the following chapters.



## Chapter Seven

### Research Findings and Analysis

#### 7.0 Introduction

This chapter presents the research findings and their analysis. The findings are presented in two parts. The first part presents the demographic profile of the respondents (Table 1), showing different demographic characteristics of the respondents. It also shows the number of hours worked by doctors and nurses (Tables 2 and 3). The second part provides empirical analytical details from the interviews, focusing on the research questions in order to achieve the main research objectives.

#### Survey Results: Demographic Details of Doctors and Nurses

**Table1. Demographic Profile of the Respondents**

Demographic Profile of doctors and nurses			
S.NO.	Demographics	Frequency	Percentage
1	<b>Gender</b>		
	Female	59	65%
	Male	32	35%
2	<b>Age categories</b>		
	30-40	44	48%
	40-50	35	38%
	Above 50 Years	12	13%
3	<b>Marital Status</b>		
	Divorced	20	22%
	Married	44	48%
	Single	22	24%
	Widowed	5	5%
4	<b>Years in Service</b>		
	0-5	31	34%
	6 - 10	50	55%
	Above 10 Years	10	11%
5	<b>Number of children</b>		
	0-3	23	25%
	3-4	58	64%
	Above 4 Children	10	11%
6	<b>Other care receivers</b>		
	1	47	52%
	2	40	44%
	3	4	4%
	<b>Expertise</b>		
7	Doctors	62	68%
	Nurses	29	32%

**Table 2 Doctors Working Hours and Shift Schedule**

Hospitals	No. of Doctors	No. of Doctors on long hours	No. of Doctors on shift schedule	0-50hrs per week	51-60hrs per week	61-70 hrs per week	71-80 hrs per week	81-90 hrs per week	91-100 hrs per week	100 hrs & above/ week
Government Hospitals	35 (56%)	35 (56%)	35 (56%)	0	0	3 (8%)	6 (17%)	8 (23%)	9 (26%)	9 (26%)
Private Hospitals	27 (44%)	27 (44%)	27 (44%)	0	0	0	5 (19%)	5 (19%)	9 (33%)	8 (29%)

**Source: Researcher's Finding 2014**

**Table 3 Nurses Working Hours and Shift Schedule**

Hospitals	No. of Nurses	No. of Nurses on long hours	No. of Nurses on shift schedule	0-50hrs per week	51-60hrs per week	61-70 hrs per week	71-80 hrs per week	81-90 hrs per week	91-100 hrs per week	100 hrs & above/ week
Government Hospitals	17 (59%)	17 (59%)	17 (59%)	0	0	0	2 (12%)	4 (24%)	6 (36%)	5 (28%)
Private Hospitals	12 (41%)	12 (41%)	12 (41%)	0	0	0	2 (17%)	4 (33%)	2 (17%)	4 (33%)

**Source: Researcher's Finding 2014**

The evidence in Table 1 shows the demographic characteristics of the respondents. The table reveals that the sample is formed of 69% female and 31% male respondents (doctors and nurses). 23% of the respondents are divorced, 54% are married; 18% are single while 5% are widowed. The table also shows the respondents' years in service, age categories, the number of their children and other people who receive care from them beside their children. Table 2 and Table 3 show the respondents' various places of work (government or private hospitals) and the respondents' work patterns, including the number of hours worked per week. Table 2 reveals that 56% of the sampled doctors work in University Teaching Hospitals (UTHs) or government hospitals, while 44% work in private hospitals. According to Table 3, 59% of the sampled nurses work in UTHs or government hospitals and 41% work in private hospitals. The sample of doctors comprises both male and female doctors. While the sample of nurses is 100% female. The reason for this is that nursing is traditionally believed to be a feminine profession in Nigeria,

a result of which makes male nurses rare. The data from Table 1 shows that the total number of the respondents who have less than five years working experience is 33%; 54% have up to ten years working experience and 13% have over ten years working experience. The data from Table 2 shows that all doctors work long hours and shift schedules every week. 55% of doctors spend over 100 hours at work every week, 59% work between 91–100 hours per week, 42% work between 81-90 hours per week, 36% work between 71-80 hours per week, while only 8% of doctors work between 61–70 hours per week. The evidence from Table 3 also shows that of 61% nurses spend over 100 hours at work every week, 53% work between 91–100 hours per week, 57% work between 81-90 hours per week, while 29% of the sample of nurses work between 71-80 hours per week. It is noted that such long hours undertaken by medical doctors in Nigeria is in sharp contrast to the UK and EU policy which provides that doctors may not work above 48 hours in one week (Bamford and Bamford 2008; British Medical Association News 2007).

### 7.1 Interview Results: The Notions of Work-Life Balance among Nigerian Doctors and Nurses

**Table 4 Respondents’ Notion of Work-Life Balance**

Respondents	Time for work only	Time for work and family duties	Time for work and religious activities	Time for work and social activities	Time for work, studies, recreational and other activities
Male Doctors	0%	87%	71%	64%	81%
Female Doctors	0%	96%	97%	87%	73%
Nurses	0%	94%	96%	77%	59%

**Source: Researcher’s Finding 2014**

This strand of analysis presents the perceptions of work-life balance among Nigerian doctors and nurses. The majority of doctors and nurses interviewed described their notion of work-life balance as engaging in their daily paid work and having ample time to attend to their numerous non-work activities. This study found there are five main non-work related activities of great importance to Nigerian doctors and nurses. They include familial duties, religious activities,

social activities (such as attending naming ceremony, house warming parties, weddings, burial ceremonies and other social functions), recreational activities and studying to advance their careers. When employees were asked to identify activities that are critical to them aside from their work in order of importance, all respondents ticked over three boxes with familial duties as their most important non-work related duties. Some identified the religious option as their number one priority. No doctor or nurse chose only one option. They all chose over three options, including familial and religious duties. This simply means that Nigerian doctors and nurses' value attending to their religious and familial duties just as much as they love and want to progress in their careers. It is evident from Table 4 that no respondent understood work-life balance as meaning just having time for work only. Respondents placed significant emphasis onto other activities (as outline above), depending on individual choice and interest at the heart of their understanding of work-life balance. Table 4 is the cumulative response of the respondents about their perceptions of work-life balance. The following statements typify their shared views.

*Work-life balance, to me, means the ability to do my work and attend to my religious activities and my family duties, most especially my children's needs and necessities...Unfortunately the very demanding nature of my work has grossly reduced my attendance at church activities and it is also affecting my parental duties to my children and other members of the family (Neurologist, Duke Hospital).*

*I would define work-life balance to mean work, having time for my family and engaging with my church activities because I am also a pastor. So, no matter what time I finish my daily work, I must also attend services (Paediatrician, Fox Teaching Hospital).*

Another respondent said.

*I will define work-life balance as the ability to work and attend to my religious, family, and recreational duties...and to have time to look after my aged*

*parents... If I can go to work and attend to all these activities, and do my weekend part-time study then I will have a balanced work and non-work life (Immunologist, Dim Hospital).*

All respondents highly prioritised religion and their duties to their family. A general practitioner at Clear UTH said:

*My family is everything to me; even though I have other paramount non-work activities, my family is the only reason why I work. I would say work-life balance is all about having time to take care of my husband, children and elderly parents...and then attend to other activities like religious and social functions.*

A nurse at Dore Hospital stated:

*Personally, I will define work-family balance as working and attending to my children and religious duties...attending to non-work activities is a problem for most nurses... we do not have enough time.*

Other respondents shared their notions of work-life balance as follows:

*Work-life balance for me is when I work and do other things outside work including my part-time study and weekend religious events...my work-life is balanced if I can fulfil these duties and obligations (Nurse, State Hospital).*

*I am a sociable person who loves to socialise...I also like to engage in my religious functions and activities and spend quality time with my family, including my mum. As long as I can do all these, my work-life is balanced, and that is my definition of work-life balance (Nurse, York UTH).*

*Work-life balance is about working and having time to go to mosque with my Muslim mates. For instance, on Friday I go for the Jumat congregational prayer. This is a Muslim dominated city, so you do not expect to find any Muslim doctors or nurses between 12pm and 2pm on Friday (Gynaecologist, Goth Hospital).*

The above statements show Nigerian doctors and nurses' understanding of work-life balance.

They value their non-work life, which comprises many activities, just as much as they value their

work. The above statements resonate with Parkes and Langford's (2008) definition that work-life balance is the employees' ability to negotiate successfully their work and family commitments and other non-work related responsibilities and activities. The whole essence of work-life balance, according to Pillinger (2001), is to fine-tune employees' work schedules so they, regardless of their age, gender, or race, can find a balance between their paid work and other non-work related responsibilities without a struggle. The majority of the respondents appeared to be religious individuals who considered their religious activities as part of their non-work lives that must be balanced with their work-life. This is in line with Dean's (2007) argument that achieving balance between religion/spiritual life and work life is now an important matter for employees so that they may derive solace and satisfaction from their work. In addition, Onuoha (2005) asserts that religion shapes the majority of an individual's way of life so that no matter what their profession is, they still want to fulfil their religious obligations.

In the same manner, employees have always attached great importance to creating a healthy balance between their work and family lives. Nigeria is a collectivist society, in which familial ties are very strong and the family acts as social security to protect its members (Mordi et al., 2013; Adisa, Mordi and Mordi, 2014). Similarly, the form of welfare system seen in many developed countries such as in the UK does not exist in Nigeria; the elderly are looked after by their children while they (the children) also engaged in full-time work (Ituma et al., 2011; Jackson, 2004). Despite this, familial commitments and duties are ranked as important among employees (Mordi, Mmih and Ojo, 2013). The above excerpts from the respondents resonate with several studies that highlight the importance of both work related and family related responsibilities (Jackson, 2004; Greenhaus and Foley, 2007). The excerpts are also in line with several studies that conclude that achieving a balance between one's social and work life is of

great importance to employees (Human Kinetics Research, 2010; Maertz and Boyar, 2011). However, the highly demanding nature of the medical profession does not give doctors and nurses enough time to attend to their non-work related activities.

A heavy workload under "non-typical" work schedules means that they have less time and energy available for family and other non-work related activities (Swanson, Power and Simpson, 1998). The foregoing excerpts revealed that Nigerian doctors and nurses include having time to look after their parents in their perceptions of work-life balance. Nigeria has no well-developed or well-managed social welfare and healthcare system that cares for the elderly. Therefore, care of senior citizens and disabled persons (which is considered part of familial duties) is part of the Nigerian workers' non-work related duties and responsibilities (Mordi, Mmieh and Ojo, 2013). Undoubtedly, the complexity of combining paid work and various non-work related activities poses many challenges to doctors and nurses' work-life balance. This study shows that their notions of work-life balance are doing their professional jobs and having sufficient time to attend to their various non-work related activities (including religious, social and recreational activities) (Boyar, Maertz and Keough, 2003). Furthermore, both doctors and nurses assert that their work and non-work lives will be balanced if they are able to attend to activities in the two spheres of living.

## **7.2 The Range and Usage of Work-Life Balance Policies and Practices in the Nigerian Health Sector**

The reconciliation or harmonisation of paid work and non-work related responsibilities is desirable for individuals, organisations, businesses, government and families (Poelmans and Caligiuri, 2008). Every stakeholder is working towards achieving balance between these two most important aspects of human life. For instance, organisations around the work keep

promoting and providing work-life balance policies that will help employees achieve balance between their work and non-work life. Governments also contemplate on work-family/work-life balance policies and practices that will help workers to realise the desirable work-life balance (European Foundation for the Improvement of Living and Working Conditions, 2001; British Medical Journal, 2003; Bamford and Bamford, 2008). Work-life balance policies and practices are, however, designed to help harmonise employees' highly demanding work related and non-work related responsibilities (Raiden and Caven, 2011).

Table 4 below displays various work-life balance policies and practices. These include part-time working, family medical leave, maternity leave, parental leave, casual leave, on-site childcare, emergency childcare, backup adult and elder care, school holiday cover, an on-site work-family expert, nanny share, reduced working hours, compressed working hours, annualised hours, telework, crèche and career breaks, and some of these are available for Nigerian doctors and nurses. The table further reveals that Nigerian doctors and nurses are oblivious of several work-life balance policies which would enable them to achieve and maintain a healthy balance between their work related and non-work related commitments.

### **7.2.1 Awareness, Availability and Uptake of Respondents about Work-Life Balance Policies and Practices**

One of the key objectives of this study is to assess the range and scope of work-life balance initiatives in the Nigerian health sector (specifically for Nigerian medical doctors and nurses). The emphasis is on awareness of work-life balance policies and the availability and usage thereof by doctors and nurses. Awareness in this study is defined as the accuracy of doctors and nurses' knowledge about work-life balance policies. If doctors and nurses fully and accurately know of work-life balance policies available in their hospitals, then the awareness is high and vice versa



(Singh, 2010). Availability is the actual existence of work-life balance policies in the interviewed doctors and nurses' hospitals. Uptake is the respondents' genuine usage of work-life balance policies available in their organisations. Table 5 reports the responses of Nigerian doctors and nurses regarding the awareness, availability and usage of work-life balance policies in their various workplaces. As presented in Table 5, doctors and nurses completed 100% affirmative responses of awareness, availability and uptake of 27 work-life balance policies. The following work-life balance policies are less well-known in the medical field. They include: part-time working hours, parental leave, paternity leave, on-site child care, emergency childcare, backup adult and elderly care, school holiday cover, an on-site work-life balance expert, nanny share, reduced working hours, compressed working hours, annualised hours, teleworking, career breaks, term time working, flexitime scheme, working from home, cultural/religious leave and staggered working hours.

**Table 5 Work-Life Balance Policies Awareness, Availability, and Uptake**

WLB Policies	Awareness among doctors.		Awareness among nurses		Availability among doctors		Availability among nurses		Uptake among doctors		Uptake among nurses	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
Full time	100	-	100	-	100	-	100	-	100	-	100	-
Part time	80.0	20.0	76.4	23.6	1.9	98.1	2.2	97.8	-	100	-	100
Family medical leave	-	95	-	98.4	-	100	-	100	-	-	-	-
Maternity leave	100	-	100	-	100	-	100	-	100	-	100	-
Paternity leave	-	100	-	100	-	100	-	100	-	100	-	100
Casual leave	98.2	-	94.0	-	23.0	77.0	21.8	78.2	15.0	85.0	17.0	83.0
On-site childcare	45	55	58.2	41.8	-	100	-	100	-	100	-	100
Emergency childcare	-	100	-	100	-	100	-	100	-	100	-	100
Backup adult & elder care	-	100	-	100	-	100	-	100	-	100	-	100
School holiday cover	-	100	-	100	-	100	-	100	-	100	-	100
On-site WLB expert	-	100	-	100	-	100	-	100	-	100	-	100
Nanny share	-	100	-	100	-	100	-	100	-	100	-	100
Reduced working hours	-	100	-	100	-	100	-	100	-	100	-	100
Compressed working hrs.	-	100	-	100	-	100	-	100	-	100	-	100
Annualised hours	-	100	-	100	-	100	-	100	-	100	-	100
Teleworking	-	100	-	100	-	100	-	100	-	100	-	100
Crèche	88.0	12.0	97.0	3.0	-	100	-	100	-	100	-	100
Career break	82.0	18.0	85.5	14.5	-	100	-	100	-	100	-	100
Term time working	-	100	-	100	-	100	-	100	-	100	-	100
Sabbatical leave	-	100	-	100	-	100	-	100	-	100	-	100
Flexi-time schemes	-	100	-	100	-	100	-	100	-	100	-	100
Study leave	97.1	2.9	95.7	4.3	68.5	31.5	47.0	53.0	58	42	39	61
Shift swapping	-	100	-	100	-	100	-	100	-	100	-	100
Self-rostering	-	100	-	100	-	100	-	100	-	100	-	100
Working from home	-	100	-	100	-	100	-	100	-	100	-	100
Cultural/Religious leave	-	100	-	100	-	100	-	100	-	100	-	100
Staggered working hours	-	100	-	100	-	100	-	100	-	100	-	100

**Source: Researcher's Findings 2014**

Table 5 reveals that the number of unavailable work-life balance policies is more than outnumbered the available policies, which means that several work-life balance policies are not available in the Nigeria healthcare sector. The objectives of this segment of the findings are to find out the awareness, availability and uptake of work-life balance policies among the respondents. Table 5 above shows different work-life balance policies divided into two (leave arrangements and flexible working arrangements) for purposes of this study. Leave arrangements include maternity and paternity leave, casual leave, family leave, study leave, annual leave and cultural/religious leave. The following quotations mirror the reality of various leave

arrangements in relation to the awareness, availability and usage of work-life balance policies among Nigerian medical doctors and nurses.

*I know about maternity leave, casual leave, maybe sick leave, and everybody here is on full-time. Aside from these ones, I am sure I have never come across every other one on this list (Doctor, Hic Hospital).*

*In Nigeria maternity leave, maybe bereavement leave (depending on the relationship), study and casual leave (also depending on management) and normal annual leave are the few work-life policies we have here in our hospitals, every other one on the list, I am afraid, does not exist here in Nigeria (Senior Surgeon, Unik Hospital).*

*Aside from annual leave, maternity leave, sick leave, study leave, casual leave and bereavement leave, we have no other work-life policies operating here. The on-site crèche we have was organised by our union when a lot of us were losing our jobs because of pressure from work and managing our children...Nigeria might get there but not yet (Doctor, Vase Hospital).*

Other respondents said:

*I have requested for a week's sick leave for the past one week because I am not well. The head of my unit declined my request for the reason that there is nobody to cover my shift...look (he showed me some pills) I am using them to keep going. It is difficult here to grant your leave application (Nurse, Flex Hospital).*

*The majority of the policies on this list do not exist here and even the few available ones are not easily accessible due to shortage of nurses...this is a medical profession, we only have basic ones like annual leave, casual leave, maternity leave and maybe two other ones (Nurse, York UTH).*

This findings shows that quite several leave arrangements are not available to the Nigerian medical doctors and nurses, and even the few available ones are not easily accessible. This make work-life balance among the Nigerian doctors and nurses very difficult to achieve. The following quotations reflect the representativeness of sundry flexible working arrangements in relation to the Nigerian doctors and nurses' awareness, availability, and usage of these various work-life balance policies.

*Several of these work-life policies you mentioned are new to me, I am only familiar with two or three and I believe so do other doctors in this hospital. I have never heard of something like annualised hours, job sharing, flexi-time sharing, compressed working hours and others on the list, I am hearing them now for the first time...flexible working arrangements really do not exist here (Nurse, JMK Hospital).*

*There are some work-life balance policies that cannot be brought into medicine. How can a doctor or a nurse telework? Can you feel a patient's temperature via television? Alternatively, can a nurse administer an injection to a patient via this medium? The answer is no. Maybe in other professions in management, marketing and all that; but not medicine, and not in Nigeria (Doctor, Metro UTH).*

*Flexible working arrangements? In medicine? No, not available. Or maybe I should say I don't know if they are available. We do not know what policies are available to us...and most of the time the policies are not accessible...should those policies you mentioned be available, I personally would use them; in fact, my work-life balance problems would be, like, 90% solved (Nurse, Fox UTH) (This respondent's view also represents over 60% of other respondents' views).*

*For me, really, certain work-life balance policies cannot work here in Nigeria. Doctors and/or nurses cannot telework, and even if they want to do it where is the electricity that they will use? Work from home, self-rostering, telework, term work...how can all these be achieved in medicine? I have never heard of most of those policies (Doctor, Tab Hospital).*

*Nursing work and duties require nurses to be present in the hospital at all times. You cannot work from home; neither can you telework...Aside from the fact those policies are not available here, I do not even know how they can be practised in medicine (Nurse, Duke Hospital).*

It is clear from the above statements that most work-life balance policies are not available in the Nigerian healthcare sector. Respondents are only familiar with a few leave arrangements and are oblivious to several flexible work arrangements. Surprisingly, an overwhelming majority only heard for the first time the work-life balance policies in Table 5 during the interviews. Respondents also commented about the incompatibility of most of the work-life balance policies with the medical profession. They believe that work-life balance policies such as working from home, teleworking, flexi-time schemes, and self-roistering cannot be achieved in medicine, at least in Nigeria. Ultimately, these findings reveal that the majority of the respondents are

oblivious of WLB policies that are available to them and the few available policies are not easily accessible due to a shortage of staff. The results from the interviews leave no doubt about the fact that employees' awareness about work-life balance policies and practices in the Nigerian medical sector is low. According to Singh (2010), if employees precisely identify with the availability of the work-life balance policies in their organisation, then their awareness is said to be high; but when they are not, their awareness of work-life balance policies is low. Grainger and Holt (2005) argue that a lack of awareness of work-life balance policies available in an organisation can hinder employees' ability to achieve a healthy work-life balance. Likewise, several studies have argued that the more informed employees are of their organisation's work-life balance policies, the more loyal, committed and productive they become (Grover and Crooker, 1995; Thompson, Beauvais and Lyness, 1999; Rhodes and Eisenberger, 2002).

However, respondents voiced their concerns about various leave arrangements and emphasised a pressing need for an overhauling of maternity leave in the healthcare sector. The following statements typify their shared views and opinions:

*My experience covers both private and government hospitals across the country. Maternity leave in the government hospitals used to be three months but it was increased to four months about two years ago - on full pay, though. However, a few weeks' extension could only be granted on a special occasion...It is three months in private hospitals without extension. This is way too small for female doctors, as most of us struggle to cope with resuming work that early...an extension of maternity leave to at least six months will do us a lot of good on and off the job, trust me (Doctor, Fix Hospital).*

*Three-months' maternity leave is just too small for nurses...this is why lots of nurses do not come back to their jobs after giving birth, most especially nurses in private hospitals...I think it should be extended for our benefit and the benefit of the patients (Nurse, Zia Hospital)*

*There is an urgent need to raise maternity leave to at least six months for doctors...they don't feel strong to come back to work with the current four months' (government hospitals) or three months' (private hospitals) maternity*

*leave arrangements. We look after the nation's health, the nation should also endeavour to look after us too (Doctor, Vale Hospital).*

*Maternity leave for nurses is very pathetic...it's even worse if you work in a private hospital where your leave entitlement is three months on half pay with no extension, no matter what. I just came back last week from maternity leave...I don't feel ready and strong at all...it will be good for me and my work if I have, like, two months more off work...We need the authorities to come to our aid (Nurse, Hart Hospital).*

The above statements reflect the true state of the maternity leave policies in the Nigerian medical sector. The majority (94%) of respondents (female) complained about the meagre maternity leave and male respondents expressed their desire for paternity leave. A respondent said:

*I cannot believe we still don't have paternity leave in the Nigerian medical sector. It is a shame, when countries like South Africa, Tanzania, Gabon and Cote d'Ivoire have joined the elite of nations that offers their male workforce leave on their new born child...I want it, and so do many of my colleagues (Nurse, Moon Hospital) (the majority (87%) of male respondents shared this view).*

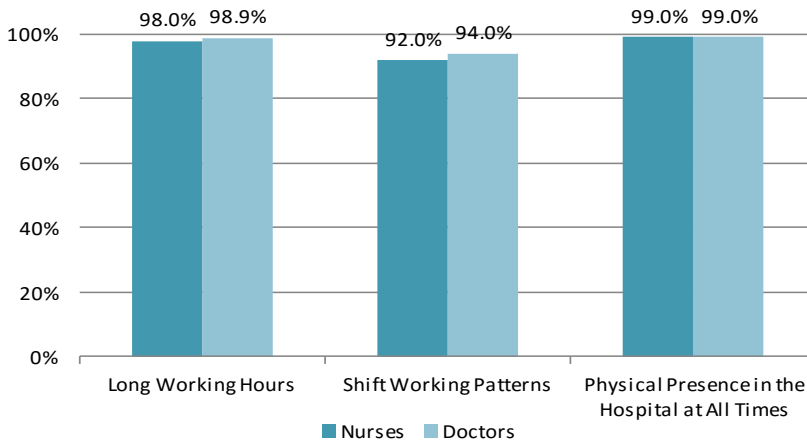
This finding reveals that paternity leave among Nigerian medical doctors is still a dream which has not yet been realised. However, the majority (87%) of male respondents expressed the desire to use a paternity leave policy if such a policy was available.

### **7.3 The Prevalent Culture in the Hospital and Perceptions of Doctors and Nurses towards Such Culture?**

As discussed earlier in Chapter Three, culture is a pattern of shared basic assumptions learned over a period of time as members of an organisation solve their problems of internal integration and external environments, then pass this on to new members as the correct and valid way to perceive, think and feel (Schein, 1985, 2010). The culture of an organisation dictates the daily activities of employees, how things are done and whether employees will use work-life balance policies or not (Sacmann, 2006). However, three main factors are prevalent and ingrained in the Nigerian medical sector's culture. The factors are (a) long working hours for doctors and nurses,

(b) shift work patterns, which include night and weekend shifts and (c) required physical presence in the hospital at every minute of the shift.

**Figure 6. Pictorial Representation of the Prevailing Culture in the Nigerian Health Sector**



**Source: Researcher’s Findings 2014**

The diagram above (Figure 6) is the summative response of the respondents about the three prevailing cultures in the Nigerian healthcare sector. The full qualitative findings of the prevailing culture in the Nigerian medical sector are as follows.

### 7.3.1 Long Working Hour Culture

An overwhelming percentage of medical doctors (98.9%) and nurses (98%) said the culture of their organisations requires them to work for long and unsociable hours. Respondents spoke of how they usually work between 12 to 36 hours in one shift. Respondents shared their views and experiences about the prevalent culture in the Nigerian medical sector; the following statements typify their shared views.

*We have traditions here as doctors. We work for unbelievably long hours to look after our patients and for our training. We do night and weekend shifts and most of us cannot even remember the last time we went on holiday. I started this shift at 8am yesterday, and I will finish by 8am tomorrow, that is 24 hours in one go. I will be off for, like, 12 hours and comeback here for*

*another shift that I am sure will not be less than 36 hours at a stretch, a very irrational shift...The job requires that; that is the tradition, the culture. Yes, it can be a very serious barrier to work-life balance but the culture comes with being a medical doctor and it has been like that for ages (Psychiatric doctor, Metro UTH).*

The above statement indicates that doctors in the Nigerian medical sector work for long hours to look after their patients and as part of their training programme. Heiligers and Hingstman (2000) and Walsh (2013) argue that the prevailing long and unsociable working hours coupled with intensive work pressure brought to bear by employers on workers to provide quality care is a significant global concern for the growing number of medical doctors in the healthcare industry.

Another doctor said:

*Long working hours comes with being a medical doctor which require us to stay in the hospital at all times of the shift...doctors spend more time in the hospital than they do in their homes with their families. Long working hours is an ancient culture of the medical profession (Surgeon, Goth Hospital).*

These findings resonate with Sibert (2011) who argues that if anyone values WLB, then such a person should not become a medical doctor. The author further asserts that a career in medicine means that you have to work for long hours and tolerate imbalances in your work and non-work lives. This also applies to nurses.

*Our patterns of work and shifts are no different from doctors, our shift is twelve hours, minimum, at a stretch; it is part of the job...I remember we were told in nursing school we should see the hospital as our main home because we will spend the majority of our working life in the hospital...that is the culture (Nurse, Vic Hospital).*

It is widely acknowledged that medical doctors and nurses all over the world are renowned for working long hours, under pressure and to experience significant work-life conflicts and/or work-life balance challenges (Heiligers and Hingstman, 2000; Walsh, 2013). Another respondent said:



*I work crazy hours weekly. I cannot remember the last time I did 70 hours in a week; it is always 90 and above. We have been told from the start that working for longer hours is part of nursing culture - it comes with the job (Nurse, Kith Hospital).*

Drawing from the evidence from Figure 3 and the statements above, long working hours, shift work patterns and a required physical presence in the hospital at every minute of the shift are prominent within the culture the Nigerian medical sector. Medical doctors and nurses have been trained to accept long working hours as an embedded culture of the medical profession which is supposedly imperative for patient care and safety, doctors training and career progression (Swanson et al., 1998). Respondents affirmed that the culture comes along with being doctors and nurses and that it has been like that for a long time. Houston (2005) believes that long working hours is not good for employees' lives and health. Wise et al. (2007) subscribe to the view that long work schedules are necessary for doctors' training, monitoring safety and promoting the continuity of patient care. It is, however, important to mention that no federal or state legislation in Nigeria restrict the number of hours which doctors and nurses may work in one shift.

Furthermore, in Nigeria, private hospitals are small-medium sized enterprises with a profit-making objective and therefore they have a tendency to require long hours working arrangements from doctors and nurses who work for them, up to 15 hours per day. However, this study discovered that a requirement for such long working hours have four major impacts on doctors' and nurses' lives: (a) it has an effect on respondents' family lives, (b) it affects doctors and nurses' lives and their health, (c) it has an effect on doctors and nurses' other non-work related duties and activities and (d) it has an impact on their performance at work.

### 7.3.2 Shift Work Patterns

The second ubiquitous culture identified in the Nigerian medical sector, according to the respondents, is the prevalence of shift work patterns, which include night and weekend shifts. Respondents, most especially female doctors and nurses married with children, expressed their difficulties in coping with shift work patterns, especially night shifts.

*The culture of this profession requires the majority of us to work shift patterns; it could be a day or a night shift with no exception for weekends...the night shift is the one I dread most, it is like fighting against nature, it is bad for my health (Nurse, Hic Hospital)*

Other respondent said:

*Shift work patterns come with the medical job. Almost all of us do it, this is because there must be doctors and nurses in the hospital at all times. Day, night and/or weekend shifts; it is the culture even though our health and family lives pay for it (Obstetrician, Duke Hospital)*

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

*Yes it's part of the job...we work all hours of the day and all days of the week...In doing so, shift patterns which include days, nights and weekends come in...nearly everybody hates it because of its negative consequences on our health, family and general lives and activities - but we have to do it (Nurse, Metro UTH)*

These findings are in line with previous studies (Oxtoby, 2003; Knutsson, 2003) and lend support to Brooks (1997) who argues that shift work patterns are bad for employees' health. The findings also lend credence to the studies of Smith and Wedderburn (1998) and Robertson (1994), who also argue that shift work patterns cause depression, heart disease, miscarriage and low birth-rate among employees. Shift work patterns or "shift mentality" according Rohrich, Persing and Phillips (2003), stay among doctors and nurses (Bamford and Bamford, 2008). The

reason, according to Cass et al., (2003), is to maintain patients' safety and care. However, Bamford and Bamford (2008) pointed out the damage that shift work often brings on employees' health and quality of home life.

Shift work, most especially night shifts is dangerous to employees' health and well-being, and could cause life-damaging accidents. The Selby rail disaster in 2001 is a typical example. The driver had been driving throughout the night and had no time to rest (BBC News, 2001). Rohrich et al. (2003), Chikwe, de Souza and Repper (2004) argue that long working hours and shift work patterns are important to developing a deeper understanding of the causes and the cures of diseases and for the continuity of patient's care. On the other hand, Gaba and Howard (2002, p. 6) stated that: "Healthcare organisations should assume responsibility for reforming work practices and for changing attitudes toward work so that exhaustion is considered as posing an unacceptable risk rather than as a sign of dedication". Nurses, too, are affected by shift work patterns (Bamford and Bamford, 2008). They are expected to stay awake throughout their shifts (including night shifts) (British Medical Association News, 2007) which, perhaps, is the reason why medical practitioners' attitudes towards shift work patterns is negative (Aitken and Paice, 2003).

### **7.3.3 Physical Presence in the Hospital**

A required physical presence in the hospital is another culture found to be prominent in the medical sector, especially among doctors and nurses. This study found out that physical presence in the hospital at every time of doctors and nurses' working hours is one of the tenets of the medical profession; it is essential for training and research and paramount to patients' care and safety. This culture, however, has been found to pose greater impediment to doctors' and nurses'

adoption of work-life balance policies and practices. The following quotations typify respondents' shared views:

*Any doctor who wishes to advance in his/her career must spend more time in the hospital than he/she spends at home or somewhere else attending to other non-work issues...the medical profession is so much aligned with the culture of being at work or what some call "presenteeism"...and, unfortunately, the number of hours you spend in the clinic speaks volumes of your seriousness about your job and commitment (Neurologist, Pym Hospital)*

*I do not know how the nurse will not be present in the hospital for her shift. The nature and culture of this profession requires all nurses on duty to be present in the hospital throughout their shift...in this way; we can monitor patients' health and administer medication to them on time, and also learn from the senior colleague (Nurse, Tab Clinic).*

*This is a medical profession and not another profession where you can telework or work from home...as a nurse, you need to be physically present in the hospital and stay there for longer hours...the number of hours you put in matter for the patients' care, your career progression and your image as a committed nurse...In this part of the world, you will be tagged as lazy, unserious and a non-committed employee if you are not always present at work (Nurse, Flex Hospital)*

The above quotations indicate that the medical profession, in a Nigerian context, has a culture of “presenteeism” whereby physical presence in the hospital is highly important for patients’ care and doctors’ career advancement. Furthermore, Nigerian organisations have not been seen to fully adhere to the practice of work-life balance policies for employees, but rather see such policies as benchmarks, whereby employees' productivity is measured by their physical presence at work (Epie, 2006). Working as a doctor or a nurse in Nigerian hospital has no other option than to be present in the hospital at all times of their shift. The "face time" or "culture of presenteeism" comes with the profession, according to the respondents. The above findings resonate with Sirajunisa and Panchanatham’s (2010) findings that physical presence at work is representative of employees’ seriousness, commitment, productivity and loyalty to the organisation. Employee who spend less time at work is considered less productive and less

committed (Beauregard and Henry, 2009). Often, management perceives an employee that works for long hours as suitable for promotion (Lewis, 1997).

#### **7.3.4 Effect of Long Working Hours on Doctors and Nurses' Familial Relationships**

51% of doctors and 62% of nurses pointed out that their familial relationships were under serious threat since they have to work for an average of 14-16 hours per day. During the interviews, 57% doctors and 59% of nurses who work 100 hours weekly pointed out that their marriages ended up with divorce due to their inability to give adequate time to their spouse and other emotional commitments. The long working hours has also led to social detachment from respondents' families, spouses or friends. Nigerian society, being collectivist, upholds that family cohesion and co-existence should not be destroyed on an account of career ambition (Mordi, Mmich and Ojo, 2013). Some of the female doctors and nurses indicated that they were experiencing enormous pressure from extended family for them to reduce the number of hours they spend in the hospital. Balancing this societal expectation with work realities within hospitals is difficult.

The following quotations typify the shared views of the respondents:

*I am a medical doctor and am on training to become a consultant. I work one hundred and three hours a week and there are many occasions when I have not gone home for three days...this happens when we have much work to do in the hospital. Today is Thursday and I have been here since Tuesday. I have not seen my wife and my new baby since Tuesday, now... That is the nature and culture of the industry where I work (Gynaecologist, York University Teaching Hospital).*

*Working for an average of 115 long hours a week is difficult, it is depressing and drives me away from my family...Undoubtedly, working over 80 hours a week means you are disconnected from your family and your relationship. For instance, my fiancée left me; he just could not cope with my not being around (Nurse, Dore University Teaching hospital).*

*I have not done less than ninety-eight hours a week for over three years now. With my young family, the impact of my long hours at work has been negative on me and my family. I do not even know anything about my children. I do not know what they like or dislike because I do not spend time with them. I have*

*attended no family social functions for only God knows when; neither do I have time for visiting friends or socialising. Apart from working during the week, I also cover the shifts on Saturday and Sunday (General practitioner, Clear UTH).*

*My family and friends are complaining about the crazy hours I am working...I lost my marriage and my relationship with my parents is strained...I think it is high time I did something (Like what? the interviewer cuts in; anything, maybe reduce the hours or even change jobs if the need arises (Nurse, Dorothy Jane Hospital).*

Nigerian doctors' and nurses' realities articulated above are in sharp contrast to the experience of doctors and nurses in countries such as Denmark, France, Sweden, Finland, Australia, Singapore and the UK who have developed family-friendly policies to ensure conflicts are minimised between work and family lives (Lai-Ching and Kam-Wah, 2012). For instance, a legislative measure was introduced in the UK in 2003 giving working parents the right to request for flexible working arrangements and their employer the duty to consider their requests (Houston, 2005). The above quotations resonate with several studies whose findings reveal that doctors and nurses who have families find working for long hours harder than those without family. Furthermore, the medical profession is people-intensive and an emotionally demanding job which often causes doctors to be drained so that they find it difficult to engage in stimulating conversation with their spouses or families (Bond, 2004; Bamford and Bamford, 2008; Swanson, Power and Simpson, 1998; Deary et al., 1996).

### **7.3.5 Effect of Long Working Hours' on the Lives and Health of Doctors and Nurses**

Another key consequence of working for long hours in the Nigerian medical sector is the number of doctors and nurses who incessantly resort to a cocktail of drugs to help them during long shifts. Approximately 37% of doctors and 23% of nurses interviewed were identified as being addicted to drugs and/or knew several colleagues who use various drugs as a coping mechanism.

They use strong analgesics to deal with migraine headaches and pains. Doctors and nurses interviewed consented to use drugs to cope with the increasing demands of the tasks they perform. Some of the interviewees commented:

*Drug abuse has evidently become a ritual among medical doctors. It is an opinion I formed having had the privilege of serving in six hospitals (both private and government) across the country, The majority are doing this to cope with the intensity of long hours shifts, which require them to stay awake and alert throughout the shifts...their health will suffer the consequences (Surgeon, York University Teaching Hospital)*

*I think out of every ten nurses on long working hour shifts; at least four use drugs, and the usage is often abusive. They always do this to deal with the challenges of long working hours that most of us will struggle with without drugs...I also use drug and am worried about its implications on our health, but we have to keep our jobs (Nurse, XTR Hospital).*

*I use drugs and alcohol to cope with the chaos of working long hour shifts. Although, frankly, my condition is better...some of my colleagues use hard drugs, I mean Indian hemp or snuff or the properly banned drugs which are absolutely unlawful. Most of us work for fifteen hours or even more at a stretch, we are expected to be physically and mentally alert throughout our shifts. I know it is wrong and unhealthy, but we use it to help us do our work and keep the jobs (Anaesthesiologist, head of his unit, Fox University Teaching Hospital).*

These findings are in line with Peng et al. (2011) who argue that highly demanding jobs push professionals (such as medical doctors and nurses) to spend more time at work, which negatively affects their health and general well-being. The Findings also support Malone (2012), who argues that it is unsettling that one in every six doctors is on alcohol and drugs to enable them cope with the mental and physical requirements of their job. In a study conducted by Dembe et al. (2005), working longer hours increases the likelihood for on-the job injuries by 61%. While Dembe (2009) also argues that there is a significant number of health issues which could arise due to working for longer hours. Respondents, most especially female, spoke about their worries

and dilemmas of functioning as wives, mothers and medical practitioners. They are concerned about the health implications of using drugs and analgesics to get going.

*I am very tired and sick...this is my seventh straight shift, and I am also married with three children. The workload at both ends is too much for me. Can you imagine that I cannot cope without my daily medication of strong painkillers? My fear now is that I am getting addicted to it and it will have a serious consequence on my health (Nurse, Wok Hospital)*

*The story is the same for all female doctors, most especially those of us who are married with kids. It is like doing two very demanding jobs...one at home, the other one in the hospital. Our health is paying dearly for this hard labour (Dentist, Flex Hospital)*

According to Skerrett (2012) and Mavroforou, Giannoukas and Michalodimitrakis (2006), doctors are seen as exemplars of health and wellness, but they are not immune to taking drugs themselves. These authors further argue that, at least one in every ten physicians develop problems with drugs in their careers and anaesthesiologists, surgeons and general practice doctors are usually the most vulnerable to drug use. In the view of Bohigian, Croughan and Sanders (1994) and Childress (2012), the abuse of drugs engenders behavioural disorder and strings of medical diseases. Brett (2009) and McVeigh (2011) recognise that there is growing demand in the UK and the US for the governments to control drug abuse among professionals, including doctors, since most doctors have been found to become vulnerable to cirrhosis of the liver because of the use of drugs. Numerous studies have also published reports on the negative effects of long working hours since 2004, of which all of them highlighted the adverse effects of long working hours on employees' health and well-being (Spurgeon, 2003; Van der Hulst, 2003; Caruso et al., 2004). Furthermore, research has also confirmed that employees who usually work an extra three to four hours a day are exposed to a 60% higher risk of suffering from a heart



attack and other serious cardiac diseases (Cookson, 2010), sleep deprivation, health problems, and susceptibility to patient-care-errors (Walter, 2012).

### **7.3.6 Effect of Long Working Hours on other Non-Work Related Duties and Activities**

An overwhelming majority of respondents voiced their concerns about the effect of long working hours on their nonwork lives. According to them, working for long hours means they cannot do anything after work because of tiredness. This, they say, cuts them off from most of their non-work related activities. A nurse at Fix Hospital remarked:

*The nature of my work has a great deal of effect on my non-work life. I do not get time to attend Sunday Church service; I cannot remember the last time I attended a family member or friend's social function. I work long hours every week (How many hours a week? the interviewer cuts in)...I have not worked for less than 80 hours a week in the last two years.*

Another doctor from the same hospital said:

*I have stopped thinking about it because the more I think about it, the more it hurts. The best way I can put it is that I have no life aside from work...no social life, no religious life, no time to do anything because most of the time I am in the hospital.*

The medical profession is people-intensive and is emotionally demanding, which can leave individuals drained and uncommunicative with life and subjects after work (Swanson et al., 1998; Buchanan and Considine, 2002). Evidence from this study reveals that Nigerian doctors and nurses rarely have time to do anything else because of working for long hours.

### **7.3.7 Effect of Long Working Hours on Doctors and Nurses' Performance at Work**

Doctors and nurses bemoaned the effects of long working hours on their performance at work. Respondents stated that they are concerned about the effects of long working hours on their performance that some described as "*heinous*". Evidence from the interviews suggests that Nigerian doctors and nurses experience a higher element of stress, fatigue as a result of long

working hours which, in turn leads to a higher rate of mistakes. This study reveals that, as the number of hours worked by doctors and nurses increases, the efficiency of their performance decreases and a series of errors creep in. The following quotations illustrate the shared views of the respondents:

*Extended long hour shifts are a problem; it makes me very tired and worn out. There are instances when I have been disorientated and made big mistakes due to exhaustion. I am a medical doctor, but am always sick. I work a minimum of 80 hours a week and it is affecting my health and performance at work. (Surgeon, Red Hospital).*

*There is an acute shortage of doctors in the country. The few around are overwhelmed with long working hours which often leaves them stressed out and burn out. This is very dangerous to the doctors' health and even puts patients' health and safety in jeopardy. A few days ago, a junior doctor working for 36 hours non-stop mistakenly administered an overdose of antibiotics to a pregnant patient. It was a very strong one, and the lady lost the pregnancy. Another doctor fell asleep and did not wake up to attend to his patients due for medications in the early hours of the morning... I can go on and on. All these things happened because they are totally burn out because of long working hours...It is sad (Cardiologist, Vale Hospital).*

*It was the sixth day of my eight straight night shifts, which were each 12hrs. I was so tired that I hardly got anything right. I was supposed to give a pregnant woman a 15ml dose of an individual drug; instead, I mistakenly gave her 25ml, which she immediately reacted to. Luckily and mercifully, senior colleagues and a few doctors were around to help me out. That was a consequence of tiredness. Trust me, long hour shifts; most especially night shifts, could be very disastrous (Nurse, Vase Hospital).*

Several studies such as Dembe (2009), Lasebikan and Oyetunde (2012, p. 6) have established that burnout and stress have immense repercussions on Nigerian medical doctors. Lasebikan and Oyetunde (2012, p. 6) stated that "The burnout syndrome is a response to chronic work stress comprising of three dimensions: (a) the experience of being emotionally exhausted; (b) negative attitudes and feelings towards the recipients of the service; (c) and feelings of low accomplishment and professional failure". The feeling of being burn out and stressed often

causes doctors to lose professional effectiveness (Shanafelt et al., 2012). This also leads to poor quality of care being rendered, and escalation of the risk of potential errors (Malik et al., 2010; Utami, 2013). The evidence in this study echoes the study of Coker et al. (2012) and Coker and Omoluabi (2010) who found that orthopaedic surgeons in Nigeria experience a certain degree of burnout and stress due to the nature of their jobs. The likelihood of errors with patient care should concern everyone as long hour shifts expose doctors to the risks of making sequential mistakes, which could be dangerous to the lives of the patients (Dembe, Delbos and Erickson, 2009). Hence, the longer the hours of work, the higher the level of burnout and patient dissatisfaction (Stimpfel, Sloane and Aiken, 2012). Similarly, nurses are susceptible to making mistakes when stressed and have insufficient sleep, which are the results of long working hours (Rogers, 2008). Team and shift work are features of the nursing profession (Wise et al., 2007) which often create pressures for nurses to remain visible for long, inflexible working hours (Evans et al., 2004).

### **7.3.8 Effect of Shift Work Patterns and Physical Presence in the Workplace on Doctors and Nurses Lives**

Shift work patterns do not include the traditional 8am-5pm Monday to Friday working arrangements (Grosswald, 2002). Rather, it is a way of organising employees' working hours to cover the whole 24hours in a day (Costa, 2003).

The majority of the respondents complained about the effects of shift patterns and the requirement to be physically present at work on their lives. According to the respondents, night shifts and a required physical presence at work at keeps them away from their families and has a negative effect on their health. 87% of female respondents said these two issues are having a

serious effect on their marriage/relationships and their ability to discharge their duties both at home and at work. The following statements typify their shared experiences and views:

*Being present in the hospital at all times of the shift and doing shift work schedules are part of medical professional culture. This is because doctors must be in the hospital with their patients. However, our familial, religious and social lives are been affected by this culture. For example, I lost my marriage because my husband did not approve of my doing night shifts, leaving him and the children at home. The management won't approve of my application of only day shifts....in the end, I lost my marriage. Also, night shifts always sickens me because of the duel between myself and nature...I am expected to be awake and alert throughout the shift...this is bad for my health as it causes several health problems. I have not attended Sunday services or any social gathering in a long time...I know this phenomenon affects all medical doctors, but it affects us...I am seriously considering a career in another profession (female doctors) more than our male counterpart (Obstetrician, Metro University Teaching Hospital) (89% of the respondents shared exactly this view).*

The preceding statement indicates that night shifts pose a lot of problems to respondents' relationships and marriages. The traditional patriarchal nature of Nigerian culture does not consent to women sleeping outside of their matrimonial home except for religious purposes and this has to be done with the full consent of the husband. The statement also indicates that night shifts present respondents with several health-related problems because they must stay awake and alert at all times of their shift, which the respondent described as "a duel between an employee and nature". This finding resonates with several studies (Smith-Coqqins, Broderick and Marco, 2014; Tempesta et al., 2013), whose findings reveal that shift work patterns, especially night shifts, have a lot of negative consequences on physicians' lives. Williams (2008) found that shift workers are more likely to complain about not spending enough time with their families and/or friends and constantly feel stressed.

Another respondent said:

*We (nurses) share the same plight with doctors because we operate the same shifts and working hours' arrangements. This is because doctors are always present in the hospital with nurses...the two are always together. Being in the hospital and shift patterns are the main things still delaying my wedding. Aside from several health problems associated with shift work, especially night shifts, I have seen several colleagues whose marriages have broken down and others who have left their jobs because their husbands will not just allow them do night shifts. My previous relationship crumbled because of this same night shift issue. So, I think I should just be patient until I can find another job where I may do only day shifts before having another relationship or getting married...These two aspects of medical professional culture make life difficult, especially, for married nurses (Nurse, Vase Hospital).*

This finding is in line with the assertion of Lowson et al. (2013) that shift work patterns, especially night shifts, have serious consequences on nurses' families including their marriages, relationships and children and their general well-being. There is also overwhelming evidence which reveals that unconventional shift patterns (evening and night shifts) have a negative impact on employees' cardiovascular systems and are injurious to employees' health, work and non-work lives (Su et al.,2008;Yazdi et al., 2014). It leaves employees open to mental disorders (Cheng et al., 2012) and adversely affects their performance (including a higher level of mistakes, less vigilance and lower quality of care (Dembe, Delbos and Erickson, 2009).

#### **7.4 Work-Life Balance and the Challenges of Female Medical Practitioners**

The foregoing findings raised several issues about the challenges facing female medical practitioners in terms of work-life balance. Work-life balance differ differs among the respondents in terms of aspiration, usage and how it affects their lives. Male nurses are rare in Nigeria because nursing is believed to be an exclusively feminine job. The issue of work-life balance and the highly demanding nature of the medical profession affects both male and female employees (Wright, Bengtsson and Frankenberg, 1994) but findings from this study, at least among Nigerian medical doctors and nurses, show that work-life balance issues affect female employees more than their male counterparts. This finding supports Williams and Alliger's

(1994) argument that managing work and home spheres makes achieving work-life balance more difficult for women than men. While male respondents are concerned about work and other aspects of non-work life including family life, female doctors and nurses are concerned about their work and family lives. They were asked about other aspects of their non-work life such as social and religious activities, but they placed more emphasis on work and family life. They shared their experiences and views on three main issues: (a) the intricacy of combining multiple roles of mothers, wives, carers, and professional doctors and nurses, (b) the effect of work demands on their family lives, and (c) the effect of familial duties on their work-lives.

#### **7.4.1 The Intricacy of Combining Multiple Roles**

It is clear from the interview results that Nigerian female medical doctors and nurses, in their efforts to function well as wives, mothers, carers and professional medical practitioners, are confronted with an array of difficulties on the two fronts of home and work. The majority described these tasks as “uphill”. According to them, the challenges of balancing these four roles in a patriarchal society, such as Nigeria, are enormous and very difficult. In Nigeria, the primary responsibility of women is to take care of their home, which includes caring for their children, husbands and other care receivers such as their own or their husbands’ parents or any member of the extended family. A developed and well-managed social welfare and health care system that cares for the elderly and disabled persons does not exist in Nigeria. These enormous responsibilities rest primarily on women while their careers are considered secondary to these responsibilities and should not affect their primary responsibilities. Any woman who prioritises her career prospects and neglects her primary responsibility as a home carer faces a domestic crisis and social sanctions. A mother-of-four, who is a surgeon, highlighted her experience as follows:

*Familial duties take precedence. That is the reason my career is moving at a snail pace...I have three children all below age 10. I cook for everybody in my house and I also make sure everything such as the laundry and the general home front is in order...plus my aged mother and mother-in-law are also under my care. Balancing all these duties is very difficult, as a matter of fact; I am thinking about taking a two year career break to perform my roles as mother, carer, and wife well, but am afraid I might not be able to come back to my job, that's my fear (Surgeon, Lox Hospital).*

Another respondent said:

*I imagine nothing more difficult than trying to manoeuvre and create a balance between my roles as a wife, a mother, and a nurse. I have had a series of problems over the years and in my effort of combining these roles, trust me, the task is Herculean, such that I lost my marriage in the end...I think I know about five colleagues with the same problems, it is very sad (Nurse, Red Hospital).*

Similarly, a nurse at Zia hospital also said.

*I know it's weird, considering our cultural stance on women's age and marriage, that I am still single at 39, and honestly I don't think I will get married soon. Nigeria is a patriarchal society where caring for one's husband, children and other members of the family are exclusively the women's paramount and primary responsibility... a woman is expected to be subservient and serve her husband at all time, no excuse. Balancing my roles as a single mother of two and a full-time nurse is already tricky and very challenging, I will not want to add the additional role of wife to it, at least for now.*

Another respondent, who had her six years old daughter with her at the time of the interview, explained the difficulties attached to balancing the multiple roles.

*Balancing the roles of a mother, a wife, a doctor and a care giver is impossible. One role will, for sure, suffer. And as a Nigerian woman, your career always suffers the role congestion. As you can see, another parent brought my daughter from school and dropped her off few minutes ago, and her latchkey sisters are at home. My husband complains every day because I don't spend enough time with him and the children...my mother is sick, I don't have time, even as a medical doctor, to look after her properly because of the very demanding nature of my job. My family life is in tatters, I need to do something urgently to save my marriage and be there for my family...it is difficult for us as female doctors (Gynaecologist, Zap Hospital).*

The above quotations demonstrate the challenges of Nigerian female doctors and nurses in their efforts to balance their multiple roles at home and work. One of the numerous family demands that most working mothers struggle with is after-school care. Regardless of the widespread nature of childcare, it has not been accorded the desired attention from workplaces and even society at large (Barnett and Gareis, 2006). Traditionally, Nigerian society is male-dominated (Epie, 2011) and even if women are involved in full-time paid employment, they are still expected to be active in their domestic responsibilities (Okonkwo, 2012). This has become a norm in Nigerian society.

#### **7.4.2 The Effects of Work Demands on Doctors and Nurses Family Lives**

An astonishing 95% of the female respondents (doctors and nurses) reported that their work demands have a negative impact on their family lives. The respondents' shared experiences highlight "stress" and "burnout" caused by the job and the negative impact on their family lives.

The following quotations typify their shared experiences:

*This job is so stressful that I feel exhausted at the end of my shift...It is even worse when I am on night duties. It is heaping a very damaging effect on my family life because I do nothing when I get home from work because of tiredness...I don't even know what to do now (Nurse, Moon Hospital).*

Similarly, a respondent who is a mother of four children said:

*My family life is totally in shambles. My marriage is on the brink of collapse because my husband has asked me to choose between my work and my home. I hardly spend time with my children and my husband. All my domestic responsibility has been delegated to my housemaid and my husband is upset and unhappy about it. My job is very demanding. By the time I finish my duty at work, I already will be so worn out and totally burn out that I will be unable to do anything at home... everybody around me (my husband, my children, my mother-in-law living with us and even my own family and friends) is complaining because I don't have time for anyone (Psychiatrist, Gap Hospital).*



It is often argued that co-ordinating work and family life is difficult for women (Emslie and Hunt, 2009), but married women find it even more problematic (Dyrbye et al., 2014). According to Mahpul and Abdullah (2011, p. 157), “as more married women participate in the labour force, they tend to experience conflict in order to occupy both work and family roles simultaneously”. For Swanson et al. (1998), doctors are especially susceptible to stress between work and home. This is because physicians are in a profession which traditionally requires a very high work commitment (Fub et al., 2008; Dyrbye et al., 2014). Similarly, Robinson (2003) and Adam et al. (2008) argue that female doctors experience burnout and high stress at work which affects their family lives. Similarly, burnout and occupational stress are highly prevalent among nurses in Nigerian hospitals (Lasebikan and Oyetunde, 2012) and this has been found to have a negative effect on the quality of patient care (Shanafelt et al., 2002). These findings resonate with the argument of Cousins and Tang (2004) that, as working wives and mothers, women find balancing work and family life tasking and frustrating. Similarly, Loder (2005) argues that women’s efforts to perform multiple roles of professionals, mothers, wives, and caretakers are always conflicting.

#### **7.4.3 The Effects of Familial Duties on Doctors and Nurses Working Lives**

The majority (89%) of the respondents, especially those who are married with children, voiced their concerns about the impact of their familial duties on their work-life. They found the stress of familial duties such as child rearing, looking after their husbands and other care receivers and answering the social calls of their extended family and friends very exhausting, which has a debilitating effect on their general working life. A respondent said.

*As a Nigerian woman, taking care of my family gets the first priority...over three-quarters of my energy and attention would have been used up by my*

*familial duties...this is affecting my performance at work, and it is affecting my career progression...It's like two workplaces (home and work), very tedious for me (Urologist, Bap Hospital).*

This finding echoes Parkway and Currie's (1992) argument that the burden of household responsibilities (including childcare) that women often bear is a major barrier to their career advancement. The above is supported in Bruckner's (1998, p. 24) study in which 82% of spouses (women) complained that the increasing demands of early morning and night time familial duties are affecting their lives. One woman said: "there is little time left for us". A Gynaecologist at XTR Hospital said she once considered an academic career, but she had to shelve the idea because of heavy familial duties taking up her energy and time.

*I have a master's degree from a reputable University teaching hospital, I could have gone on to obtain a PhD and attain senior lectureship and even beyond, but juggling family responsibilities with research (academic career), plus to be a good clinician was just impossible for me...I probably will drop dead.*

In their study of medical doctors, Connolly and Holdcroft (2009) found that women doctors find it difficult to progress in their careers due to their heavy family commitments. A matron (nurse) at Via Hospital shared her experience.

*...nurses, especially married ones, invest a lot of energy and time in putting their home in order, which affects their performance and sometimes, their concentration at work...in recent times, I have, as the matron, seen many instances where nurses make mistakes or perform below standard due to their unattended family commitments or family issues...*

The statements above confirm the negative impact of familial duties on female doctors' and nurses work-life balance. The statement from the matron at *Via Hospital* reverberates with Perry's (1982) study in which 53% of the respondents admitted to have made mistakes at work because of family commitments to which they had not attended. Rogers (1992) argues that 53%

of women reported that family stress affected their ability to concentrate at work, while Parson et al. (2009) argue that female doctors always feel guilty for not doing enough both as mothers and as doctors. The demands of work and family form an incompatible conflict between the two spheres of life (Fub et al., 2008). This conflict is more pronounced among female doctors than male doctors. Jefferson (2013, p. 77) indicates: “Conflict between home and work spheres may be greater for female doctors as a result of traditional stereotyped expectations that are placed on women’s role in the home-leading them to feel torn between their roles in the workplace and in the home”. Undoubtedly, however, the complexity of combining paid work and familial duties poses many challenges to female doctors’ and nurses’ everyday lives and activities. This research illuminates the dilemmas and challenges facing Nigerian female doctors and nurses when trying to balance their work demands and family responsibilities.

## **7.5 Factors Affecting the Choices and Use of Work-Life Balance Policies and Practices in the Nigerian Healthcare Sector**

There are several factors shaping and constraining the use of work-life balance policies and practices in the Nigerian healthcare sector. Firstly, the three ingrained cultures (long hour working, shift working patterns and the required physical presence at work) affect the choice and use of work-life balance policies and practices in the Nigerian healthcare sector. Other factors include: organisational time expectation, fear of lack of career progression, management support, supervisor support and co-workers’ support.

### **7.5.1 Organisational Time Expectation**

This has an overarching influence on the uptake and general principles of WLB policies and practices. A respondent said:

*The organisational time expectation in the medical profession is high...as a nurse, I must be physically present in the hospital and I have to stay there for longer hours...the number of hours I put in matter for the patients' care, my career progression and my image as a committed nurse...that is the culture and it has been like that for ages (Nurse, RTM Hospital).*

The above quotation indicates that the medical profession in Nigeria has a culture of “presenteeism” whereby physical presence in the hospital is highly important for patients’ care, and doctors’ career advancement. For Sirajunisa and Panchanatham (2010), organisational time expectation is also attributed to seriousness, commitment, productivity and organisational loyalty. This finding reiterates Beauregard and Henry’s (2009) proposition that an employee who spends less time at work is considered less productive and less committed. Management also perceive an employee that work for long hours as being suitable for promotion (Lewis, 1997).

#### **7.5.2 Fear of Lack of Career Progression**

Another key factor that helps in shaping or constraining the use of work-life balance policies and practices in the Nigerian health sector is fear of lack of career progression. Healthcare workers, most especially doctors and nurses, are deterred from utilising organisational WLB initiatives aimed at harmonising their work and non-work life because of the fear that this will adversely affect their career development. Many of the doctors interviewed were training to become consultants and, they argued that they needed to be present in the hospital most of the time for this reason. Furthermore, respondents voiced their reluctance and unwillingness to use WLB initiatives even if they were available. This, according to them, is because using work-life balance policies might work against them in terms of their desire for promotion and career progression. Nigerian doctors and nurse believe that using work-life balance policies will have negative consequences on their career and make them look lazy and not serious before management. A respondent commented on her personal experience:

*The problem is that WLB and the medical profession do not seem to align with each other. For instance, I was on maternity leave about three years ago and on returning from the leave I had to reduce the number of hours I did, although it wasn't easy as the management would not approve it. In the end, it was approved but it had a serious consequence on my career... When all of my mates have become consultants earning improved salaries, I am still in training because the maternity leave and the reduced working hours affected me. This is one reason why many doctors, especially resident doctors on training, don't want to use WLB policies even if they are available (Paediatrician, Unik Hospital).*

This finding is in line with McDonald, Bradley and Brown's (2008) argument that employees' perceptions of the negative career consequences is a potential barrier to the success of WLB in an organisation. However, because the Nigerian medical sector is encroached in a culture of long working hours, shift work patterns and a required physical presence at work at all times, management and majority of the supervisors or line managers and even co-workers are often unsupportive of work-life balance policies and practices. Hence, support from management, supervisors, and colleagues has become part of the cardinal factors shaping the use of work-life balance policies and practices in Nigerian healthcare sector.

### **7.5.3 Management Support**

Management support, according to Eisenberger et al. (2002), is the degree to which the management cares about its employees' well-being and contribution to the organisation and allows them to use work-life balance policies. In any organisation, usage of work-life balance policies begins at management level. Management formulates WLB policies and is encumbered with the responsibility of creating and spreading its awareness. In the Nigerian healthcare sector, various hospitals do not seem to be concerned about what happens to employees outside of their work environments. Management often perceives doctors and nurses who complain about WLB as being lazy and unserious. A respondent corroborated this assertion with her experience:

*I requested for flexibility in my working hours to care for my sick parent....after a series of meetings at the unit level, I was summoned by the Chief Medical Director and he advised me to find someone to look after my parent...as you can imagine, I was devastated and had a terrible time at work over that period (Gynaecologist, Hart Hospital).*

Also, a matron who is a member of the senior nursing staff said:

*As a senior nurse and member of the hospital management, I expect no nurse or doctor to complain about not being allowed to use work-life balance policies, this is medicine...I think they should be more concerned about patients' safety and care and their career progression (Zia University Teaching Hospital).*

The foregoing statements indicate that management of various hospitals in the Nigerian healthcare sector are not supportive of work-life balance policies and practices. This finding supports Wise et al. (2007) who revealed that hospital management is more concerned about patients' care and doctors' training and often perceive doctors or nurses who complain about not being allowed to use WLB policies as lazy and not serious.

#### **7.5.4 Supervisors' Support**

Supervisors support also plays a crucial role in shaping the use of work-life balance policies and practices. The majority (94.8%) of the respondents complained about the attitude of their supervisors towards WLB policies. Most of the time, the actions of supervisors are a reflection of management's decisions. However, supervisors usually use their discretion in dealing with operational issues, including employees' work-life balance. Supervisors' support has been described as an important determinant of whether an employee signs up to work-life balance policies or not. This is because a lack of supervisors' support will prevent employees from moving freely within work and non-work domains and also lead to making them feel undervalued and excluded (Hammer et al., 2009; Ryan and Kossek, 2008). The following are the respondents' views and experiences:

*My supervisor will not hear of WLB...I'm not even sure whether there is anything like WLB 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's all about work here... Even to get the legal annual leave is difficult. For sure, you can't get more than a week at a go...we do not have enough manpower (Dermatologist, JMK Hospital).*

*I have worked under different supervisors, some allow you to use work-life balance policies, some don't or I can even say the majority don't...they determine whether we use it (Psychiatrist, Hic Hospital).*

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

*The head of the unit or supervisors don't allow us to use WLB policies...they don't use it themselves. WLB does not exist here...it is all about caring for the patients, your career, the financial incentives and nothing more (Nurse, Tab Hospital).*

The preceding statements indicate that most supervisors in Nigerian hospitals are inclined towards the traditional ingrained culture of the medical profession, which leaves little or no room for flexibility at work. The respondents' views reverberate with comments made by Peper et al. (2011) that supervisors' attitudes towards WLB vary and individuals' supervisors determine whether their subordinates use WLB policies or not. This finding is also supported by Julien, Somerville and Culp (2011) who contend that having a supportive supervisor who informs his subordinates about the WLB policies available to them will improve their levels of work-life conflicts.

### 7.5.5 Co-workers' Support

Co-workers' support is another factor shaping the use of work-life balance policies and practices in the Nigerian healthcare sector. Respondents spoke about their colleagues' attitudes towards using WLB policies. Some related their experience with their colleagues which a respondent described as a "shame". Due to the shortage of doctors, when one or more doctors absent from work, his or her colleagues at work feel the pinch in the workload. They therefore strongly dislike any colleague who often keeps away from work. A nurse related her experience as follows:

*I have suffered, in the past, abuse and insinuations from my colleagues because I always use work-life balance policies. My situation then demands that I use those policies but some of my colleagues believed I was lazy and always revolt against my using WLB policies (Nurse, State Clinic).*

Another respondent said:

*The support we get from our colleagues depends on how frequent any of us uses work-life balance policies...shortage of staff is an issue most hospitals are struggling to cope with; when one member of staff is absent, the workload is shouldered by his/her colleagues at work which they don't mind doing once in a while...but they resent and sometimes revolt against their colleagues who persistently use work-life balance policies...I have seen this happen frequently (Surgeon, Let Hospital)*

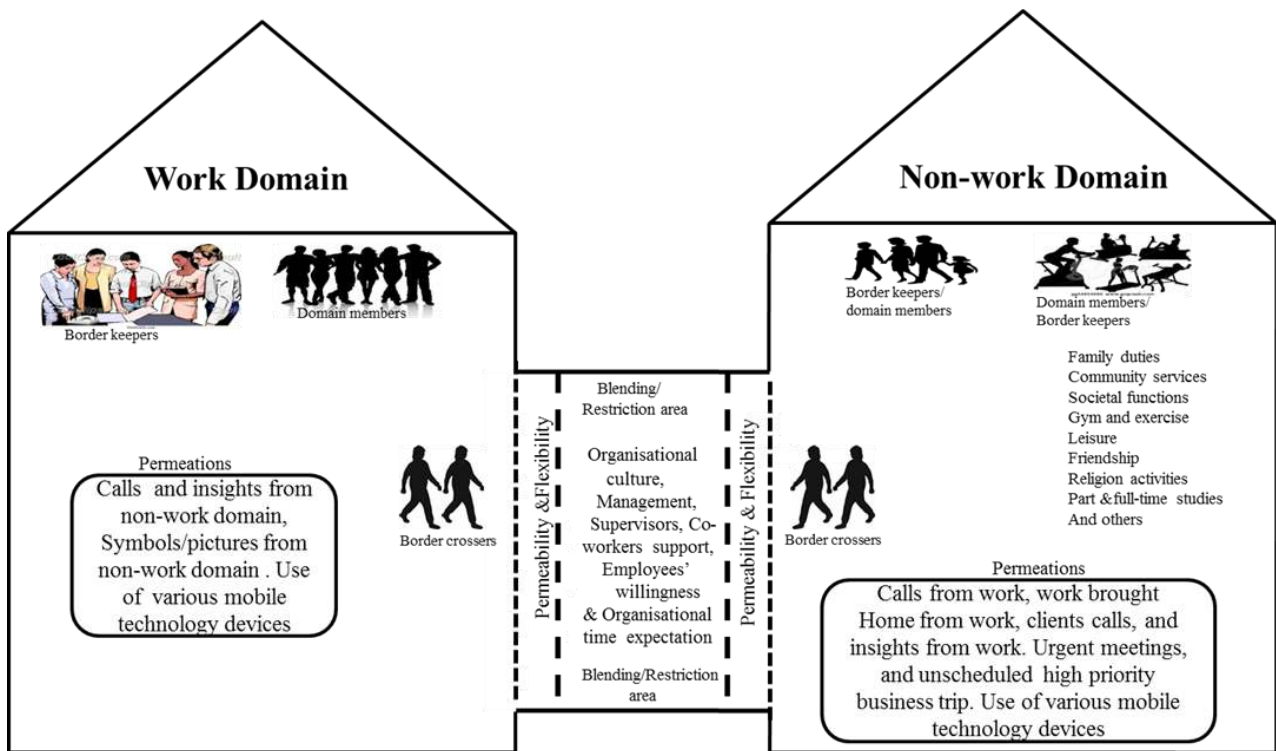
These quotations resonate with studies undertaken by Thompson and Prottas (2006) and Ferguson et al. (2012) which reveal that colleagues' support positively influences the process and take-up of WLB policies in an organisation. In addition, Moore (2007) argues that employees who often use WLB are open to accusations of malingering from their fellow workers. Even though this respondent at the State Clinic needed flexible working arrangements to attend to her non-work related obligations, her co-workers were not supportive. This confirms that employees who often use WLB policies are confronted with revolt and bitter resentment from their colleagues, who think they are lazy and not committed.



## 7.6 Work-Life Border Control Model

Having found and explained the factors that help shape the use of work-life balance policies and practices in the Nigerian healthcare sector, work-life border control model (with the findings of this study) now incorporate forces that determine employees' movement across the border and activities that are contained in the non-work domain. This model presents an important theoretical contribution of this study.

**Figure 8 Pictorial Representation of Work-Life Border Control Model**



**Source: Researcher's Finding 2014**

This model offers theoretical and empirical extensions to the previous work on border theory. Theoretically, the model extends constituents of border theory by identifying an important shift in the construct and application of border theory. Empirically, it expands the conventional database on the subject and offers a fresh perspective to the studies of work-life balance. This model is divided into the domain of work, in which daily work activities take place; and the non-

work domain, in which non-work related activities happen. Work activities comprise a daily work routine which fully engage domain members throughout their working hours. Non-work related activities include; family duties, community services, societal functions, gym exercise, leisure, friendship, religious activities, part-time or full-time studies, and so on. The work domain provides employees with income and a sense of accomplishment, whereas the non-work domain balances this by providing employees with fulfilment and personal happiness (Clark and Farmer, 1998). The borders which Clark (2000) describes as lines of demarcation that separate the domains of work and non-work are influenced by the five factors fully discussed below. These factors also determine whether blending or restriction prevails in the border area. Clark (2000, p. 757) stated that “when a great deal of permeability and flexibility occurs around the border, blending occurs”. However, in inverse proportion, the work-life border control model proposes that restriction occurs in the border area when all or any of these forces are present in the border area. Concisely, borders allow every domain member to move independently between work and non-work spheres in a differentiated manner. The development of this model has three main objectives: (a) To explicate how organisational culture, management/supervisors’, co-workers’ support, organisational time expectation, and employees’ willingness stand as the main factors that determine the porosity of the borders, and the flexibility of the border crossers (b) To examine other non-work related activities that are also important to employees (aside from family obligations) and (c) To contribute to the literature on work-life border theory. Previous studies on border theory have done a fair justice to the discussions of work-family theory (Zerubavel, 1991, Nippert-Eng, 1996, Clark, 2000, Ashforth, Kreiner and Fugate, 2000, Voydanoff, 2005), but they have ignored all other activities equally important to the employees. For instance, the non-work related activities of an unmarried employee with no children and no

other care responsibilities could include part-time studies, going to the gym or religious activities, to which obstruction of attendance to these activities will grossly upset the employees and cause imbalance. These forces determine how strong or weak the border area is, in that when any or all factors are prevalent in the border area, the border will be very strong and border crossing will be restricted. However, when the forces are less pronounced in the border area, then a weak border will prevail and border crossing will be easy and frequent. Briefly, borders allow every domain member to move independently between work and non-work spheres in a differentiated manner. An employee knows when movement is imminent and such an individual may move as the circumstance dictates (Ashforth, Kreiner and Fugate, 2000). In addition, previous studies on border theory did not specify whether the formulated theory applies to all environments or not. The work-life border control model seeks to remedy all these shortcomings.

### **7.6.1 Determinant Factors**

#### **(a) Organisational Culture**

Organisational culture is one of the principal determinant forces in the work-life border control model. In an organisation, culture represents the written and the unwritten rules and norms about the organisation. The spoken and unspoken widely shared assumptions unobtrusively manipulate organisational members (Schein, 1992). That a policy exists on paper does not mean that it is always acceptable and available for employee usage” (Kirby and Krone, 2002, p. 51). Most of the time, however, culture is invisible (Stinchcomb and Ordaz, 2007). Organisations may have work-life balance policies in place, but employees may not sign up to them (Kinnunen et al., 2005). It may be well ingrained in the culture of an organisation that employees may sign up to work-life balance policies for several reasons and employees who often ask about the policies are stigmatised as lazy and non-committed. This is explained in Schein’s (2010) three levels of

culture. These range from the very tangible overt manifestations that are visible and touchable to the deeply embedded, unconscious and basic assumptions that Schein described “as the essence of culture” (Schein, 2010, p. 23).

According to Schein, the basic underlying assumptions are the core of an organisation’s culture with espoused beliefs and values forming the next level and artefacts being the surface aspect of the organisational culture (Schein, 1985). With Schein’s model of culture, there is a hierarchy between these levels, which distinguishes between observable and unobservable elements of culture (Dauber, Fink and Yolles, 2012). However, the mere existence of work-life balance policies on the pages of the company’s human resource book (seen by everybody in and out of the company) is the artefacts. According to Ramachandran, Chong and Ismail (2011), artefacts are easy to recognise but their meaning and interpretations are very ambiguous and difficult to understand to non-members of the organisation. Whether the work-life balance policies are available to the employees or not is known only to the organisation and its members.

Some have argued that members of an organisation collectively learn and create a belief system (Testa and Sipe, 2011) which is a conscious philosophy about the organisation (Schein, 2010). Likewise, the basic underlying assumptions are the rituals about the organisation, which are not debatable and may be resistant to alterations (Schein, 2010). A particular company may parade itself as a firm which is supportive of work-life balance to the world, but in reality, they are not. Their employees understand this paradox, but they may not discuss it with non-members of the organisation. To support Schein’s model of culture, Thompson, Beauvais and Lyness (1999, p. 394) define work-family culture as “the shared assumptions, beliefs, and values regarding the extent to which an organisation supports and value the integration of employees work and private lives”. Employees will view a supportive organisational culture as that which takes care of the

well-being of its employees and a non-supportive culture as that which cares less about the well-being of its employees (Peeters et al., 2009).

However, there are certain organisations whose system of operations and culture restrict employees from signing up to work-life balance policies because they believe it will grossly affect the effectiveness and efficiency of the service they provide. The medical profession is people-intensive and emotionally demanding which can leave individuals drained and not able to communicate well with their spouses and family (Swanson, Power and Simpson, 1998). This profession has a culture of visibility which is equal to productivity, which causes gross imbalance in medical doctors' lives (Osoian, Lazar and Ratiu, 2011, p. 337). Furthermore, the culture of long hours and shift work patterns culture is prominent among doctors and nurses to monitor safety and promote continuity of patient care (Wise et al., 2007).

Unfortunately, this culture restricts the permeability and flexibility of employees' movement between work and non-work domains, holding up the progress in offering employees a better work-life balance (Timmins, 2002). Therefore, it not an exaggeration that organisational culture is a critical factor in determining the movements of workers across the border area (Kossek, Lewis and Hammer, 2010). Hence, a supportive work-life organisational culture will facilitate easy and frequent movements of workers across the border while an unsupportive culture will restrict employees' movement and that will eventually lead to work-life conflict (Burke, 2006).

### **7.6.2 Management/Supervisors' Support**

Management/supervisors' support is another factor that determines employees' movement across the border. The work-life border control model proposes that, if management and its supervisors are unsupportive of work-life balance policies for any reason, employees' movements across the

border will be restricted. Management support is the degree to which employees believe their organisation cares about their well-being and values their contributions (Adkins et al., 2013; Rhoades and Eisenberger, 2002). This support is critical to the success of their work-life balance initiatives. Many scholars have identified the importance of both formal and informal support from the management towards achieving WLB (Allen, 2001; Thompson, Beauvais and Lyness, 1999). Supportiveness within this context, according to the work-life border control model, refers to the extent to which an organisation's management and its supervisors at all levels support and allow their employees to make use of work-life balance policies whenever the need arises. According to Thompson, Beauvais and Lyness (1999), the importance of management support to the success of WLB practices is vested in management's power of making choices regarding the enactment of WLB policies and when and who may use them. An overwhelming number of researchers have posited that management support promotes positive outcomes, facilitates employees' general well-being and also enhances a positive spill-over from work to family which is particularly useful in promoting employees' confidence in their organisation (Ayman and Antani, 2008; Hammer et al., 2009). The work-life border control model perceives that the responsibility of formulating work-life balance policies lies in the hands of the organisation's management who will then make those policies available and accessible to the employees or do otherwise.

Supervisors' support is the extent to which employees perceive that their supervisors care about them and value their contributions (Simosi, 2012; Eisenberger et al., 2002). Note that supervisors' support differs from management support i.e. supervisors represent management by overseeing and directing employees' performance and general behaviour (Eisenberger et al., 2002). Supervisors are, mostly, responsible for operational decisions at work and they are

responsible for the decisions about who uses what policies at what time (Maxwell and McDougall, 2004) and their decisions are regarded by employees as reflective of an organisation's views (Simosi, 2012). Supervisors have an enormous influence on employees' tendency to use WLB policies, and their support is advantageous to employees' WLB (Ueda, 2012). The work-life border control model proposes that supervisors have the power and ability to make the border area very strong or very weak by preventing or allowing employees to use various work-life balance policies. This is because even if management provides work-life balance policies for its workforce, supervisors may still prevent the use of those policies. They can restrict their usage or even not allow employees to use them. Supervisors determine whether employees use work-life balance policies or not (De Cieri et al., 2005). Supervisors' disinclination to sanction the use of work-life balance policies could be personal or a reflection of the organisation's embedded culture. Sakazume (2009) posits that some supervisors reject work-life balance initiatives because they plausibly harbour the belief that when an employee or group of employees are allowed to use WLB policies, the performance of other employees will be negatively affected and workplace peace will be disrupted.

### **7.6.3 Co-workers' Support**

Another factor that determines employee's movements across the border is co-workers' support. Co-workers' support has been acknowledged as an important source of employee support (Simosi, 2012). It is the extent to which employees perceive that their co-workers respect their contributions and care about their well-being (Eisenberger et al., 2002). According to the work-life border control model, co-workers' support encourages employees to use work-life balance policies, which enhances free movement across the border. This assertion is supported by Marks (1977) argument that having supportive colleagues can be very helpful and often lead to positive

effects. Furthermore, several studies have revealed that co-workers' support is a potential predictor of good WLB and its absence could lead to work-life conflict (Lu et al., 2009; Ng and Sorensen, 2008; Ferguson et al., 2012). In addition, according to the work-life border control model, an absence of co-workers' support will restrict employees from using work-life balance policies, which will then prevent or slow down movements across the border. White et al. (2003) expound that fear of alienation and resentment from co-workers often form a significant concern for many workers. Kirby and Krone (2002) argue that resentment from co-workers often discourages (especially women) from using work-life balance policies in order that they will not be seen as less-committed workers. The work-life border control model proposes that unsupportive co-workers will restrict employees' movement across the border and vice-versa.

#### **7.6.4 Organisational Time Expectation**

Organisational time expectation is another factor that determines employees' movement across the border. It concerns the numbers of hours which employees are required to devote to working or work related activities (Lobel and Kossek, 1996). For instance, if an organisation attaches long hours at work to loyalty, criteria for promotion, organisational commitment and productivity, employees will be prevented from using work-life balance policies, even if those policies are available (Pocock et al., 2001; Bailyn, 1997; Joyce et al., 2010). For instance, some organisations perceive employees who often use work-life balance policies and who do not give the maximum expected organisational time as less committed and less productive compared to their colleagues who seldom use WLB policies and are notorious for working long hours (Lewis, 1997). The work-life border control model suggests that, wherever organisational time expectation is high, employees' movement across the border will be greatly restricted. This is



because the number of hours worked will be high and this will invariably affect members of and activities in the non-work domain.

### **7.6.5 Employees Willingness to Cross the Border**

The last factor that determines employees' movement across the border, as proposed by the work-life border control model, is that of the employees' willingness to cross the border. It is important to note that employees' willingness to cross the border sometimes hangs on some overarching factors such as employees' marital status, the level of employees' non-work commitments and responsibilities, fear of negative consequences that crossing the border might have on their career and colleagues and employers' attitudes towards employees who often use work-life balance policies. For example, employees who are not married and have no care responsibilities usually make less or no use of work-life policies. Studies have confirmed that employees who are not married with any care responsibilities often perceive their married colleagues (who often use work-life balance policies because of their families, care and other non-work responsibilities) as lazy and less committed (CIPD, 2007; Eikhof, Warhurst and Haunschild, 2007; Beauregard and Henry, 2009). This always makes employees who need to use work-life balance policies reluctant to use them even if they are available (McDonald, Townsend and Wharton, 2013).

In the same manner, some employers classify employees who make use of work-life balance policies as less productive (Osoian, Lazar and Ratiu, 2011) and uncommitted (Wharton, Chivers and Blair-Loy, 2008). Another factor that determines employees' willingness to cross the border is fear of lack of career progression. Some professions place serious importance on employees' presence at work. They align this with the core tenets of their profession and to the employees' career advancement. McDonald, Bradley and Brown (2008) and Wu et al. (2011) argue that

employees' movement across the border will grossly limited if such movement will have negative consequences on their career. Similarly, a report of the American Bar Association stipulates that 95% of the law firms in the US offer work-life balance policies but only 3% of lawyers subscribe to them due to the fear of the negative consequences it will have on their career advancement (Cunningham, 2001).

A greater unwillingness to cross the border prevails in a situation in which there is a circulated perception among employers and employees that crossing the border will have damaging consequences on their career progression. Employees' thoughts of the negative consequences that using work-life balance policies will have on their career progression powerfully demotivate them from using those strategies. Having established the work-life border control model which develops work/family border theory, this study will is now guided and make conclusions based on these two theories.

## **7.7 Conclusion**

This chapter provided the findings and a detailed analysis of the data collected for this study. The analysis of the findings in this chapter is majorly qualitative, though with a minute filament of a quantitative method; such the use of tables and percentages. This has been done to optimally realise the aims and objectives of this study. All interviews were audio-taped and meticulously transcribed by the researcher without the support of a research assistant. 22 themes were generated from the participants' statements and they became the headings under which this chapter was developed. The chapter also presents work-life border control model, a model that develops work/family border theory. The results of the findings satisfactorily answered the research questions. The discussion of the analysis is presented in the next chapter.

## **Chapter Eight**

### **Discussion of the Findings**

#### **8.0 Introduction**

This chapter presents the thesis discussion, considering all of the aspects of the findings and analysis. The chapter also presents the implications for theory and practice and concludes by presenting the relevance and application of border theory and the work-life border control model.

#### **8.1 Discussion**

The business case for this study hinges on the interrelationship between organisational culture and work-life balance. This was done by examining the relationship between the prevailing culture in the Nigerian healthcare sector and its effects on the uptake of various work-life balance policies and practice in the sector. This study provided an insight into our understanding of the effects of organisational culture on the work-life balance of Nigerian medical doctors and nurses. Empirical evidence from the case study revealed that there are three overarching organisational cultures prevalent in the Nigerian healthcare sector: the culture of long working hours, shift work patterns' culture and the culture of the required physical presence in the hospital otherwise known as the culture of "presenteeism". Drawing from the evidence arising from this study, medical doctors and nurses have been trained to accept long working hours as an embedded culture of the medical profession which is supposedly imperative for patients' care and safety and doctors' training which aids their career progression. To achieve these objectives, respondents work as much as 100 hours in a week (Tables 2 and 3). The study further revealed that the culture of long working hours is pronounced among doctors and nurses working in private hospitals. This is because private hospitals in Nigeria are small-to-medium-sized enterprises with a profit making objective. Their financial capability to hire enough human

resources is limited causing them to implement working arrangements of long hours, with doctors and nurses who work therein sometimes working up to 15 hours in a day. The long work hours undertaken by the Nigerian medical doctors and nurses is in sharp contrast to the EU and UK policy whereby doctors and nurses may not work over 48 hours in a week (Bamford and Bamford, 2008; British Medical Association News, 2007).

Similarly, another finding of this study revealed that long working hours have detrimental effects on doctors' and nurses' familial relationships, hence causing a barrage of work-family conflicts. Respondents repeatedly complained that working long hours keeps them away from their families, fuelling domestic conflicts. This finding articulates the realities of long working hours of Nigerian medical doctors and nurses and the effect that this has on their family lives. It is in sharp contrast to the experience of doctors and nurses in countries such as Denmark, France, Sweden, Finland, Australia, Singapore and the UK. These countries have placed a limit on the number of hours their doctors and nurses could work in a week and have also developed family-friendly policies to ensure conflicts between work and family lives are minimised as much as possible (Lai-Ching and Kam-Wah, 2012).

An intriguing result of this study revealed how some doctors and nurses depend on drugs to cope with the challenges of working for longer hours which is inimical to their health. The majority of doctors and nurses work continuously for 12 and/or more hours in one go and they are expected to be physically and mentally alert, which most find difficult to do. An astonishing number (31%) of respondents admitted that they were addicted to drugs and/or knew colleagues who use various drugs as a coping mechanism. This resonates with Malone (2012) and Steeves (2011) whose studies worryingly show that one in every six doctors is on alcohol and drugs to enable them to cope with the mental and physical requirements of the medical career. These actions

have a tendency to affect the health of doctors and nurses themselves in the long run and could have a damaging effect on the health and safety of their patients as well. Similarly, evidence from the interviews suggests that Nigerian doctors and nurses, because of the long working hours, experience higher elements of stress and fatigue which consequently leads to a higher rate of mistakes. A doctor working for 36 hours non-stop revealed how he mistakenly administered an antibiotics injection to a pregnant patient which caused her to miscarry, a nurse also fell asleep and did not wake up to attend to her patients due for medications in the early hours of the morning. This evidence echoes the study of Coker et al. (2012) as well as Coker and Omoluabi (2010) who found that orthopaedic surgeons in Nigeria experience a certain degree of burnout and stress due to the nature of their jobs. This finding is in line with Shanafelt et al. (2012) that the feeling of being burn out and stress often causes doctors to lose professional effectiveness. Malik et al. (2010) and Utami (2013) argue that this often leads to poor quality of care and escalation of the risk of medical errors.

The study revealed that the culture of shift work patterns is deeply ingrained in the Nigerian healthcare sector. Evidence from this study revealed that 92% of nurses and 94% of doctors (Figure 3) of the surveyed respondents are on a shift schedule. The results show that the medical profession in Nigeria comes with shift work patterns which include night and weekend shifts about which respondents, especially married female doctors and nurses, voiced the challenges and threats it presents to their health, marriages and families. Even though it has been argued that shift work patterns are necessary in the medical profession to provide and ensure continuity of patients' care (Bamford and Bamford, 2008) yet shift work, especially night shifts, remain dangerous to employees' health and well-being, and could cause life-damaging accidents.

Another culture revealed by this study which has an influence on work-life balance policies and practices in Nigerian healthcare sector is the culture of a required physical presence at work otherwise known as “presenteeism”. This study found that the required physical presence in the hospital at all times of doctors’ and nurses’ working hours is one of the creeds of the medical profession. Respondents commented that medicine in the 21<sup>st</sup> century should have advanced beyond staying in the hospital at all times of their shifts. According to them, this separates them from their families and afflicts them with huge psychological effects. Most Nigerian organisations still have not adhered fully to the practice of work-life balance policies and still measure productivity by employees’ physical presence at work. This culture is known to exist in most Nigerian organisation, especially medical organisations, for over a hundred years now.

This study also provided insights into our understanding of Nigerian doctors’ and nurses’ notions of work-life balance. Evidence from the case study revealed that Nigerian doctors’ and nurses’ understandings of work-life balance surpasses work and family commitments. An astonishing percentage of the respondents (Table 4) define work-life balance as having time for work, family, religious, recreational and social activities, studies and other events and activities. None of the respondents defined work-life balance to only mean having time for work and family duties. This shows that Nigerian medical doctors and nurses desire to be involved in various activities alongside their professional commitments. This study, however, revealed that their inability to attend to these activities and events often leads to serious conflict and under-performance at work and home. This finding is in line with Parkes and Langford’s (2008) definition of work-life balance as employees’ ability to negotiate successfully between their work and family commitments, and other non-work responsibilities and activities. The majority of the respondents appeared to be religious individuals who considered their religious activities

as part of their non-work life that must be balanced with their work-lives. All respondents included having time to attend to their religious events and activities in their understanding of work-life balance. This finding confirms the studies of Dean (2007), who stated that achieving balance between religious/spiritual life and work life is now an important matter for employees in deriving solace and satisfaction from their work. In addition, Onuoha (2005) argued that religion shapes the majority of individuals' way of life to the extent that no matter what they do, they still want to fulfil their religious obligations.

Similarly, respondents also attached great importance to having time to attend to various familial duties and commitments. Nigeria is a collectivist society with strong family ties and the family acts as a social security that protects its members (Chakrabarty, 2009). Furthermore, the welfare system obtainable in many developed countries such as UK does not exist in Nigeria; children, the disabled and the elderly are looked after by their children and other members of the family usually engaged in full-time work (Ituma et al., 2011; Jackson, 2004). Family commitments and duties are ranked important among employees and having time to attend to these numerous familial duties stands at the heart of the respondents' definition of work-life balance (Mordi, Mmieh and Ojo, 2013).

Empirical findings from this study reflect several studies that work and familial responsibilities are becoming increasingly essential in the lives of employees (Jackson, 2004; Greenhaus and Foley, 2007). The findings also resonate with several studies that achieving a balance between social and work life is of great importance to the employees (Human Kinetics Research, 2010; Maertz, Scott and Boyar, 2011). However, the highly demanding nature of the medical profession does not give doctors and nurses enough time to attend to their non-work related activities.

The range, scope and usage of work-life balance policies and practices in the Nigerian health sectors is abysmal. This study revealed that doctors and nurses are oblivious to several work-life balance policies. Maternity leave, casual leave, sick leave, study leave and annual leave are the few work-life balance policies that exist in the Nigerian medical sector. A number of other work-life balance policies are rare or non-existent in the medical field. These include: part-time work, parental leave, paternity leave, on-site child care, emergency childcare, backup adult and elder care, school holiday cover, on-site work-life balance expert, nanny share, reduced working hours, compressed working hours, annualised hours, teleworking, career breaks, term time working, flexitime scheme, working from home, cultural/religious leave and staggered working hours. The few available work-life balance policies are not easily accessible by doctors and nurses due to the shortage of workforce.

This phenomenon is different in developed countries in which employees enjoy a variety of work-life balance policies. For instance, the European Time Working Directive (ETWD) stipulates how many hours an employee may work in a week in all EU member countries (Bamford and Bamford, 2008); and the EU directive which imposes a minimum level of maternity leave for all member countries (Moss, 2010). In Germany, the Maternity Protection Act (*Mutterschutzgesetz*) allows employees to be out of work for a maximum of three years with entitlement to return to the same position held before the leave (Block et al., 2006). Similarly in the UK female employees are entitled to a different sort of maternity leave benefits (Employment Law Explained, 2014). However, having learnt about various work-life balance policies from the researcher, respondents believed that the availability and accessibility of those policies to them would go a long way in alleviating and cushioning their WLB problems. Participants, most especially female doctors and nurses with childcare responsibilities, believe that the availability



of on-site childcare would grossly reduce child-minding problems and help them keep their focus and concentration at work. For Grover and Crooker (1995), different work-life balance policies such as part-time work, job sharing, variable starting and finishing times, family-leave policies, childcare assistance such as referral service, on-site child and day care centres would help in ameliorating work-life conflicts. However, a disheartening finding of this empirical study revealed that many work-life balance policies are not available in the Nigerian healthcare sector (Table 5), a phenomenon that represents the negligence of the authorities towards work-life balance issues.

This study revealed the dilemma of Nigerian female doctors and nurses (considering the social responsibilities of women in Nigerian society) in their efforts to achieve work-life balance. Evidence from case studies showed that combining multiple roles is difficult for Nigerian female doctors and nurses. They found the occupational workload of medical profession to be all-consuming so that they become fatigued, drained and unable to perform their familial duties at the end of their daily work. This finding resonates with Noor's (2002) argument that when an employee devotes so much time to one part, the other function is assumed to be negatively affected. It should be noted that some professionals such as medical doctors and nurses do not fit the typical 9am-5pm work pattern of working hours (Burke, 2009); rather, their patterns of work are characterised by long working hours (Gjerberg, 2003), overtime, and sometimes they work during vacations and bank holidays (Perlow and Porter, 2009). All of this makes achieving WLB difficult (Johnson, 1991). Furthermore, medical doctors and nurses have obligations to put their work duties such as patients' care above their responsibilities towards their families.

The study also showed the intricacy of combining the roles of mothers, wives, caregivers, and professional among female Nigerian doctors and nurses. The results showed that, in Nigeria, the

primary responsibility of a woman is to take care of her home and family while every other activity including her job is classified as a secondary role. As previously noted, a developed and well-managed social welfare and health care system that cares for the elderly and disabled persons is non-existent in Nigeria. Hence, the responsibility of taking care of senior citizens, children and disabled persons squarely rests on women, whether employed or not. These domestic expectations and the highly demanding nature of the medical profession makes work-life balance difficult to achieve for female doctors and nurses in Nigeria.

However, these problems seem to be universal because it is not specific to Nigerian female doctors and nurses. For instance, Allen (1988) reported that many British female doctors found having children a great barrier to their career progression, Norwegian female doctors also found balancing work and family roles problematic (Lindahl and Killi, 1984) and the same issue is prevalent in the US (Kletke, Marder and Silverberger, 1990). These findings are also in line with several studies (Duxbury and Higgins, 2008; Mahpul and Abdullah, 2011; Greenhaus and Beutell, 1985) that found that when the cumulative demands of work and family roles are incompatible, involvement in one role will make participation in other roles difficult. Doctors and nurses specifically find balancing the multiple roles of wife, mother, carer and professional difficult. Sibert (2011, p. 1) comments: “you will never be the perfect wife and mother and have a high-powered career at the same time”.

This study examined factors affecting the choices and use of work-life balance policies and practices in the Nigerian healthcare sector and found several factors responsible for shaping and constraining the choices and use of work-life balance policies and practices therein. The first and probably the most dominant of them is organisational culture. This is because every other practice in the Nigerian healthcare sector is deeply ingrained in the organisational culture of the

sector. Embedded in the culture of the Nigerian medical sector, as discussed earlier in the chapter, are long working hours, shift work patterns and the culture of a required physical presence in the hospital at all times of the shift. These cultures invariably affect the choices and use of work-life balance policies and practices among Nigerian doctors and nurses. Long working hours prevent doctors and nurses from using work-life balance policies because it keeps them in the hospitals for incredibly long hours, prevents them from attending to non-work duties and separates them from their families. This study argues that long working hours greatly restricts the use of work-life balance policies and practices in the Nigerian healthcare sector.

In addition, this study revealed the prevalent shift work patterns as another culture that constrains the use of work-life balance policies and practices in the Nigerian medical sector. Unlike bankers and other professionals, doctors and nurses work various shift patterns which includes nights, weekends and bank holidays (public holidays). Undoubtedly, this poses greater impediment for doctors and nurses to adopt work-life balance policies and practices. The next factor, which constrains the use of work-life balance policies and practices in the Nigerian healthcare sector, is the “face time” culture or culture of “presenteeism”. This study revealed that the Nigerian medical sector is blighted with the culture of “presenteeism” whereby doctors and nurses are mandated to be physically present in the hospital at all times of their shift. This culture, undoubtedly, stands at variance with the principles of work-life balance.

This study also revealed that organisational time expectation is another factor that affects the choices and use of work-life balance policies and practices in the Nigerian healthcare sector. The organisational time expectations of medical profession is high. The study found that, in Nigeria, the number of hours that doctors and nurses work speaks volumes of their loyalty, commitment and seriousness about their jobs. This stands at variance with the principles of work-life balance,

preventing doctors and nurses from using work-life balance policies and practices. Another key factor that helps to shape or constrain the use of work-life balance policies and practices in the Nigerian healthcare sector is fear of lack of career progression. Doctors and nurses are unwilling to use work-life balance policies because they believe this would have a negative impact on their career progression. This perception of fear presents a serious barrier to achieving successful work-life balance in the Nigerian medical sector. In Nigeria, doctors and nurses spend longer hours in the hospitals not because they want to but they do so as a career stratagem to facilitate them to climb the career ladder and to also earn decent salaries at the expense of their physical, social and emotional well-being. This finding thus confirms the study of McDonald, Bradley and Brown (2008) who argue that the fear of not being promoted restrains doctors from using WLB practices in the medical working environment. An intriguing result of this study, therefore, revealed that doctors and nurses who want to progress in their careers shun the use of work-life balance policies and practices.

A surprising dynamic within the Nigerian healthcare sector is that management, supervisors and co-workers are not supportive of WLB. Co-workers feel burdened with extra work from employees who use WLB policies, while supervisors consider doctors and nurses who request to use WLB policies as lazy and not serious about their jobs. Their efforts to balance their work and non-work lives is impeded by this lack of supports. In the view of Sakazume (2009) and Ueda (2012), WLB practices will not be successful in an organisation in which supervisors are unsupportive of them.

Another disheartening result of this study is the growing weakness of The MDCN and The National Association of Nurses and Midwifery of Nigeria (NANM), the bodies that regulate medical doctors' and nurses' practices in Nigeria. The MDCN and NANM seem weak to

proactively regulate these damaging working patterns of doctors and nurses. This is worrying as MDCN and NANM have no laws that regulate or cater for doctors' and nurses' work-life balance. Compounding this problem is the disturbing silence and apathetic approach of the Nigerian government towards employees' work-life balance and to finding solutions to the challenges that face medical doctors and nurses especially when trying to balance their work and non-work lives. Again, the Nigerian Medical Association (NMA) and the associated medical trade unions are too weak to take action in matters affecting the welfare of union members (such as issues relating to how WLB can be achieved). Therefore, the non-intervention policy of government and its agencies undermine WLB policies and practices in the Nigerian medical sector and give more impetus to shrewd private sector employers to benefit from keeping doctors and nurses at work (sometimes for three days) for profit-making purposes. In the view of Fleetwood (2007) and Forson (2013), this is in sharp contrast to the UK in which the government has espoused several business cases to address WLB for NHS employees in order to help them better manage their work related and non-work related activities.

The study further revealed that WLB is gender-specific in Nigeria as most of the doctors and nurses who have used WLB policies or who have had issues with using them, were female doctors and nurses. The study argues that the interrelationship of work-life balance and organisational culture is entrenched in the influence of organisational culture on the ability of employees to subscribe to various work-life balance policies and practices at will. This perhaps explains why Sibert (2011) argues that whoever desires work-life balance should not seek to become a medical doctor.

## **8.2 Implication for Theory**

The primary aim of this study has been to examine the interrelationship between work-life balance and organisational culture among doctors and nurses in the Nigerian health sector. The study makes important contributions for academics researching work-life balance (especially in Nigeria and organisational practitioners, especially in human resource development (HRD)). The study identifies that organisational culture has a significant influence on work-life balance policies and practices in an organisation. The novelty of this research is based on work/family border theory which was used as the theoretical framework to examine the interrelationship between work-life balance and organisational culture among Nigerian healthcare practitioners. This theory explains how employees negotiate their daily movements across work and family domains but fail to recognise that family is by no means the only non-work related duty that matters to employees. This shortcoming is alarming especially now that “Generation X” employees (workers born after 1963) prefer work arrangements that also cater to their non-work related duties and responsibilities (Maxwell, 2005; Shabi, 2002). Work-life border theory did not expound factors that determine employees’ movements across the border. Because of these shortcomings, the work-life border control model (Figure 4) was developed. The work-life border control model recognises other non-family activities that matter to employees and set out factors that determine employees’ movement across the border. It is, therefore, important to note that developing this model was in strict acquiescence with Ransome’s (2007, p. 374) argument that “it is rather important to use an established theory and concepts as a basis to develop a new one”. To the best of the researchers’ knowledge, this model is new, no study has hitherto developed a model of its kind and it is important for work-life balance researchers because it provides a comprehensive and coherent understanding of a framework within which employees’ movements from work to non-work domains can be studied. The work-life border control model

provides the theoretical framework which has been missing in work-life balance study. This contribution is, therefore, theoretically appealing particularly now that the study of work-life balance is attracting serious attention and also provides a theoretical basis for future studies.

### **8.3 Implication for Practice**

This study has implications for HRD, employees and management practitioners in Nigeria. The study revealed the essential role of organisational culture towards the practices and implementation of work-life balance policies in Nigeria. It is essential to note that work-life balance remains under-researched in Nigeria because the subject has not yet been well established in this part of the world as it has been in western nations. Therefore, an empirical study of this nature which expands the conventional database and provides a valuable insight into the reality of work-life balance practices in Nigeria is essential. However, the findings of this study indicate that the culture of the medical profession stands at variance with work-life balance policies, making work-life conflicts more pronounced among Nigerian medical doctors and nurses. For instance, medical doctors and nurses, according to the findings of this study, work for unbelievably long hours on different shift patterns that include nights and weekends. This practice is embedded in the profession's culture and it poses stiff constraints and barriers to the use of work-life balance policies and practices. It is, however, essential to prioritise doctors and nurses' work-life balance by providing them with various work-life balance policies and encouraging them to use the policies. Therefore, in order to embrace and absorb work-life balance as a leverage point for practice, government and policymakers must flag and support work-life balance programs, while management at various hospitals and the Nigerian healthcare sector must also make informed decisions about and alter their culture and policies to accommodate work-life balance policies and practices in Nigerian healthcare organisations. It is

essential that healthcare organisations demonstrate that employees' work-life balance is part of their core business model. This means a strong work-life culture with supportive and committed personnel (managers, heads of units, and medical directors) who will help employees to achieve practicable and desirable work-life balance. This study sensitises and calls Nigerian organisations' attention to the need for running family-friendly or work-life friendly organisations to enjoy the numerous advantages of work-life balance and to also meet the standard of their counterparts in the world, especially western nations.

#### **8.4 Relevance and Application of Border Theory and Work-Life Border Control Model**

As mentioned earlier in Chapter Four, this study is guided by border theory which proposes that employees are border crossers who journey between work and home domains daily. According to Clark (2000), individual employees manage and negotiate between the two spheres and the borders between them in order to attain balance. However, the success of balancing these two settings is varied among employees. It depends on individual employees' statuses and conditions. It means "that border-crossers often modify their focus, goals, and interpersonal style to fit the unique demands of each domain" (Clark, 2000, p. 751). Border theory illustrates how Nigerian doctors and nurses could cross the borders between work and non-work-domains using various work-life balance policies available to them.

Based on border theory and as represented in the diagrams (Figure 3 and 4) Nigerian doctors and nurses are domain members, border keepers and border crossers who journey, daily, between work and non-work domains. It can be noted from the diagrams the series of activities in the non-work domain which are as important to Nigerian medical doctors and nurses as familial duties. However, the boundaries that exist between their work and non-work domains are strong, inflexible and impermeable. This applies to both the physical and psychological borders. In term



of the physical border, doctors and nurses are not allowed to leave the hospital premises if they are on duty. While in terms of the psychological border, the medical profession is emotionally demanding, which gives little or no room for psychological movement across the border (Swanson et al., 1998). Their desires to cross the border are shortly thwarted because the border is strong. As discussed previously in this study, various factors are responsible for the strong boundaries such as organisational culture, shift work patterns, long working hours, lack of support from management, supervisors, co-workers and employees' reluctance to cross the border. These factors, undoubtedly, often hamper employees' movements across the border in the Nigerian healthcare sector. All of these factors have been ingrained in the Nigerian medical sector's culture for a long time and they are still prevalent.

**Table 6 Summary of the Findings and Implications**

Research Questions	Findings	Implications
(a) What is your understanding of work-life balance?	Doctors and nurses define WLB to mean the ability to work and at the same time the ability to attend to their non-work related duties and activities such as family, religious, studios, social, recreational and other activities.	Employees' ability to fulfil these duties and responsibilities is a panacea to solving some organisational and employees' work-life balance problems. It also has a positive impact on employees' work and non-work lives. Employers need to be aware of this to get the best out their employees.
(b) What are the varieties and uses of WLB policies and practices available in the Nigerian healthcare sector?	The findings were different from what exists in literature. Nigerian doctors and nurses are oblivious of many WLB policies and they have free will to use the few existing ones.	Employees, especially female doctors and nurses, struggle to balance their work demands and non-work related responsibilities, which affects their performance at work and cause major conflicts at home.
(c) How would you describe your work culture and what is your perception of the prevalent culture?	Culture of long working hours' a culture of shift patterns, and a culture of required physical presence at work were found to be prevalent in the Nigerian healthcare sector. Respondents resented at these cultures because they prevent them from	The medical professional culture stands at variance with the principles of work-life balance policies and practices and has a negative impact on doctors' and nurses' performance at work. Employers need to find a common ground to

	using WLB policies and have negative effects on their work and non-work lives.	accommodate work-life balance.
(d) What are the factors that help or constrain the use and choice of WLB policies and practices in the Nigerian health sector?	Organisational time expectation, fear of lack of career progression, management support, supervisors' support, and co-workers' supports were found to be among the main factors shaping the use of WLB policies and practices in the Nigerian healthcare sector.	Employees are disgruntled about these forces which affect their performance, commitment and loyalty to their jobs. To hire and retain the best and most happy workforce, employers must consider reconciling their practices with employees' needs, such as work-life balance policies.
(e) What is the perceived impact of WLB on the attitude and performance of doctors and nurses?	An overwhelming majority of doctors and nurses averred that the medical profession's culture is in contradiction to WLB practices and so are the attitudes of various management, supervisors and co-workers. All of these make combining work and non-work life difficult	Cultural and attitudinal change is necessary in the Nigerian healthcare sector for WLB to have a positive impact on doctors' and nurses' work and non-work lives.

**Source: Researcher's Findings 2014**

## 8.5 Conclusion

This chapter explained the results of the research findings. The results obtained from this study revealed that there are three overarching organisational cultures prevalent in the Nigerian healthcare sector: a culture of long working hours, a culture of shift work patterns, and a culture of a required physical presence in the hospital otherwise known as the culture of "presenteeism". Drawing from the evidence from this study, medical doctors and nurses have been trained to accept long working hours as an embedded culture of the medical profession which is supposedly imperative for patients' care and safety and doctors' training which hitherto aids their career progression. Nigerian health organisations are not concerned about doctors' and nurses' work-life balance. They are more work and results-oriented rather than people oriented. Furthermore, the Nigerian government and the African Union (AU) have not established any legislation that considers and caters for employees' work-life balance, like their western and EU

counterparts. It is disheartening to find that many work-life balance policies are non-existent in Nigeria, a phenomenon that represents the negligence of the authorities towards work-life balance issues. This chapter also revealed the growing and worrying weaknesses of the MDCN, and the NANM, the bodies that regulate medical doctors' nurses' practices in Nigeria. The MDCN and NANM seem weak to proactively regulate the damaging working patterns of doctors and nurses. MDCN and NANM have no laws that regulate or cater for doctors' and nurses' work-life balance.

The chapter provided a strong argument that the interrelationship of work-life balance and organisational culture is entrenched in the influence of organisational culture and the ability of employees to subscribe to various work-life balance policies and practices at will. The chapter, therefore, provided significant contributions to both theory and practice and discussed the relevance and application of the chosen framework (border theory) to the findings of this study.

## **Chapter Nine**

### **Conclusion**

#### **9.0 Introduction**

This chapter summarises the entire thesis. The chapter presents the study overview, suggestions for future research, recommendations, contributions and personal reflections about the study.

#### **9.1 Research Overview**

The purpose of this study was to examine the interrelationship between work-life balance and organisational culture among doctors and nurses in the Nigerian medical sector. The study employed a qualitative research method to achieve this aim and the thesis has been structured as follows: the introductory chapter (Chapter 1) briefly explored the concept of work-life balance. The chapter also stated the background of the study, the research objectives, the research questions, a statement of the research problem and justification for the study. Also contained in Chapter One are: the research methodology and the research framework which have guided the study. The chapter then ended with the structure of the thesis. The literature review was divided into two (Chapter Two and Chapter Three). Chapter Two provided an overview discussion of flexibility and a broad review of work-life balance literature. The chapter also presented a discussion on work-life balance for doctors and nurses and the general outlook of work-life balance in Nigeria. Chapter Three explored organisational culture literature, hospital culture and work-life culture. Chapter Four presented conceptual framework for the study (border theory) and introduced a newly developed theory, which developed work/family border theory to find a suitable balance for the discussion and application of border theory.

Chapter Five provided the context of the study which is the Nigerian medical sector. The chapter presented a brief history of Nigeria and the Nigerian medical sector and the healthcare plans which have been introduced in the Nigerian medical sector over the years. This chapter also presented the state of nursing in Nigeria, the current state of the Nigerian healthcare sector, the Nigerian labour market, and different trade union activities in the Nigerian labour market. Subsequently, Chapter Six offered the description of the research methodology employed for this study and discussed the various approaches used and the research design. The chapter also provided the highlights of the methodology adopted, the process used to select the respondents, the method of data collection and data analysis.

Chapter Seven presented the findings and the analysis of the study. This was divided into different subsections for clarification. The chapter discussed the notions of work-life balance among Nigerian doctors and nurses, the range and usage of work-life balance policies and practices in the Nigerian healthcare sector, the different culture prevalent in the Nigerian healthcare sector and the perceptions of doctors and nurses about the culture. In addition, the chapter looked at effects of the prevailing culture on doctors and nurses families, relationships, health, performance at work and ability to use work-life balance initiatives. Factors affecting the choices and use of work-life balance policies and practices in the Nigerian healthcare sector were all discussed in Chapter Seven.

Chapter Eight discussed the findings of the study. The chapter also discussed the relevance and application of border theory and the work-life border control model to the study. However, the main conclusion drawn from this study is that the interrelationship of work-life balance and organisational culture is entrenched in the influence of organisational culture in terms of the ability of employees to subscribe to various work-life balance policies and practices at will. The

study highlighted the notions of work-life balance among Nigerian medical doctors and nurses. The study highlighted the limited range and scope of work-life balance policies and practices in the Nigerian healthcare sector and the challenges and difficulties confronted by doctors and nurses in their efforts to sign up to such initiatives.

The study identified various cultures preventing effective work-life balance ingrained in the Nigerian medical profession such as lack of management support, supervisors' support, co-workers' support, organisational time expectation and employees' lack of willingness to use work-life balance initiatives. These factors shape the choice and use of work-life balance policies and practices in the Nigerian healthcare sector. These factors and cultures, and the increasingly demanding nature of the medical profession undoubtedly make it very difficult for doctors and nurses to harmonise the work related and non-work related aspects of their lives. However, this study argues that the cultural and institutional forces responsible for driving work-life balance initiatives in the Nigerian medical sector are weak. Furthermore, this study identified the nonchalant attitudes of the Nigerian government towards employees' work-life balance. This attitude prevents Nigeria from joining the league of the elite nations who have in place employment laws, regulations and supervisory structures that ensure the best HMR practices for the benefit and general well-being of their working citizens.

This study acknowledges that the medical sector is probably the most important sector of a nation. This is because the sector looks after the nation's health through the services of doctors and nurses. However, findings from this study show that Nigerian doctors and nurses are unhappy with their heavy work schedule which is attributed to a shortage of manpower and that several work-life balance policies are not available to them. An overwhelming majority of doctors and nurses blame the government for this dire situation. An interesting dynamic in the

findings of this study is that the majority of doctors and nurses believe that medical professional culture does not align with the tenets of work-life balance practices. According to them, the main culture on which the medical profession was founded stands at variance with the doctrines of work-life balance and that it will take huge efforts and determination to alter this culture. Respondents also believe that their inability to use various work-life balance policies and practices when needed is detrimental to their performance at work and their other non-work related commitments. This is consistent with the view of McCarthy et al. (2010) that the averseness of the authorities to enact and implement work-life balance initiatives can be detrimental to employees' performance at work. It is hoped that this study will serve as a "wake-up call" to the Nigerian government to emulate the corporate HR practices of developed nations and flag up work-life balance campaigns just as the British government did in 2000. It is also hoped that management at all levels in the Nigerian medical sector will try to implement work-life balance policies and practices in their respected units.

## **9.2 Overview of the Research Findings and Discussion**

This section provides an overview of the research findings and discussion in relation to the research objectives as outlined in the chapter one of this study. The rationale for this section is to demonstrate that the research objectives have been achieved. Therefore, the overview will be discussed in ascending order of which the research objectives were listed in Chapter one.

### **9.2.1 Overview of Findings and Discussion on Research Objective 1**

The first research objective of this study sought to examine the notions of work-life balance among doctors and nurses in the Nigerian health sector. The findings indicated that Nigerian doctors and nurses' notion of work-life balance is not limited to just work and family commitments. All of the respondents define work-life balance as having time for work, family,

religious, recreational, and social activities, studies and some other events and activities. None of them defined work-life balance to mean time for work and family duties only. In essence, this finding shows that Nigerian medical doctors and nurses have the desire to be involved in various activities alongside their professional commitments. Aside from work obligations, they desire to be able to attend to various other non-work activities as much as they attach great importance to having time to attend to various familial duties and commitments. The study thus revealed that doctors and nurses' inability to attend to activities and events that matter to them often leads to under-performance at work and conflict at home.

### **9.2.2 Overview of Findings and Discussion on Research Objective 2**

The second research objective sought to assess the range and scope of work-life balance initiatives in the Nigerian health sector. The range, scope and usage of work-life balance policies and practices in the Nigerian health sectors is drastically low. This study revealed that doctors and nurses are oblivious to several work-life balance policies. Maternity leave, casual leave, sick leave, study leave and annual leave are the few work-life balance policies that exist in the Nigerian medical sector. A number of other work-life balance policies such as part-time work, parental leave, paternity leave, on-site child care, emergency childcare, backup adult and elder care, school holiday cover, on-site work-life balance expert, nanny share, reduced working hours, compressed working hours, annualised hours, teleworking, career breaks, term time working, flexitime scheme, working from home, cultural/religious leave and staggered working hours are non-existent in the Nigerian medical field. Unfortunately, the few available work-life balance policies are not easily accessible by doctors and nurses due to a shortage of workforce. However, having learnt about various work-life balance policies from the researcher,



respondents believed that availability and accessibility of those policies to them would go a long way in alleviating and cushioning their work-life balance.

### **9.2.3 Overview of Findings and Discussion on Research Objective 3/4**

The third and the fourth research objectives of this study sought to evaluate the perceptions of doctors and nurses towards work-life balance initiatives and organisational culture in Nigeria; thereby it assessed the culture and determined whether the prevalent culture aligns with work-life balance. The Nigerian doctors and nurses' perceptions of work-life balance and organisation culture is that the duo stands at variance in their organisations. Most work-life balance initiatives do not work in the medical profession. The study revealed the three most prevalent cultures in the Nigerian health sector: (a) long working hours among doctors and nurses, (b) shift work patterns, which include nights and weekend shifts and (c) physical presence in the hospital at every minute of the shift. These cultures are typical in the Nigerian health sector and unfortunately, they do not align with work-life balance policies and practices. Doctors and nurses have been trained to accept long working hours, shift work patterns and a physical presence at work as an embedded culture of the medical profession. This, supposedly, is imperative for patient care and safety and doctors' training. Any doctor or nurse who refuses to comply with these cultures faces sanctions from management and medical board.

### **9.2.4 Overview of Findings and Discussion on Research Objective 5**

The fifth research objective of this study sought to identify the forces helping or constraining to shape the choices of work-life balance practices in the Nigerian health sector. The findings revealed several factors responsible for shaping and constraining the choices and use of work-life balance policies and practices in the Nigerian health sector. The first and probably the dominant of them is organisational culture. As discussed, embedded in the culture of the Nigerian medical

sector are long working hours, shift work patterns and the culture of physical presence in the hospital at all times of the shift. These cultures invariably affect the choices and use of work-life balance policies and practices among Nigerian doctors and nurses. Long working hours prevent doctors and nurses from using work-life balance policies because it keeps them in the hospitals for incredibly longer hours, prevents them from attending to other non-work duties and separate them from their families. This study, however, argues that long working hours is a great obstruction to the implementation and use of work-life balance policies and practices in the Nigerian health sector. The culture of shift work patterns constrains the use of work-life balance policies and practices in the Nigerian medical sector. Unlike bankers and other professionals, doctors and nurses work various shift patterns, which includes nights, weekends and bank holidays (public holidays). This poses a great impediment to doctors and nurses from adopting work-life balance policies and practices. The next factor, which constrains the use of work-life balance policies and practices in the Nigerian health sector, is the “face time” culture or culture of “presenteeism”. This study revealed that the Nigerian medical sector is blighted with the culture of “presenteeism” whereby doctors and nurses are mandated to be physically present in the hospital at all times of their shift. This culture undoubtedly stands at variance with the principle of work-life balance.

Other factors include: organisational time expectation which is connected with the number of hours that doctors and nurse work. The organisational time expectation of the medical profession is high. The study found that, in Nigeria, the number of hours that doctors and nurses put in at work speaks volume of their loyalty, commitment and seriousness about their jobs. This stands at variance with the principle of work-life balance, prevents doctors and nurses from using work-life balance policies and practices. Fear of lack of career progression is another issue. Doctors

and nurses are unwilling to use work-life balance policies because they believe this would have a negative impact on their career progression. This perception of fear presents a serious barrier to achieving successful work-life balance in the Nigerian medical sector. A lack of support from management, supervisors and co-workers support was found to be among factors helping or constraining adoption of work-life balance practices in the Nigerian health sector. Management and supervisors are not supportive of work-life balance policies and practices, which restricts doctors and nurses usage thereof. They consider doctors and nurses who request to use work-life balance policies as lazy and unserious about their jobs and careers. Also, co-workers feel burdened with extra work from employees who do use work-life balance policies. Therefore, doctors and nurses' efforts to use work-life balance policies are impeded by a lack of support.

### **9.3 Future Research**

This exploratory study has contributed to the extant literature in the specific context of Nigeria. The study is justified by the relative paucity of knowledge in existing literature on work-life balance among medical doctors and nurses in Nigeria. Undoubtedly, this study will enhance further work-life balance discourse and HRM studies in Nigeria and Africa. It is expected that the ideas in this study will be seen as a case study for future studies. Since this study concentrates on one sector (the healthcare sector) and one country (Nigeria in the sub-Saharan (SSA) region) future studies should explore other sectors and countries in Africa. The findings of this study should not be generalised as being representative of all countries in SSA. In addition, it will make an interesting study to investigate the influence of organisational culture on work-life balance policies and practices of non-medical staff of the Nigeria healthcare sector. Future research may repeat this same study in other African countries and see what culture is prevalent in their hospitals and how these cultures influence the use of work-life balance policies and

practices in these countries. The author of this study further suggests that future research should use a longitudinal approach to generate a unique set of data over a designated period. It would equally be useful to investigate the negative medical consequences including the cost of human life that is associated with doctors' and nurses' work overload and work-life imbalance in Nigeria, given the exceptionally high working hours.

#### **9.4 Recommendations**

This study makes several recommendations for the Nigerian government, the policymakers and hospitals' management. In view of the serious implications of the lack of work-life balance among doctors and nurses, the Nigerian medical professional culture (long working hours, unconventional shift schedules and the requirement of physical presence in the hospital at all times) to the doctors' and nurses' work and non-work lives, this study makes four recommendations. Firstly, Nigerian policymakers should follow the steps of the EU and enact a "Nigerian Working Time Directive" to protect employees' health and safety by stipulating the maximum number of hours that they can stay at work in one day. This would, however, require a re-engineering of the healthcare delivery system and convincing all stakeholders, such that there is fair and transparent distribution of the workload of doctors and nurses. The collapse and failure of the primary and secondary healthcare systems (Akinyemi and Atilola, 2012), which is the neighbourhood surgery where people with less severe illnesses may receive quick-fix treatments is putting many work pressures on the resident doctors and nurses in the public sector hospitals (UTHs). Secondly, this study recommends that the primary and secondary healthcare systems should be strengthened and re-invigorated, which will relieve nurses and tertiary doctors of their excessive workload. Medical specialist centres (e.g. Orthopaedic, Eye, Ear Nose and Throat centres) have the benefit of shedding and sharing some of the heavy workloads of public

hospitals' health workers and such centres are rare in Nigeria. Thirdly, the study recommends that more specialist centres should be established to alleviate the doctors' and nurses' workloads and reduce the burden of care for the needy patients and contribute to their work-life balance.

The number of existing and practising medical professionals' vis-à-vis the required and recommended number is a major contributory factor to heavy workloads and the non-existence of WLB initiatives among doctors and nurses. This is, however, intertwined with the challenges of the required long training periods, expensive facilities and qualified human resources to deliver training of doctors and nurses. For instance, the ratio of patients to doctors available; is 1 doctor to 3, 500 patients against the WHO's recommended standard of 1:600. Despite this shortage, more doctors are migrating regularly to greener pastures in North America, Europe and Asia in search of better conditions of service. The fourth policy recommendation is there should be a purposive government policy initiative to address doctors and nurses training including a targeted policy at improving their condition of service and more regulated permissible working hours. This would assist in addressing the significant work life imbalance that this study has reported. Better working conditions may also reverse the "brain drain" in the profession to a "brain gain" as some Nigerian doctors may relocate in order to Nigeria to advance their career.

This study recommends a cultural and attitudinal change to hospital management and employees (doctors and nurses) of the Nigerian medical sectors. The medical professional culture, which keeps doctors and nurses in the hospital at all times of their shift and for longer hours must change if doctors and nurses ever hope to have any form of balance between their work and nonwork lives. Similarly, both the employer's and employees' attitude towards working hours and work-life balance must change for the better. This resonates with Gamble, Lewis and Rapoport's (2006, p. 54) argument that a "change in individuals' mind-sets and orientations can

be an impetus for changing in their own working practices and can perhaps contribute to wider organisational change”.

## **9.5 Contributions**

This study makes both theoretical and empirical contributions to the study of work-life balance. Theoretically, the study identifies an important shift in the construct and application of border theory. Border theory explains how employees negotiate their daily movements across work and family domains but the theory failed to recognise that family is by no means the only non-work duty that matters to employees. Also, border theory did not expound factors that determine employees’ movements across the border. These shortcomings are alarming especially, now that Generation X employees prefer work arrangements that also cater to their non-work related duties and responsibilities. Following these shortcomings, and with the data collected, the work-life border control model was developed. Practically, the work-life border control model extends work-life border theory by incorporating other non-work related activities including familial duties and outlines factors that determine employees’ movement across the border. To the best of the researcher’s knowledge, this model is new, no study has hitherto developed a model of its kind and it is absolutely important for work-life balance researchers because it provides a comprehensive and coherent understanding of a framework under which employees’ movements from work to non-work domains can be studied. The model provides the theoretical framework which has been missing in work-life balance studies. This contribution is, therefore, theoretically appealing; particularly now that the study of work-life balance is attracting serious attention and also provides a theoretical basis for future studies. Practically, this study has implications for HRD, employees and managers in Nigeria. In the under-researched context of Nigeria, an empirical study of this nature expands the work-life balance database, it provides a valuable

insight into the reality of work-life balance practices in Nigeria and creates an avenue for further studies. Furthermore, this study helps to identify work-life conflicts and provides both employers and employees with practicable solutions on how to implement a healthy work-life balance.

### **9.6 Personal Reflection on the Study**

This doctoral expedition presented me with all sorts of challenges during the fieldwork exercise and the academic environment. Gaining access to doctors and nurses, especially those working in government hospitals, was bureaucratic and cumbersome. In addition, doctors and nurses rarely have time for face-to-face interviews due to the nature of their work. Another challenge I confronted during the fieldwork was that I had to explain the meaning of work-life balance to many of the respondents. Even though they understand the need for having time for other non-work related commitments and activities, yet the phrase “work-life balance” is relatively new among them. For instance, a respondent said: “what do you mean by work-life balance?” she was learning the term for the first time. Furthermore, the data collection process was exhausting and expensive with three trips to Nigeria to collect data. For fair representation, the researcher travelled across the six geo-political zones of Nigeria to collect data. Furthermore, the Nigerians attitude toward research was not friendly and encouraging, to the extent that some respondents out-rightly declined to be interviewed because of the fear that management might not be happy with it; even though management sanctioned the exercise. Some requested to be fed with snacks and soft drinks to take part in the interview.

The data analysis and discussion stage, however, was fascinating as it allowed me to fully engage with concepts of the study, put the data in its distinct perspectives, then discuss the findings and categorising them into different themes. This stage also allowed me to compare the

situation in Nigeria with what is obtainable in the developed world, especially the UK. On the whole, the experience has been rich and priceless.



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# Appendix A

## **Research Questions**

1. How would you define work-life balance?
2. What are the work-life balance policies available in your organisation?
3. How often do you make use of them?
4. What culture would you say is prevalent in your organisation?
5. Does the prevalent culture allow you to use WLB policies and practices?
6. What are the factors that help you or constrain you from using WLB policies?
7. Would you say the culture of your profession/organization is supportive of WLB?

## Appendix B

### Triangulation Table

Process	Description
Categorisation	Categorise and sort findings from each data source (indicate specific examples) or method (indicate specific methods, e.g. interviews, observations, documents etc. if you used any of these) into categories that address each research question to determine areas of content similarities and differences.
Evaluate Theme Convergence	Emerging themes from each data source are identified and compared to examine the extent or otherwise of convergence.
Partial Agreement to no agreement themes	Evaluate themes from all data sources to identify themes that depict partial agreement, those not found in all given sources up to themes that show disagreement on results between all data sources
Evaluate convergence in the context of scope and coverage.	Review all emerging themes from various data sources to arrive at an overarching evaluation of the level of convergence. Evaluate the scope and coverage of data source or method.
Analyses Feedback and Review	Analyse emerging themes, feedback the triangulated results to some stakeholders (some respondents, HR directors, etc.) for review and clarification.

The triangulation approach taken in this study followed the processes indicated in the Triangulation Table above

# Appendix C

## CBASS Research Ethics Review Checklist – Part 1

### Section I: Project details

1. Project title: The Inter-relationship between work-life balance and organisational culture: An empirical study of Nigerian Health sector	
2. Proposed start date: November 2013	3. Proposed end date: February 2014

### Section II: Applicant details

4. Name of researcher (applicant)	Toyin Ajibade Adisa
5. Student Number	1041518
6. Status	PGR Student
7. Department	Brunel Business School
8. Brunel e-mail address	toyin.adisa@brunel.ac.uk
9. Telephone number	0757229801

### Section III: For students only

10. Module name and number:	PhD in Management Studies
11. Supervisor's name:	Chima Mordi
12. Brunel supervisor's e-mail address:	chima.mordi@brunel.ac.uk

	Ye s	No
13. Does this research involve human participants?	<input checked="" type="radio"/>	<input type="radio"/>
14. Does this research raise any ethical or risk concerns as set out in the University Code of Research Ethics or relevant disciplinary code?	<input type="radio"/>	<input checked="" type="radio"/>
15. Risk Assessment – are there any elements of risk related to the proposed research? (See Risk Assessment – FAQs)	<input type="radio"/>	<input checked="" type="radio"/>

If you have answered **Yes** to any of questions 13-15, you must **complete Part 2** of this form.

**Students:** If you have answered No, please email this document to your supervisor who will confirm that the research does not involve ethical issues. Once electronically signed by your supervisor, please submit Part 1 of this form via BBL within 1 week. Please keep a copy for yourself and bind it into your dissertation/thesis as an appendix.

**Staff:** If you have answered No, please sign below and submit your form via BBL. Please keep a copy for yourself.

**If your research methodology changes significantly, you must submit a new form.**

For Supervisor's/Staff e- signature

I confirm that there are no ethical or risk issues relating to this research and the applicant can proceed with the proposed research.
e-signature/ Date:

CBASS Research Ethics Review Checklist – Part 2

**Section IV: Description of project**

Please provide a short description of your project:
This exploratory study aims to examine the relationship between the work-life balance and organisational culture of medical doctors and nurses in Nigeria. There has been an overwhelming majority of work-life balance studies undertaken in Western countries. This leaves Africa, most notably Nigeria, an understudied area of investigations. In order to achieve this objective, this study intends to apply a qualitative research method. Semi-structured qualitative interviews will be carried out with 62 medical doctors and 29 nurses across the six geopolitical zones of Nigeria. This study will provide an important and timely understanding about the working and non-working lives of Nigerian doctors and nurses and provides feasible and practicable recommendations for the relevant authorities.

**Section V: Research checklist**

Please answer each question by ticking the appropriate box:

	YES	NO
1. Does the project involve participants who are particularly vulnerable or unable to give informed consent (e.g. children/ young people under 18, people with learning disabilities, your own students)?	<input type="radio"/>	<input checked="" type="radio"/>

	YES	NO
2. Will the research involve people who could be deemed in any way to be vulnerable by virtue of their status within particular institutional settings (e.g., students at school, residents of nursing home, prison or other institution where individuals cannot come and go freely)?	<input type="radio"/>	<input checked="" type="radio"/>
3. Will it be necessary for participants to take part in the study without their knowledge and consent (e.g., covert observation of people in non-public places)?	<input type="radio"/>	<input checked="" type="radio"/>
4. Will the study involve discussion of sensitive topics (e.g., sexual activity, drug use) where participants have not given prior consent to this?	<input type="radio"/>	<input checked="" type="radio"/>
5. Will the study involve work with participants engaged in breaking the law?	<input type="radio"/>	<input checked="" type="radio"/>
6. Will the publications/reports resulting from the study identify participants by name or in any other way that may identify them, bring them to the attention of the authorities, or any other persons, group or faction?	<input type="radio"/>	<input checked="" type="radio"/>
7. Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?	<input type="radio"/>	<input checked="" type="radio"/>
8. Will the study involve the use of human tissue or other human biological material?	<input type="radio"/>	<input checked="" type="radio"/>
9. Will blood or tissue samples be obtained from participants?	<input type="radio"/>	<input checked="" type="radio"/>
10. Is pain or more than mild discomfort likely to result from the study?	<input type="radio"/>	<input checked="" type="radio"/>
11. Could the study induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?	<input type="radio"/>	<input checked="" type="radio"/>
12. Will the study involve prolonged or repetitive testing?	<input type="radio"/>	<input checked="" type="radio"/>
13. Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?	<input type="radio"/>	<input checked="" type="radio"/>
	YES	NO
14. Will the study require the co-operation of another individual/ organisation for initial access to the groups or individuals to be recruited? If yes please attach the letters of permission from them.	<input type="radio"/>	<input checked="" type="radio"/>
15. Will you be undertaking this research as part of a work placement or in conjunction with an external organisation? If Yes and the organisation has conducted its own research ethics review, please attach the ethical approval.	<input type="radio"/>	<input checked="" type="radio"/>

If you have answered ‘yes’ to any of questions 1-13, you will need to complete the University Application Form for Research Ethics Approval. **Students:** If you have answered ‘No’ to all of questions 1-13, please **sign below and submit this completed Checklist, consent form, information leaflet and any other documents and attachments for your supervisor’s**

**approval by email . Once you have received it back from your supervisor you will be able to submit via BBL. Forms that do not have your supervisor’s approval will be rejected.**

**Staff:** If you have answered ‘No’ to all of questions 1-13, please **sign below and submit this completed Checklist, consent form, information sheet and any other documents and attachments via BBL.**

Please note that it is your responsibility to follow the University’s Code of Research Ethics and any relevant academic or professional guidelines in the conduct of your study. **This includes providing appropriate information sheets and consent forms, and ensuring confidentiality in the storage and use of data.** Any significant change in protocol over the course of the research should be notified to the Departmental Ethics Coordinator and may require a new

Applicant (Principal Investigator) Name: Toyin Ajibade Adisa
Applicant’s e-signature: Toyin Adisa
Date: 17/06/2013

application for ethics approval.

***Supervisor Section (for students only)***

*Please tick the appropriate boxes. The study should not be submitted until all boxes are ticked:*

<input type="checkbox"/>	The student has read the University’s <u>Code of Research Ethics</u>
<input type="checkbox"/>	The topic merits further research
<input type="checkbox"/>	The student has the skills to carry out the research
<input type="checkbox"/>	The consent form is appropriate
<input type="checkbox"/>	The participant information leaflet is appropriate
<input type="checkbox"/>	The procedures for recruitment and obtaining informed consent are appropriate
<input type="checkbox"/>	An initial risk assessment has been completed
<input type="checkbox"/>	If there are issues of risk in the research, a full risk assessment has been undertaken and a risk assessment is attached.
<input type="checkbox"/>	A DBS check has been obtained (where appropriate)

Any comments from supervisor:

Supervisor or module leader (where appropriate):
E-signature:
Date:

**Supervisors:** Please **email** this form to the student who will then need to submit it and related appendices via BBL.

**Student:** Once you have received this form back from your supervisor, submit this completed Checklist, consent form, information sheet and any other documents and attachments via BBL.

**Departmental/Division Ethics Coordinator section:**

This request for expedited review has been:	<input type="checkbox"/> Approved (No additional ethics form is necessary)
	<input type="checkbox"/> Declined (Full University Ethics Form is necessary)
	<input type="checkbox"/> Declined (Please give reason below)

Departmental Ethics Coordinator Name:
E- signature
Date:



# Appendix D

**Brunel**  
**UNIVERSITY**  
LONDON

Brunel Business School

Research Ethic Approval

**From:** Natasha Slutskaya

**Sent:** Tuesday, October 15, 2013 1:01 PM

**To:** Toyin Adisa

**Subject:** ethics form.

Dear Toyin

The school's research ethics committee has considered the proposal recently submitted by you. The committee is satisfied that there is no objection on ethical grounds to the proposed study. Approval is given on the understanding that you will adhere to the terms agreed and to inform the committee of any change of plans in relations to the information provided in the application form.

Best regards

Natasha Slutskaya

## Appendix E



Brunel Business School

### Work-life balance and organisational culture in the Nigerian health sector

Dear Participant,

I am a PhD researcher at Brunel Business School, Brunel University London. I am undertaking a study on the interrelationship of organizational culture on the application of work-life balance initiatives. I am conducting a survey to find out the impact of organizational culture on medical doctors and nurses' abilities to utilise work-life balance policies and practices in the Nigerian health organisations. Also in this study, I am interested in finding out what work-life balance policies are available in the Nigerian health organisations and how often are doctors and nurses allowed to use them.

Your participation in this study has no encroachment on your privacy. The study is voluntary and you have the right to withdraw at any stage of the study. All the information you provide will be treated as confidential and will only be used for academic research purposes.

Basically, the interview questions are seven but supplementary questions could surface in the course of the interview process. The interview will take around one hour. Please answer all questions as honest and comprehensive as possible. Your cooperation is highly appreciated and will contribute to the success of this study.

Thank you very much for your time!

Yours Sincerely

Toyin Ajibade Adisa

## Appendix F

### SAMPLE CONSENT FORM TO BE ADAPTED AS APPROPRIATE

The participant should answer every question

	YES	NO
1. I have read the Research Participant Information Sheet.	<input type="checkbox"/>	<input type="checkbox"/>
2. I have had an opportunity to ask questions and discuss this study.	<input type="checkbox"/>	<input type="checkbox"/>
3. I understand that I am free to withdraw from the study:		
- at any time (Please note that you will unable to withdraw once your data has been included in any reports, publications etc)	<input type="checkbox"/>	<input type="checkbox"/>
- without having to give a reason for withdrawing	<input type="checkbox"/>	<input type="checkbox"/>
- without it affecting my future care	<input type="checkbox"/>	<input type="checkbox"/>
4. I agree to my interview being recorded	<input type="checkbox"/>	<input type="checkbox"/>
5. I understand that I will not be referred to by name in any report/publications resulting from this study	<input type="checkbox"/>	<input type="checkbox"/>
6. I agree that my comments can be quoted as long as they do not directly identify me when the study is written up or published	<input type="checkbox"/>	<input type="checkbox"/>
7. I agree to take part in this study	<input type="checkbox"/>	<input type="checkbox"/>

Research Participant Name:
Research Participant signature:
Date:

<b>Principal Investigator name:</b>
<b>Principal Investigator signature:</b>
<b>Date:</b>