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Challenges perceived by nursing professionals in physician-centred organizations: An exploratory qualitative study

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Abstract

Aim: To explore and analyse contextual challenges in nursing that have affected nurses' perceptions and role performance.

Background: Health system hierarchy and patient/family-centred care has led to a high demand for skilled nurses. However, patriarchal organizations create challenges for nursing clinicians in Pakistan and elsewhere.

Methods: A qualitative exploratory research (phenomenology) design was used. Twenty-five participants identified through purposive sampling contributed to the study. The data analysis was conducted using NVivo 12 Plus. We generated six major themes. Reporting was accomplished according to the consolidated criteria for reporting qualitative research checklist.

Results: Gendered division of labour places nurses in a submissive position in clinical practice. Decreases in nurse-to-patient ratio and increase in patient-focused care adversely affect evidence-based practice. The gap between theory and practice in delivering quality care is increasing due to existing communication barriers among health-related professionals and an inadequate work environment. Comparatively inactive nursing leadership and directorate roles are not improving the social image of nursing, and are promoting role conflict and poor nursing self-concepts among nurses. In fact, cultural shock experienced by young nurses has produced inherent disorientation in their professionalism and fostered displays of horizontal violence towards them by senior nurses.

Conclusion: These challenges are influencing nurses' decisions to remain in or to join nursing as a profession that is confronted by severe recruitment and retention shortages due to the social and cultural stigmatization of this female dominated profession.

Implications for nursing, health and social policy: This study promotes the concept of evidence-based practice to deliver quality health services in public hospitals and to improve the social status of nursing in Pakistan. It provides influential evidence to policymakers who should urgently address nurses' workplace health and safety issues as a global right.

KEYWORDS

feminine domain, gender identity, healthcare, nurse shortage, nursing professionals, organizational challenges, power relations

INTRODUCTION

Globally, nursing shortages and staff turnover are increasing due to multiple flaws in many healthcare systems, which affect the quality and safety of services offered to patients. The working environment within health service organizations further reinforces the hierarchy and stereotypical roles of clinical nurses, mostly female, who complete their assigned tasks under the instructions of physicians who are mostly male (Minamizono et al., 2019). Few researchers have examined the gendered labelling of nurses as healthcare professionals who continuously provide services requiring prescriptive and presentational emotional labour (Simpson, 2007) to their patients. Such expectations form the foundations of professional conduct in nursing (Gunn et al., 2019). In Pakistani hospitals, clinical nursing tasks are mainly assigned by

physicians whom nurses are trained to obey (Abbas et al., 2020). One of the many consequences of this situation is a shortage of nurses willing to practice in such an environment (Tamata et al., 2021).

Beyond Pakistan, different regional models have been proposed for employment and regulation policies to strengthen health services (Hudspeth & Klein, 2019). The World Health Organization reported that issues of gender and class are linked to the insufficient financial recognition of nurses, who require equality for economic growth (George et al., 2017). The International Council of Nursing reported a need to promote the elimination of poverty and improve workplace conditions. Spreitzer's framework explains that different conceptualizations or dimensions, such as self-perceptions, could enhance the psychological empowerment of nurses (Loes & Tobin, 2020).

Internationally, the integration of cultural competence has attuned nurses to deliver effective care (Antón-Solanas et al., 2021). But in the United Kingdom a culturally embedded hierarchy has been shown to adversely impact upon female nursing identity (Uzar-Ozcetin et al., 2021). In China, misogyny has deleterious effects on the clinical performance of nurses (Lu et al., 2020). In Saudi Arabia, female nurses are considered less competent than males (Abou-Hashish et al., 2020). In Afghanistan, inappropriate safety measures and cultural factors have affected clinical decisions in caring services (Jabarkhil et al., 2021). In India, nurses have been ascribed the status of second-class citizens (Hollup, 2014).

In Pakistan, the public health sector struggles to deliver quality care. A blame-shifting culture and absence of informed consent from clients have built barriers to developing trusting relationships between health services and the general public. The Pakistan Nursing Council Act of 1973 set nurse's induction to the profession at the lowest ranks and recommended a single-gendered curriculum that did not teach professionalism to novice female nurses (Gallegos & Sortedahl, 2015). In 2021, the Pakistan Nursing Council Ordinance politicized the gender identity of a female nurse for financial gain and attention (PK Nurses, 2021). The ongoing decrease in the nurse-to-client ratio (Islam et al., 2019) is a result of these poor decisions. This study explores the organizational hierarchy and working conditions for Pakistani nurses that are affecting nurses' perceptions and curtailing their professional development. Specifically, the power-influenced and subordinated identity challenges perceived by nursing professionals in physician-centred hospitals in Pakistan need to be examined. Therefore, the present study aims to explore and analyse contextual challenges in nursing that have affected nurses' perceptions and role performance.

METHODS

Design

A qualitative exploratory research design, along with hermeneutic interpretative phenomenology, was used to explore the contextual and situationally lived experiences of nurses. This approach is proven to help the exploration of hidden feelings, emotions and pure narratives of participants. The philosophical stance of epistemology supports the idea of the researcher enquiring about these phenomena in the natural settings of the nursing profession (LoBiondo-Wood et al., 2018). The key theoretical assumption is supported by Foucault's (1980) power theory and a feminist perspective. The decentralized approach of bracketing enabled the researchers to set aside their prior knowledge of the field and avoid bias in order to collect pure description.

Sample

A purposive sampling technique was utilized to collect information from 25 nurses. The sample was selected from five public hospitals in Lahore, Pakistan. Inclusion criteria focused on the characteristics of nurses with a range of years of clinical experience. Those with only recent nursing experience were excluded (Table 1).

Participants were selected from multiple departments, different age groups (ranging from 22 to 51 years), various backgrounds from both rural and urban areas, married and unmarried, of different social classes and castes/religions, and different duty shift patterns. All participant nurses had studied and worked mainly in Pakistan. Nurses of different experience levels and grades were suitable for interviewing due to their practical knowledge of clients, families and their everyday interactions and interprofessional communication (Casida & Parker, 2011).

Data collection

Pilot interviews were conducted with a few nurses at their homes. Data were collected and recorded through one-to-one interviews by using a semi-structured interview guide, and the interviews lasted 60–90 minutes each. The semi-structured interview guide had four main questions derived from the literature on relevant issues. Data were collected from October 2019 to February 2020.

Rigour

Several measures were adopted to ensure rigour prior to, during and after data collection. A synthetic content analysis of the literature was conducted to develop the semi-structured interview guide. The researcher developed rapport with the participant nurses in order to gain trust and elicit authentic information.

Ethical considerations

The present study was undertaken for a doctoral study approved by the Board of Advanced Studies of Punjab University, Lahore. The interviewees were accessed after the

TABLE 1 Demographic profile of nursing professionals

Public hospitals	Nurses	Qualification	$n = 25$	Years of experience
a, b, c	Nursing students	Enrolled in general nursing + diploma	7	Third year of diploma + final years of generic students
a, c, d	Registered nurses	Qualified + specialization	7	10 years of clinical
b, d, e	Head nurses	Qualified + diploma + postgraduation	7	12 years of ward management
b, c, e	Deputy chief nursing superintendent	Qualified + diploma + postgraduation + foreign diploma holders in administration	4	23 years of whole experience including clinical, management and as an administrator

researcher followed instructions from the ethical boards of the public hospitals involved. Informed consent was received after providing information about the research and assuring participants of the confidentiality and anonymity of their data.

Data analysis

Primary data were analysed using NVivo 12 Plus. This generated six major themes emerging from the following processes. During the coding process, the essence of accurate information can be captured and clustered into related codes. Coding involved hand-coding of interviews with 18 study participants, which were then processed using NVivo 12 Plus to ensure credibility. In terms of the circular process of qualitative research, the interview guide was slightly refined after the first 19 interviews. No particular detail was derived from further additional interview guides. The last two interviews confirmed the repetition of information, and thus saturation was deemed to have been reached. In the first round of coding, before importing the data into NVivo 12 Plus, preliminary codes were developed through line-by-line and sentence analysis of the first eight interviews. This further generated dominant codes from the data (see Supplementary File). Along with the second round, which continued with the open codes of the eighth to twentieth interviews, we generated next-level codes labelled as leading codes after combining all the similarities in the data. These first- and second-level codes provided the framework for higher-order coding in this study. During the third round of coding, closely similar leading codes and open codes from all the interview transcripts were collapsed together with the last five interview transcripts in order to develop major themes at the end of the data analysis. The coding process produced 20 preliminary and dominant codes at the first level, 34 common codes and common themes at the second level, and only one code at the third level. Finally, six major themes were developed at the third level, with 55 codes (see Table 2).

RESULTS

In this study, unusual connections are made between the real-life stories of nurses and the situational challenges in the workplace that affect their personal, professional and organizational identity and growth.

Gendered division of labour in the workplace

The first theme was the subdivision of female nurses on the basis of gender identity, which placed them in a submissive position within the organizational hierarchy. Professionalism and gender equality policies at the macro-level are seen to be creating a power imbalance for nurses, causing them to feel disempowered. Their responses give the impression to physicians that they are 'battle axes'. A deputy chief nursing superintendent shared her story about her administrative life:

> *I'm under the strict control and influence of the hospital administration, which is mostly run by doctors. Although I need to follow policies, I'm still facing issues in my nursing administration such as not to allow sick leave for nurses, or paid leave for nurses, and to resolve issues of a sensitive nature for nurses. (Participant 23)*

There were also pay gaps between male and female nurses. This situation is a reflection of the economic impact of the patriarchal physicians who control the hospitals and resources. In Pakistani society, even within the household, money-holding power relates to hegemonic notions of masculinity. The lower income of nurses prevents them from gaining economic or organizational power and status.

Work overload and poor working conditions

The second theme was about workplace issues that hinder nurses from achieving their organizational goals and undermine their performance. Historically, the positional power of the contemporary organization is held by male physicians. This power arrangement becomes a political factor in an organizational culture that prioritizes males who operate within hospital policies developed by their gender. A head nurse explained her position:

> *I've been working as a nursing supervisor in this hospital since 2000, but I have to follow and maintain the power structure of the work environment because if I say something this administration will sue me. That's why most nurses stay quiet and don't express their issues to others, to save their job. (Participant 13)*

TABLE 2 Major themes and common codes of perception analysis about organizational challenges among nurses

Major themes	Common codes
Gendered division of labour in the workplace	• Feminine identity penalized women in patriarchal organizational • Discredit in refusal of assigned roles and tasks • Handmaiden to physicians • A dominant disempowered group in health care
Work overload and poor working conditions	• Increasing number of clients and decreasing number of nurses • Adoption by nurses of more medical roles for acknowledgement • Theory practice gap
Facing ethical dilemmas within the hospital	• False accusation by patients or relatives • Lapse in client needs and demands • Less autonomy in nursing roles • Forced to comply with ethical violations
Interprofessional conflict and harassment from patients	• Communication gaps among professionals • Poor coordination of teamwork to achieve organizational goals • Power relationship differences in patriarchal management • Workplace harassment of nurses
Cultural shocks experienced by nurses	• Allocation of male ward duties to naïve nurses • Less support given to nursing administrators • Senior nurses work hands off from clinical roles • The hidden curriculum of risk–benefit analysis • Emotional burnout in nurses' family life
Enculturation of the nursing profession	• Inequitable work distribution among nurses • Historical scars among senior nurses • Horizontal violence • Least interested in use of technology • Forced to stay quiet on reportable issues to avoid shame

Another workplace issue is the implementation of nursing care, in which there is an increasing gap between theory and practice due to the assignment of tasks by doctors. This has shifted the dynamics to adopt more medical roles among nurses to fit into the health environment dominated by medicine. Doctors are well compensated while senior nurses are allocated lower wages.

Facing ethical dilemmas within the hospital

The third theme was nurses' problems with facing moral dilemmas while working in a hostile environment. Nurses experience false allegations from the public as well as having to do difficult, dirty work and also endure sexual harassment from doctors. A registered nurse shared her story:

> *I have faced various kinds of offensive remarks when I worked in private-sector hospitals. I was making a bed for a patient. The patient I was attending made comments by saying that: 'If you studied a higher degree then you wouldn't work at housekeeping jobs', which were hurtful to me, but I wasn't able to give a response. (Participant 16)*

Nurses also face issues in their attempts to access adequate quantities of medicines in time for their administration, and necessary items for ward management. Other than providing nursing care for their patients, nurses are not actively engaged in the decision-making process about patients' treatment or recovery from health break-down.

Interprofessional conflict and harassment from patients

The fourth theme of the study was collaboration among doctors, nurses and paramedical staff to provide evidence-based practice. Lack of effective communication and the development of separate identities for each profession became a legitimate reason for conflicted identities among nurses. In addition, nurses face sexual harassment in the workplace from doctors. An unmarried nurse with a diploma explained her experiences with a very senior doctor:

> *I faced issues of sexual harassment from the medical superintendent of the hospital. He threatened me if I did not accept his demands for favours of a sexual nature, and when I refused he cancelled my duties many times within a month. After doing all this, he stopped and withheld my salary for one year. I filed a case and he was terminated in the end, but the deputy chief nursing superintendent did not support me at all in this matter. (Participant 6)*

Besides facing issues arising from notions of hegemonic masculinity, the prevalent culture within the hospital set-up, nurses sometimes faced harassment from their patients as well. A head nurse shared the story of a junior staff nurse:

> *I had faced physical harassment. One of the patients was male and I went to inject him with a painkiller. While I was injecting him, he grabbed my hand and stared at me with a sexual gaze. I got scared and reported the incident to senior sister, but they didn't support me well and blamed me. After doing this, he finally got discharged but he said 'I like this girl'. And if sometimes doctors harassed nurses, senior nurses blamed the nurse who was being victimized. (Participant 19)*

Nurses also experienced workplace violence over which they have no control or defence, such as incivility in public behaviour, unnecessary touching by patient attendants, and bad behaviour by housekeeping and janitorial service staff in the hospital. A third-year student shared her story of when she had experienced inappropriate remarks from housekeeping staff.

> *Once I faced immoral remarks from housekeeping staff. In case of any dispute with the public or attendants, nursing administrators never support nurses and don't listen to their issues about what they have faced, and they remove nurses from their duties or punish them without an explanation. (Participant 4)*

Cultural shocks experienced by nurses

The fifth theme of cultural shock is mostly experienced by novice nurses, despite working alongside experienced nurses in clinical practice. The professional socialization of novice nurses is an important part of their studies and ward experience. Some nurses adapt easily but others suffer from stress due to culture shock. A general nursing student explained her story:

> *I faced a cultural shock about night duties on male wards and then the thought came into my mind to leave this profession, but my nursing teacher persuaded me to continue because it can secure my future. (Participant 5)*

Nurse incivility towards each other spreads negative opinions regarding nursing work, such as poor job performance and carelessness in clinical practice. Novice nurses observe unprofessional behaviour from senior nurses or physicians. A third-year general nursing student told her story when she joined nursing and clinical practice:

> *One of my junior nurses was being physically harassed by a young doctor while they worked together. He forcefully changes her duties multiple times and followed her into other departments where she performed her duties later on. Ultimately, she was transferred to another hospital. (Participant 7)*

Socialization is a hidden curriculum in the nursing profession that occurs during their clinical practice and shapes their perceptions of professional identity and roles. A senior nurse explained the story of management during her experience of about 15 years:

> *External factors (parliamentarians, medical superintendent, and nursing references) affect healthcare professionals in their duty hours and replacement of duties. These practices flow from senior rank to junior ranks and mainly come from DCNs, and corruption is common in the nursing profession. If you point out something for improvement, they will return things using the same force on you, but for bad things. (Participant 11)*

Enculturation of the nursing profession

The sixth theme of enculturation requires mentoring in three areas: mutual dependence, benefit and regular interaction. Unfortunately, not all experienced nurses are interested in the development of others, and some have had bad experiences that have shaped their attitudes and values. This means that they may not be suitable as a mentor for junior nurses. A student who was studying a diploma narrated her story:

> *I still remember when I joined the nursing profession. I had a very beautiful haircut. One senior instructor pulled my hair very harshly to tie it up into a bun to look like a professional nurse. That was physical violence for me. (Participant 2)*

Guilt or shame arises when a person breaches social standards. Nurses suffer simultaneously from both shame and guilt when forced by their seniors to violate professional nursing ethics within a patriarchal organization. A head nurse explained her story:

> *Once during my evening shift, a senior doctor made vulgar verbal comments directly to me in front of the public. That was very painful for me. That hurt my dignity. It was a very painful experience for me. I didn't inform my superior because there was no harm done except defamation of me. So I decided to keep silent. (Participant 21)*

DISCUSSION

The discussion of the findings of this study links the main themes together logically and reveals an orderly pattern of practical nomenclature. The phenomenological arrow diagram (Figure 1) illustrates the interrelation between the

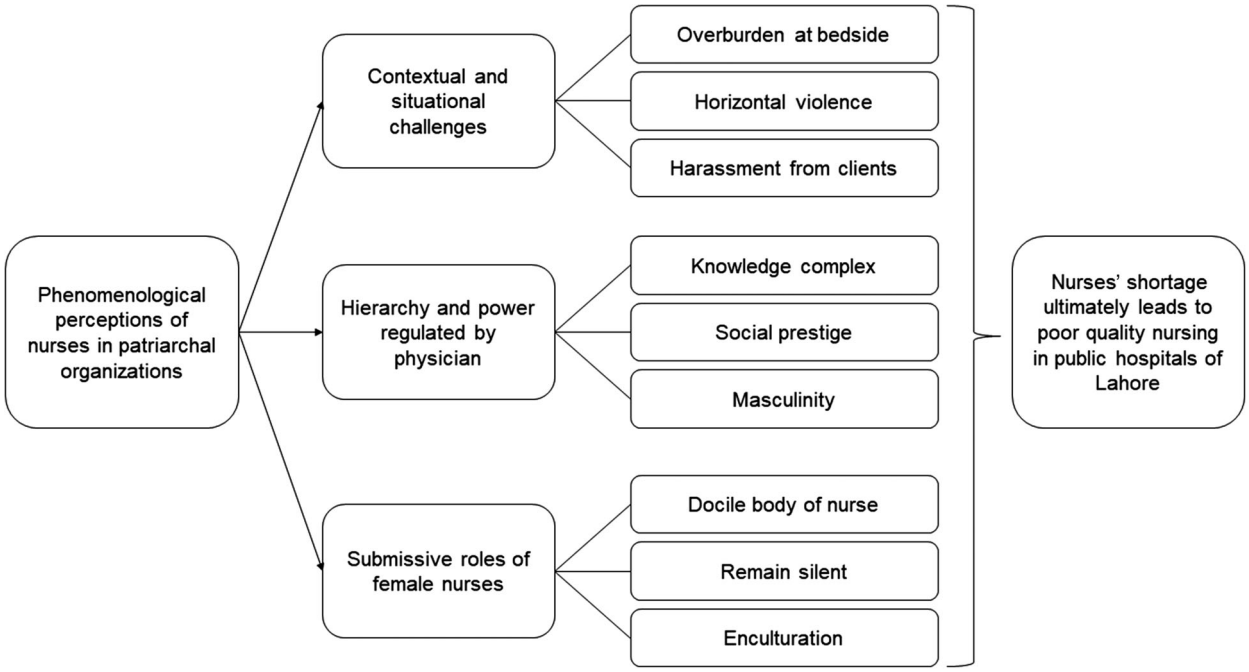

FIGURE 1 Content analysis to merge theory and phenomena

single results. This figure reveals that the gendered division of labour in the nursing profession is context based (Andrew et al., 2021). In local Pakistani culture, the preference for females is to learn and perform ascribed feminized roles based on being the caring gender, nurturing and sentimental. Foucault (1990) explained that the body does not exist materially outside its context in terms of knowledge and practice, but sometimes embodies the self in a situation such that it matches the social relations. In nursing, the hierarchy continuously controls nurses' perceptions, and if a woman wants to change the momentum of social movement, she faces negative confrontations from men, who seek to maintain their masculine power over them.

The role of a man in Pakistan and in many other cultures is different, due to the way in which society accepts and reinforces him as head of the family. Cottingham et al. (2018) explained that men could experience the benefits of nursing if they were shielded from the social construction around gender roles, and engaged in emotional labour to maintain balance. However, the patriarchal environment also keeps men away from the caring services. This vertical and horizontal division of labour is based on gender norms.

In the local discourse, nurses experienced an overburdening of duties and preferred to leave their present profession to seek more suitable work environments. Foucault's (1990) concept of the microphysics of power addresses the transformations needed by people to overcome burdens and use their experiences to support change. The nurses left-behind are required to perform their duties with a greater turnover and displacement, often resulting in poor quality health services. The broader picture of this scenario leads to a negative positioning of nurses as being uncommitted or uninterested in their profession (Sarwar et al., 2020).

Therapeutic touch, a foundation skill of nursing, involves physical assessment their patients' bodies. Many people in Pakistan perceive such touching as immoral activity (Angel & Vatne, 2017). Consequently, nurses can face physical harassment from their patients. Foucault (1980) believed that notions of manhood are regulated under the different gendered power relationships, in which sociocultural norms are sustained through the physical interaction of practice with individuals. Male patients sometimes regard nurses' clinical tasks as a type of intimate touch and respond by gazing at the nurse's body as a sexual object.

Nurses also experience moral harassment because the public perceives their image as having low value according to cultural norms. Foucault (2012) described how sociocultural practices shape individual behaviour without being normalized through social interaction. He explained that the body is a site for cultural inscription which already has the unwelcome effects of undermining women's agency and pushing them back into a position of silence. Uneducated people engage in verbal bullying more than educated people in a hospital. Bullying and abusive language are also a reality, but nurses remain silent about such behaviours (Thupayagale-Tshweneagae et al., 2020).

Junior nurses experience sexual harassment from senior physicians because these physicians control hospital policies as well as clinical services. The nurse administrators usually avoid engaging with such issues because they think that it is not easy to raise arguments against the dominant discourse (Mushtaq et al., 2015). Issues of harassment are also being reported to higher authorities but, in the end, matters are handled by changing the nurse's situation rather than the perpetrator's, by displacing the nurse to another work area or telling her to stay on paid leave for a number of days. In nursing,

the power–knowledge complex turns the human body into a docile body in which disciplinary power is used to reward and punish in a way that reinforces gendered behaviours (Foucault, 1980).

The standard expected of nursing practice is to follow ethical obligations along with upholding the respect and dignity of patients and never criticizing doctors; hence, nurses face ethical dilemmas as a matter of routine (Goethals et al., 2013). Issues of evidence-based practice arise when there is inadequate availability of medicines and no vacant beds for patients in hospital and nurses are the ones who must deliver the bad news and apologize for the lack of services and efficiency and poor medical outcomes. In this situation, instead of a healthy bonding, the patient's family's trust shifts towards the physician and reinforces their perceptions of physician competence. A feminist perspective also supports the deconstructed category of genders, which practically excludes concerns about women's struggles in daily life that are essential for identity progression. Foucault (2012) believed that docile bodies are incapable of autonomy because they do not have the power within themselves.

Nurses' perceptions of their expertise and knowledge shape the intragroup harmony, but the hospital administration does not consider that nurses need to learn advanced knowledge (Roscigno et al., 2009) for the tasks they are expected to perform. Nurses are professionally socialized to be obedient and are punished by nursing managers for being outspoken. This practice reinforces the notion that, to be good, women must keep silent: Discipline needs to achieve its goal and the body must internalize the practical demands of that discipline, whereas knowledge of the body is not separable from the power invested in it (Foucault, 2012).

Lastly, the present study recognizes enculturation as a factor that is increasing workplace violence. Verbal violence and derogatory language from the general public create incivility towards nurses when nurses follow medical orders that go against the will of their patients. Sometimes workplace violence extends to physical violence such as hitting, slapping or even throwing acid at nurses (Shahzad & Malik, 2014). The extension of this for nurses is that it causes stress and imbalance in work–family life, an area where nurses are already facing sociocultural stigmas. The socially constructed position of women's identity proceeds gradually under the notions of power and subjection, which also rely on professional socialization (and enculturation) in nursing (Foucault, 1997).

Implications for nursing, health and social policy

If nurses in Pakistan and elsewhere remain downtrodden by poorly managed health systems and power imbalances, then the option of adopting professionalism in clinical practice and positively touching their patients' lives is not feasible. Policy recommendations include (1) gender integration by providing equal opportunities for male nurses who share equally in the burden of care duties. In this way the concept of receiving nursing attentionfrom bothgenders will become normalized. (2) Enforcing health policies that eliminate harassment of nurses by patients during clinical interventions and to raise awareness of nurses rights among new nurses and patients. (3) Minimizing horizontal violence by engaging nurses in hospital-based awareness courses for all nursing personnel. (4) The image of nursing could be rebranded and its status raised through financial recognition and involvement in hospital policy decisions. (5) Attract stakeholders to develop a business model based on nursing contribution to health and national productivity.

Limitations and strengths

A major limitation of this study was not to include private hospitals in metropolitan cities, because it was more time consuming and expensive. However, the study has included all the major primary and secondary levels of public hospitals in a multicultural city, which helped in creating the foundations for collecting a variety of narrated stories and unique experiences. This qualitative approach has provided an open field to study subjects and allowed them to express their lived experiences and explain their perceptions about the phenomena under study.

CONCLUSION

Patriarchy in hospitals influences nurses' perceptions of whether or not to stay in the profession or recommend other potential students to join nursing as a career. Intraprofessional communication needs to be established and respected. Senior nurses who are perpetrating horizontal violence towards other nurses are contributing to the degradation of clinical nurses and the profession. The workplace situation in Pakistan is causing emotional burnout among nurses and encourages them to leave nursing, thereby further aggravating the nursing shortage in the national healthcare system.

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CONFLICT OF INTEREST
The authors declare that no conflicts of interest exist.

ETHICS STATEMENT
The study was approved by the Board of Advanced Studies of Punjab University, Lahore. Informed consent was received after assuring participants of the confidentiality and anonymity of all data.

AUTHOR CONTRIBUTIONS
Study design: SA, RZ; data collection: SA; data analysis: SA; study supervision: RZ, FF, AG; manuscript writing: SA; critical revisions for important intellectual content: RZ, FF, AG.

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