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From Chosen to Forced: A Qualitative Exploration of Nurses' Experiences With Overtime

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Abstract
Overtime is a hot issue in the nursing profession. Despite much debate around this topic in North America, few research has questioned how overtime is perceived by nurses. Using a qualitative research design, this paper offers an in-depth analysis of nurses' perceptions of overtime in the province of Quebec, Canada. We drew on data from 42 semi-directive interviews, led by one of the authors with nurses in various healthcare establishments between March 2020 and February 2021. It emerged from our content analysis that (1) nurses' experiences of overtime are dependent on both contextual (ie. workplace, department, position, general context) and individual (ie. negotiation, time management skills) factors; (2) despite important differences in how much and how often they were required to do so, most participants reported having been in the obligation to do overtime either from their own sense of professional duty or by submission to persuasive tactics by the employer; and (3) there were reports of negative outcomes resulting from being forced to work overtime, for nurses and healthcare institutions alike. These findings contribute to the literature by mapping out the ways in which nurses may experience overtime and identifying the most vulnerable cases. Practical implications are discussed in an effort to think of solutions for nurse well-being and retention in the profession.

Keywords Nursing · Overtime · Work-family conflict · Boundary work · Work-life balance · Greedy institutions

Introduction

"Are you going to keep working eighty hours a week?
_Oh no I won't, I won't! Well, no, it would be the death of me.
_So, you are going to refuse the overtime? Is your employer going to accept this?

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_Yeah, well, there are strategies to do. I could play on the strings that: I can, or I can't. You know? But you know, it's not everyone who has strong enough balls to refuse.
_To refuse overtime?
_Yeah. Because they're giving disciplinary measures to those who don't stay. Then it becomes a fight."

Overtime work in the nursing profession has been a hot issue for the past decade in North America. Recently, the province of Quebec in Canada has seen much debate around mandatory overtime for nurses and its use by hospital managers (Lévesque, 2022), with reports of nurses being forced to work 16-h shifts (Jonas, 2021). The Covid-19 pandemic has further amplified the overtime issue by increasing healthcare professionals' working hours, in Canada (Carrière et al., 2020) and elsewhere (Ayar et al., 2022). A provincial survey indicated that the means of weekly overtime work in Quebec rose from 6.2 h in May 2019 to 16.9 h in May 2020, constituting the highest rise and means of overtime amongst all Canadian provinces (Carrière et al., 2020). While nurses are the backbone of the healthcare system (Gordon, 2012), there are alarming reports of a global nurse shortage (Murphy et al., 2012). Practitioners and scholars observe that the "staffing crisis" in nursing (Jonas, 2021) leads to heavier workloads for the remaining nurses, resulting in increased levels of work-family conflict and more people leaving the profession. As put by Varma and colleagues, "the current nurse shortage has created a cycle in which increased workload and other factors, such as increased overtime, has led to decreased job satisfaction and increased work-life conflict, causing some nurses to resign" (Varma et al., 2016, p. 59). Likewise, it appears that several potential nurses never enter the profession in their anticipation of time-based work-family conflict (World Health Organization, 2001). Therefore, nurses' working times are a central matter in the question of attracting and retaining nurses in the profession. As put by Berney and colleagues, "if undesirable working conditions contribute to the nurse shortage, overtime is certainly part of the problem" (2005, p.165).

Indeed, overtime work is not without negative consequences for nurses' health and well-being. It has been linked to work-related injuries and illness (de Castro et al., 2010). A study about Turkish nurses indicated that increased work hours during the pandemic "negatively affected their family life, their roles, and responsibilities in the family" (Ayar et al., 2022, p.648). In Belgium, overtime was found to increase work-family conflict (Lembrecht et al., 2015). A Japanese study showed that involuntary overtime had a direct negative effect on work-nonwork balance satisfaction (Watanabe & Yamauchi, 2016). Another study showed that longer shift length and weekly hours negatively affected nurses' physical and mental health (Bae & Fabry, 2014). Yet, there are indications that nurses may desire to work overtime, as a personal preference to make extra income for instance. There are even nurses who "work more overtime for the fun of work" (Watanabe and colleagues, 2018, p.686). Still, it seems that the distinction between voluntary and involuntary overtime is not always clear. Despite being called "voluntary", nurses may feel that overtime is required or necessary and, in that sense, poses the question of what really constitutes a personal choice for the nurse. A qualitative study amongst Canadian nurses revealed that, aside from the financial gain, overtime was experienced by nurses as detrimental in terms of physical effects, impact on patient care, balancing family and work, and safety, leading to a global sense of resentment (Lobo et al., 2017). In some cases, employers may even be "exempt" from paying shift workers' overtime hours (Sullivan, 2014). There is therefore a tension between hospital management agendas and nurses' desire to work a certain number of hours. However, it is not clear how often nurses are obliged to working overtime, nor

how much they do it; neither are the circumstances in which they are "forced" to do so. In this way, it seems to us that research is so far lacking a clear view about nurses' subjective experiences of overtime.

In this light, the aim of this study is to describe the perceptions held by nurses concerning their experience of overtime. There have been calls for more research about nurses' perceptions of overtime (Varma et al., 2016). This is especially important since the pandemic context, where nurses' work hours have been considerably increased (Jonas, 2021). While quantitative research has revealed disruptions in nurses' work-life balance because of increased work hours (Ayar et al., 2022), there is a need for an in-depth exploration of the subtleties in which mandatory overtime and other hospital management strategies may impact nurses.

Theoretical Background

The work-family interface literature regroups several theoretical strands. Role theory considers the interaction between the various roles that individuals play in different spheres of their lives. Greenhaus and Beutell (1985) explain that work-family conflict occurs when the requirements associated with one role make it difficult to meet the demands required in the other role. In particular, such conflict may be time-based, where "multiple roles conflict for a person's time" (Greenhaus & Beutell, 1985), particularly as it relates to excessive work time and schedule conflict dimensions (Pleck et al., 1980). Conversely, work-life balance refers to "satisfaction and good functioning at work and at home, with a minimum of role conflict" (Clark, 2000, p. 751).

The work-life interface can also be understood in terms of borders and boundaries (Allen et al., 2014). Border theory recalls that individuals are proactive in shaping the work-life border, rather than reactive to external factors (Clark, 2000). In other words, employees tend to be proactive in "crafting" their own work-life balance (Sturges, 2012), that is using strategies to achieve satisfaction in reconciling their work and non-work roles. According to Kossek (2012), individuals with high boundary control are able to establish boundaries that best suit them. For instance, an individual with personal influence will be able to negotiate preferred boundaries and be better adjusted at work and at home. However, organizational policies and practices often constrain individuals as concerns managing boundaries (Olson-Buchanan & Boswell, 2006). Indeed, "organizational culture and human resource management practices can impede or enable boundary work" (Desrochers & Sargent, 2004, p. 43). This echoes the concept of "greedy institutions" coined by Coser, (1974), which describes how institutions (eg. workplace, family) compete to make the most of the committed individual's resources in time and energy. Some institutions will make unreasonable demands and "use non-physical mechanisms" as well as "cultivate voluntary compliance as a means of encompassing their members." (Sullivan, 2014, p. 3).

Hobfoll's (1989) Conservation of resource theory (COR) further helps understand how nurses may experience overtime. The COR posits that "people strive to retain, protect, and build resources and that what is threatening to them is the potential or actual loss of these valued resources." (Hobfoll, 1989, p. 513). Resources include personal traits and skills that aid resilience. Energies such as time and money, are also important resources which can be determined by an individual's external conditions, such as one's position within an organization. In this model, stress occurs when individuals lose valued resources. The Job demands-resources theory further developed by Bakker and colleagues (2001) builds on

the COR to propose a model of burnout. In this model, excessive job demands (ie. aspects of the job requiring sustained physical mental effort) will influence employees through a health pathway leading to emotional exhaustion, while insufficient job resources (ie. health protecting aspects of the job) influence employees through a motivational pathway leading to disengagement (ie. job burnout, Maslach, 2005).

These elements of theory will enable a more thorough understanding of our findings.

Methods

Participants and Procedure

This paper stems from a research project seeking to assess factors contributing to nurse attraction and retention in the profession, by paying attention to aspects including organizational changes, work-life balance, well-being and psychosocial safety at work. This project was done in collaboration with the provincial *Ordre des infirmiers et infirmières du Québec* (Order of Quebec nurses), who gave us access to a list of nursing professionals who were first invited to fill out an online questionnaire. In this survey, participants were asked if they would like to participate in a semi-directed interview for the qualitative part of this research. An invitation was forwarded by e-mail to the participants who volunteered. The semi-directive interviews were led by one of the authors. Ethical and confidentiality matters were carefully explained at the beginning of each interview, which happened by phone or videoconference between April 2020 and March 2021. We met 42 nurses, who all agreed to being recorded and signed a consent form. The average length of the recorded interviews is of 63 min. Interviews were then transcribed manually into verbatims and pseudonyms were attributed to participants.

Interview Guide

Qualitative research has the "aim to describe and understand the nature of reality through participants' eyes with careful and on-going attention to context" (Milne & Oberle, 2005, p. 413). Interviews allow researchers "to obtain both retrospective and real-time accounts by those people experiencing the phenomenon of theoretical interest" (Gioia et al., 2012, p. 19). In that perspective, our interview guide was developed on the basis of our literature review and it starts with questions aiming to capture participants' overall trajectory as a nurse.[1] Further questions were asked about the changes that had occurred throughout their career. These open questions welcomed their sharing experience related to any type of change, including schedule-related changes, thereby allowing to capture emerging data regarding overtime work. While leaving room for emerging data, precise questions regarding overtime were also asked: "Do you happen to work overtime hours? Is it by choice?"; "What do you think about your work schedule, the number of daily and weekly work hours? Is there any mandatory overtime?";

[1] This questionnaire was developed on the basis of our literature review with a grant from the Social Sciences Research Council. While we adhere to the idea of sharing research instruments, the author of the questionnaire would appreciate being credited for it and receiving information if it used (email: diane-gabrielle.tremblay@teluq.ca). See appendix 3.

"Have you observed any changes regarding the intensification of work tasks, or working time? Explain how." In the second part of our interview guide, open questions were asked about participants' experiences with work-life balance and work stress, allowing to capture their perceptions on that matter.

Data Analysis

We used a conventional qualitative content analysis, which is appropriate to explore a phenomenon where theory or research literature is limited (Hsieh & Shannon, 2005). According to Hsieh and Shannon (2005), the main advantage of this method is to gain direct information from the participants without the imposition of preconceived categories, "allowing the categories and names for categories to flow from the data" (Hsieh & Shannon, 2005, p. 1279). We followed the process proposed by the authors: after reading the data as a whole, we then identified key thoughts and concepts relating to the subject of work schedule. The theme of mandatory overtime emerged as a puzzle to focus on (Grodal et al., 2021). After determining a certain number of codes, we then started to sort them into categories, showing how different codes are related and linked, with such emergent categories serving to "organize group codes into meaningful clusters" (Hsieh & Shannon, 2005, p. 1279). Throughout this process, some categories were merged, split, and dropped (Grodal et al., 2021). Overarching categories were determined after reaching a threshold where each unit of meaning could not be further reduced, and when each category contained enough codes to be considered relevant. Definitions for each category and subcategories were then developed (Hsieh & Shannon, 2005). Prolonged engagement with the data, member checks and a negative case analysis were performed to maximize the credibility of the findings (Manning, 1997). Once the code book established (Appendix 2), we engaged in pattern matching, that is "identifying the patterns in data, and then comparing this against one or more patterns that are proposed in the literature (Almutairi, Gardner, & McCarthy 2014). The transversal theme of choice consistently found throughout our data encouraged us to look into several theoretical strands pertaining to the work-life interface literature, as well as to the field of occupational health and psychology.

Findings

The main themes emerging from our data were regrouped in three overarching sections. The first section offers an overview of the diversity of situations found among nurses regarding the quantity and frequency of overtime hours that they do, also reporting on the contingent factors influencing these aspects. The second section presents an analysis of the reasons given by nurses as to why and how they found themselves engaging in undesired overtime. Finally, the third section reports on the negative consequences of mandatory overtime on nurses' health, well-being and organizational behavior (see Appendix 2 for the full list of codes). The following paragraphs synthesize our findings for each category, with three tables presenting representative quotes for each code resulting from our qualitative content analysis. The characteristics of cited participants that are relevant regarding our findings (ie. position, workplace, employer) are presented in Appendix 1.

Varieties of Overtime

We found considerable variation in nurses' reported experiences of overtime, ranging from a few hours that are freely chosen on occasion for personal interest to what appeared as enormous amounts of weekly unwanted, mandatory overtime, as reported in Table 1. Our negative case analysis revealed that a few participants never experienced overtime, or only a few hours occasionally that were not deemed as a problem. A few other participants reported working overtime hours on their own free will (eg. Participant #1). They were not experiencing constraining working hours and had a satisfying degree of control over their schedule. However, the majority of our participants experienced hardship regarding their working times. It was possible to identify throughout our participants' accounts several factors influencing the ways in which overtime was going to be experienced.

The workplace appeared determinant in the way nurses were going to encounter overtime. Participants consistently reported that working at a hospital, especially after the fusion of hospital centers into big regional administrations in 2015–2017, was a certain recipe to be subjected to mandatory overtime. Those that were not experiencing it were aware that it was the case in other departments (Participant #13). During the pandemic, many nurses were forced to go work in other departments or even go back to work at the hospital when they had managed to secure a position in a more favorable work environment, such as a clinic of family doctors (Participant #35). They lost a great deal of control over their schedule in the process, which highlights the gap between different workplaces when it comes to working times. Many participants had tried or were trying to move to departments where they would not be subjected to too much overtime, or that they would at least be able to compensate with a degree of control over their schedule (Participant #2).

Individual characteristics also appeared to play a role in whether nurses would be subjected to unwanted overtime or not. Table 1 offers an example of a nurse who feels comfortable setting their boundaries (Participant #1), while others struggle to do so (Participant #19). The capacity to organize oneself, which comes with experience was also sometimes cited as a reason why one would not do so much overtime (Participant #25), as well as organizing oneself with the colleagues. However, the workload was sometimes too important for this to be possible.

Reasons Behind Involuntary Overtime

While some participants, reported doing overtime on occasion by "professional conscience" (Participant #3), most nurses who worked in hospitals justified doing overtime out a sense of duty towards their colleagues and the patients. Our participants were aware of lacking human resources and expressed a willingness to do more hours in order to compensate for the absence of colleagues, in the sense that each does "their turn" for the team (Table 2, Participant #33). While all our participants found it normal from a deontological viewpoint to do some overtime hours on occasion, issues started arising when they found themselves working overtime in a systematic way. Most nurses who worked at a hospital, that is the majority of our participants, felt that the employer's demands to work more hours had become unreasonable over the years, particularly since the political reform of hospital merging in Quebec. In that sense, nurses reported that the Covid-19 pandemic only accentuated already existing human resource problems. The expectation of doing regular overtime hours was perceived as problematic, with a sense that it had become a

Table 1 Varieties of overtime—Verbatims

Code	VARIETIES OF OVERTIME Representative quotes
VARIATIONS IN QUANTITY AND FREQUENCY	"Do you happen to do overtime hours? – A little bit on occasion." (Participant #3) "Yes, I do a few overtime hours, it varies between five and seven hours per week. It's quite regular." (Participant #28) "Since Covid, much more. Before, it was more by period." (Participant #16) "Do you happen to do some overtime? – Oh yes, a lot! Oh yes, it's at least six shifts in overtime each fifteen days. That's twenty-one hours per week." (Participant #4) "Do you happen to do overtime that isn't your choice? – Yes madam, too often! It varies. In fact, in 2016 I didn't do any. But since 2017, regularly there has been compulsory overtime every Thursday, Friday, Saturday, and Sunday." (Participant #21)
VARIATIONS DEPENDING ON THE WORK ENVIRONMENT	"In fact at the clinic, we can arrange our work hours according to our availability, so it was good for work-life balance. We start at 8:30, we finish at 4:30–5:00, but if I have an appointment or something for the kids I arrange my schedule and I work another day instead. No weekends… Now at the hospital, it's really complicated." (Participant #35) "The mandatory overtime stresses me a lot, I can't do my activities (…) I changed for another service and that is where I am led to working in standby team, where we have more choice regarding our schedule. So I can't complain." (Participant #2) "Working for agencies, I choose when I work and what kind of work I do. We have this freedom." (Participant #9) "Compulsory overtime, in other services, that's for sure. But not in my service, no." (Participant #13)
VARIATIONS ACCCORIDNG TO PERSONAL ORGANIZATION AND NEGOTIATION ABILITIES	"If I do a little overtime, it's on my free will, because there was not necessarily an obligation, I don't really have problems reconciling the two. If anything, projects are just going to wait. And if they pressure us to do something, well they understand very well that it was because I wasn't available, simple. So, it goes really well on that side." (Participant #1) "Maybe having more experience, my priorities have shifted and some things I'm able to put on the side to focus on the essential (…) whereas before when you are new, you linger more on the details and it doesn't bother you to finish your shift late, it'll take the time it'll take, I can leave at one, two in the morning and I will finish my stuff. But you know I have to go get my boy at daycare and I have a lot of work around this, at midnight I need to be gone. So it depends how you manage your things." (Participant #25) "We are the ones who decide a little bit what's going on with our schedule, so we are maybe a little more vulnerable sometimes to put too much… I think we are not able to put our limits [laughs] because it's not my boss who decides (…) I've got my caseload of patients, I have five hundred patients and more, the clinic is open and the patients make appointments, so you know…they're going to be there." (Participant #19)

"management practice" and a new norm, as opposed to an option for making extra income or something that nurses may agree to do on occasion to accommodate the work team. One participant mentioned that he didn't "know of any other profession that ha[d] this" (Participant #31).

On top of overusing mandatory overtime, several participants offered a detailed description of being pressured into accepting these overtime hours (Table 2). They reported how management had their way to influence and guilt nurses into coming to or staying at work at times when they had not planned to be working, very often at a few hours' notice. Moreover, the arguments given by management to make them stay at work were not always perceived as justified. While nurses recognized the necessity of doing overtime on occasion for deontological reasons, they strongly felt that management resorted to using their deontology code as a pretense, even a threat, to make them stay to meet the current nurse-to-patient ratio. Several participants thus reported feeling forced into complying to those demands, yielding to the threat of being accused of failing their duty towards the patients. Such situations were excruciating for nurses already exhausted from a previous shift, constrained to stay extra hours at work to meet a given pre-established ratio, when in some cases the workload does not even require it (Participant #21). Here again, the presence of such tactics varied from one employer to the other, evident when comparing two cases: Participant #24, who worked in a dispensary as an employee of a Federal health agency, indicated that nothing was ever forced on her. On the opposite, Participant #7, working in a dispensary under the regional Integrated Center of Health and Social Services administration, described a situation of enormous amounts of overtime, some even unpaid, with extremely poor attitude and no support from her supervisors (Table 2). Several nurses from different establishments had encountered intimidation as a managerial practice during their career, and one participant had just quit the profession for this very reason, after experiencing harassment in the two workplaces she had been employed at over her short career as a nurse.

Consequences of Involuntary Overtime

The longer working hours and mandatory overtime conflicted with nurses' responsibilities and plans outside their employment (Table 3). With children to tend to, even fifteen minutes of unplanned overtime create a lot of stress given the strict hours of daycare centers (Participant #11). As a result, nurses may be forced to leave the position or the hospital altogether to find another work environment (Participant #8). Mandatory overtime was particularly difficult for single mothers who could not rely on a partner to replace them in case of absence, one senior nurse reporting that she would have mothers crying on the phone to try and find solutions to care for their child overnight (Participant #15). During Covid, some nurses that were working part-time by choice were obliged to work full-time, with the imposition of twelve-hour shifts, which led to grave disturbances to their home life and cause burnout. Even outside the pandemic context, the lack of personnel forces nurses to continually go beyond their limits and exhaust themselves, which eventually ends up in a plethora of burnouts and nurses struggling to come back to work.

Not only did the mandatory overtime add considerable stress to our participants' home life and personal health, it was also described as an important risk for nurses who were obliged to stay at work while exhausted, making them more vulnerable to making mistakes. This could lead to serious consequences for a patient, and to the nurse who is held responsible no matter the circumstances of her being forced to stay at work by the employer Being aware of their reduced concentration levels, this situation created paradoxical situations and cognitive dissonance for nurses regarding their mission to treat patient safely (see Table 3, penal consequences).

Finally, our participants were conscious of the human resource crisis in healthcare and reflected on employers' strategies to solve these staffing issues. Mandatory overtime was not perceived as an effective strategy and was seen as the cause of other human resource

Table 2 Reasons behind involuntary overtime – Verbatims

Code	REASONS BEHIND INVOLUNTARY OVERTIME Representative quote
A SENSE OF DUTY	"There are days, like before going in holiday, there were documents to finalize, well I did a little overtime there. It's by professional conviction to complete certain documents, let's say. But it's not a case where I have patients coming in with no resources. Like, it's not a case where someone's life is in danger. It's more by professional conviction." (Participant #3) "We are paid 35 h, but the rest it's unpaid [laughs]. Me, I'm a senior nurse. Our hours aren't counted honestly. I always come in at 7:00 to see my night team, I leave later to see my evening team as well." (Participant #12) "I have a patient who is more or less well, who called me earlier and she's not well. Director of youth protection in the file…I am obliged to add them in my schedule, I can't let them go. It's deontologically impossible, morally impossible, and ethically impossible not to put them somewhere. So I'm going to do more that day." (Participant #19) "I didn't want to take a medical leave to avoid compulsory overtime or things like that, because…it's everybody's turn, so… if it's my turn, I don't want to give it to the next person. Everybody's exhausted, so if it's my turn, I'm going to do it." (Participant #33)
EMPLOYER PRESSURE	"But as anywhere else, they are lacking personnel. So sometimes we find ourselves doing more. Yeah. Well, it's not compulsory, they never forced any one to stay or… it's always a free choice." (Participant #24) "Sometimes I do overtime hours, but it's not all my hours that are paid, because they don't want to pay some of our hours. I'm going to do twenty hours of volunteering per week sometimes…. Sometimes it's more than this." (Participant # 7) "Look, sometimes we're a bit slower in the evening… but in the evening, we never get paid. Unless there is something…Because, classic, right? If we're late in the evening, it's always because we didn't organize ourselves." (Participant #18) "You know sometimes, we are pressurized. You know: 'Well, there is no one, we're going to have to put someone in obligation to stay, and…'. So sometimes we say ok, we take it, I'll take it. You know but it's not always what I would've wanted, you know? If it's a day let's say I wanted to be off, or I would have wanted to take my evening off… well now they ask me and they insist on the question, saying: 'Yes but there's only you who could…'. There is a lot of pressure. I would do fifteen hours [ie. of weekly overtime], but maybe not twenty-one all the time, you know. (Participant #4) "They guilt trip us a lot – They play with your feelings? – Ah, all the time. All the compulsory overtime…it's always like this: 'You are abandoning your team, you are abandoning the patient…' But who looks after my family at home? Who goes get my child at school? Who will wake up in the night…?" (Participant #26) "But when at midnight they tell you: 'You're going to have to stay until 4 am, because we're lacking personnel tonight, there are only three people', and then there's no work to do, but they force me to stay, it kills me (…) They play with our deontology code: 'If you don't stay, we're going to file a complaint to the Order of Nurses.'" (Participant #21)

management problems, on top of making the working conditions unattractive for future generations of nurses. Several participants reported on a trend amongst nurses to work part-time in reaction to the recurring long hours and mandatory overtime, in order to reduce their overall amount of work hours and regain a little bit of control over their schedule (eg. Participant #31). Overall, most participants agreed that the present working conditions in hospitals were unattractive and unsustainable throughout one's working life as a nurse, with mandatory overtime counting as a major reason.

Discussion

Summary of Findings

In this explorative research, we have sought to capture nurses' perceptions about overtime, answering calls for more research on this topic (Oh & Choh, 2020; Varma et al., 2016) and considering recent political events around mandatory overtime in the province of Quebec (Lévesque, 2022). Our paper contributes to the literature by providing a clear representation of nurses' various experiences of overtime. Our inductive approach allowed three salient themes to emerge from our data, allowing a useful classification of the important factors associated with overtime in the nursing profession. An inclusive figure was developed to offer a visual synthesis of our findings, emphasizing the most important aspects to consider when dealing with the question of overtime in the nursing profession according to our participants (Fig. 1). The figure also integrates relevant concepts pertaining to several theoretical strands that will be discussed below.

Theoretical Contribution

Our inductive findings offer important contributions to the literature about overtime in the nursing profession. Our first inquiry was to shed light on how much and how often nurses experienced overtime. The important aspect that our paper points out in this respect is that there is a diversity of experiences when it comes to overtime in the nursing profession, which is determined by two main factors: the work environment, and personal abilities (Fig. 1). These factors, in turn, determine the amount and frequency of overtime done by nurses and most importantly, the degree to which it is actually chosen. A spectrum of experiences of overtime emerged from our findings, ranging from working a few extra hours on one's own terms (i.e. high boundary control, Kossek, 2012), to being coerced into staying long hours at work against one's will and without notice (i.e. low boundary control, Kossek, 2012). In the former case, no work-family conflict (Greenhaus and Beutell, 1985) and even satisfaction with work-life balance was reported, while serious issues were reported in the latter case regarding the reconciliation of work and non-work lives. Taking the viewpoint of the COR theory (Hobfoll, 1989), the more personal resources nurses have, especially in terms of interpersonal relationships to assert oneself with one's management and colleagues, but also in terms of work experience and organization capabilities, the more likely they are to maintain a schedule that suits them. In that sense, overtime is partly within the locus of control of nurses. However, it is clear from our findings that the most determining factors regarding the presence of overtime pertain to the work environment itself,

which will more or less encroach upon nurses' non-work lives. For instance, a nurse working in a hemodialysis service at a hospital will be far more likely to experience excessive overtime than a nurse working at a family doctors' clinic. A nurse working at a dispensary for a federal agency may receive much less pressure than a nurse working at a dispensary under a regional CISSS administration. Therefore, in our participants' experience, most factors influencing overtime are beyond their control.

Our second inquiry was to examine under which circumstances nurses are led, or forced, to do overtime that is not wished for from a personal interest viewpoint. Two salient reasons emerged from our findings: a sense of duty, and employer pressure. It was clear that our participants were motivated by a strong solidarity towards their fellow coworkers. They were aware that not engaging in overtime meant that someone else would have to do it, and therefore were bound by this duty towards their team. While unwanted from the viewpoint of one's own desire for work-life balance, coming to work in the spirit of helping the team constituted a motivation in itself which, according to the Job demands-resources theory (Bakker & Demerouti, 2007), is positive considering the motivational pathway through which demands and resources influence employee outcomes. In other words, offering one's time to help out one's colleagues and patients out of a strong identification to one's role as a nurse can be experienced as a positive challenge, which would not result in negative outcomes. This is especially true considering that a collective of nurses who know each other are apt to judge who is the most in need for some time off and can therefore, according to the principle of social exchange (Emerson, 1976), expect to he helped out at another time. For these reasons, "duty" was included as a reason for desired, voluntary overtime (Fig. 1). However, negative outcomes were obvious when management intervened by using this sense of duty as a tactic to force nurses to do overtime (see Fig. 1), which is a completely different process than nurses arranging themselves together. By guilting nurses regarding their colleagues and patients, and even threatening them of professional misconduct, this authoritative and sometimes intimidating management style significantly added to the stress experienced by nurses. Our participants consistently reported a gap between recommendations by the Order of Nurses in terms of rest and what they were forced to do by their management to meet the established nurse-to-patient ratio, highlighting an opposition between two different rationales: one that is motivated by the well-being of patients and nurses, and another one that is focused on meeting ratios and budgets. Figure 1 illustrates how this notion of "duty" is at the core of the problem at hand and how hospital management exploits this grey zone to the detriment of nurses' well-being, perpetuating absenteeism cycles. In that sense, it can be concluded that public hospitals stand out as greedy institutions according to the definition proposed by Coser in 1974.

Finally, our findings confirm previous studies regarding the negative outcomes of involuntary overtime for nurses in terms of work-life conflict (eg. Watanabe & Yamauchi, 2018) and for hospital human resources in terms of attraction and retention of nurses (Varma et al., 2016). Our findings also show how nurses are particularly vulnerable to job burnout, which occurs when employees are consistently subjected to stressors from the job and experience emotional exhaustion, cynicism and a sense of ineffectiveness (Maslach, 2005). It is obvious that hospital nurses tend to be subjected to a managerial logic which is far from the reality of the field and which can take meaning out of their work, such as when one is forced to stay for an extra shift while the current workload does not require it. Importantly, we add knowledge to the literature by showing how mandatory overtime constitutes a risk for patients and nurses by increasing the odds of making a mistake due to extreme fatigue. These findings press the need for a stronger protection of nurses from a perspective of occupational health and safety, but also to protect them against unfair legal repercussions.

Table 3 Consequences of involuntary overtime – Verbatims

CONSEQUENCES OF INVOLUNTARY OVERTIME	
Code	Representative quote
WORK-LIFE CONFLICT AND BURNOUT	"Let's say that my husband is waiting for me to get my boy at school, well it's more complicated, sometimes I didn't even know what time I was going to finish. Most days I finished fifteen minutes to half an hour later. Otherwise, I had to cut on my lunch hour for dinner. Maybe twice or three times I had to cut on my lunch hour to finish my things if I didn't want to finish late." (Participant #11) "But when I came back to intensive care, I realized that with a child at home, with the overtime, I wasn't capable. The mandatory overtime, they started at that time it was in 2003, I worked one month, and I couldn't do it anymore." (Participant #8) "You know when you are a young nurse and you have children at daycare, and then at 4:00 pm you get told that you won't be getting out and you are in obligation to stay because they are lacking personnel that evening, what do you do with your children at daycare? Well what we have is nurses that start crying on the units, who are taken to call a parent, a neighbor, a friend, a this, a that… it's hell for these people." (Participant #15) "Me, I've got a child but there are many more who don't have a child and who have a life, they have the right to know when they will leave the hospital to do something else because we are so drained from all our energy with that kind of work that we need to recharge elsewhere… When you've done three sixteen-hour shifts in the week, you can't sleep, because you are not sleeping well, because you are going back to work but you don't know when you'll be out again. You come into work with a knot in your stomach all the time, it's…You've got a schedule, but you don't know if it will be respected." (Participant #26) "We are in the region so often we are going to make up for absent personnel. We're going to back up, back up, back up, but eventually it's us who are paying because since we are a small team and we respect each other and we work as a team and we try to help each other, but at the end of the day we get till burnout, and people that leave are not replaced because of lacking resources." (Participant #28)
PENAL CONSEQUENCES FOR NURSES	"Nurses are a bit like the slaves of modernity. They don't have the right to be sick, they don't have the right to say no. There is this ambivalence in the management with nurses…they recommend us if we are tired…if I am tired, exhausted, well I must withdraw. But if I respect my deontology code, well I can be fired or suspended if I refuse to do an extra shift, a sixteen-hour or stuff like this. So there is a dichotomy between what is written by the Order of Nurses and what goes on in practice." (Participant #9) "At fifty-three years old, when I'm obliged to do a sixteen-hour, I put my license at stake. Because after twelve, thirteen hours, I'm sorry, but I'm becoming really tired. And if I make a mistake, it's not them who are going to be reprimanded, it's ME. And them, they are like… 'Ok whatever, you're doing a sixteen hour, you're doing a sixteen hour.' So it's not… it's not correct. If they would tell me instead: 'Ok Corinne, if you make a mistake while you are in mandatory overtime, we are going to take the responsibility'. Ok, fine. But it's not them who will take the responsibility, it's ME who is going to be obliged to respond to my actions." (Participant #33) "In our deontology code, we are not supposed to work when we are inapt to work. Well now, our deontology code… then what are they going to ask you? 'Well now you have to work, you have to come into work Madam, you are apt to work'. Well what do we do now? We are like caught in a trap. You have to make a living, earn your job, I cannot allow myself to leave right now." (Participant #38)

Table 3 (continued)

Code	CONSEQUENCES OF INVOLUNTARY OVERTIME Representative quote
WORKAROUNDS/ WITHDRAWAL	"There are places, you go to work and you don't know if you are going to get out at night, and it causes problems because people are saying: 'I won't put myself available full time, I will do three sixteen hours'. So, people put themselves part-time, they're going to do some overtime. It pays their full-time. It creates a funny dynamic. Since the fusion of hospitals, it looks like the managers who were in charge of this are not able to manage anymore, it's as tough something was lost in the process." (Participant #31) "Mandatory overtime does not solve anything, on the contrary. If a nurse is forced to stay sixteen hours, she won't be coming to work the next morning. It's a vicious circle." (Participant #24) "By doing what they are doing, new nurses won't come, no one wants to be a nurse right now. Doing mandatory overtime, doing weekends for the rest of your life… it's not attractive to do this." (Participant #23)

Practical Implications

Our findings highlight the problematic case of mandatory overtime, raising the question of nurses' right to refuse overtime. When faced with a request to stay at work for an extra shift, the Order of Nurses, which has authorship of the deontological Code, recalls that

> After evaluating their capacity to work as well as the context in which they have been asked to do overtime, such as the complexity of care, the state of the patients, etc., the nurse may accept to stay at work. If they judge that they are not in a state to work, they then must withdraw from work and refuse to do overtime (Létourneau, Brisson and Maitre, 2018).[2]

Therefore, mandatory overtime does not constitute a deontological obligation, and nurses are even expected to refuse overtime hours if they judge that they are not in a condition to provide safe care for the patients. Our findings showed that several participants found themselves in a situation where they could not refuse the overtime despite being exhausted and found themselves inapt to work. The Order of Nurses further recalls that "the employer must not use the deontological Code to manage a situation of lack of resources nor to exert pressure on nurses" and that "The use of mandatory overtime is a measure of last resort that should always be considered in the aim to provide quality care and services to the clients, in all safety." (OIIQ, 2018). Our findings indicate that the reality is sometimes far from these expectations, with several nurses reporting to be pressurized, either by indirect, guilt-inducing remarks, or directly by threat of denunciation and accusation of professional misconduct. Furthermore, the Order of Nurses states that employers are "encouraged to search for other measures and to communicate to the nurses all the steps taken before imposing mandatory overtime, as well as encourage nurses to speak

[2] Translated from French: « Après avoir évalué sa capacité à exercer ainsi que le contexte dans lequel on lui demande d'effectuer des heures supplémentaires, tels que la complexité des soins, l'état des clients, etc., l'infirmière peut accepter de rester au travail. Si elle juge qu'elle n'est pas en état d'exercer, elle a alors le devoir de se retirer du travail et de refuser de faire des heures supplémentaires.» (Létourneau, Brisson and Maitre, 2018).

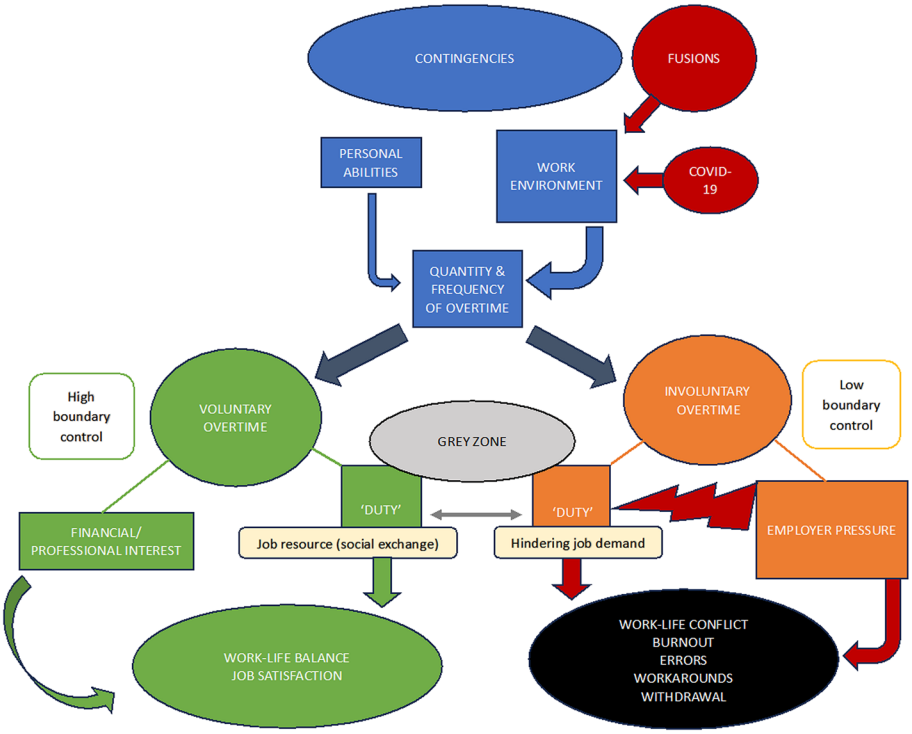

Fig. 1 Overtime in the nursing profession in Quebec (2020–2021)

with their management to find satisfactory solutions." While the Order seemingly expects a discussion between nurses and their management, our findings indicate that there is no such space for discussion. Nurses on mandatory overtime are warned at a few hours' notice and very little time is left to find solutions. Moreover, these discussions often take the form of a confrontation.

Our results have shown the mechanisms through which hospitals act as greedy institutions (Coser, 1974) trying to make nurses devote more of their time and energy to the workplace, by using non-physical mechanisms and cultivating voluntary compliance (Sullivan, 2014). The Covid-19 pandemic accentuated these already existing problems (Ayar et al., 2022; Jonas, 2021). The fact that public health institutions are becoming increasingly "greedy" on nurses' time and energy is alarming for the future of the public healthcare system as a whole, considering that nurses are the backbone of the healthcare system (Gordon, 2012). Nurses may leave for private agencies, leading to a privatization of care and thereby worsening societal inequities. The enormous amount of involuntary overtime to which many hospital nurses are subjected is a symptom of management issues on a larger scale. Many participants indicated a trend where the current generation of nurses will only spend a few years at the hospital and then leave to work elsewhere due to the unsustainable working conditions. In the meantime, nurses develop strategies to achieve work-life balance in spite of the highly constrained context. They may do so by choosing to work part-time, to gain more control over their schedule. However, part-time nurses do not suit hospital needs and employers may impose part-timers to work full-time, generating significant

disturbances to their employee's work-nonwork balance and leading to burnout, as showed within the Covid-19 context. Therefore, mandatory overtime clearly appears as an unsustainable solution from a human resource management point of view, at least in its apparent misuse by hospital managers.

Yet, previous research indicated a great variation of overtime use between hospitals, suggesting that other solutions can be found to meet staffing needs (Berney et al., 2005). Recently, a mobile application introduced in a Quebec CISSS, allowing nurses to manage their schedule, was reported to "soften" a management system highly marked by the use of mandatory overtime (Morissette-Beaulieu, 2022). This appropriation of new technologies by nurses themselves may help reinforce or reintroduce a collective organization between nurses, and move toward more satisfactory schedules for each team members. Such innovations may offer alternative solutions to mandatory overtime, which may prove less conflictual and more respectful of nurses' lives.

Limitations and directions for future research

It would have been interesting to consolidate the validity of our results by resorting to data triangulation, either by contacting experts or interviewing hospital managers altogether. Future research should aim to analyze the subjective experience of managers and compare them to the experience of nurses to get more precise information regarding the way overtime is managed from both sides. Moreover, it would have been interesting to interview members of the union and Order of nurses to shed more light on the subject. Still, we believe that our method is valid and offers reliable findings, which adequately reflect the complexity characterizing the current issue of overtime in the nursing profession. Another limitation is that the data was collected in the early manifestations of the Covid-19 pandemic, which is known to have exacerbated feelings of exhaustion amongst nurses. It is possible that our participants held more negative views about their work environment because of this exceptionally difficult period. Still, they could clearly express problems that were specifically related to the previous minister's political decision to regroup Quebec hospital centers under integrated administrations, and what happened for nurses in the wake of this reform. A longitudinal research design would help collect reliable quantitative data about the amount of overtime and nurses' levels of exhaustion and attrition.

Conclusion

This paper answers calls for more research about overtime in the nursing profession. Our in-depth, qualitative exploration of nurses' various experiences with overtime has allowed to map out key antecedents and consequences to voluntary and involuntary overtime. While doing overtime may result from a personal choice, our findings reveal cases of nurses pressured to do extra work shifts against their deontological duty to refuse overtime in a state of exhaustion. While some workplaces offer more attractive conditions regarding the choice of working times, public hospitals tended to make a systematic use of mandatory overtime and for this reason were identified as "greedy institutions" (Coser, 1974) competing for nurses' time and energy, to the detriment of their health, the quality of patient care, and the retention and attraction of nurses in the profession.

Appendix 1 Characteristics of cited participants

Participants	Gender (W/M/Non-Binary)	Position at time of the interview	Workplace at time of the interview	Employer at time of the interview	Years in current position
Participant #1	W	Nurse	Hospital	Integrated Center of Health and Social Services	6
Participant #2	W	Nurse	Hospital	Integrated Center of Health and Social Services	2
Participant #3	W	Nurse and nursing care advisor	Field work	Integrated Center of Health and Social Services	10
Participant #4	W	Nurse	Hospital	Integrated Center of Health and Social Services	3
Participant #6	W	Inhalotherapist	Hospital	Integrated Center of Health and Social Services	13
Participant #7	W	Nurse	Dispensary	Integrated Center of Health and Social Services	6
Participant #8	W	Nurse	School	Integrated Center of Health and Social Services	> 1
Participant #9	W	Nurse	Dispensary	Private Agency	11
Participant #10	W	Nurse	Dispensary	Integrated Center of Health and Social Services	6
Participant #11	W	Nurse	Hospital	Integrated Center of Health and Social Services	12
Participant #12	W	Head nurse	Hospital	Integrated Center of Health and Social Services	> 1
Participant #13	M	Nurse	Hospital	Integrated Center of Health and Social Services	5
Participant #15	F	Head nursing care advisor	Field work	University Integrated Center of Health and Social Services	19
Participant #16	W	Nurse	School	Integrated Center of Health and Social Services	3
Participant #19	W	Nurse	Clinic of general family doctors	University Integrated Center of Health and Social Services	5
Participant #21	W	Nurse	Hospital	Integrated Center of Health and Social Services	4
Participant #23	W	Nursing care advisor	Hospital	Integrated Center of Health and Social Services	7
Participant #24	W	Coordinating nurse	Dispensary	Government of Canada Agency	11
Participant #25	W	Nurse	Hospital	Integrated Center of Health and Social Services	10
Participant #26	W	Nurse	Hospital	Integrated Center of Health and Social Services	> 1
Participant #28	W	Nurse	Hospital	Integrated Center of Health and Social Services	3

Participants	Gender (W/M/Non-Binary)	Position at time of the interview	Workplace at time of the interview	Employer at time of the interview	Years in current position
Participant #31	M	Nursing care advisor	Hospital	University Integrated Center of Health and Social Services	10
Participant #33	W	Nurse	Hospital	Integrated Center of Health and Social Services	17
Participant #35	W	Nurse	Hospital	Integrated Center of Health and Social Services	13
Participant #38	W	Coordinating nurse	Long-term care center	Integrated Center of Health and Social Services	7

Appendix 2 Final codebook

Code	Description
VARIETIES OF OVERTIME	Describes the various characteristics of the overtime. Namely, in what forms and shapes does the overtime manifest itself in nurses' work experiences, in terms of quantity, frequency
Quantity, Frequency	How much and how often nurses are led to do overtime
Work environment	The characteristics of overtime vary depending on the employer (eg. CISSS, Agency), the workplace (eg. hospital, dispensary, school), department (eg. hemodialysis, emergency, surgery), the position (nurse, head nurse, nursing advisor)
Individual skills	Time management skills, ability to say no, to organize oneself and negotiate with supervisors and coworkers determine doing more or less overtime
REASONS BEHIND UNWANTED OVERTIME	Reasons identified by nurses as to why and how they engaged in undesired overtime
Professional Duty	Professional conscience or a sense of duty towards the coworkers and patients is the main reason behind doing overtime
Employer Pressure	Employer pressure, guilt-inducing tactics, and others are the reasons leading to doing undesired overtime
CONSEQUENCES OF COMPULSORY OVERTIME	Consequences of unwanted / forced overtime on nurses' well-being (ie. burnout, work-life conflict) and organizational behaviors (ie. workarounds, withdrawal)
Work-Life Conflict	Work-life/family conflict and burnout due to unwanted, unpredictable overtime
Penal	Nurses at risk of being penalized for making mistakes due to extreme fatigue
Withdrawal	Nurses withdraw from their work either by looking for other positions, using tactics to avoid overtime, leaving the profession, never entering the profession
NEGATIVE CASE	Participants happy with their schedule

Apppendix 3 Interview Guide

Workforce Attraction and Retention in Healthcare

Work-Family Balance, Working Conditions, and Work Organization

Interview Guide

I. Your Job and Work

1. Can you tell me about your job? Contract type; full-time, part-time; usual number of hours; shift; establishment; employment status.
2. What has been your professional journey, including education?
3. Why did you choose this career?
4. Does the job meet your initial expectations?
5. How many years have you been in this position?
6. How many years have you been in this establishment?
7. Could you describe your daily tasks at work (speed, complexity, intensity, fragmentation)?
8. Tell me about the organizational climate and your commitment to work.
9. What do you think about working hours, the number of hours per day/week? Is there mandatory overtime?
10. Overall, have working conditions changed since you entered the profession? (Changes in work organization over the years, e.g., staff reduction, regulatory changes, lean practices, ratios, etc.)
11. What do you think about the workload? How has it changed since you started working (nurse-patient ratios)? Are you satisfied? Why?
12. Who decides on the organization of your work (supervisor or employer, or joint committee, or other)?
13. Have there been changes in work organization in recent years? Can you tell me about them (e.g., participation, teamwork, lean practices, etc.)?
14. Can you tell me how these changes (e.g., lean practices, ratios) occurred?
15. What have been the consequences on your work? In your opinion, has it had a positive effect on patients (quality of care or waiting times)?
16. Have you observed changes in workload intensity (heavier patient load, students with more difficulties), or schedules? Explain how.
17. What was your reaction to these changes? Has your perspective evolved over time, or has it remained the same?

18. In your opinion, has management implemented a strategy to manage changes in your workplace? Was there a communication strategy or other? Was it sufficient, adequate? Explain a bit.
19. Would you say these changes have had an effect on your health? And your stress level? Explain.
20. My next questions concern the autonomy you have in your work, tasks, and the use of skills. Are you satisfied with the autonomy you have to do your job? Why? Do you want more?
21. Do you have the opportunity to use your personal initiative or judgment in performing certain tasks or proposing new ideas and creative solutions to problems?
22. Do you sometimes make decisions on your own without consulting your superior?
23. Do you feel that all your skills are being well utilized in your work?
24. What do you think about training and personal development opportunities in your environment? Are you satisfied? Why?
25. Does your work have meaning for you? Explain what could make it more enjoyable and rewarding.
26. Do you think you could contribute more to your work if you had the opportunity or autonomy to do so? Explain.
27. Without being imposed, do you develop certain knowledge or skills yourself? Why?
28. Do you think all your prescribed tasks align with your needs and interests? Do you perform additional tasks beyond those formally requested?
29. I have some questions about the use of new technologies in your workplace. Do you think technological innovations (artificial intelligence, robots, etc.) could reduce workload?
30. Could these technologies lead to a reconsideration or reconfiguration of your work and tasks? How?
31. Do you think these innovations would improve or worsen well-being at work? Could the introduction of these technologies make work more enjoyable, enriching, and meaningful, or rather boring? How?
32. How do you see the future of your profession in the context of digital transformation?
33. Do you use technology tools (telemedicine, mobile health, electronic medical records, Quebec Health Record, and new software platforms) that automate or reorganize certain tasks (work aid)? If yes, explain what these tools are. Is it by choice, or are they imposed on you? Do you think they improve accuracy, reliability, and efficient use of time?
34. Do you use new technologies to facilitate communication or collaborative work? Do you also use them to find solutions to various work-related problems?
35. What do you think of technological innovations (artificial intelligence, robots, etc.) implemented in some healthcare settings (e.g., Da Vinci robot)? Do you think they are there to assist you or replace you?
36. Do you think there are repetitive or other tasks that could be delegated to intelligent machines (e.g., vital sign measurement, medication administration, etc.)? Can you provide more examples?

37. How do you envision a work team composed of both robots and humans? Are there tasks that can be performed in collaboration with robots? Can you give examples?
38. Coming back to you, do you try to expand your role at work by adding tasks that are not required, for example? If yes, for what purpose? Conversely, are there less important tasks that you try to ignore or transfer to other colleagues?
39. Would you say that since you started, you have greatly expanded your social network in the workplace, getting closer to your colleagues, superiors, patients? Do you still want to develop or expand this professional network?
40. Do you sometimes avoid others at work (supervisors, colleagues, patients, lawyers, or other service groups) to reduce additional work demands?
41. Before moving on to the second part of this interview, would you say that you are overall satisfied with your job and working conditions? Do you intend to continue in this career? This specific workplace? Why? If not, what would it take to keep you in the profession? In this establishment?

II. Your Job and Your Personal Life

42. What is your marital and family situation (children, extended family, caregiver)?
43. Have you returned to school since starting your job? Have you had access to work-life integration measures?
44. If you have children: How many? How old are they? Or do you plan to have them, and why? If yes:

a) Have you or your spouse taken maternity, paternity, or parental leave when your child(ren) was/were born or adopted?

b) What factors played a role in your decision for taking leave and the distribution of parental leave?

c) How did it go with your employer and colleagues? Were there comments? Give examples.

d) For your spouse, how did it go with their employer? Could they take leave when desired and for the desired duration?

e) Have you requested other accommodations later (4-day workweek, flexible hours, daytime hours, or others) for family reasons, and were they granted?

f) Even if you haven't requested accommodations, do you feel that they were available? Are there specific reasons why you didn't use them?

g) Are you the primary caregiver? If yes, for whom and how? Expand.

h) Can you reconcile work and family well? Why? What could help facilitate reconciliation? Has it become easier over the years or more difficult?

i) Do you manage to have your vacations when you want them? Explain.

j) Do you feel supported by your colleagues? Your superior? Your family (spouse, children, others)?

k) Is there a work-family-study reconciliation or work time adjustment policy in your collective agreement? What do you think? What rights or procedures for requesting leave or adjustments (leaves, reduction in the number of days, hours, etc.)?

l) What measures, policies, or services exist? What do you use? If you don't use them, why? Would you like something else? What?

m) What can management do to help staff, and what exists in your workplace? Are your superior and colleagues supportive in terms of reconciliation?

III. Your Job and Stress

45. Personally, do you find your job difficult, tiring, stressful, or otherwise? Especially for what reasons (eg. ratios, lean practices, etc.)?
46. What are the main job requirements (eg. emotional, physical, others)?
47. Do you feel that your tasks have changed since you entered the profession? Do these changes influence your level of work stress?
48. Is there a lot of stress or emotional distress around you? And do you sometimes feel tired, exhausted? Do you remain committed to your work despite all this? How do you manage all of this?
49. I imagine that you are regularly in contact with the patients' family environment. Does this sometimes stress you?
50. Would you say that the people you interact with at the hospital are supportive of your work (patients/colleagues/doctors/patients' families; children and parents of children)?
51. Are you satisfied with your relationships with your colleagues and superiors? Why? (ask for concrete examples).
52. Do you sometimes come to work even if you are sick or not in very good shape? And your colleagues? Tell us a bit about that (why, frequency...).
53. What initiatives, practices, or policies do you identify in your establishment as sources of support that can help you do your job better, be less stressed? Do colleagues and superiors help?
54. Would you say that there are particularly negative or stressful aspects in the current context of your work?
55. Would you say that there have been changes in your professional identity, in how you see yourself in this job?
56. Do you find professional recognition in your workplace? From your superiors? Your colleagues? In your circle and in society?
57. Do patients, colleagues, or your superior appreciate what you do? How do they show it? And your family?
58. What would be the most useful form of support that your establishment could provide you over the next year to help you perform your professional and family role well?
59. In terms of mental health, what do you think of the means or resources available to protect your mental health at work? Are you satisfied? Why? (ask for concrete examples).
60. Can you tell me about the positive elements associated with your job? Are there things you wouldn't want to see change?
61. What are the negative elements associated with your job that need improvement? And how?
62. Finally, do you feel that there are differences between generations in your workplace? How does that manifest?
63. Do you have anything else to add? Thank you for your cooperation!

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Declarations

Ethical Approval This project received ethical approbation by the university's committee of ethics and the participants included in this research consented to the anonymized publication of their data.

Conflict of Interest The authors have no relevant financial or non-financial interests to disclose.

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