BEHIND CLOSED DOORS: UNVEILING THE INTRIGUING DYNAMICS IN THE DOCTOR-NURSE COLLABORATION IN JOS UNIVERSITY TEACHING HOSPITAL, PLATEAU STATE, NIGERIA

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Abstract

The working relationship between doctors and nurses is crucial to delivering high-quality healthcare, but it often presents its own set of challenges. This paper explores the less visible aspects of how doctors and nurses relate with each other on the job, paying attention to how they communicate, the roles they play, and the power structures that influence their interactions. A qualitative approach was used for this study, relying on in-depth interviews to understand the real-life experiences of both professionals. Interviews were held with 20 participants—10 doctors and 10 nurses—drawn from departments such as Surgery, Internal Medicine, Obstetrics and Gynecology, Orthopedics, and Emergency Medicine. The selection covered a mix of departments and job levels to reflect different perspectives within the hospital system. The study found that issues like ego clashes, rivalry, poor teamwork, work-related stress, and the constant tension between urgent and important tasks all have an impact on doctor-nurse collaboration at Jos University Teaching Hospital.

Keywords: collaboration, workplace dynamics, healthcare teams, interprofessional relationships

Introduction

In today's fast-changing healthcare environment, working together across professional lines is key to delivering quality care (Peduzzi et al., 2019). Among all the relationships in healthcare, the one between doctors and nurses stands out. These two groups often work side by side to diagnose, treat, and support patients (Berduzco-Torres, 2020). When this partnership works well, it can make a big difference in patient safety, outcomes, and overall experience (Wall, 2009; Hansson et al., 2010).

Doctor-nurse collaboration looks different in different parts of the world. It's shaped by culture, hospital policies, rules, and the broader healthcare system (Hojat et al., 2003). In many places, doctors are traditionally seen as being above nurses in the professional pecking order. This can create a power gap that makes open communication harder (Rourke & Blumenthal, 2016). Still, there's a growing push worldwide to level the playing field and build more balanced relationships.

Historically, medicine and nursing have also been divided along gender lines. Nursing was mostly seen as "women's work," tied to caregiving, while the role of doctor was seen as male, linked to leadership and authority (Evans, 2004; Davies, 1995). These ideas helped reinforce the power imbalance between the two professions. But things are changing. More women are becoming doctors, and more men are going into nursing. In Nigeria too, these shifts are starting to show, even though some old attitudes still linger (O'Connor, 2017; Adeyemi & Lawal, 2021).

Team-based care is now the standard in many places. Healthcare teams made up of doctors, nurses, pharmacists, social workers, and others are expected to work together to provide patient-centered care (Johnson & Johnson, 2023). In countries like the UK, US, Netherlands, Spain, and Switzerland, nurses often have more autonomy and take on wider roles, which has helped to improve teamwork and reduce conflict (WHO, 2013; Heale & Buckley, 2015; Schober, 2016).

Culture also plays a big part. In some settings, strict hierarchy can block honest communication. In others, a more open and team-based culture makes collaboration easier (Deering, 2022). Even within the same country, collaboration can look very different depending on the hospital or region (Amarneh & Nobani, 2022). In places like the US, doctors and nurses tend to have clearly defined roles, and efforts have been made to support teamwork through training and system reforms (Vazirani, 2005). Continuous learning also helps keep collaboration strong. The COVID-19 pandemic has further shown just how crucial it is for healthcare workers to function as a team, especially in emergencies.

In Africa—and Nigeria in particular—doctor-nurse collaboration is shaped by everyday challenges such as strict workplace hierarchies, shortages of staff and equipment, and long-standing ideas about who holds authority in hospitals. While efforts like interprofessional education and international support are helping to

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promote teamwork, these changes are not always easy to put into practice. In Nigeria, there are still only a few studies that look closely at how doctors and nurses work together in real settings, especially in teaching hospitals. Most of the existing work relies on surveys or general descriptions, without exploring the real-life experiences or everyday struggles that affect how professionals relate to one another (Adeyemi & Lawal, 2021).

There's also not enough research that shows how things like professional rank, gender roles, and cultural expectations affect doctor-nurse relationships—especially in public teaching hospitals in places like North-Central Nigeria. While some private and urban hospitals are beginning to show signs of more equal teamwork, public facilities often still face deep-rooted challenges. In particular, the working environment at institutions like Jos University Teaching Hospital has not been studied in enough detail to guide real improvements in teamwork.

This study helps fill that gap by taking a closer look at how doctors and nurses in Jos University Teaching Hospital interact in their daily work. It explores the realities they face, the sources of tension, and the ways they try to manage their professional relationships. By focusing on this often-overlooked area, the study adds to the growing conversation about teamwork in healthcare and offers practical ideas for improving how professionals work together in Nigeria's health system.

Literature Review

Effective collaboration between doctors and nurses is central to quality patient care. Yet, in everyday hospital practice, this collaboration is often strained by communication gaps, overlapping responsibilities, and entrenched professional hierarchies. At the heart of these challenges are real people—dedicated professionals—trying to do their best within systems that often position them differently in terms of authority and recognition.

Studies consistently show that while both doctors and nurses aim to care for patients, the nature of their interactions with each other differs markedly from the way they relate to patients and families. As Tang et al. (2021) observed, the professional-to-professional dynamic is shaped by power, expectations, and often unspoken norms that govern whose voice carries more weight.

Drawing on Role Theory, which explores how people navigate expectations tied to their professional positions, AbuAlRub, El-Jardali, and Jamal (2020) found that collaboration suffers when those roles are not clearly defined—or worse, when they are defined in ways that reinforce inequality. Their qualitative study across various hospitals revealed a consistent pattern: nurses often felt sidelined in decision-making, while physicians expressed discomfort over unclear role boundaries. This mismatch in expectations bred tension and dissatisfaction on both sides.

In high-pressure environments like emergency rooms or surgical theaters, Lee, Doran, and Tourangeau (2022) found that "role stress" emerges when healthcare workers are unsure of where their duties begin and end. For nurses, this can mean being expected to perform tasks outside their formal training—sometimes without acknowledgment—leading to burnout and emotional fatigue.

One underlying issue, often overlooked, is how healthcare professionals are trained. Despite growing support for interprofessional education (IPE), Johansson and Ewertsson (2023) argue that many institutions still teach doctors, nurses, and allied health workers in silos. This limits opportunities for learning with and about each other, making future collaboration harder. Without shared educational experiences, it becomes easier to misunderstand, undervalue, or simply not appreciate each other's contributions in the clinical setting.

Encouragingly, when structured efforts are made to bridge these gaps, the results can be transformative. Mulvale et al. (2021) found that interprofessional training programs, especially in units like orthopedics and surgery, improved team communication and mutual respect. Participants in their study reported a clearer understanding of each other's roles and, just as importantly, a deeper appreciation for the challenges the other side faces daily.

Still, challenges persist—especially in systems where hierarchy is deeply ingrained. In sub-Saharan African tertiary hospitals, Ojwang, Ogutu, and Mwaura (2021) documented nurses' frustrations with being micromanaged or excluded from clinical decisions. In such settings, power is often concentrated among doctors, making it difficult for nurses to fully participate in shaping patient care. This reflects Foucault's (1977) idea that power in institutions is not just something people possess, but something that is constantly acted out through every day routines, language, and professional norms. In hospitals, doctors often have more authority not simply because of their training, but because the system is built in a way that recognizes their voice as more important. Nurses, on the other hand, are often expected to carry out instructions rather than contribute to decisions. Over time, this creates a pattern where nurses' knowledge is undervalued, and their role in decision-making is limited—not by formal rules alone, but by the unspoken ways in which respect, authority, and

legitimacy is distributed.

These issues are not just about workflow—they're about dignity, trust, and the emotional well-being of the individuals who comprise the healthcare workforce. That's why any effort to improve collaboration must go beyond surface-level training and address the structural and cultural foundations of how health teams' function. As Ibrahim, Idris, and Abubakar (2022) argue, the solution lies in changing not just hospital policy but also professional curricula and organizational culture. Until this happens, collaboration risks remaining a buzzword rather than a lived reality.

Methodology

Research Design

This study adopted a qualitative research design, using an exploratory approach to uncover the everyday realities and deeper factors influencing doctor-nurse collaboration at Jos University Teaching Hospital (JUTH). A qualitative design was particularly suited for this research because it allows for a rich, layered exploration of social interactions, professional hierarchies, and communication patterns that are often difficult to capture through quantitative methods (Creswell & Poth, 2021). The overall aim was to understand how collaboration unfolds in real time—through stories, reflections, and the lived experiences of healthcare professionals working in a high-pressure institutional setting.

Study Area

The study was carried out at Jos University Teaching Hospital (JUTH) in Plateau State, Nigeria. As a major tertiary healthcare institution, JUTH provides specialized care and serves as a key training center for health professionals from across the region. With its diverse workforce, layered organizational structure, and large patient load, JUTH offers a rich context for exploring how doctors and nurses relate, communicate, and navigate their professional roles on the frontlines of care.

Study Population and Sampling

The study focused on doctors and nurses from a variety of clinical departments within JUTH. A purposive sampling technique was employed to recruit participants who had at least two years of clinical experience in the hospital. This criterion ensured that respondents had sufficient professional exposure to reflect meaningfully on patterns of collaboration and professional interaction (Palinkas et al., 2020).

In total, 20 participants were interviewed—10 doctors and 10 nurses—drawn from departments such as Surgery, Internal Medicine, Obstetrics and Gynecology, Orthopedics, and Emergency Medicine. The choice of 20 participants is consistent with qualitative research principles that prioritize depth over breadth. According to Guest, Bunce, and Johnson (2006), data saturation in qualitative interviews often occurs within the first 12 interviews, with basic themes emerging as early as six. Thus, 20 participants provided a sufficient range of experiences and perspectives to explore the research questions in depth while maintaining analytical manageability.

Attention was paid to ensuring diversity not only in departments but also in the professional ranks of participants to capture variations in collaboration practices that may arise from distinct departmental cultures, role expectations, and hierarchical positions—factors known to influence professional interaction and communication in clinical environments (Tong, Sainsbury, & Craig, 2007; Patton, 2015).

Data Collection

Data were collected through in-depth, semi-structured interviews, allowing participants the space to reflect on their work relationships in their own words. An interview guide, aligned with the study objectives, was developed and pre-tested to ensure clarity and relevance. Core areas explored during the interviews included communication styles, role boundaries, professional respect, teamwork experiences, institutional culture, and perceived barriers to collaboration.

All interviews were conducted in English, lasted between 30 and 45 minutes, and were audio-recorded with participants' consent. Interviews took place in quiet, private settings within the hospital over a six-week period, allowing for a flexible and respectful engagement with participants' busy clinical schedules.

Data Analysis

Thematic analysis was used to make sense of the data, following Braun and Clarke's (2021) six-step framework: becoming familiar with the data, generating initial codes, identifying themes, reviewing those themes, defining and naming them, and finally writing the report. Transcripts were read and re-read with care, and codes were generated inductively, allowing patterns and meanings to surface naturally from participants' accounts.

To ensure the rigour and trustworthiness of the analysis, member checking was conducted by sharing summaries of interview findings with some participants for validation. An audit trail was also maintained throughout, documenting how themes were developed

and refined. NVivo software supported the organization and coding of the data.

Ethical Considerations

Ethical approval for the study was granted by the JUTH Health Research Ethics Committee. Every participant was fully briefed on the purpose of the study, the voluntary nature of their participation, and the measures in place to ensure confidentiality. Written informed consent was obtained before each interview, and all identifying information was anonymized using pseudonyms to protect participants' privacy.

Discussion of Themes

The qualitative data collected from JUTH revealed critical factors affecting doctor-nurse collaboration, which were organized into overarching themes reflecting the main issues uncovered during the interviews. Below, the themes are analyzed and compared with existing literature to assess how they align with or differ from previous studies.

1. Ego Conflicts and Professional Rivalry

A prominent issue that emerged in this study was the prevalence of **ego conflicts** and **professional rivalry** between doctors and nurses. This finding reflects how personal pride and boundary disputes hinder effective teamwork, resulting in friction and reduced efficiency. Several doctors expressed concerns about fragile professional egos, with one doctor explaining that sometimes nurses do not recognize the urgency doctors place on tasks. One doctor stated: "Actually, the relationship between medical doctors and nurses is good but not perfect. Sometimes, there are some decisions you may like the nurse to carry out on a patient which you see as so urgent or very important for the patient. But oftentimes the emergency you place on it is not treated as such at the other end."

This communication gap, where doctors' sense of urgency is not shared by nurses, is often due to professional insecurity or resistance to perceived authority, which is consistent with findings from West et al. (2014), who argued that such interprofessional rivalry often stems from power imbalances and differences in professional identity. Furthermore, the sense of rivalry and hesitation among healthcare professionals to accept each other's instructions was also observed in the experiences shared by one doctor in this study: "When I was in the gastroenterology unit, there was this patient that was having liver failure and was not passing stool... The nurse called my attention and asked if I was the one who had written the rectal washout. You think that thing is easy to do?"

This finding supports Grainger and Bolan (2017), who identified that ego conflicts and a lack of mutual respect between doctors and nurses often contribute to strained relationships and hinder effective teamwork. Similarly, Pires et al. (2021) found that these professional boundaries and competition for authority could undermine interprofessional collaboration and affect patient care.

The nurses in this study also expressed their frustration with the hierarchy, with one nurse stating: "Whenever the doctor comes into the ward, he expects the nurse to go along with him even when he does not need their services, the nurses feel I am not under his control." This reflects Tarrant et al. (2021)'s finding that professional identity struggles, exacerbated by overlapping roles, contribute to strained interactions between healthcare teams. These rivalries and communication breakdowns emphasize the need for initiatives that promote role clarity and foster mutual respect between doctors and nurses.

2. Fragmented Teamwork and Lack of Cohesion

Another major theme identified in this study was the lack of unified teamwork and cohesion among medical personnel. Effective collaboration relies on mutual respect and a shared commitment to patient care, both of which were reported as lacking. One nurse described the doctor-nurse dynamic as often troubled: "The doctors and the nurses tend to have some grey areas most of the time. It manifests like an unhealthy rivalry. The doctor feels he has arrived, and so, the issue of carrying others along when he comes into the ward is not there."

This comment underscores the absence of an inclusive team spirit, which results in tension and mistrust. These findings are consistent with Sullivan et al. (2019**)**, who noted that the lack of inclusive and collaborative practices in healthcare teams often leads to disjointed care and communication breakdowns. Interestingly, one respondent observed that tensions sometimes lessen with professional experience, suggesting that as individuals gain more exposure and maturity, their ability to collaborate improves: "Earlier in the program, there is this antagonism that calms out a little with increasing levels of professionalism."

This observation aligns with Tarrant et al. (2021), who found that more experienced healthcare professionals often overcome initial tensions and improve their collaboration over time. However, despite these observations, the core issue of fragmented teamwork remains a significant challenge, echoing

Sullivan et al. (2019)'s assertion that the structural and cultural factors affecting interprofessional collaboration persist regardless of experience.

3. Pressures of Overwork and Burnout

A third recurring theme was the strain caused by overwork and burnout, which were aggravated by insufficient staffing and high patient volume. This theme is well documented in the literature as a major barrier to effective teamwork and quality care. One doctor shared their experience:

"In our last clinic, more than half of the department went for an update course... patients' load keeps multiplying. We had only 2 doctors doing the work of six doctors. Honestly, we were in that clinic till 3:45 pm, yet we could not finish seeing all the patients that day. You are not even coherent."

This comment captures how stress from inadequate staffing leads to exhaustion, disorganization, and diminished quality of care, which ultimately affects teamwork. Similarly, a chief nursing officer described the strain on nurses:

"Most times, you have two people on duty; one has probably taken a patient for dialysis, another, working somewhere... What we have here is 2 nurses to 30 patients, but by WHO standard, it is 1 nurse to 4 patients. So having 2 nurses to 30 patients means they are heavily overworked."

This finding is consistent with Aiken et al. (2014), who found that poor nurse-patient ratios and overwork significantly affect both the well-being of healthcare providers and the quality of care they provide. Shanafelt et al. (2016) also reported that excessive workloads contribute to burnout and stress, which impede effective collaboration. These findings suggest that addressing staffing shortages could have a significant impact on improving collaboration and reducing burnout among healthcare professionals.

4. The Urgent vs. Important Dilemma

The final theme identified in the study was the tension between handling urgent tasks and addressing important but less immediate responsibilities. This dilemma creates fragmented care and affects team dynamics. One doctor shared:

"Several times, you see only one doctor in the medical ward. Probably, he is on call, his attention is needed in ward 6 and in ward 17. Most times, you get so overwhelmed and transfer your aggression on anyone."

This reflects how limited manpower and competing demands lead to stress-induced outbursts and communication breakdowns, damaging collaboration and patient care. Drucker (2009) has argued that healthcare professionals in high-pressure environments are often forced to prioritize urgent tasks over important ones, which can compromise overall care quality. Furthermore, Bates et al. (2020) found that overburdened healthcare professionals often transfer stress onto colleagues, leading to interpersonal conflicts and deteriorating collaboration. These findings align with the experiences shared in this study, where doctors reported feeling overwhelmed and resorting to aggression when the workload became unmanageable.

Conclusion

In conclusion, the findings of this study highlight critical barriers to effective doctor-nurse collaboration, including **ego conflicts**, **fragmented teamwork**, **overwork**, and the **urgent vs. important dilemma**. These themes are well-supported by existing literature, which identifies similar challenges in healthcare settings globally. However, while previous studies emphasize the importance of **experience** and **professional development**, the findings in this study suggest that more structured interventions are necessary to address these persistent issues. Future research could further explore interventions such as **joint training programs**, **communication skills workshops**, and strategies to **mitigate burnout** and **improve staffing** to enhance interprofessional collaboration and improve patient care outcomes.

Recommendations

Based on the findings of the study, the following specific recommendations are made:

1. **Organize joint training programs and workshops**: These programs should focus on fostering a deeper understanding of each professional's roles, responsibilities, and expertise. Regular sessions (e.g., quarterly) should be scheduled to address common challenges in interprofessional collaboration, with emphasis on reducing ego conflicts and enhancing teamwork between doctors and nurses.
2. **Introduce structured team-building activities**: Regular team-building activities should be implemented, particularly those emphasizing mutual respect and shared goals. For instance, quarterly retreats or interactive workshops designed around solving clinical problems together can improve collaboration, reduce professional rivalry,

and strengthen the working dynamic across different hospital departments.

3. **Advocate for increased investment in healthcare staffing**: A key recommendation is to ensure adequate staffing levels to address the issues caused by overcrowding and overwork. This can be achieved by conducting regular staffing audits and advocating for policy changes to support hiring efforts. Adequate staffing will not only improve patient care but also reduce burnout among medical practitioners.
4. **Implement monthly inter-professional case-review meetings**: These meetings should be dedicated to discussing complex patient cases, practicing shared decision-making, and enhancing communication between doctors and nurses. A structured format that includes joint problem-solving and open discussion will foster collaboration, improve conflict resolution, and enhance overall teamwork.

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