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Research Paper

Doctors' job satisfaction in resource-constrained health systems: A model development

Mumtaz Ali Memon[1,2,3*], Zunaira Sajjad[3], Muhammad Zeeshan Mirza[4,3], Berik Sabdenaliyev[1], Rameen Arshad[4], and Karisma Sri Rahayu[5]

[1]*SDU University, Kazakhstan*
[2]*Asia Pacific University of Technology & Innovation, Malaysia*
[3]*National University of Sciences and Technology, Pakistan*
[4]*New Uzbekistan University, Uzbekistan*
[5]*Brawijaya University, Indonesia*

*Corresponding author: mumtazutp@gmail.com

Abstract

Doctors' job satisfaction is vital for sustaining quality healthcare delivery, especially in resource-constrained systems where hospitals face persistent service pressures. Adopting a phenomenological approach, this study seeks to understand the lived experiences shaping doctors' job satisfaction and dissatisfaction. Using purposive sampling, semi-structured interviews were conducted with 13 doctors from diverse clinical settings. Thematic analysis produced three interrelated dimensions shaping doctors' satisfaction and dissatisfaction: work environment and organizational support, professional growth and performance management, and workload and compensation challenges. While doctors valued collegial supervision and informal learning, they voiced concerns about resource shortages, limited formal evaluation systems, inequitable pay structures, and excessive workloads. These challenges also undermine doctors' morale, retention, and performance. Building on these insights, the study proposes a model that illustrates how organizational, interpersonal, and systemic factors collectively shape doctors' job satisfaction. The findings offer actionable implications for hospital administrators and policymakers seeking to enhance retention, motivation, and service outcomes within resource-limited health systems.

Keywords: Healthcare, Job satisfaction, Doctors, Phenomenology.

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Introduction

Human resources constitute the most critical asset of any organization, as their skills, motivation, and commitment directly influence organizational effectiveness and sustainability. In particular, employees' job satisfaction remains a key factor in organizational growth and competitive advantage (Varshney and Goel, 2025). Understandably, job satisfaction is one of the most widely researched topics in human resource management and organizational behavior (Gazi et al., 2024; Jogi et al., 2025; Kumar et al., 2026). Prior research indicates that job satisfaction is a major determinant of work performance (Gazi et al., 2024; Mumford et al., 2025). Employees with higher job satisfaction perform better, are more productive, and show more commitment to their work (Coetzee and Stoltz, 2015; Olafsdottir and Einarsdottir, 2024). Job satisfaction not only influences the quality of life, but it also affects an organization's performance, especially in the case of the service industry, where the behaviors and attitudes of employees play a central role in shaping the quality of service (Oliver, 1980; Al-Refaei et al., 2024). These effects are particularly pronounced in low- and middle-income countries, where physician satisfaction is tightly linked to service quality and health outcomes (Nawi, 2025).

Healthcare is widely recognized as one of the most demanding and challenging professions, with very little margin for error (Familoni, 2008; Wang et al., 2025). Recent estimates indicate that more than 3 million deaths occur annually worldwide due to unsafe and substandard health care, with approximately one in ten patients experiencing harm during the provision of care (World Health Organization [WHO], 2023). The burden is particularly severe in low- and middle-income countries, where unsafe care is estimated to result in approximately four deaths per 100 individuals receiving treatment (WHO, 2023). In such high-pressure environments, the quality and safety of healthcare delivery depend heavily on physicians' performance and psychological well-being. Job satisfaction, therefore, becomes a critical factor influencing doctors' effectiveness and their capacity to deliver safe and reliable care (Lu et al., 2019).

Past studies indicate that dissatisfied doctors are more likely to generate patient dissatisfaction and are more susceptible to burnout (Tarcan et al., 2017; Zhou et al., 2017), work stress (Pedrazza et al., 2016), and mental illness (Mache et al., 2017). Low levels of job satisfaction among doctors are also associated with poorer quality of patient care (Kvist et al., 2014), higher turnover (Mufarrih et al., 2019), and greater work–family conflict (Lu et al., 2016). These conditions partly explain why dissatisfied doctors in developing countries migrate to more privileged nations (Ali et al., 2019; Meo and Sultan, 2023; Khaliq et al., 2025). Approximately 3,800–4,000 doctors formally emigrated from Pakistan, marking the highest annual outflow ever recorded in official data (Gallup Pakistan, 2026). This ongoing outflow has resulted in significant shortages of qualified and skilled physicians, thereby posing serious challenges to national healthcare systems (Sohail et al., 2025; Khaliq et al., 2025). Comparable patterns of healthcare professionals' migration have been documented across several low- and middle-income health systems (Caino and Castillote, 2024; Nawi, 2025; Noman et al., 2025). These patterns suggest that doctors' dissatisfaction is not merely an isolated attitudinal issue but a systemic risk that may weaken workforce capacity and long-term healthcare resilience.

The objective of this study is to understand the lived experiences shaping doctors' job satisfaction and dissatisfaction in Pakistan. Most prior studies have relied on quantitative approaches (Khan et al., 2012; Khan and Aleem, 2014; Shah et al., 2016; Ali et al., 2019; Hussain et al., 2019). In their systematic review of 73 studies published between 2012 and 2022, Alkhateeb et al. (2025) noted that research on job satisfaction in the healthcare sector remains predominantly quantitative, with comparatively little qualitative inquiry. Moreover, much of the existing healthcare literature has concentrated on related outcomes such as burnout, well-being, work–life balance, career satisfaction, and retirement intentions (Hojat et al., 2010; Miyasaki et al., 2017; Krishnan et al., 2022). However, comparatively less attention has been given to exploring job satisfaction as a focal construct in its own right. What remains insufficiently understood is how doctors interpret and make sense of the factors shaping their satisfaction within the healthcare system. Examining these lived experiences is essential for developing a better understanding of the professional and organizational realities in which doctors operate.

This study also addresses a broader gap in the literature, which remains dominated by evidence from Western healthcare contexts (e.g., Dowell et al., 2000; Dunstone and Reames, 2001; Bensing et al., 2013; Shkolnikova et al., 2017). By focusing on Pakistan, it offers much-needed insight into job satisfaction in a resource-constrained context. A resource-constrained context refers to systemic conditions characterized by limited public health care funding, workforce shortages, high patient volumes, infrastructure limitations, and restricted professional mobility. Such conditions shape organizational structures and professional expectations in ways that differ substantially from those observed in developed systems. Thus, this study aims to provide a more context-focused understanding of doctors' professional experiences in a developing country. Understanding the factors that enhance or undermine satisfaction in such environments is critical for fostering resilient, motivated, and effective healthcare workforces.

The remainder of this paper is organized as follows. The next section reviews the existing literature on job satisfaction among healthcare professionals and presents the theoretical background of the study. The methodology section then outlines the qualitative design, sampling strategy, and data collection procedures. The subsequent section presents the findings and introduces the model developed through thematic analysis, illustrating the relationships among the factors influencing doctors' job satisfaction. This is followed by a discussion that situates the results within the broader literature. The paper concludes with theoretical and practical implications, limitations, and directions for future research.

Literature Review

Job Satisfaction among Medical Professionals

Locke (1976) described job satisfaction as a positive and pleasurable emotional response that arises from an individual's evaluation of their work and work-related experiences. As a psychological construct, job satisfaction is a critical determinant of motivation, performance, and productivity, career-related outcomes (Aziri, 2011; Kautonen et al., 2012). It is often regarded as an indicator of organizational effectiveness and employee well-being, as well as several other individual- and

organizational-level outcomes (Spector, 1997; Coetzee and Stoltz, 2015; Olafsdottir and Einarsdottir, 2024).

Extensive research in both developed and developing countries has shown that the quality and efficiency of healthcare systems are closely linked to the job satisfaction of medical professionals (Dowell et al., 2000; Bensing et al., 2013; Shkolnikova et al., 2017; Ali et al., 2019). Prior research often suggests that doctors in developed nations experience higher levels of job satisfaction than those in developing contexts. For instance, general practitioners in New Zealand reported high satisfaction overall, though factors such as extended working hours, administrative burdens, and health reforms were identified as sources of discontent (Dowell et al., 2000). Similarly, a study across ten European Union countries found that only 26.4% of doctors were dissatisfied with their jobs (Bensing et al., 2013), a result often attributed to stronger institutional support and favorable working conditions. In contrast, research from Sri Lanka reported that only 43.6% of doctors were satisfied with their jobs (Rodrigo et al., 2013). Another study found that doctors in private hospitals reported higher satisfaction (67%) than those in public institutions (11%) (Shkolnikova et al., 2017).

In lower-income settings, workload and time pressure frequently emerge as major sources of dissatisfaction. Suliman et al. (2017), in a study on Sudanese doctors, identified these factors as key contributors to low satisfaction levels, alongside demographic influences such as age and specialty. Pediatricians and internists, in particular, were found to be less satisfied compared to other specialists, a pattern opposite to that observed in Switzerland, where the same group reported higher satisfaction (Bovier and Perneger, 2003). The variation may be due to differences in healthcare system structures and patient management practices between developed and developing contexts.

In India, research has highlighted the multifaceted nature of doctors' job satisfaction. Factors such as remuneration, benefits, working conditions, workload, communication, and supervision were all found to significantly influence satisfaction (Jaiswal et al., 2015). Similarly, Kaur et al. (2009) identified long working hours and lack of financial incentives as primary causes of dissatisfaction among doctors in tertiary hospitals in Delhi. Joyce and Wang (2015) reported comparable trends among Australian doctors, linking lower satisfaction to limited professional development opportunities, extended working hours, and overseas training requirements.

Job Satisfaction among Healthcare Professionals in Pakistan

In Pakistan, job satisfaction among healthcare professionals has received growing scholarly attention. Yaseen (2013) found that salary, meaningful work, promotion opportunities, and recognition were significant determinants of doctors' satisfaction, while inadequate service structures and limited financial incentives contributed to dissatisfaction. Kumar et al. (2013) similarly reported that job description, work environment, and time pressure negatively influenced satisfaction among Pakistani doctors. Other studies have highlighted insufficient training, improper supervision, and a lack of incentives as recurring challenges that continue to undermine morale and motivation within the medical profession (Aziz et al., 2015). Later, Umrani et al. (2019) investigated the determinants of job performance among hospital physicians in Pakistan, emphasizing the mediating role of job satisfaction within the healthcare

sector. The study demonstrated that job satisfaction functions as a mediating mechanism linking both job security and organizational support to performance outcomes. The study highlighted the centrality of employment stability and institutional support in shaping physicians' attitudes and performance.

Moreover, Ahmad et al. (2022) examined job satisfaction among nurses in Pakistan by integrating organizational support and perceived work environment within the framework of organizational empowerment theory. The study demonstrated that organizational commitment mediates the relationships between perceived organizational support and job satisfaction, as well as quality of care. In addition, the perceived work environment exerts a direct influence on both job satisfaction and perceived quality of care. The findings emphasize that improvements in institutional support and the work environment are not only central to enhancing nurses' job satisfaction but are also directly linked to perceived healthcare quality outcomes. In another quantitative study, Aman-Ullah et al. (2022) examined the determinants of employee retention among doctors working in public hospitals in Pakistan, situating job satisfaction within a broader social exchange framework. The study demonstrated that job security has a direct positive effect on doctors' retention intentions, while job satisfaction and job embeddedness function as significant mediating mechanisms. The findings highlight the importance of stable employment conditions and positive work-related attitudes in sustaining workforce continuity within the healthcare sector.

In light of the above discussion, most existing studies on doctors' job satisfaction in Pakistan have relied on quantitative surveys that identify determinants but seldom capture the lived experiences underlying them. Consequently, limited insight exists into how doctors interpret and make sense of the factors that shape their work satisfaction and dissatisfaction. The present study addresses this gap by employing a qualitative approach to explore the subjective experiences of doctors working in Pakistan, with the aim of providing a richer contextual understanding.

Theoretical Background

While Herzberg's two-factor theory (Herzberg and Hamlin, 1961) differentiates hygiene conditions from intrinsic motivators, and job demands–resources (JD–R) theory (Demerouti et al., 2001; Bakker and Demerouti, 2017) conceptualizes the interaction between job demands and resources, these frameworks were largely developed in institutional environments characterized by relative structural stability. In resource-constrained systems, however, hygiene deficiencies and structural demands may become systemic rather than episodic, thereby altering the mechanisms through which satisfaction is formed. This study, therefore, adopts an integrative theoretical lens to examine how structural scarcity, institutional governance, and perceived fairness jointly shape doctors' professional experiences.

Methodology

Research Strategy

This study adopted a descriptive qualitative strategy grounded in phenomenology to obtain firsthand insights into how doctors perceive and experience their work

environments (Sandelowski, 2000). Descriptive phenomenological inquiry is particularly appropriate when the aim is to capture and articulate the lived experiences of individuals while remaining close to participants' own accounts. This approach generates a clear and contextually grounded description of a phenomenon. As such, it is well-suited for exploring the "what," "how," and "why" of human behavior and organizational experiences in applied settings (Neergaard et al., 2009). Given the study's objective of exploring job satisfaction and dissatisfaction among doctors in Pakistan, the exploratory orientation informed the use of semi-structured, conversational interviews, which enabled participants to articulate their experiences in their own words. The emphasis was not on producing definitive or generalized claims but on eliciting reflective narratives that accurately represent lived experience (Morgan and Spanish, 1984; Ye et al., 2020).

Sampling and Data Collection

This study focused on doctors employed in both public and private hospitals across major cities in Pakistan. A purposive sampling strategy was adopted, allowing participants to be selected deliberately based on characteristics relevant to the study's objectives (Memon et al., 2025). Eligible participants held an MBBS degree and had been officially employed in their respective hospitals for at least two years. This ensured that participants possessed sufficient professional experience to provide meaningful insights into the study topic.

Following Saunders et al. (2023), an interview guide was developed that included a comprehensive set of thematically structured questions to explore doctors' perceptions of their work environment, workload, performance evaluation, career development, training, compensation, and time management. The questions were derived from the study's research objectives and informed by themes identified in the existing literature on job satisfaction within healthcare settings, ensuring conceptual alignment between the inquiry and the phenomenon under investigation. The guide was reviewed and validated by two academic experts familiar with the subject area to ensure relevance, clarity, and content adequacy. The interview guide served not only as a framework to maintain focus but also facilitated in-depth exploration of participants' perspectives (Dicicco-Bloom and Crabtree, 2006).

A maximum variation purposive sampling technique was used to ensure diversity in terms of gender and institutional type (public or private), thereby contributing to a more comprehensive understanding of the factors influencing doctors' job satisfaction. Thematically structured semi-structured interviews were conducted, allowing participants to discuss their experiences freely while enabling the researchers to probe deeper where necessary. Prior to each interview, participants were informed about the purpose of the study, the voluntary nature of their participation, and their right to withdraw at any stage without consequence. Informed consent was obtained before the interviews commenced. Written consent was not requested, as several participants expressed discomfort with signing formal documents. Participants explicitly requested that their names and identifying information remain confidential. Accordingly, strict procedures were implemented to safeguard anonymity in both the handling of data and the reporting of findings. During the interviews, participants were interrupted only when clarification was required to ensure mutual understanding, a practice that supported the study's rigor and authenticity (Milne and Oberle, 2005). Data collection

continued until thematic saturation was reached (Lim, 2025). Saturation was observed after the twelfth interview, as no new themes or substantive insights emerged. One additional interview was conducted to confirm this redundancy, which likewise yielded no new information.

Of the participants, 69% were male and 31% female. Most were aged between 30 and 35 years (53.8%), followed by those aged 35 to 40 years (30.8%), while the remaining participants (15.4%) were under 30 years of age. In terms of institutional affiliation, 62% of the participants were employed in the private sector, whereas 38% were from the government sector. To maintain confidentiality, participants' names and hospital affiliations were removed from all transcripts and replaced with coded identifiers.

Results

Thematic analysis was employed to analyze the data (Clarke and Braun, 2017). This approach involves the identification, analysis, and reporting of patterns within a dataset and offers flexibility in the interpretation of qualitative material. According to Braun and Clarke (2006), one of the principal strengths of this technique lies in its adaptability and its capacity to present findings in a format accessible to policymakers and practitioners.

Data analysis followed a systematic thematic procedure in which transcripts were read repeatedly to achieve immersion, and initial codes were generated inductively from participants' narratives (Clarke and Braun, 2017). These codes were compared across interviews to identify recurring patterns and categories. The analytic process began with repeated reading of the transcriptions to develop familiarity with the data and to identify patterns and underlying meanings within the dataset (Braun and Clarke, 2006). For each interview, initial codes were generated and subsequently examined across cases to detect similarities and differences. Related codes were grouped into broader categories, after which potential themes were searched, reviewed, defined, and named. The final themes represented the key factors influencing doctors' job satisfaction in Pakistan.

To ensure the trustworthiness of the data and findings, we adhered to established qualitative procedures, including credibility, transferability, dependability, and confirmability criteria (Ahmed, 2024). Credibility was strengthened through repeated and careful examination of transcripts and emerging interpretations to ensure an accurate and faithful representation of participants' accounts. Dependability and confirmability were enhanced through an iterative coding process in which categories were systematically refined, and all analytical decisions were documented to maintain a transparent audit trail. Transferability was supported by providing rich, contextualized descriptions of the research setting and participant characteristics, enabling readers to assess the applicability of the findings to comparable contexts. To protect confidentiality, each participant was assigned a unique identification code. Interviews lasted approximately thirty to forty minutes, allowing sufficient time for detailed, reflective, and contextually grounded responses.

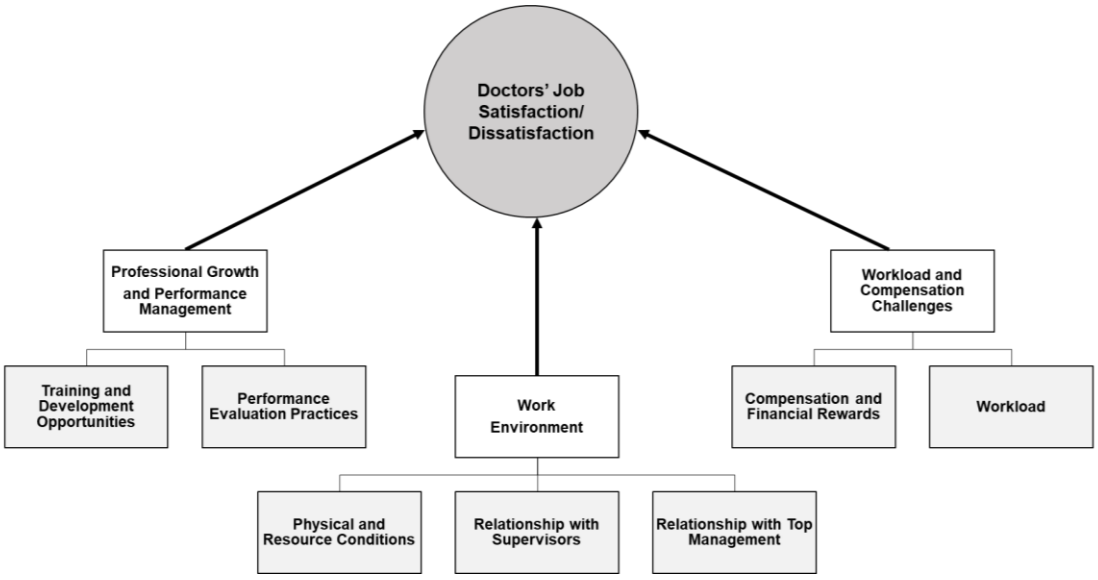
The model presented in Figure 1 was developed through an iterative, inductive thematic process. Initial line-by-line coding generated data-driven codes that closely reflected participants' perceptions and experiences of satisfaction. These codes were

systematically compared across interviews to identify recurring patterns and areas of convergence. Conceptually overlapping codes were merged, while codes that were insufficiently supported or peripheral to the research objectives were refined or excluded from further abstraction.

In the next stage, related codes were grouped into broader categories representing recurring domains described by participants, such as training opportunities, evaluation practices, workload pressures, compensation concerns, physical conditions, and relational dynamics. Through further abstraction and constant comparison, these categories were consolidated into higher-order themes capturing three interrelated domains: Professional Growth and Performance Management; Work Environment; and Workload and Compensation Challenges.

Finally, these domains were positioned in relation to the central phenomenon of doctors' job satisfaction, resulting in a multi-level model that reflects the structural, relational, and resource-based influences described by participants. The model therefore emerged inductively from the data, with its hierarchical structure reflecting the patterned organization of themes within the dataset rather than a priori theoretical imposition.

Figure 1: Multifactor model of doctors' job satisfaction



Theme 1: Work Environment and Management Support

Theme 1 centers on the organizational context within which doctors perform their duties, encompassing both working conditions and relational dynamics within the hospital structure. The data highlight three interrelated dimensions: physical and resource conditions, relationships with supervisors, and relationships with top management. Together, these dimensions reflect how the immediate work setting and institutional support mechanisms influence doctors' daily professional experiences. The following sections examine each of these categories in detail.

Physical and Resource Conditions

Physical and resource conditions refer to the material and infrastructural environment within which doctors perform their clinical duties, including the availability of medical supplies, equipment adequacy, hygiene standards, workspace facilities, and basic operational support required for safe and effective patient care. More than half of the respondents (54%) reported dissatisfaction with the physical and resource conditions of their workplaces. Shortages of medical supplies, unhygienic environments, and the absence of basic facilities such as clean washrooms were identified as key concerns requiring attention. Participants emphasized that limited resources not only constrained patient care but also made routine professional responsibilities more difficult to perform. The following verbatim excerpts reflect these experiences:

"Resources as compared to patients are very less." (P3)
*"Environment here is not hygienic and it is very difficult for us to work here and treat the patients." (*P7)
"No such facilities are not present like in our OPD there is a washroom for patients but not for doctors. We need to go to other wards for washrooms. These washrooms need to have hand sanitizer, soap, towel etc." (P8)

Relationship with Supervisors (Line Managers)

Relationship with supervisors refers to the quality of interactional and professional support provided by immediate line managers, including accessibility, guidance, feedback, mentoring, and day-to-day problem resolution. A supportive relationship with immediate supervisors emerged as an important positive factor within the work environment. Most doctors expressed satisfaction with their supervisors, describing them as cooperative, approachable, and willing to provide assistance when required. Supervisory support was viewed as reducing workplace stress and facilitating smoother clinical functioning. The following verbatim excerpts illustrate these perspectives:

"When we have queries then we ask from our supervisors and they help us out every time." (P3)
"In my department the supervisors are very good. They are very supportive. There is nothing wrong with the supervisors in our surgery department. They give us presentations. We take help from them and they are very supportive." (P9)

Relationship with Top Management

Relationship with top management refers to doctors' perceptions of institutional-level leadership responsiveness, including administrative communication, decision-making transparency, policy fairness, and management's openness to professional input. In contrast to supervisory support, the majority of doctors reported dissatisfaction with hospital management. Participants described limited responsiveness, inadequate communication, and a perceived lack of engagement from administrative leadership. Several doctors indicated that their feedback regarding patient care, ward conditions, and professional concerns was rarely acknowledged, which contributed to frustration and reduced morale. One participant stated:

"At supervisor level everyone is very supportive but at the administration level they

never listen to us. And they don't take our feedback related to our queries, regarding patients, wards and regarding doctors. They never ask from us but if they do, things can be different and improved." (P12)

Theme 2: Professional Growth and Performance Management

The second theme that emerged from the data relates to professional growth and performance management within hospital settings. Participants frequently discussed issues concerning training opportunities and performance evaluation practices when describing their workplace experiences. These discussions reflected how doctors perceive opportunities for development and how their work is assessed within the institutional structure. The following sections present the categories of training and performance evaluation in detail.

Training

Training refers to structured or informal opportunities provided by the institution to enhance doctors' clinical competence, professional knowledge, and skill development, including on-the-job learning, mentoring, workshops, and continuing medical education. Training opportunities emerged as an important aspect of doctors' professional experiences. Many participants emphasized that access to training enhanced their skills and clinical knowledge, which supported their ability to perform effectively in their roles. Training practices varied across departments; however, most participants indicated that training was primarily conducted on the job. One doctor explained:

"Training is very good here and most of them are on the job trainings and the supervisors are very supportive and they give proper training to the junior doctors." (P1)

Another doctor stated:

"Maximum trainings are held in the hospital which is good." (P3)

Although the majority expressed satisfaction with on-the-job training, some doctors indicated that these opportunities were limited and lacked external exposure. As one participant stated:

"What type of training! No not much! Most of the training is on the job. They don't send us anywhere for training." (P12)

Performance Evaluation

Performance evaluation refers to the formal or informal systems used by hospitals to assess doctors' clinical competence, professional behavior, and career progression, including appraisal criteria, feedback mechanisms, promotion processes, and transparency of evaluation standards. Performance evaluation practices emerged as a significant concern among many participants. A majority of doctors indicated that their hospitals lacked clear and formalized evaluation criteria, and promotions were often perceived to be based primarily on seniority. Several participants stated that they were

either unaware of formal evaluation standards or uncertain whether such criteria existed. This perceived lack of transparency contributed to dissatisfaction and uncertainty regarding career progression. Two doctors described the situation as follows:

"There is no proper procedure for our performance evaluation. No proper structured and framed procedures are there related to our evaluation." (P4)
"No performance is evaluated here. And if there are any performance evaluation criteria on the basis of which we are being evaluated then we don't know, and we are not informed." (P12)

In contrast, some doctors reported structured evaluation mechanisms within their hospitals. These included daily supervisory assessments, case presentations, and periodic examinations conducted quarterly or semi-annually. Participants in these settings viewed the evaluation process as constructive and fair. For example:

"Yes! There is performance evaluation. We must do short and long cases under the supervision of our supervisor, and they take presentation from us and daily classes to evaluate us and tell us our weaknesses. This is fair because supervisor on the spot evaluate you. It is 100% fair." (P8)

Theme 3: Workload and Compensation Challenges

The third theme that emerged from the data relates to doctors' workload pressures and compensation concerns within hospital settings. Participants frequently discussed financial rewards and patient volume when describing the challenges of their professional roles. These discussions reflected perceived imbalances between effort, responsibility, and institutional rewards. The following sections present compensation and workload as two closely related categories shaping doctors' workplace experiences.

Financial Rewards

Financial rewards refer to the compensation structure provided to doctors, including salary levels, allowances, incentives, and perceived fairness of remuneration relative to workload, qualifications, and responsibilities. Financial rewards emerged as a prominent concern among many participants. A majority of doctors expressed dissatisfaction with their pay structure and perceived that their earnings did not adequately reflect their qualifications, responsibilities, and workload. Several participants compared their salaries with those in other professions or healthcare settings and described a perceived mismatch between effort and financial reward. Two doctors expressed their views as follows:

"In my point of view if a laborer works for the same hours for which we work, he can earn more than us. After a lot of education, we have reached to this level but still they are paying us very less as compared to our duties." (P4)
"No, not at all. We are not satisfied with our pay. Here the pay is only 18000 rupees for one month which is my pay. And apart from this in other civilian setups pays are very good around Rs. 80000 and no as such compensation has been given to me." (P10)

Workload

Workload refers to the quantitative and temporal demands placed on doctors, including patient volume, time pressure, working hours, administrative burden, and doctor–patient ratios affecting capacity to deliver quality care. Workload emerged as a significant concern, particularly in outpatient departments (OPDs). Many doctors described an imbalanced doctor–patient ratio, resulting in substantial time pressure and difficulty managing clinical responsibilities within regular working hours. Participants emphasized that high patient volumes limited their ability to provide adequate attention and thorough diagnosis for each case. For example, one doctor stated that:

"It is very difficult for us to manage all the patients that come to us for treatment. We are under pressure because there are many patients waiting for the treatment that have different needs and to diagnose them properly, we need proper time which is very difficult for us to manage." (P6)

Another doctor said:

"Very much; very much pressure is upon us related to time management; you can calculate it by yourself like if we give minimum 5 minutes to every patient and let's suppose if 100 patients come to you. Then multiply 5 to 100 which means 500 minutes which is impossible for a human and it is beyond human capacity." (P10*)*

Collectively, the three themes reveal that doctors' job satisfaction and dissatisfaction are shaped by interconnected organizational, developmental, and structural factors. Work environment and management support highlighted the importance of physical conditions and hierarchical relationships in shaping daily professional experiences. Professional growth and performance management reflected how training opportunities and evaluation practices influenced perceptions of development, fairness, and recognition. Workload and compensation challenges highlighted concerns regarding financial rewards and patient volume pressures, pointing to perceived imbalances between effort, responsibility, and institutional support. Together, these findings suggest that doctors' workplace experiences cannot be attributed to a single factor; rather, satisfaction and dissatisfaction emerge from the combined influence of relational dynamics, institutional practices, and systemic resource constraints within the healthcare context.

Discussion

The study explored the factors influencing doctors' job satisfaction across hospitals in Pakistan. Thematic analysis indicated that key influences included the work environment, opportunities for career development, workload, and compensation. Working conditions that offered adequate facilities, supportive supervision, and cooperative management were viewed as important for maintaining satisfaction. Participants reported concerns about limited resources and basic amenities at their workplaces. They noted that shortages of medical supplies and reliance on outdated equipment collectively constrained their ability to perform their duties effectively.

From a theoretical perspective, these findings suggest that in this context, job

satisfaction can be understood as a structurally embedded rather than a merely attitudinal concept. When institutional constraints limit doctors' ability to perform according to professional standards, dissatisfaction emerges not simply as a personal reaction but as a response to systemic misalignment between role expectations and organizational capacity. In this sense, work environment operates as a foundational determinant of professional fulfillment.

These findings are consistent with Kumar et al. (2013), who also reported that limited resources constrain the performance of public health professionals in Pakistan. Insufficient funding for the health sector remains a major contributor to this challenge (Tasneem et al., 2018). Although both public and private systems operate in Pakistan, public hospitals, serving most of the population, often face persistent shortages that affect doctors' ability to work efficiently. Similar concerns were raised by Sohail et al. (2025), who noted that inadequate infrastructure and lack of basic facilities, including staff washrooms and hygiene provisions, were common sources of dissatisfaction. In low- and middle-income countries, such constraints influence not only service quality but also the perceived credibility of healthcare institutions (Nawi, 2025). This pattern indicates that satisfaction is closely tied to institutional legitimacy; when hospitals lack adequate infrastructure, doctors may experience a diminished sense of alignment with the organization's professional mission.

The findings indicate that most doctors were satisfied with their supervisors, describing them as approachable and supportive in addressing work-related concerns. However, despite positive perceptions of supervisory support, many participants expressed dissatisfaction with hospital management. They described management as insufficiently responsive to feedback and largely absent from decision-making processes affecting doctors' work. This distinction between supportive supervisors and disengaged management reflects a pattern also observed by Liang et al. (2024), where physicians reported strong relationships with local leaders but limited influence over higher-level administrative decisions. A lack of open communication at the managerial level can diminish trust and motivation, particularly in public hospitals where bureaucratic structures prevail. As noted by Tasneem et al. (2018), weak managerial engagement and exclusion from discussions contribute to persistent dissatisfaction among doctors.

Conceptually, this divergence between supervisory support and managerial disengagements suggests a multi-level structure of organizational experience. While supervisors provide interactional support that enhances relational satisfaction, hospital management represents the procedural and structural layer of the organization. Dissatisfaction at this level signals concerns about voice, fairness, and institutional responsiveness rather than interpersonal dynamics alone.

The second theme highlights the importance of career development opportunities in shaping doctors' job satisfaction. While several participants expressed moderate satisfaction with the on-the-job training provided by their hospitals, many pointed to broader gaps in structured career advancement, mentoring, and evaluation systems. Most trainings were informal and delivered by supervisors through daily or weekly feedback, which participants generally appreciated. However, they also noted the absence of clear training roadmaps or systematic professional development programs. Previous studies emphasize that continuous learning and refresher training are essential

for maintaining competence and motivation among healthcare professionals (Lima et al., 2006; Van Dormael et al., 2008). The absence of transparent performance evaluation criteria was viewed as a significant limitation, as existing assessments tended to focus more on theoretical knowledge than on clinical or practical skills. These findings suggest that while training is recognized as valuable, its limited structure and uneven implementation may hinder doctors' sense of professional growth and long-term commitment. Theoretically, professional development functions not only as skill enhancement but also as an institutional signal of future opportunity and recognition. When evaluation systems lack transparency or advancement relies heavily on seniority, perceptions of procedural fairness may weaken, thereby affecting motivation and long-term organizational attachment.

These findings are consistent with earlier research, which reported widespread dissatisfaction among doctors with existing service structures and limited opportunities for career progression (Ghazali et al., 2007). Ali et al. (2019) similarly observed that doctors in tertiary care hospitals were dissatisfied due to poor working conditions, inadequate pay, and constrained professional development. More recent evidence supports the persistence of these concerns. Participants in the present study also echoed these sentiments, describing promotion systems that rely heavily on seniority rather than performance. From an organizational perspective, ambiguous and inconsistent promotion policies can reduce motivation, weaken commitment, and increase turnover. Addressing these challenges requires policymakers and hospital administrators to develop transparent, performance-oriented career pathways that promote fairness and recognize professional achievement. This dynamic reflects a tension between traditional hierarchical advancement systems and emerging expectations of merit-based progression, highlighting how institutional norms shape perceptions of justice and professional value.

The third key theme highlights the influence of income and compensation on doctors' job satisfaction. Many participants expressed dissatisfaction with their current salary structures, noting that their pay and benefits did not correspond to the long hours and demanding workloads associated with their roles. These findings align with earlier research indicating that financial rewards remain a central determinant of satisfaction among healthcare professionals. Tasneem et al. (2018) reported similar concerns regarding inadequate pay, poor working conditions, and limited benefits. Recent evidence continues to highlight this issue. Sohail (2024) found that financial insecurity led 82% of physicians to consider alternative employment. Bradacs et al. (2025) associated perceptions of unfair compensation with disengagement among junior doctors in low- and middle-income countries. Financial dissatisfaction has also been linked to turnover intentions, as noted by Landon et al. (2002), who observed that dissatisfied physicians are more likely to leave their positions within a short period. One contributing factor may be the limited public investment in the health sector, which restricts the capacity of hospitals to offer competitive compensation. From a theoretical standpoint, compensation operates not only as an economic reward but also as a symbolic indicator of professional worth. When remuneration is perceived as disproportionate to effort and expertise, dissatisfaction reflects perceived distributive injustice and institutional undervaluation of medical labor.

High workload emerged as a key factor that intensifies doctors' dissatisfaction. Many participants noted that the high influx of patients limited the time they could devote to

each consultation, creating constant time pressure and emotional strain. These findings align with those of Kumar et al. (2013), Suliman et al. (2017), and Oh et al. (2019), who reported similar challenges among physicians in Pakistan, Sudan, and Korea. Previous studies have also shown that time constraints can compromise the quality of patient care (Kim and Oh, 2010) and elevate stress levels among healthcare professionals (Tadese et al., 2015). Such pressures have broader implications for both doctors and healthcare systems. Participants described how prolonged stress and overwhelming caseloads led to emotional exhaustion, reduced empathy, and strained interactions with patients. In low- and middle-income countries like Pakistan, these conditions have also been associated with increasing incidents of aggression toward medical staff (Ejaz, 2024; Nawi, 2025). In public hospitals, long patient queues and brief consultations further exacerbate frustration on both sides, reducing patient satisfaction and weakening mutual respect. Collectively, these dynamics highlight how excessive workload and stressful working environments undermine both job satisfaction and the quality of doctor–patient relationships.

Conceptually, excessive workload represents a structural demand that depletes cognitive and emotional resources over time, contributing to cumulative strain rather than episodic dissatisfaction. When high patient volumes intersect with limited institutional support, job satisfaction becomes increasingly fragile, shaped by the interaction between systemic pressures and organizational capacity.

Within the JD–R theory, the elements identified in this study can be interpreted as functionally shifting between job demands and job resources depending on their availability and quality within the organizational context. Workload pressures, time constraints, and high patient volumes are core job demands that require sustained physical and cognitive effort and contribute to strain (Demerouti et al., 2009; Wingo et al., 2016). Similarly, deficiencies in physical infrastructure and medical resources do not merely reflect the absence of support but actively intensify job demands by constraining doctors' ability to perform effectively (Ngcobo and Mhlanga, 2022). In contrast, supportive supervisory relationships (Abualigah et al., 2024), access to training and opportunities for professional development function as job resources when they are available, as they facilitate learning, provide guidance, and enhance coping capacity (Memon et al., 2020). However, when these elements are weak, inconsistent, or absent, they do not remain neutral; instead, they reduce the capacity to cope with job demands and amplify their strain-inducing effects (Bakker and Demerouti, 2017). Therefore, in resource-constrained systems, structural conditions reshape the demand–resource dynamic by simultaneously elevating demands and limiting the buffering role of resources, thereby influencing how job satisfaction is experienced.

Overall, these findings suggest that doctors' job satisfaction in resource-constrained healthcare systems is shaped by the interaction of structural constraints, perceived fairness, and institutional responsiveness. Rather than being driven by isolated factors, satisfaction appears to emerge from the alignment, or misalignment, between professional expectations and organizational capacity across multiple levels of the system. This reframes job satisfaction in such contexts as a system-level phenomenon rather than merely an individual-level attitude. The findings extend existing satisfaction literature by highlighting how institutional design, governance practices, and resource allocation mechanisms jointly influence professional fulfillment.

Theoretical Implications

This study offers several theoretical implications for the literature on job satisfaction, healthcare management, and organizational behavior. First, it advances a context-sensitive understanding of job satisfaction by shifting attention from variable identification to structural configuration. Traditional multifactor models of job satisfaction conceptualize determinants such as workload, compensation, leadership, and the work environment as independent antecedents whose effects can be examined in isolation. Much of this evidence has emerged from quantitative designs (Ali et al., 2019; Khan and Aleem, 2014; Khan et al., 2012; Hussain et al., 2019). In contrast, the present study demonstrates that in resource-constrained healthcare systems, these factors operate as interdependent structural conditions embedded within institutional design. Satisfaction and dissatisfaction, therefore, emerge not from isolated predictors but from the alignment, or misalignment, between professional expectations and institutional capacity.

Second, the study repositions job satisfaction as a focal construct within healthcare research. Prior scholarship has predominantly examined related outcomes such as burnout, turnover intentions, career satisfaction, well-being, or work–life balance (Hojat et al., 2010; Miyasaki et al., 2017; Krishnan et al., 2022). By focusing on doctors' lived experiences, this study emphasizes job satisfaction as a central phenomenon and provides qualitative insight into how physicians make sense of their professional experiences within structurally constrained systems.

Third, the findings extend established theoretical frameworks, particularly Herzberg's two-factor theory (Herzberg and Hamlin, 1961) and the JD-R theory (Demerouti et al., 2001; Bakker and Demerouti, 2017), by illustrating how structural scarcity reshapes traditional motivational mechanisms. In contexts characterized by chronic workforce shortages, limited funding, and high patient volumes, hygiene conditions and job demands function merely as situational variables. Instead, they become systemic features that shape perceptions of fairness, institutional legitimacy, and professional fulfillment. This reframing moves the explanation of job satisfaction from an individual-level attitudinal response toward a multi-level, system-oriented conceptualization.

Practical Implications for Asian Business

This study offers meaningful insights into the organizational and systemic factors shaping doctors' job satisfaction in Pakistan and provides guidance for healthcare policymakers and administrators. Importantly, these implications are derived from the specific economic and administrative conditions of Pakistan's healthcare system and should be interpreted within this contextual boundary. Nevertheless, while the findings are grounded in the specific context of Pakistan's healthcare system, they offer indicative insights for similar resource-constrained healthcare environments.

This study suggests that many doctors valued the training opportunities and supportive supervisory relationships available within their institutions, yet their overall satisfaction was influenced by limited resources, perceived limitations in managerial

responsiveness, lack of transparent performance assessment systems, low pay, and heavy workloads within Pakistan's healthcare organizations. These findings suggest that job satisfaction is not simply a personal matter but a strategic concern that directly affects the quality and reliability of healthcare delivery. When these issues remain unaddressed, employees' morale may decline, turnover intention may increase, and the continuity of care may be affected. Over time, such dissatisfaction may also discourage young professionals from entering or remaining in the field, potentially contributing to challenges in retaining skilled healthcare workers. Policymakers and hospital leaders must therefore view doctors' job satisfaction as an organizational priority linked to institutional effectiveness and patient outcomes, rather than as a secondary human resource concern. This is particularly important in the context of Pakistan's healthcare system, which is characterized by resource constraints and administrative inflexibility that directly shape doctors' work experiences and satisfaction.

At the policy level, the government can help strengthen the system by expanding structured training programs, creating clear pathways for job rotation and advancement, and ensuring that compensation structures reflect both workload and responsibility. Establishing pay-for-performance systems, fair and transparent incentive mechanisms that reward performance and commitment, may also help address the increasing tendency of medical professionals to seek opportunities abroad (Herzer and Pronovost, 2015; Akinwale and George, 2023). These recommendations are especially relevant for Pakistan's healthcare system, where differences across institutions and unequal availability of resources (e.g., pay and incentives) continue to influence doctors' work experiences and limit opportunities for professional recognition.

The findings extend beyond Pakistan, but their applicability remains contingent on the presence of comparable structural and institutional conditions across healthcare systems. Within such contexts, doctors' job satisfaction emerges from the interaction of key organizational factors, including work environment and support, opportunities for professional development, performance management practices, and equitable compensation. Rather than operating in isolation, these elements collectively shape both physicians' well-being and the functioning of healthcare institutions. Their combined influence is reflected in critical outcomes such as service reliability, patient safety, and institutional credibility. Accordingly, for hospital administrators operating under similar resource and workforce constraints, improving doctors' job satisfaction may represent a strategic priority rather than an isolated human resource concern.

Hospitals that invest in supportive and well-managed environments, where supervision is fair, communication is open, and leadership is responsive, are more likely to build trust and commitment among their staff. Establishing clear and merit-based performance assessment systems and career progression frameworks can enhance doctors' work engagement as well as their job satisfaction (Gupta and Kumar, 2012; Kampkötter, 2017). Addressing the persistent imbalance between workload and compensation is equally critical for maintaining motivation and ensuring that doctors feel respected and valued for their expertise. In healthcare settings where such imbalances are frequently reported, these actions may become particularly important for sustaining workforce morale. When doctors perceive fairness, recognition, and genuine concern for their growth, their commitment to patient care and institutional goals strengthens accordingly (Hess et al., 2011; Kao et al., 2018).

Overall, healthcare organizations that embed fairness, recognition, and development opportunities into their practices may be better positioned to retain skilled doctors, deliver consistent and high-quality patient care, and support the long-term resilience of their institutions. However, these implications should be understood as contextually grounded insights rather than universally generalizable prescriptions. Their relevance beyond Pakistan depends on the extent to which other healthcare systems reflect similar structural constraints and resource conditions. By prioritizing doctors' job satisfaction as a strategic concern, healthcare leaders in comparable contexts may be able to move toward more sustainable, responsive, and trustworthy health systems.

Limitations and Future Recommendations

This study has several limitations. First, the model developed by this study is grounded in inductive thematic analysis and reflects patterns identified within the specific research context. As a descriptive qualitative inquiry, the aim was not statistical validation or cross-setting generalization, but the development of a contextually embedded conceptual understanding. While the findings provide analytical insights into factors shaping doctors' job satisfaction, the model should be interpreted as context-sensitive. Future research may examine its applicability and robustness across different healthcare systems, organizational types, or demographic subgroups.

Second, while semi-structured interviews generated valuable insights, integrating additional qualitative techniques, such as focus groups or workplace observations, would enhance methodological depth and reveal collective and contextual dynamics that interviews alone may not capture. Future work should also incorporate the perspectives of hospital administrators, nurses, and patients to develop a more comprehensive, system-level understanding of how managerial practices, interprofessional collaboration, and patient interactions jointly influence satisfaction and performance.

Lastly, longitudinal and cross-country qualitative studies, particularly within South and Southeast Asia, could explore how doctors' satisfaction evolves over time and across different institutional and cultural environments, thereby strengthening theoretical generalization. Taken together, these directions call for context-sensitive, multi-stakeholder, and methodologically plural research designs. It will help to conceptualize doctors' job satisfaction as a dynamic and systemic phenomenon rather than a static individual outcome.

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Declaration

The authors disclose that ChatGPT (GPT-5, developed by OpenAI) was used to improve clarity, readability, formatting consistency, and reference formatting in accordance with the journal's requirements. In addition, one of the authors used the professional version of Grammarly to enhance grammar, readability, and stylistic consistency. All intellectual contributions, analytical decisions, interpretations, and theoretical developments are solely those of the authors. The authors carefully reviewed and verified all references, approved the final

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