

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

Abstract

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

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

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

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

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

Introduction

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

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

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

specific SSA context in order to explore the interrelationship between WLB and organisational culture among Nigerian medical doctors.

This article examines the prevalent culture in Nigerian medical organisations and the factors that constrain doctors' abilities to use WLB policies. The implications of a supportive or unsupportive culture on doctors' work and non-work lives are also explored. The rest of the paper is organised as follows: Firstly, we contextualise WLB, which is followed by a discussion on doctors' WLB. Secondly, we discuss organisational culture and professional culture. Thirdly, we outline the research context, which is then followed by the methodology section. Then, we present the findings and then discuss their implications. Finally, we draw conclusions.

Work-life Balance in Context

The debate about WLB is linked to the search for employee flexibility (Zeytinoglu et al., 2009), which has been fuelled by several factors such as the need and push for a round-the-clock business hours (Tan and Klaasen, 2007; Torrington, Hall and Taylor, 2008), demographic and social changes (Sharma and Mishra, 2013), changes in the labour market (Cegarra-Leiva, Sauchez-Vidal and Cagarra-Navarro, 2012), the increase in the number of dual-earner families (Cegarra-Leiva et al., 2012), and the current economic situation that requires most families to increase their financial power (Walker, Wang and Redmond, 2008). WLB, however, means different things to different people (Lockwood, 2003). The concept recognises the multiple roles of paid work and the non-work related responsibilities of employees, which often affect each other (Kalliath and Brough, 2008). WLB means an employee's ability to successfully negotiate work related and family commitments, as well as other non-work responsibilities and activities (Parkes and Langford, 2008; Kesting and Harris, 2009; Wheatley, 2012). The purpose of WLB policies is to adjust employees' work schedules in order to find a balance between their paid

work and other non-work related responsibilities (Pillinger, 2002). The term “work-life balance” has replaced the terms “work-family balance” (Hudson Resourcing, 2005), “work-family facilitation” (Rotondo and Kincaid, 2008) and “work-family synergy” (Beutell and Wittig-Berman, 2008). This replacement is due to the fact that WLB is more inclusive of employees’ work related and non-work related activities (Lyness and Judiesch, 2014). The importance of an effective balance between employees’ work demands and non-work commitments cannot be overlooked (Liechty and Anderson, 2007). Carlson et al. (2008) noted that facilitating WLB can provide an organisation with a competitive advantage. WLB also reduces work-family conflict (Frone, 2003), promotes work-family enrichment (Mishra, Gupta and Bhatnagar, 2014) and helps organisations to attract and retain high-quality employees (Murphy and Doherty, 2011). High self-esteem, job satisfaction and an overall sense of harmony in life have been identified as indicators of successful WLB (Clarke, Kosh and Hill, 2004).

Working hours are a significant factor in achieving and managing WLB (Mubeen and Rashidi, 2014). This is because excessive working hours can create imbalances which negatively affect employees’ personal and social lives (Bielby, 1992). There is growing evidence that patterns of long working hours without flexibility results in poor WLB (Othman, Yusof and Osman, 2009; Walter, 2012). These patterns of work without flexibility turn households upside down (Bamford and Bamford, 2008) and expose doctors to high risks of making sequential mistakes (Dembe, Delbos and Erickson, 2009). However, literature acknowledges that flexible working patterns will only enhance WLB (Vandeweyer and Glorieux, 2008).

Literature also emphasises the importance of formal and informal support in the realisation of WLB. Scholars have argued that management, supervisor and co-worker support are also essential for WLB (Ayman and Antani, 2008; Maxwell and McDougall, 2004; Ferguson et al.,

2012). Management support reflects the extent to which the wellbeing and socioemotional needs are met to enhance WLB (Eisenberger et al., 1986; Behson, 2002) and supervisor support involves general expressions of concern by supervisors that is intended to enhance employee well-being (House, 1981).

Doctor's Work-life Balance

Over the years, issues pertaining to medical doctors' WLB have generated significant discussions among academics and practitioners (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 recognised the value and importance of doctors' WLB, but also believed that the requirement of physical presence in the hospital and the high intensity work environment appear incompatible with WLB principles. Medical doctors are people who constantly juggle work 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 they have less time and energy available for their family and other non-work related activities (Swanson, Power and Simpson, 1998). 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. Therefore, patterns of work without flexibility turn households upside down (Bamford and Bamford, 2008) and present doctors with a high degree of burnout and a feeling of exhaustion and depersonalisation (Deary et al., 1996).

There have been few notable studies on the work life balance of women doctors in western perspectives. Women continue to maintain majority of domestic and caring responsibilities (Crompton and Lyonette, 2011; Walsh, 2013). Women's WLB have in some

cases benefitted from strong professional body such as the British Medical Association (BMA). This has been possible because medicine is a principally public sector occupation. Consequently for both male and female doctors the BMA has successfully negotiated to reduce long working hours (Crompton and Lyonette, 2011). Pas, Peters and Doorewaard (2011) noted in their study of Dutch female doctors that offering family-friendly HR practices such as flexible working hours offers scope for improving WLB. Consequently, they suggest an appropriate interaction between HR practices and organisational culture as key to realising best HR outcomes.

Understanding Organisational Culture

Culture is a collective programming of the mind that distinguishes members of one group from another (Hofstede, 1991). Organisational culture can therefore be defined as a “deep and complex part of an organisation that can strongly influence organisational members” (Choi and Scott, 2008, p. 34). It can also be viewed as the relationship between employer and employee which is influenced by workplace traditions and regulations (Sackman, 2006). For Schein (2010), organisational culture reflects widely shared values and assumptions that are deeply rooted in an organisation, which members learn over an extended period as they solve problems.

Employees (doctors) working in medical organisations work for longer hours than other professions which often affects ability to make time for non-work activities (Wilson et al. 2007). Most organisations have now embraced the culture of long working hours, which is considered a prerequisite of organisational commitment (Mubeen and Rashidi, 2014). Employees should have control over how, when and where their daily work is carried out (Anxo, Boulin and Fagan, 2006), which is otherwise known as work-life balance (Kesting and Harris, 2009). This gives rise to the issue of work-life culture (Holt and Thaulow, 1996; Thompson, Beauvais and Lyness, 1999). For Thompson, Beauvais and Lyness (1999, p. 394), “work-family culture is the shared

assumptions, beliefs, and values on the extent to which an organisation supports and values integrating employees' work and family lives". This definition focuses on work and family life and ignores other non-work related activities. Bond (2004, p. 3), however, extends this definition to include other non-work related activities by defining work-life culture as "an organisation's support and valuing of the integration of employees' work and non-work lives." A work-life culture is developed when employees receive organisational support for managing their work-life responsibilities (Wu et al., 2011). Overall, the success of WLB initiatives depends on the nature of the prevailing culture of an organisation.

It is essential to note the relationship between organisational culture and professional culture. Professional culture dictates not only tasks and social norms but also defines the entire work environment, including what makes sense and how things are done. 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. Professional culture is a subculture of organisational culture, but it is strong and dominant; and often referred to by doctors as their organisational culture (Montgomery et al., 2011; Scott et al., 2003). Hence, the relationship between professional culture and organisational culture is not in conflict, rather it is mutually interwoven. In medicine, however, organisational culture is a good representation of professional culture (Helmreich and Merritt, 1988) and will be treated as synonymous to professional culture in this study.

Wheatley (2012) studied dual career couples (with managerial, professional, or associate professional occupations) in the UK and observed that work-group cultures prevent employees,

especially women, from achieving WLB. Employees may experience long hours in response to professional work-group cultures which often engenders undesirable consequences, especially working mothers (Wheatley, 2012). Bond (2004) found that unsupportive organisational culture promoted work-life conflict (WLC) among the UK employees in the financial sector. Previous studies indicate that organisational culture is a critical factor in achieving WLB (Lewis, 1997; Lewis, 2001, Thompson et al., 1999).

The Research Context

Nigeria is a West African country with a population of over 180 million people and over 250 diverse ethnic groups (CIA World Fact Book, 2015). The workforce is estimated to be 51.33 million and the unemployment rate to be 23.9% (CIA World Fact Book, 2011). The Nigerian health sector comprised of private and government/public hospitals. The Medical and Dental Council of Nigeria (MDCN) regulates its affairs. According to the Human Resources for Health (HRH) Fact Sheet (2010), Nigeria has the largest base of health workers in Africa; with 55,375 doctors practising in different parts of the country. This makes Nigeria a unique research context. The health sector has been chosen as the empirical focus because it allows the evaluation of the relationship between medical professional culture and doctors' WLB. As far back as 35 years ago, the Nigerian health sector was reported to be so under-staffed that there were only approximately 500 doctors available for 1 million Nigerians (Bower and Purcell, 1978). Recently, the President of the Nigerian Medical Association (NMA) suggested that Nigeria has 71,740 medical and dental practitioners and they are listed on the register of the MDCN (Muanya, 2013), out of which only approximately 27,000 are practising in Nigeria. The dearth of doctors in Nigeria is further aggravated by the issue of doctors migrating to wealthier nations in order to further their careers and thereby improve their economic and social situations (Healy

and Oikelome, 2007). For instance, more than 8,893 doctors migrated from Nigeria to countries like the UK, the US, Ireland, South Africa, the West Indies, Germany, Poland, and other countries between 2005 and 2007 (HRH Fact Sheet, 2010). This continuous migration of doctors has led to a situation in which there are only 600 paediatricians to care for its over 40 million population of children compared to the UK that has over 5,000 paediatricians for 20 million children (Ovuorie, 2013). This perhaps explains the high infant mortality rate in Nigeria, which stands at 73 deaths/1,000 live births (CIA World Fact Book, 2015). The shortage of medical doctors remains a problem for Nigeria and this influences the level of doctors' workloads which in turn leads to long working hours for doctors.

Methodology

WLB in the context of SSA has been underexplored, so we adopt a qualitative approach to data collection and analyses. A qualitative research approach is deemed ideal because of its strength in providing rich insights into issues of importance (Cassell, 2009). The study draws on interpretive-constructivist and constructivist-phenomenologist traditions which highlight individual experiences (Guba and Lincoln, 1994). This methodological position provides researchers with an in-depth understanding of this under-studied phenomenon (Cresswell, 2008), and will eventually lead to the discovery of richly detailed accounts of individual experiences (Fassinger, 2001). Several qualitative studies have also adopted this approach among different professional groups in different environments (Hennequin, 2007; Ituma et al., 2011). In addition, a case study approach has been employed in order to give the researchers the chance to explore employees' daily activities, experiences, and views on the subject matter (Cresswell, 2008). A qualitative method creates an interactive process between literature and evidence which helps to understand representativeness across a wider range of circumstances (Ciao, 2011). For the

purpose of fair representation, medical doctors working in different hospitals across the six-geopolitical zones of Nigeria were interviewed for the study. Data was collected from 60 medical doctors (33 male, 27 female) in public and private hospitals with an age composition ranging from 36-54 years. This was achieved through semi-structured interviewing. The researchers opted for the method of semi-structured interviews because of its strengths in revealing important and often hidden facts about human and organisational behaviour (Qu and Dumay, 2011).

Participants were solicited through the MDCN, which is an umbrella association for medical doctors. Sampling later developed into snowballing. Participants were asked the same questions at different times and locations in order to reduce any chance of bias. All participants passed the eligibility criteria as they were registered with the MDCN. Specifically, the participants were asked the following research questions: (a) What is the prevalent culture in your organisation? (b) What are the factors that constrain you from using WLB policies and practices in your organisation and would you say these factors are part of your organisational culture? (c) What are the implications of a supportive or unsupportive culture on your work and non-work lives? It should be noted, however, that pseudonyms have been used to represent the names of hospitals in this study in order to fulfil the promise of confidentiality made to the sources of the primary data. Consent forms were presented to the participants at the start of every interview stating the purpose of the study. Participants were informed of their right to participate or not to participate and that they could withdraw from participation at any stage of the interview process. All of the interviews were conducted in English and they lasted between 20-60 minutes. All of the interviews were electronically recorded with the permission of the participants in order to capture the participants' words verbatim. Furthermore, the recordings can help to identify what

might have been missed during the interview so that supplementary interviews could be conducted where relevant. After interviewing 48 participants, it was perceived that emerging themes were recurrent and it would be unlikely that further data collection would uncover new themes. In order to improve the reliability of the interviews and to ensure that no important themes had been left uncovered, a further 12 “confirmatory” interviews were conducted, therefore 60 interviews in total were undertaken. The findings of the 12 additional interviews corroborated the themes found in the previous 48 interviews and there were no new emerging themes. This means that we have reached a point at which Glaser and Strauss (1967, p. 61) referred to as “theoretical saturation”.

After the transcription, the researchers meticulously went back to the beginning of the recording and followed through every word to ensure that the transcribed version of the interviews exactly matched the recorded version. 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 researchers’ ability to question the meaning of particular words or phrases and to think carefully about their meaning and interpretations (Corbin and Strauss, 2008). The researchers then grouped the first set of codes into categories according to their common codes. Through the combination of codes that had similar underlying ideas, two dominant themes and eight sub-themes emerged (see Table 1). The researchers did not impose coding categories a priori; rather the researchers remained open to surprising insights by allowing the categories to emerge from the data in order not to miss any important themes. Although the researchers considered labelling the categories to be accurate and reflective of the meanings of the participants’ feelings about their WLB and organisational cultures, the researchers recognised that this is an inherently subjective exercise; given that one

“cannot escape background preconceptions embedded in the language and life of their authors” (Gill and Johnson, 1997, p. 144). The categories were then marked with different colours in order to facilitate analysis of the data and a thematic map was drawn. The main categories were further fine-tuned by frequent comparisons until a representative overview was achieved. For the exploratory nature of this study, data-driven thematic analysis was employed. The application of thematic analysis was based on the guide given by Braun and Clarke (2006) and the steps in data analysis were based on Corbin and Strauss’s (2008) recommendation. Emerging themes from the data became the categories for analysis (prearranged enigmas were verified twice in order to ensure reliability) and investigator triangulation (Polit and Beck, 2004) was applied.

Findings

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

Table 1 Emerging themes with illustrative extracts

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

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

Researchers' Findings 2015

Long Working Hours

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

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

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

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

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

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

Shift Work Patterns

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

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

Other participants said:

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 (Immunologist, Lox Hospital).

Yes, it is 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. In fact, it is now threatening my marriage (Dermatologist, Metro UTH).

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

The Required Physical Presence in the Hospital

A required physical presence in the hospital is another culture found to be prevalent within the profession. This study reveals that physical presence in the hospital at all times of doctors' working hours is one of the tenets of the medical profession; it is essential for doctors' training and medical research and is paramount to patients' care and safety. This culture, however, has been found to pose a great impediment to doctors' adoption of WLB policies and practices. The following quotations typify the participants' 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 non-work related issues...the medical profession is so much aligned with the culture of being at work at all times or what some call "presenteeism". The number of hours a doctor spends in the hospital speaks volumes of his/her seriousness and commitment about his/her job. This is the nature of the medical profession (General Practitioner, Pym Hospital).

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

Having established the prevalent culture in Nigerian health organisations, participants were asked about the factors that constrain their use of WLB policies and practices and whether such factors form a part of their organisational culture. The following themes were found to be typical: management support, supervisors' support, colleagues or co-workers' support and organisational time expectation (OTE). These themes (according to the participants) prevent them from using WLB policies and they are part of the medical professional culture.

Organisational Time Expectation

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

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

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

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

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

Management Support

This is the support that employees receive from management in order to ease the competing and contradictory responsibilities of work obligations and non-work related duties. Eisenberger et al. (2002) described it as the degree to which management cares about its employees' well-being and contribution to the organisation and therefore allows them to use WLB policies. WLB begins at management level, since they are responsible for formulating policies and creating awareness thereof. In Nigerian healthcare organisations, hospital managers are not supportive of doctors using WLB. In fact, doctors who complain of a lack of WLB policies or frequently request to use them are perceived as being lazy and unserious. When asked about managerial support, the following responses were typical:

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...the management are not supportive of me to balance my work demands and non-work related activities (Gynaecologist, Hart Hospital).

As a senior surgeon and a member of the hospital management, I do not expect any doctor to complain about not being allowed to use work-life balance policies, this is medicine...I think doctors should be more concerned about patients' care and medical research which will facilitate their career progression. I am not being personal...it is the culture in medicine (Senior Surgeon, Tower Hospital).

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

Supervisors' Support

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

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

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

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

I don't have the privilege of any supervisors' support for using 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. 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 participants shared this view).

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

Colleagues or Co-workers' Support

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

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

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

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

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 believe I was lazy and always revolt against my using those policies (Dentist, State Hospital).

An experienced participant who is nearing retirement said that the lack of support from co-workers is part of the medical profession in Nigeria. She said that she had experienced it throughout her career in different hospitals and suggested a change in attitude.

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

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

Supportive Culture

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

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

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

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

Unsupportive Culture

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

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

Another participant said:

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

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

Discussion

This article examined the influence of organisational culture on WLB policies and practices. We analysed the relationship between the prevailing Nigerian healthcare organisational culture and its influence on the adoption (by doctors) of WLB policies and practices. Long working hours has been a dominant feature of the medical profession (Walsh, 2013); however, in the Nigerian context the reported 94hours per week, for example, is excessive. In practice, this exceeds acceptable standards (Lee, McCann and Messenger, 2007). In the context of medical doctors in Nigeria, the suggestion that long hours of work shows loyalty and commitment is a result of organisations culture agrees with findings by Wheatley (2012), in a setting of a Western country, that employees may experience long hours as a result of professional work-group cultures. Therefore, there is the need for some form of external influence to curb this culture to increase

the potential of achieving WLB. In the EU, Australia, and Singapore, for example, doctors may not work over 48 hours in one week (Bamford and Bamford, 2008; British Medical Association News, 2007; Lai-Ching and Kam-Wah, 2012). Our findings lead us to conclude that because the medical professional group in Nigeria is not strong enough, or perhaps does not value WLB enough, to be able to negotiate favourable working hours as shown in the case of the UK in the study by Crompton and Lyonette (2011). In addition, the absence of labour laws relating to working hours and working time directives also has implications on WLB. However, even if the Nigerian medical association were strong enough it would be challenging to negotiate more suitable working hours within the constraint of reported shortage of doctors (Ovuorie, 2013) arising from fewer locally trained doctors and the brain drain. Our findings align with studies by Wheatley (2012) that professional work-group cultures prevent employees, especially women, from achieving WLB. Whilst this is not peculiar to the medical profession, in the Nigerian context, no attempt has been made to incorporate family friendly HR practices (Pas et al., 2011). In addition, male participation in domestic and caring responsibilities has not reached similar levels in Nigeria compared to Western countries and therefore female Doctors in Nigeria struggle, even more, to achieve WLB. Societal expectations make it difficult for career Nigerian mothers with young children to enjoy adequate WLB. In our study we also note that, in the Nigerian context, the underutilisation of ICT worsens WLB of medical professionals. Unfortunately, most Nigerian organisations continue to measure productivity in terms of employees' physical presence at work (Adisa, Mordi and Mordi, 2014). Although the literature emphasises that organisational culture is a critical factor in achieving WLB (Lewis, 1997; Lewis, 2001, Thompson et al., 1999), our findings with respect to Nigerian medical doctors in particular show a culture that does not support WLB. This unsupportive culture is not being

challenged by state and professional institutions. Since most organisations in Nigeria in general and the medical practice in particular have not developed the organisational cultures required to enhance the appropriate interaction between HR practices and organisational culture as suggested by Pas et al, (2011) the challenge of achieving WLB is exacerbated. This implies that, whilst the government has failed to institute and implement national working time directives, the medical associations have also failed to strongly influence the status quo. This is adversely affecting the WLB of Nigerian workers, especially those in the medical profession. This emphasises that good HR practice requires strong professional bodies and state led policies.

Our findings also agree with Bond (2004) that unsupportive organisational culture promoted work-life conflict (WLC). What is peculiar about our study is that, unlike other studies in developed countries about medical doctors, this is the first study that shows that fellow doctors do not support colleagues using WLB policies. This phenomenon is connected to the critical shortage of medical doctors in Nigeria (Ovuorie, 2013) and the emigration of a considerable number of Nigerian-trained doctors to high-income developed nations (Eastwood et al., 2005). Our research evidence in terms of the effect of organisational cultures on WLB is context-specific and may interact with cultural and institutional norms. This has implications for WLB and related theories. The empirical evidence gathered in this study indicates that authority figures (managers and supervisors) appear to ignore the effect of WLB on productivity. However, employees tend to be more productive when provided with HR policies that promote WLB (Beauregard and Henry, 2009). The appropriate interaction between HR practices and organisational culture as suggested by Pas et al. (2011) to realise HR outcomes such as WLB and productivity are missing and we suggest that this exacerbated by the absence of state and professional body support. Social exchange theory (Blau, 1964) emphasises that maintaining

reciprocally supportive relationships enhances organisational attachment and productivity (Shore et al., 2006). Our findings suggest that the general culture of Nigerian healthcare organisations does not support WLB because such organisations fail to appreciate WLB's essential links with productivity. Although Sibert (2011) argued that, in general, whoever desires WLB should not seek to become a medical doctor our findings, however, raise context-specific questions about whether WLB is achievable for medical doctors in general and whether the situation is exacerbated in developing countries; where the institutional, organisational and national cultures are at variance with the very practice of WLB.

Research Implications

Since the state and strong professional bodies support to encourage the required interaction between HR practices and organisational culture is absent, research needs to find out how WLB can be enhanced. Research needs to capture how effective WLB may be implemented in a developing country where state and professional arrangements do not necessarily support WLB. Can the professional bodies influence the state to change human resource practices and indeed organisational culture? If the absence of institutional arrangements such as those relating to the implementation of working time directives prevents the implementation of effective WLB policies and practices, then what can professional bodies do about it? How can such professional bodies influence the expectations of employers and employees in terms of both national and organisational cultures and how do these affect WLB policies and practices? Can organisations themselves work towards changing the perceptions about WLB? Therefore, if the WLB issues in developing countries, such as those in SSA, are to be understood then future studies should explore the interactions between HR practices, national and organisational cultures and institutional influences. Our research has limitations for generalisability in the developing

country, SSA and Nigerian context, since we focus on one sector in one country. There is the need to conduct similar studies in other developing countries in SSA in particular to evaluate if the findings resonate across the sub region. In addition, it is important to conduct similar studies in the region that looks at and compares gender as well as other professional groups such as the one by Crompton and Lyonette (2011) who compared women's success and work-life adaptations in the accountancy and medical professions in Britain.

Practice Implications

Starting from the individual level, institutional, cultural and attitudinal change on the part of management and employees (doctors) in Nigerian healthcare organisations towards working hours and WLB would need to change because of possible realisation of HR outcomes and productivity gains. This resonates with Gamble, Lewis and Rapoport's (2006, p. 54) argument that a "change in individual's mind-sets and orientations can be an impetus for changes in their own working practices and can perhaps contribute to wider organisational change". The medical association and indeed the other relevant professional bodies should seek to influence national policy on working arrangements that incorporate WLB policies and practices. This would inevitably influence organisational culture. The introduction of a Nigerian Working Time Act would regulate working hours as in other developed country. But that would not be sufficient if the Nigerian Medical Association (NMA) does not get involved to incorporate the peculiarities of the Nigerian medical profession. In addition, to assisting the state to improve labour laws and working practices, the professional bodies could organisation training programmes for supervisors, managers and employees to improve the appreciation of WLB and its links to productivity and organisational outcomes. This could lead to individual organisations organising similar training programmes. Since our findings also show that shortage of employees affect the

support for WLB, more could be done in terms of HR planning at the state, institutional and organisational levels. Healthcare organisations, therefore, need to make concerted efforts towards developing a professional culture that seeks to encourage WLB. Furthermore, those responsible for human resource management (HRM) must ensure the implementation and monitoring of WLB initiatives. This would lead to good WLB with consequent well-being and satisfaction, which would increase employee morale and high performance (Hammer et al., 2011; Butts et al., 2013; McCarthy et al., 2013) and productivity.

Conclusion

The focus of this article was to explore the influence of organisational culture on WLB practices using Nigerian medical doctors as a case study. Long working hours (strongly influenced by shift work patterns, a required physical presence at work at all times of one's shift, and organisational time expectation) were found to influence doctors' abilities to practice WLB. This is compounded by the medical organisational culture, which is characterised by a lack of support from managers, supervisors and colleagues. We found that the medical professional culture (which is also the organisational culture) perpetuates long working hours, which adversely influences WLB policies and practices. Our findings exemplify the importance of institutional arrangements that would ensure the adherence to working time directives in developing countries in order to improve employees' WLB. Our findings also complement the existing literature on this subject to emphasise that the limited use of ICT leads to a high demand for the physical presence of medical practitioners at work with consequent organisational time expectations, resulting in a lack of WLB for employees. Whilst it is evident that the medical profession across the world places enormous demands on medical doctors, this article contributes to the relevant literature in order to emphasise that, in a developing country setting in general and specifically

the SSA context, societal culture, organisational culture and institutional arrangements have a great influence on the adoption and utilisation of WLB policies and practices. In the wider sense, HRM requires a nuanced country-specific approach that appreciates that HRM policies and practices are influenced by distinct organisational, cultural and institutional settings. Although our findings give an essential country-specific context of WLB for the medical profession, future studies could explore multi-sector and multi-country studies in SSA. Future research also needs to evaluate the effect of cross-national cultural variation on WLB policies and practices.

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