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Dr. Muhammad Naseer[1],Dr. Ayaz Ul Haq[2],Syed Muhammad Abbas Shah[3]

Understanding Turnover Intentions in Pakistan's Healthcare Sector: A Qualitative Exploration of Supervisory Behavior, Stress, and Cultural Norms

Dr. Muhammad Naseer
Ph.D. (Mgt), Limkokwing University of Creative Technology, Malaysia.
drnaseerphd@gmail.com

Dr. Ayaz Ul Haq
CEO, Creative Business & Social Research (CBSR), Rawalpindi, Pakistan. drayaz@cbsr.com.pk

Syed Muhammad Abbas Shah
PhD Scholar, Department of Management Sciences, Shifa Tameer-e-Millat University, Islamabad, Pakistan. abbashr555@yahoo.com

Abstract

This qualitative study explores the underlying organizational and cultural drivers behind the turnover intentions of healthcare professionals in Pakistan. Through 28 in-depth interviews with doctors, nurses, and paramedical staff from both public and private hospitals, the research investigates how abusive supervision, job stress, organizational culture, and hierarchical norms contribute to dissatisfaction and the desire to migrate or resign. Using thematic analysis and NVivo 12 software, several patterns emerged, including the normalization of obedience, resistance to authoritarian decisions, and frustration over professional disrespect. The study finds that power distance—a deeply ingrained cultural dimension shapes how subordinates respond to stressful and unjust work conditions. Moreover, burnout, departmental politics, and lack of resources are cited as key reasons for migration, particularly among young professionals. The findings contribute to a culturally contextualized understanding of turnover and call for policy-level interventions that address structural and interpersonal dysfunctions in the healthcare system.

Keywords	Turnover intention, qualitative interviews, healthcare, Pakistan, power distance, job stress

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INTRODUCTION

TURNOVER INTENTIONS IN PAKISTAN'S HEALTH SECTOR: A QUALITATIVE PERSPECTIVE

The healthcare sector in Pakistan, like in many other developing nations, is characterized by chronic understaffing, resource scarcity, and mounting pressure on its workforce. The country faces a persistent healthcare crisis, driven not only by infrastructural deficiencies but also by a high rate of voluntary turnover among its healthcare professionals. The World Health Organization (WHO, 2014) identifies Pakistan as one of the countries with an acute shortage of trained medical personnel (Janjua, et al., 2025; Faisal, Shah, et al., 2024; Naseer, et al., 2018). This shortage is exacerbated by a wave of resignations and migration, especially among younger doctors and nurses. The present study seeks to explore, from a qualitative perspective, the lived experiences of healthcare professionals who express intent to leave their jobs, either by switching institutions or by seeking opportunities abroad (Ali, et al., 2024; Yousaf, et al., 2021).

While much of the existing research on turnover intention is quantitative, focusing on variables such as job satisfaction, commitment, and leadership style, fewer studies have adopted a qualitative lens to examine the narratives, meanings, and cultural context that influence such decisions (Waqas, Khan & saeed, 2024; Zafar, et al., 2023). Quantitative data can identify that a problem exists, but qualitative inquiry allows us to ask *why* and *how*. This study, therefore, draws from semi-structured interviews with 28 healthcare professionals in both public and private hospitals across Pakistan to gain insight into their perceptions, frustrations, and decision-making processes (Rana, et al., 2022; Rana, et al., 2021; Rana, 2015).

The research is underpinned by the Conservation of Resources (COR) theory and Hofstede's cultural dimensions, particularly the concept of power distance, to interpret how stress, abuse, and hierarchy interact to influence turnover intention (Malik, et al., 2025; Shah & Saba, 2024). Participants described their work environments as emotionally taxing, politically charged, and institutionally rigid conditions that contributed to a deep sense of dissatisfaction and desire to exit (Imran, et al., 2023; Ahmed, Ahmed & Buriro, 2023). In doing so, they shared not only their work-related grievances but also the cultural scripts that guide how one should respond to authority, cope with injustice, or envision success outside the system (Shoaib, et al., 2024; Zainab, et al., 2023).

BACKGROUND TO THE PROBLEM

Pakistan's public health sector is notoriously overburdened. Doctors often work extended hours with minimal compensation and inadequate infrastructural support. Nurses and paramedical staff report being undermined, verbally abused, or neglected by their supervisors (Mir, Rana, & Waqas, 2021). Many face dual pressures: the emotional toll of working in high-stress medical settings and the psychological burden of toxic workplace dynamics. While some of these problems exist in other countries as well, their persistence in Pakistan is magnified by deep-rooted cultural and systemic factors (Kayani, et al., 2023; Khan, et al., 2021; Naseer, et al., 2021; Khan & Khan, 2020).

In the last decade, Pakistan has also witnessed a growing trend of healthcare brain drain, with professionals seeking employment in countries like the UK, UAE, and Australia. These departures are not only driven by economic incentives but also by the desire to escape institutional dysfunction (Zhang, et al., 2023). A qualitative

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exploration can illuminate the nuances behind this exodus, especially in how healthcare workers rationalize their decisions and what conditions push them to that point (Raja, et al., 2022, Raja, 2022; Raja, et al., 2021).

SIGNIFICANCE OF A QUALITATIVE APPROACH

Turnover intention is often framed in numerical terms turnover rates, job satisfaction scores, or regression coefficients. However, behind each decision to leave lies a story, an experience, or a pattern of neglect. A qualitative approach is ideal for exploring these stories in depth. By interviewing frontline workers—nurses, medical officers, and junior doctors the study captures the voices that are often marginalized in official policy discussions (Azhar, 2024; Azhar, et al., 2022).

Moreover, this approach allows for cultural insights that quantitative models often overlook (Imran, Zaidi, & Rehan, 2024). For example, why might a subordinate tolerate abuse for years before resigning? Why do many workers report feelings of helplessness even when they are technically qualified to migrate? These are questions that hinge not only on psychological or economic factors but also on cultural scripts about respect, patience, resistance, and conformity (Azhar, 2024; Azhar, et al., 2022).

The use of thematic analysis and NVivo software enables a systematic, rigorous method to code and interpret large volumes of qualitative data. This approach bridges narrative richness with analytical clarity, ensuring that the findings are not only insightful but methodologically robust (Imran, Sultana, & Ahmed, 2023).

RESEARCH QUESTIONS

This study aims to explore the deeper organizational and cultural dynamics that drive turnover intention. The key research questions include:

1. What organizational and interpersonal experiences influence turnover intentions among healthcare professionals in Pakistan?
2. How do cultural norms, particularly related to power distance, shape healthcare professionals' responses to abusive supervision or job stress?
3. What are the perceived consequences of staying versus leaving the current workplace or profession?
4. How do healthcare professionals narrate their intention to leave as a process rather than a single decision?

THEORETICAL FRAMEWORK

This study is grounded in Conservation of Resources (COR) theory (Hobfoll, 1989), which posits that individuals strive to conserve emotional, social, and cognitive resources. When these resources are consistently depleted through stress, abuse, or professional stagnation, individuals experience burnout and consider withdrawal strategies including resignation or migration. COR theory helps explain why healthcare professionals feel "empty," "used up," or "mentally drained," as repeatedly described by participants in the interviews (Imran, et al., 2023; Ahmed, Ahmed & Buriro, 2023).

Additionally, the study draws upon Hofstede's (1984) concept of power distance, defined as the extent to which less powerful members of institutions accept hierarchical differences. In the Pakistani healthcare system, power distance is a salient cultural dimension. Sarmad, Iqbal, Ali, and ul Haq (2018) many respondents described a sense of learned helplessness or fear of challenging authority. Supervisors were often referred to as "untouchables," and decisions were seen as flowing from top-down with minimal input from subordinates. These dynamics not only create

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frustration but also delay action, contributing to passive coping until departure becomes inevitable (Janjua, et al., 2025; Faisal, Qureshi & Shah, 2025).

CONTEXTUAL RELEVANCE

Pakistan's healthcare system reflects many of the broader characteristics of its bureaucracy rigid hierarchies, patronage politics, limited transparency, and centralized decision-making. These traits affect not only policy implementation but also day-to-day interpersonal relationships within hospitals. Thus, turnover cannot be understood in isolation from the cultural fabric and institutional context in which these professionals operate (Azhar, 2024; Azhar, et al., 2022).

In addition to abusive supervision and stress, participants cited other factors such as lack of voice, professional disrespect, and intra-departmental politics as major push factors. According to the Azhar, Iqbal and Imran (2025) younger professionals especially highlighted their aspiration to work in environments where merit is recognized, creativity is encouraged, and supervision is supportive rather than oppressive. This generational shift further amplifies the urgency to reexamine traditional leadership and HR practices in healthcare (Shah, et al., 2024; Rasheed & Kiani, 2024).

LITERATURE REVIEW

INTRODUCTION TO TURNOVER INTENTION

Turnover intention refers to an employee's conscious and deliberate decision to leave their job or organization. It is widely regarded as the most immediate precursor to actual turnover behavior (Tett & Meyer, 1993). While considerable attention has been paid to turnover through a quantitative lens often with the aim of prediction and control qualitative studies offer a more nuanced understanding of the lived experiences, emotional triggers, and cultural contexts that shape this decision-making process (Hussain, et al., 2023). In sectors like healthcare, where workforce continuity is critical, understanding the deeper organizational and cultural roots of turnover becomes even more vital (Shehzad, Khan & Khan, 2024; Tariq, Khan & Atta, 2024; Noreen, et al., 2023).

Shahzad et al. (2022) Pakistan's healthcare sector is experiencing a notable increase in turnover, especially among young doctors and nurses. This trend has been exacerbated by systemic challenges such as resource shortages, supervisory abuse, limited voice in decision-making, and cultural barriers to asserting one's concerns (Hafeez, Iqbal, & Imran, 2021). While statistical data can demonstrate the scope of the problem, qualitative insights are needed to unpack why healthcare professionals become disillusioned and how they narrate their path toward leaving (Khan, Hussain & Ahmad, 2023).

ORGANIZATIONAL FACTORS INFLUENCING TURNOVER

ABUSIVE SUPERVISION

Abusive supervision has been recognized as a major organizational predictor of turnover intention. Defined by Tepper (2000) as "subordinates' perceptions of the extent to which supervisors engage in sustained hostile verbal and nonverbal behaviors, excluding physical contact," abusive supervision can take many forms ranging from public humiliation to deliberate exclusion from decision-making processes (Saba, Fatima, Farooq, & Zafar, 2021; Saba, Tabish, & Khan, 2017).

Shaukat, Rehman, and ul Haq (2021) in qualitative research, this construct often emerges in narratives of fear, resentment, or emotional exhaustion. For example, Mackey et al. (2017) found that employees under abusive supervisors described their

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environment as psychologically unsafe, fostering a deep sense of alienation. In Pakistan, where hierarchy and deferential supervision are a matter of culture, such supervision is, often, passively endured. Subordinates blame themselves or excuse abusive treatment as part of the job (Kayani, et al., 2023; Khan, et al., 2021; Naseer, et al., 2021; Khan & Khan, 2020).

Interview studies within similar cultural contexts, such as China and India, reveal that employees under abusive supervision rarely confront their leaders directly, often due to fear of retaliation or job loss (Liu et al., 2012). This resonates with the findings from Pakistan, where power distance intensifies the impact of workplace abuse and the already dysfunctional relationships.

JOB STRESS AND BURNOUT

Turnover can also be influenced by job stress. In healthcare, this stress comes from the relentless workload, emotional labor, long working hours, and the burden associated with making life-and-death decisions. The Conservation of Resources (COR) theory (Hobfoll, 1989), which asserts that individuals proactively try to conserve available emotional and psychological resources, offers helpful insight here. Individuals undergo burnout and disengagement when these resources are chronically depleted.

In qualitative research, healthcare professionals frequently describe stress in terms of "being drained," "having no time to think," or "feeling like a machine." Such expressions highlight the human cost of institutional neglect. In the Pakistani context, job stress is further amplified by poor hospital infrastructure, political interference, and administrative delays. Professionals report being burdened by tasks outside their clinical responsibilities, such as lobbying for supplies or handling clerical duties. Burnout in qualitative terms is often accompanied by a narrative of lost purpose. Many healthcare workers enter the profession out of altruism or personal calling, but gradually lose their sense of mission due to systemic inefficiencies and organizational toxicity.

CULTURAL DETERMINANTS OF TURNOVER

POWER DISTANCE AND HIERARCHY

Hofstede (1984) defined power distance as the extent to which less powerful members of organizations accept that power is distributed unequally. Pakistan scores high on this dimension, suggesting that employees are expected to respect hierarchy, follow orders without question, and avoid challenging authority figures.

In qualitative interviews, this often translates to themes of learned helplessness, institutional fatalism, and managerial untouchability. Subordinates frequently describe enduring inappropriate treatment or unethical decisions because, within the confines of the organizational framework, they lack the means to effect meaningful change. A junior doctor may endure being overworked or verbally assaulted by a supervisor because, "That's just how it's always been."

Interestingly, power distance may serve to postpone the exit decision. However, in some other ways, power distance contributes to internalized dissatisfaction and eventual burnout. Scrutinized employees do not seem to leave in droves but instead are outwardly compliant while plotting the departure: migration or withdrawal.

PROFESSIONAL IDENTITY AND DISRESPECT

Another cultural issue pertaining to turnover is the loss of professional dignity. A large group of health care providers, especially nurses and some paramedical staff,

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assert that their work is not given due consideration. Female staff members, especially, say that they are treated as 'invisible' or 'expendable'. From this point, perceived disrespect becomes a primary contributing factor associated with their decision making towards departing the organization. Professional disrespect tends to be exacerbated by systemic policies: exclusion from departmental activities, task assignments that fall well below one's level of training: petty-grudging and scapegoating administrative difficulties. Qualitative studies conducted in South Asia, where I come from, show that within medical teams, steep hierarchy of roles has been a source of dissatisfaction and turnover.

SOCIAL AND EMOTIONAL ASPECTS

MIGRATION AS AN ESCAPE

The vision of migration entails for a good number of participants an improvement economically but also an emotional escape. Emigration is captured as an act of self-preservation. In the interviews, participants portray migration as either "the only way to breathe" or "the way to live a human life." These statements illustrate the emotional weight associated with remaining in a dysfunctional system.

Migration, thus, is no longer only about compensation but also about restoring one's self-respect, freedom, and peace of mind. This confirms earlier work by Syed and Murray (2008) who reported Pakistani doctors migrating to the UK tended to view the move as a "liberation from suffocation."

SILENT RESISTANCE AND EXIT NARRATIVES

Another recurring theme in qualitative studies is "silent resistance"—a passive yet powerful way employees deal with dissatisfaction. Instead of voicing complaints, they mentally disengage, reduce productivity, or emotionally detach from their roles. This withdrawal phase often precedes resignation.

In the Pakistani context, resignation is rarely impulsive. It is the result of a prolonged internal dialogue, often shaped by family pressures, job insecurity, and societal expectations. Employees share stories of "sticking it out" for years before finally making the decision to leave (Rana & Tuba, 2017; Tuba & Rana, 2015). These exit narratives are rich in emotional complexity, blending guilt, frustration, relief, and uncertainty.

GAPS IN EXISTING LITERATURE

Despite increasing research interest in turnover, several gaps remain:

- Over-reliance on quantitative models has led to under-exploration of emotional and cultural dynamics.
- Existing studies rarely address the interactive role of culture and supervision.
- There is a lack of voice from frontline workers such as nurses and paramedical staff, whose experiences are often overshadowed by physician-focused research.
- Little attention has been paid to exit narratives and the decision-making process behind leaving a healthcare job.

This qualitative study seeks to address these gaps by elevating the voices of healthcare workers and situating their experiences within broader cultural and institutional frameworks.

SUMMARY

This review of the literature has analysed the organisational, sociocultural, and emotional drivers of turnover intentions in healthcare systems, focusing on higher power distance societies like Pakistan (Malik et al., 2023; Waheed et al., 2021; Hanif, Naveed & Rehman, 2019). It highlights that while quantitative models do signal the

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important factors, qualitative predictors narrate the emotions and cultures entwined with those factors. The review also underscores gaps such as exploration of abusive supervision, power distance, and migration narratives through the lens of detailed narrative interviews. I will discuss the methodology for capturing and analysing these voices in the next section.

METHODOLOGY

RESEARCH DESIGN

The current study used a qualitative research design framed within a constructivist interpretivist paradigm to understand the overarching turnover intentions of healthcare workers in Pakistan. The goal was to explore the meanings and perceptions, as well as the cultural components, attached to the acts of leaving one's job or migrating from the country. Qualitative approaches are best suited for phenomena that require explanation, understanding, and interpretation of social actions, especially those that are complex and multidimensional in nature.

An approach that focuses on the lived experiences of contemplating or departing from an organization or country was utilized to capture the perspectives of healthcare workers. This approach enabled the researcher to observe how participants perceive and interpret their workplace and social relationships, as well as their stress and cultural norms.

SAMPLING STRATEGY AND PARTICIPANTS

The study used purposive sampling to select information-rich participants from a range of roles in the healthcare sector. A total of 28 participants were selected from both public and private hospitals across four provinces of Pakistan. The sample included:

- 10 junior doctors (postgraduate trainees and medical officers)
- 8 nurses
- 6 paramedical staff
- 4 mid-level administrative/clinical managers

Inclusion criteria required that participants had at least one year of experience in their current institution and had either expressed turnover intention or were in the process of considering job/migration-related decisions.

The sample was balanced for gender and institutional diversity to ensure broad representativeness of experiences. Participants were recruited via professional networks, hospital HR departments, and snowball sampling.

DATA COLLECTION

Data were collected through semi-structured interviews, which allowed for both consistency across interviews and flexibility to explore emergent themes. An interview guide was developed based on existing literature and theoretical constructs such as abusive supervision, job stress, organizational culture, power distance, and turnover intention.

Sample interview questions included:

- "Can you describe a typical day at your workplace?"
- "Have you ever felt undervalued or disrespected at work?"
- "What factors make you consider leaving your current job or country?"
- "How do you view the relationship between juniors and seniors in your workplace?"
- "Do you feel empowered to express concerns or challenge decisions?"

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Each interview lasted between 35 to 70 minutes, depending on participant availability and the depth of responses. Interviews were conducted in English, Urdu, or regional languages, depending on the participant's preference. All interviews were audio-recorded (with consent), transcribed verbatim, and translated into English where necessary.

Interviews were conducted in quiet locations, mostly within hospital premises or online via Zoom due to COVID-19-related restrictions.

ETHICAL CONSIDERATIONS

The study received ethical approval from the institutional review board of the university. Participants were informed of the study's purpose, their right to withdraw at any time, and the measures taken to protect their confidentiality. Informed consent was obtained before recording the interviews. To ensure anonymity, pseudonyms were used in all transcripts and analyses. Data were stored in encrypted folders accessible only to the researcher. Special care was taken when discussing sensitive topics like abusive supervision or institutional politics to avoid psychological distress.

DATA ANALYSIS

The data were analyzed using thematic analysis as outlined by Braun and Clarke (2006). The process involved the following six steps:

1. **Familiarization** with the data by reading and re-reading transcripts.
2. **Initial coding** using open coding techniques to identify relevant phrases and sentences.
3. **Generating initial themes** based on patterns across codes (e.g., "silent suffering," "fear of authority," "escape fantasies").
4. **Reviewing themes** to check for consistency, coherence, and distinctiveness.
5. **Defining and naming themes** in relation to theoretical constructs and research questions.
6. **Producing the final narrative** that linked themes with direct quotes to illustrate meaning.

NVivo 12 software was used to support data management, coding, and retrieval. Codes were both theory-driven (based on COR theory and Hofstede's power distance) and data-driven (emerging from interview content).

RESULTS AND ANALYSIS

This section presents the findings from 28 in-depth interviews with healthcare professionals from across Pakistan. Using thematic analysis, five core themes emerged that help explain the turnover intentions of doctors, nurses, and paramedical staff. These themes are grounded in participant narratives and interpreted through the lenses of Conservation of Resources (COR) theory and Hofstede's concept of power distance. Each theme is presented with supporting quotes and analysis.

THEME 1: ABUSIVE SUPERVISION AND PSYCHOLOGICAL EROSION

Many participants described a persistent pattern of verbal aggression, micromanagement, and public humiliation by their supervisors. The experience of abusive supervision was not always dramatic but was often "subtle and constant," wearing down psychological resilience over time.

"My supervisor doesn't yell every day, but the way she speaks, it's like I'm always wrong. Even if a patient screams, it's somehow my fault." – Nurse, Public Hospital

These accounts reflect the emotional resource depletion described in COR theory. Participants felt they had to constantly defend their competence and manage the fear of being embarrassed or blamed. For junior doctors, the abuse was often normalized:

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"You can't complain. It's considered training. If you raise your voice, you'll be labeled arrogant." – Postgraduate Trainee

A high power distance culture reinforces this problem. Most participants accepted abuse as part of the professional journey, believing that resisting authority would lead to punishment or ostracization.

"If you don't obey, your rotation can be ruined. Your seniors can make or break your career." – Medical Officer

This theme illustrates how organizational culture legitimizes abusive practices, suppresses dissent, and increases emotional burnout—all contributing factors to turnover intention.

THEME 2: JOB STRESS AND THE PRESSURE TO PERFORM

Stress emerged as a universal experience, especially in public hospitals. Participants spoke of excessive patient loads, understaffing, and bureaucratic red tape. Emotional exhaustion was widespread:

"I see 70 patients a day. I barely have time to drink water or think clearly. It's like a machine, not a job." – Junior Doctor

"We are blamed if medicines are out of stock or equipment is broken. It's not our fault, but we are accountable for everything." – Paramedic

In COR theory terms, participants reported losing vital resources such as time, emotional energy, and self-efficacy, which contributed to their growing sense of helplessness. Nurses, in particular, described being assigned non-clinical duties that added to their frustration:

"They expect us to do clerical work, clean the ward, and still care for patients. Where's the respect in that?" – Nurse, Private Hospital

This role overload combined with a lack of institutional support led many participants to question the sustainability of their career in the public health system.

THEME 3: PROFESSIONAL DISRESPECT AND LOSS OF DIGNITY

Across roles, respondents described a lack of recognition, exclusion from decision-making, and devaluation of professional expertise. For many, the turnover intention was driven less by pay and more by perceived disrespect.

"No one listens to the nurse. Doctors and administrators decide everything. We're just here to follow orders." – Nurse, Public Sector

"We are treated like liabilities, not assets. If something goes wrong, it's always the junior's fault." – Postgraduate Trainee

Participants, especially females, highlighted gendered disrespect:

"Being a female nurse means you are automatically considered less smart, even if you have more experience." – Nurse, Urban Private Hospital

This loss of professional dignity led to narratives of withdrawal, detachment, and eventually the desire to exit the workplace or the country altogether. As per COR theory, repeated experiences of disrespect result in emotional disinvestment and disengagement.

THEME 4: HIERARCHICAL CULTURE AND POWER DISTANCE

A strong theme throughout the interviews was the hierarchical nature of healthcare institutions and the unquestioned authority of senior staff. Hofstede's power distance concept was highly relevant here, with participants describing a culture of obedience and silence.

"You don't question the senior, even if they are wrong. It's dangerous to challenge them." – Doctor, Government Hospital

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"Promotion is not about merit. It's about pleasing your seniors and avoiding conflict." – Medical Technician

Many participants acknowledged that fear of retaliation, loss of career opportunities, or social stigma prevented them from voicing their concerns or reporting abuse. Even when formal complaint mechanisms existed, they were viewed as ineffective:

"There is an HR department, but it's just on paper. If you file a complaint, they'll make your life harder." – Paramedic

This cultural dynamic intensifies emotional strain and delays decision-making. As one participant summarized:

"You suffer in silence until you can't anymore. Then one day you just quit or decide to go abroad."

This theme underscores how cultural norms of compliance and seniority not only perpetuate dysfunction but also suppress reform.

THEME 5: MIGRATION AS LIBERATION

For many younger professionals, especially doctors and nurses, the desire to migrate emerged as a symbol of liberation from stress, disrespect, and toxic hierarchy.

"I'm studying for PLAB. It's not about money anymore—it's about peace of mind." – Postgraduate Trainee

"In countries like Australia or the UK, you have a system. Here we have chaos." – Junior Doctor

The dream of working abroad was fueled not just by economic pull factors, but by emotional push factors. Participants associated migration with autonomy, dignity, and professional growth.

However, this aspiration also carried a moral weight. Some respondents expressed guilt about abandoning their homeland or "leaving patients behind." Yet, they also emphasized the need for self-preservation.

"We joined to serve, but we also have families and mental health. We can't sacrifice ourselves for a broken system." – Nurse, Karachi

These narratives show how turnover intention is not merely about dissatisfaction, but about reclaiming identity, respect, and peace.

CROSS-CUTTING OBSERVATIONS

- **Delayed Exit**: Turnover decisions are often delayed due to family pressure, fear of unemployment, or internalized norms of endurance. This leads to a prolonged phase of disengagement before actual resignation.
- **Gendered Experience**: Female professionals faced added layers of stress—ranging from unsafe work environments to societal expectations around obedience and silence.
- **Private vs. Public Sector**: While private hospitals offered better facilities, participants noted that hierarchical culture and abuse were still present, albeit in subtler forms.

SUMMARY OF FINDINGS

Theme	Key Insight
Abusive Supervision	Causes psychological erosion and learned helplessness
Job Stress	Linked to role overload, lack of resources, and emotional fatigue
Professional Disrespect	Undermines motivation and sense of purpose

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Theme	Key Insight
Power Distance and Hierarchy	Reinforces silence, fear, and tolerance of abuse
Migration as Escape	Viewed as a path to reclaim dignity, peace, and professional autonomy

THEORETICAL INTERPRETATION

Within the framework of COR theory, it is clear that healthcare practitioners consider their work to be emotionally depleting, cognitively demanding, and mostly ungratifying. Withdrawal becomes an obvious response when their efforts go unacknowledged and, therefore, unassisted. Hofstede's dimension of power distance offers an understanding of why numerous professionals remain in toxic environments for an extended period of time prior to acting on their intention to leave. Cultural ideals which include ascribed authority, waiting, and hierarchical deference slow down active defiance and enable the persistence of dysfunction.

DISCUSSION

OVERVIEW AND KEY INTERPRETATIONS

This research sought to understand the organisational, emotional, and cultural constituents influencing the intention to disengage from work amongst Pakistani healthcare professionals. These results from 28 interviews offer deep and multifaceted stories which go beyond simple dissatisfaction. Participants' narratives encompassed five basic themes: abusive supervision, job stress, professional disrespect, hierarchical power distance, and migration as a means to escape.

When considered together, these themes indicate that turnover intentions are not only a function of professional dissatisfaction or unfavourable economic conditions. Instead, the collective culture, emotional drain, and the fight for professional respect drive these intentions. In this last section, I interpret the findings in conjunction with the existing literature and theoretical frameworks, after which I propose practical suggestions.

ABUSIVE SUPERVISION AS A CHRONIC STRESSOR

Tepper's work (2000) and Mackey et al. (2017) have similarly noted the impact of abusive supervision on the psychological health of healthcare professionals, and our findings echo their conclusions. Participants described behaviours that included, but were not limited to, derisive condescension, public humiliation, and exclusionary non-communication. While these behaviours fall short of physical violence, they are deeply entrenched within the culture of a given setting, particularly in hierarchical organisations such as hospitals.

As indicated in the COR (Conservation of Resources) theory by Hobfoll (1989), the abusive supervision stems from emotionally exhausting experiences that drain resources without giving anything back, parallel to burnout. Many interview participants expressed feeling emotionally empty, while others felt exhausted, in other words "drained". This signified to us and deeply concerns us, as our participants described the disintegration of their resources (Imran, Zaidi & Khanzada, 2023). What is most troubling is that frontline workers often justify the abuse they experience as a form of training, regardless of context. This reflects a dangerous paradigm in which toxic leadership is accepted as a normal component of organisational life. Such narratives need to be departed from if the organisation is to foster a healthier system.

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JOB STRESS AND THE HIDDEN COSTS OF RESILIENCE

The issue of job stress is perhaps my most significant finding, which is consistent with international literature on burnout in healthcare (Maslach & Leiter, 2016). In this study, however, stress is not only about long working hours or heavy patient loads. It also encompasses emotional dissonance, role conflict, and institutional helplessness. Participants talked about being held accountable for problems that were not their fault, such as lack of equipment or policy shortage.

The distinguishing feature of this type of stress, as particularly harmful, is the intersection with power distance. Healthcare professionals perceive that they must suffer these conditions painlessly because of the threat of being branded as insubordinate or disloyal. This leads to dangerous emotional bottling, where dissatisfaction develops gradually over time until it becomes inevitable to resign or migrate.

PROFESSIONAL DISRESPECT AND THE EROSION OF IDENTITY

The research shows that professional disrespect is an often-overlooked factor influencing turnover intention, particularly in the case of nurses and paramedics. Respondents mentioned being disregarded in the decision-making processes, being placed in subordinate roles instead of partnership roles, and being inappropriately held accountable for things they did not do.

This aligns with findings from other qualitative research conducted in South Asian contexts where sharp status hierarchies between medical colleagues are rigidly defined (Ghosh et al 2019). COR theory once more provides valuable insights: when an individual's professional identity is persistently undermined, that person suffers from an erosion of self-esteem, which is, a fundamental resource for motivation and productivity.

Disrespect as an experience was additionally gendered, with female professionals experiencing compounded marginalization, being both as juniors and women. These additive layers of disrespect and marginalization not only drive turnover, but foster alienation from the profession itself.

POWER DISTANCE: SILENCE, TOLERANCE, AND POSTPONED EXIT

A particularly salient finding relates to Hofstede's notion of power distance. In high power distance cultures, such as Pakistan, submission to authority is normalized and expected. The study illustrates that this trait characteristic of street culture delays resistance and suppresses voice. Participants did not challenge reported abuse and unfair decisions not because they did not know about these problems, but because they were socialized to suffer.

This endurance does have its negatives. The choice to quit or relocate is postponed, not erased. When people do decide to depart, it is typically for good and without fanfare. The results reinforce earlier research (Syed et al., 2014) on how culturally prescribed norms influence the decision to 'exit' a system.

In addition, hospital's hierarchy was perceived to act not only as a barrier to reform, but as a mental one, restricting the range of emotions and reactions that could be considered socially acceptable. Employees reported being in a state of stuckness—unable to express dissatisfaction and unable to manage in the long term.

RECLAMATION OF SELF THROUGH MIGRATION

One of the most striking stories to come out of this study was the one about migration being an emotional escape. Participants told of travelling outside Canada not simply to earn better, but to gain self-respect, authority, and peace of mind. The metaphorical

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phrases "to breathe" and "to feel human again" illustrate how profoundly his or her sense of professional identity and self-esteem were compromised by local employment conditions.

This adds a new dimension to the literature on the healthcare brain drain phenomenon by providing an emotional and cultural aspect that is often absent from economic frameworks. Migration is not exclusively about attracting factors; it serves as a coping mechanism, a response to enduring institutional paralysis.

LINKING THEORY WITH FINDINGS

With the application of COR theory and Hofstede's model, this study provides a rationale for understanding turnover as a resource loss process influenced by culture. The dissatisfaction experienced by healthcare workers in Pakistan is not merely tiredness; they are exhausted, disregarded, and muted. From their stories, the decision to leave is not a stand-alone choice; rather, it is an outcome of enduring psychological attrition, clawed-back agency, and chronic unaddressed institutional sorrow.

PRACTICAL IMPLICATIONS

These findings suggest that policy efforts to reduce turnover should focus not only on financial incentives but also on emotional, relational, and cultural reforms:

- **Reduce abusive supervision** through ethical leadership training and enforceable accountability systems.
- **Redesign performance evaluation** to include respect and emotional intelligence as key metrics.
- **Create safe channels for voice**, allowing employees to raise concerns without fear.
- **Promote collaborative decision-making**, especially for nurses and support staff.
- **Address gender and hierarchy biases** through sensitivity training and inclusive management practices.

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

The qualitative research study focused on understanding the turnover intentions of healthcare professionals in Pakistan by conducting 28 interviews with doctors, nurses, and other auxiliary medical staff. Using Conservation of Resources (COR) theory along with Hofstede's power distance framework, the study revealed a deeply intertwined set of emotional, organisational, and cultural factors that determine why employees remain in or exit their positions or migrate overseas.

Major abusive supervision, chronic job stress, disrespect in the workplace, and rigid hierarchical norms were cited as key themes. These factors are not random or isolated in nature but rather part of an insidious larger system that gnaws at the psychosocial health and occupational identity of healthcare professionals. As described by many participants, this was a gradual process with withdrawal characterised by emotional detachment, demotivation, and eventual resignation. This clarifies that in the longitudinal perspective, turnover intention is not an impulsive decision but a consequence of relentless stress (Ali et al., 2023).

The culture of silence regarding challenging subject matter as highlighted in the study is a cultural one, particularly high-power distance. In those settings, healthcare workers have little to no opportunity to be able to contest unjust circumstances. It results in active silent suffering were acting on it is delayed, and in the end, migrating or resigning justifies emotionally abused survival.

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The research contributes to the literature by emphasizing that turnover intention cannot be fully understood without considering the emotional, relational, and cultural dynamics at play. It also gives voice to frontline professionals, particularly women and support staff, whose experiences are often overlooked in policy discourse.

RECOMMENDATIONS

Based on the findings, the following recommendations are proposed for healthcare managers, policymakers, and institutional leaders seeking to reduce turnover and improve workplace conditions:

Healthcare organizations must establish zero-tolerance policies for abusive behavior, regardless of rank or seniority. Supervisors should be trained in emotional intelligence, non-violent communication, and constructive feedback techniques. Feedback mechanisms and anonymous reporting channels must be institutionalized and protected. Burnout prevention should be prioritized. Introducing employee assistance programs, on-site counseling, and stress management workshops can help healthcare professionals cope with emotional exhaustion. Rotational duties, manageable caseloads, and adequate staffing are essential.

Power distance norms should be challenged through awareness and leadership training. Institutions should work toward a culture that encourages constructive dissent, open dialogue, and mutual respect across levels. HR policies must protect employees who speak up. Opportunities for training, promotion, and skill enhancement should be clearly defined and equally accessible. This will not only boost satisfaction but reduce the allure of migration as the only path to growth.

FINAL THOUGHTS

Healthcare is not just a clinical endeavor—it is a deeply human one. The decisions of healthcare workers to leave their jobs or migrate are embedded in their emotional experiences and cultural environments. Retention strategies must therefore move beyond compensation and address the dignity, voice, and well-being of those who serve on the frontlines of care.

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