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# Understanding Managerial and Organizational Factors Influencing Power Relinquishment Among Nursing Managers: A Qualitative Study

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## Abstract

# Background:

Nursing managers require professional power as a key resource to achieve organizational goals and effectively perform their leadership roles. However, organizational and managerial challenges may limit their professional influence and leadership effectiveness. This study aimed to explore the managerial and organizational factors influencing power relinquishment among nursing managers from their perspectives.

# Methods:

This qualitative study was conducted using a conventional content analysis approach. Thirteen nursing managers working at middle and senior managerial levels in Iran were selected through purposive and snowball sampling. Data were collected through semi-structured interviews and analyzed concurrently with data collection. The analysis process involved initial coding, category development, and the extraction of main categories.

# Results:

The data analysis resulted in four main categories: (1) organizational structure and resources, (2) professional and hierarchical culture, (3) scientific expertise and governance, and (4) macro-level policies and institutional support. The findings indicated that power relinquishment among nursing managers occurs mainly within the context of structural constraints, medico-legal constraints, lack of formal authority and decision-making power, insufficient resources, and limited institutional support. In addition, the data showed that responses to power relinquishment were not uniform. Nursing managers demonstrated a range of reactions, including forced compliance with existing structures, covert forms of resistance, and efforts to maintain professional control within constrained environments

# Conclusions:

Power relinquishment in nursing management is a contextual and multilevel phenomenon that cannot be explained by individual-level factors alone. Rather, it emerges from the interaction of structural, cultural, professional, and policy-related factors within the health system. Strengthening nursing governance structures, expanding the participation of nursing managers in formal decision-making processes, enhancing institutional support mechanisms, and revising hierarchical organizational arrangements may help reduce conditions that lead to power relinquishment and support the exercise of professional nursing authority.

# Background

Today, nursing teams and their leaders face numerous challenges in achieving their goals in healthcare organizations. Therefore, it is essential to identify and effectively utilize all available resources, among which power is considered a valuable asset that can help nursing teams accomplish these goals (1) (2). Power in nursing is a complex and multifaceted concept with implications for health policies, organizational structure, and nursing practice (3).

Nursing managers need power to support patients, communicate effectively with authorities and physicians, and influence organizational decisions (4). Having access to power and using appropriate power strategies are essential leadership skills for nursing managers in managing human resources, improving the quality of care, and handling workplace conflicts (3). Hersey et al. suggested that managers who understand power and know how to use it effectively are more successful in their managerial roles. Managers who perceive themselves as capable of influencing change also report higher job satisfaction and provide greater access to power for their staff (5).

Despite the recognized importance of power in nursing management, nursing managers' ability to exercise professional authority may be constrained by organizational and structural conditions. The organizational status of nursing, dominance of other professional groups, the value attributed to the nursing role, and the availability of resources all shape the extent to which professional power can be exercised. Studies conducted in Iran indicate that, due to professional competition and unequal distribution of power, authority is often concentrated in the hands of particular professional groups. As a result, many healthcare workers, especially nurses, face limitations in exercising their professional power (4).

In such circumstances, the way nurse managers use power and exercise authority can significantly shape workplace relationships, influence decision-making, and maintaining organizational balance (5). However, the exercise of power is not always straightforward. In some situations, nursing managers may withdraw from their professional positions or refrain from defending and exercising their legitimate authority in order to maintain their job position, reduce organizational tensions, or avoid conflict with higher levels of management (6). Power relinquishment refers to situations in which nursing managers intentionally or unintentionally refrain from exercising their legitimate authority, defending their professional position, or actively participating in decision-making. Some studies suggest that relinquishing power in interprofessional settings may reflect professional maturity and wise leadership, especially when nurse managers deliberately avoid direct confrontation with other managers to maintain team synergy and reduce organizational conflict (7).

Power relinquishment by nursing managers in interactions with higher-level managers and other professional groups, especially physicians, is an important challenge. This phenomenon may occur when nursing managers refrain from defending their professional position or exercising their authority because of historical medical dominance, underestimation of nursing knowledge, organizational pressures, or hierarchical structures within the health system (8).

Although many studies have examined nursing leadership, empowerment, and management challenges, the managerial and organizational factors influencing power relinquishment among nursing managers have received limited attention. In particular, little is known about how these factors shape the experiences of nursing managers within the cultural and organizational context of the Iranian health system, where hierarchical relationships, centralized decision-making, and interprofessional interactions may strongly influence the exercise of professional power.

Therefore, this study aimed to explain and identify the managerial and organizational determinants affecting power relinquishment among nursing managers from the perspective of nursing managers.

## Methods

# Study design and setting:

This study employed a conventional qualitative content analysis approach and was conducted between 2024 and 2025 among nursing managers at middle and senior levels within the Ministry of Health and Medical Education, selected Universities of Medical Sciences, and affiliated hospitals in Iran

## Participants and Sampling:

Participants were nursing managers working at middle and senior management levels in the Ministry of Health and Medical Education, Universities of Medical Sciences, and selected hospitals in Iran

Purposive sampling with maximum variation was employed to recruit participants with at least three years of managerial experience and willingness to participate. Variation was ensured across gender, levels of nursing management hierarchy, and different hospital settings to capture a wide range of perspectives and strengthen the transferability of the findings.

Sampling and analysis were conducted concurrently and continued until both code saturation and thematic saturation were achieved. Saturation was determined through iterative team discussions, when successive interviews no longer generated new codes or contributed additional conceptual insights. The final sample consisted of 13 nursing managers. Two additional eligible individuals declined participation due to workload constraints and unavailability.

## Data collection:

Data were collected through in-depth, semi-structured, one-on-one interviews. This method allowed participants to elaborate freely on their experiences and provide detailed accounts of the phenomenon under study. Interviews were conducted by two researchers with prior experience in qualitative research and familiarity with the nursing management context. Any prior professional relationships with participants were disclosed and addressed at the beginning of each interview to minimize potential bias.

Before the interview, written informed consent was obtained from each participant, which included information about the study, as well as issues related to the anonymity and confidentiality of the participants' statements. The voluntary nature of participation and the right to withdraw from the study at any time were also explained to the participants. Permission to use a voice recorder during the interview was obtained, and participants were assured that by assigning a unique identification number (code) to each person, their identity would remain anonymous.

All interviews were conducted in Persian between 2024 and 2025. The interviews were held face-to-face in a private setting at the workplace or, at participants' request, via the online platform Skyroom. The interviews lasted between 30 and 60 minutes, with an average duration of 45 minutes. The semi-structured interview guide was developed specifically for this study by the research team. An English version of the interview guide is provided (Supplementary File 1).

The interview process was conducted in four stages. In the introduction stage, the researcher introduced herself and explained the study title, general and specific objectives, the expected interview duration, permission for audio recording, and the possibility of further contact if clarification was needed. In the second stage, participants were asked the main research question: "What are the managerial and organizational factors affecting the relinquishment of power in nursing?" In the third stage, exploratory questions were asked to gain a deeper understanding of the participants' experiences and to clarify ambiguities. In the final stage, participants were invited to express any additional comments or points they considered important. The interviews continued until data saturation was achieved. Data saturation was considered to have been reached when successive interviews did not generate new codes or provide additional insights into the emerging categories.

# Data analysis:

Data collection and analysis were performed simultaneously using conventional qualitative content analysis.

All interviews were transcribed verbatim and imported into MAXQDA 2020 for management and coding. The unit of analysis consisted of meaning units, defined as words, phrases, or paragraphs related to the research aim. An inductive approach was primarily used. In the first stage, transcripts were read repeatedly to achieve immersion. In the second stage, meaning units w ere identified, condensed, and assigned initial codes. In the third stage, codes were continuously compared and grouped into subcategories and broader categories through an iterative and reflective process.

Coding was independently conducted by two researchers. Discrepancies were resolved through discussion and, when necessary, by returning to the original transcripts until consensus was achieved. A constant comparative method was used throughout the analysis to refine categories and ensure internal consistency. An audit trail and reflective notes were maintained to enhance transparency and confirmability. All quotations were translated into English and reviewed by a bilingual expert to ensure accuracy while preserving meaning and anonymity

## Trustworthiness:

The rigor of the study was ensured using Lincoln and Guba's criteria, including credibility, transferability, dependability, and confirmability. Credibility was enhanced through member checking with five participants, who reviewed and confirmed the preliminary interpretations. Peer debriefing was conducted with two independent qualitative researchers who critically reviewed the analytic process. Prolonged engagement with the data and iterative analysis further strengthened credibility. Transferability was supported through thick description of context and participant characteristics, accompanied by illustrative direct quotations. Dependability and confirmability were ensured through maintenance of an audit trail, documentation of analytic decisions, and regular reflexive discussions among the research team. Researchers also kept reflective journals to critically examine their assumptions and potential influence on data collection and interpretation.

## Findings

This qualitative study included 13 nursing managers, comprising 10 men (76.92%) and 3 women (23.07%), with a mean age of 51 years. Additional demographic characteristics are presented in Table 1. The variation in participants' managerial positions and professional backgrounds provided a range of perspectives and contributed to a more comprehensive understanding of power in nursing practice.

Analysis of the interview data indicated that nursing managers' experiences of enacting their managerial and professional roles are shaped within a set of structural and organizational constraints. These constraints influence how nursing managers exercise power at different organizational levels, as well as the scope, direction, and effectiveness of their decision-making. Four main categories were identified: "organizational structure and resources", "professional and hierarchical culture", "scientific expertise and governance", and "higher-level policies and support" (Table 2)

Table 1
Demographic information of participants

| Demographic characteristics | | N (%) | Mean |
|---|---|---|---|
| Sex | Male | 10 (76.92) | |
| | Female | 3(23.07) | |
| Job position | Head nurse | 2(15.38) | |
| | Hospital supervisor | 2(15.38) | |
| | Dean of the Nursing Faculty | 2(15.38) | |
| | Current and former Deputy Minister of Nursing of The Ministry of Health and Medical Education | 3(23.07) | |
| | Head of Nursing Home | 1(7.69) | |
| | Current and former Head of Iranian Nursing Organization | 2(15.38) | |
| | Current and former Secretary of the National Nursing Education Board | 2(15.38) | |
| | Cultural Deputy Minister of Iranian Nursing Organization | 1(7.69) | |
| Education | Bachelor | 3(23.07) | |
| | Master | 1(7.69) | |
| | PhD | 9(69.23) | |
| Work Experience | | | 23 Years |
| Age | | | 51 Years |

**1) Organizational structure and resources**:

One of the main categories extracted in this study was organizational structure and resources, which participants described as a major barrier to the effective exercise of power. According to the participants, the absence of independent nursing decision-making bodies, the dominance of other disciplines—particularly medicine—in key decision-making positions, and the limited representation of nurses in managerial and policy-making roles reduced nursing managers' ability to exercise their authority. The findings also indicated that the lack of formal status and authority plays a decisive role in the relinquishment of power. Participants emphasized that although nurses possess legal and professional rights, they often lack the organizational position and practical mechanisms necessary to exercise those rights. The absence of clearly defined employment positions for roles such as community health nurses was cited as an example of this challenge, limiting nurses' ability to use their professional power.

Another participant believed that the limited number of nursing representatives in management and decision-making positions, along with the reduced presence of nurses at policy-making levels, weakens nursing institutions and limits their influence on macro-level policymaking. This exclusion from decision-making processes may increase the tendency to maintain control at the individual level and reduce the willingness to relinquish power. Participants also identified factors such as insufficient financial and human resources as barriers to relinquishing power. Budget limitations in the Iranian health system have resulted in delays in nurses' payments, incomplete implementation of policies such as the tariffing of nursing services, and persistent workforce shortages. These constraints increase workload and compel nursing managers to maintain control over limited resources and centralized task management. In such circumstances, nurses are often forced into a "crisis management" mode, which is less compatible with collaborative behaviors and the relinquishment of power.

**2) Professional and hierarchical culture**:

The findings showed that the hierarchical professional culture governing the health system plays an important role in limiting the power of nursing managers. The dominance of more powerful professional groups over nurses often imposes the relinquishment of power on them. Within this category, forced obedience to authority emerged as one of the most frequently reported codes. Most participants stated that relinquishment of power is not voluntary but is imposed by higher authorities, requiring nurses and nursing managers to comply with decisions made at upper organizational levels. According to the participants, this culture of forced obedience is so deeply rooted that nurses are often expected to follow the directives of senior authorities or physicians, even when they believe those directives to be inappropriate. In this regard, one of the participants stated:

*"Because the person in charge tells us to relinquish power, those at lower levels have to comply."*

Another participant stated:

*"Even if a medical order or a head nurse's instruction is wrong—and everyone knows it is incorrect—because it is issued through the system, it must still be implemented"*

Another participant noted that physician-dominated governance, the imbalance of power, and nurses' subordinate position within the organizational hierarchy contribute to efforts to maintain control and a reluctance to relinquish power. Participant 5 stated:

*"In Iran, hospital structures are often physician-centered, and nurses are seen as executors rather than decision-makers. This imbalance can prevent nurses from relinquishing power, as they themselves occupy a limited position of authority. Decision-making structures within the Ministry of Health are also largely physician-dominated, and nurses have less involvement in macro-level policymaking. This leads nurses to exercise greater control over their tasks rather than relinquishing power, in order to avoid errors or criticism. These power imbalances place nurses in a defensive position, which hinders collaborative behaviors such as relinquishment of power"*

**3) Expertise and scientific governance**:

The lack of scientific governance in nursing also acts as a fundamental obstacle to the development of professional power. Participants believed that even in situations where the administrative or managerial structure is not fully controlled by nurses, the presence of scientific governance can provide a foundation for professional influence and impact. In their view, integrating scientific governance with managerial structures significantly enhances the effectiveness and efficiency of the nursing system, whereas its absence diminishes or silences the professional voice of nurses. In this regard, one of the participants stated:

If someone has scientific governance—for example, in administrative and managerial structures—efficiency and effectiveness would be much higher. But in our hospitals, we do not have scientific governance; only structural governance exists. If scientific governance were in place, maybe what I am saying would not be ignored

Another factor affecting nurses' relinquishment of power was the underutilization of their specialized competencies in positions that are not commensurate with their education and skills. Participants stated that despite years of training in community health and mental health nursing, these specialized nurses are often employed in general, emergency, or unrelated departments. From their perspective, this mismatch between expertise and area of practice reflects a loss of power and, consequently, a reduction in professional power. In other words, when professional roles are not clearly defined, the opportunity to exercise specialized power is also diminished.

**4) Higher-level policies and support**:

The findings showed that a lack of support from superiors, along with restrictive organizational policies, plays an important role in limiting nurses' power. Participant 10 stated: *"When you are not supported by higher authorities and your strengths are not appreciated, you become discouraged. You are suppressed by those above you so that your power does not increase"*, which reflects a perceived experience of managerial suppression and a lack of recognition of nurses' decision-making authority. Participant 8 also believed: *"The governing policies do not allow us to express ourselves"*

In addition, negative workplace behaviors and pressures, such as physicians' anger, inappropriate behavior, patient-related discomfort, and head nurses' hostility, repeatedly lead nurses to refrain from exercising their power. Participants also pointed to a lack of organizational justice, particularly in the private sector, stating: "Senior managers do not want their subordinates to have power because they are afraid of being replaced. It is not based on merit," which reflects the limitations of organizational policies and lack of managerial support, and their impact on undermining nurses' professional status. Overall, the findings highlight that existing policies and the absence of formal support from higher-level authorities systematically contribute to nurses' relinquishment of power in order to avoid criticism and managerial or peer-related undermining, thereby limiting their professional capacity.

Table 2
Main categories and primary codes

| Main categories | Primary codes |
|---|---|
| Organizational structure and resources | Shortage of financial and human resources |
| | Limited nursing representation in managerial and decision-making positions |
| | Lack of formal position and authority |
| | Absence of an independent decision-making body |
| | Decision-making dominated by other professions, particularly physicians |
| Professional and hierarchical culture | Medical dominance |
| | Compulsory compliance with orders |
| | Imbalance in power distribution across professions |
| | Dominance of power groups over nursing |
| | The impact of the status of doctors on the work of nurses |
| | The hierarchy of work influenced by doctors |
| Scientific expertise and governance | Underutilization of nurses' professional capacity |
| | Lack of scientific governance |
| Higher-level policies and support | Restrictive policies |
| | Lack of support from higher-level authorities |
| | Suppression by management |
| | Undermining of decisions |
| | Criticism and undermining by colleagues |
| | Workplace pressure and negative behaviors |

# Discussion

The findings of this study indicate that the power of nursing managers within the Iranian health system is not an individual phenomenon, but rather a multilayered construct shaped by complex interactions among organizational structures, professional culture, scientific positioning, and upstream policies. The results emphasize that the relinquishment of power is an adaptive response to a set of structural and institutional constraints that systematically limit the scope of authority and the opportunities for nursing managers to act.

In this study, the lack of independent nursing decision-making structures and the limited presence of nurses at senior management levels were identified as among the most fundamental factors contributing to the reduction of power. Although nurses are recognized as key actors in policy implementation and organizational management, and possess specific legal and professional rights, evidence shows that they often lack formal positions, executive authority, and employment ranks commensurate with these rights. In addition, they rarely participate in policy development, strategic planning, and decision-making processes (9).

In Iran, the dominant perspective of the Ministry of Health and Medical Education toward nursing, along with their limited involvement in policymaking, has led to nurses being overlooked as active agents in health system transformation (9–11). Consequently, this situation disempowers nurses and creates a perception that they have little influence over the social contexts in which they work (12).In this regard, Yazdani et al. also reported that policymaking in the Iranian health system regarding the nursing profession is inadequate, and that the limited involvement of nurses in related policymaking represents one of the key power-related challenges they face (13) (13). Similarly, a study by Dunn (2025) indicated that power dynamics are shaped by political constraints, which limit nurses' capacity to advocate, lead, and make autonomous decisions (14).

At the same time, the findings of the present study reveal a seemingly contradictory dual situation: on the one hand, the lack of nursing representation at policy-making levels leads to a weakening of institutional power and the relinquishment of power; on the other hand, the structural exclusion of nurses leads some nursing managers to maintain control and resist the relinquishment of power. This pattern can be explained within the framework of "defensive power," a situation in which actors with limited power, in order to survive within unequal structures, tend to concentrate power in micro-level domains. Such behavior is not an expression of authority, but rather a reflection of structural insecurity and a lack of institutional support.

The chronic shortage of financial and human resources has placed nursing managers in a continuous state of crisis management. Pressures resulting from staff shortages, delays in salary payments, and the non-implementation of approved policies have narrowed the space for participatory decision-making and equitable power distribution. In such circumstances, the relinquishment of power is not a professional choice but rather an inevitable consequence of systemic constraints. This is consistent with the findings of Afshani et al. (2019), who reported that nurses' sense of powerlessness primarily arises from financial dissatisfaction (12).

The findings showed that the hierarchical culture dominating the health system, which is often physician-centric and power-driven, exposes nurses and nursing managers to organizational coercion. In such a context, the compulsion to follow orders and systemic pressures, even when decisions are perceived as incorrect, leads to the relinquishment of power. Evidence from other studies also indicates that organizational factors such as policies, organizational culture, and hierarchical power dynamics within healthcare organizations can inhibit nurses' willingness to express their opinions (15). Consistent with

the findings of the present study, Vos et al. reported that the primary structural condition limiting nurses' experience of power was the hierarchical relationship between nurses and other healthcare professionals, particularly physicians (16). Similarly, Lee et al. (2024) found that hierarchical culture and nurses' orientation toward power distance were significantly associated with feelings of futility, which in turn led to silence in the workplace (17).

However, the present study suggests that power imbalances do not always lead to the relinquishment of power. In some cases, nurses perceived structural inferiority leads them to adopt strategies of control and covert resistance. This finding is consistent with critical perspectives in the sociology of professions, which conceptualize power not merely as a resource, but as a dynamic and context-dependent relationship. In other words, when nurses are unable to participate in genuine decision-making processes, maintaining control over limited professional domains becomes a means of protecting themselves from blame, errors, and external interference.

Another factor identified in the findings as influencing the exercise of power in nursing is medical dominance and the impact of physicians' position on nurses' performance, which generates a dual response among nurses and nursing managers. Some participants stated that they are compelled to obey and defer to physicians' authority due to its dominance. In contrast, others reported that medical dominance places nurses in a subordinate position within the power structure, leading them to attempt to maintain control and resist relinquishment of power. In this regard, a qualitative study by Afshani et al. also found that nurses identified the discriminatory system of medical dominance and physicians' authoritarian behaviors as barriers to their professional power (12).

One of the prominent findings of this study is the participants' emphasis on the pivotal role of scientific governance in achieving professional power. From their perspective, even in the absence of independent managerial structures, scientific governance can provide a foundation for professional influence and leadership. Previous studies have also highlighted the importance of scientific expertise in strengthening nurses' professional roles. For example, Lamb's descriptive study on the leadership abilities of specialist nurses demonstrated that specialist nurses possess strong leadership capabilities, which enable them to create better conditions for the delivery of high-quality patient care (18). Similarly, the findings of Mahbobkhah et al. (2017) identified specialized expertise as one of the most important sources of power for nursing managers (19). However, despite the growing need for specialist nurses, the provision of master's-level education in various nursing specialties, and the existence of job descriptions for both general and specialist nurses, many nurses with bachelor's and master's degrees continue to work as general nurses in hospital wards, and their specialized roles remain underutilized (20). When professional positions are not clearly defined, specialized knowledge cannot be translated into professional power, and nurses are compelled to conform to dominant organizational structures.

Restrictive organizational policies and the lack of support from higher authorities directly undermine the power of nursing managers. Experiences of managerial suppression, disregard for professional decisions, and the absence of formal recognition not only reduce the motivation to exercise power but

also contribute to the development of a form of “professional self-censorship.” In such an environment, the relinquishment of power becomes a strategy for survival and conflict avoidance. Consistent with the findings of the present study, Yazdani et al. reported that inappropriate health system policies toward the nursing profession, inadequate compensation for services, and insufficient recognition of nursing contributions weaken the professional position of nurses (13). Farsi et al. believe that political and public support plays a pivotal role in increasing motivation in Iranian nurses Similarly, Farsi et al. emphasized that political and public support plays a pivotal role in enhancing the motivation of Iranian nurses (21).

The lack of organizational justice and senior managers’ reluctance to empower their subordinates reflect the dominance of control-oriented approaches over participatory management. This pattern, which contrasts with global evidence linking nurse empowerment to improved quality of care and better organizational outcomes, limits the professional capacities of nurses and reinforces existing power inequalities.

## Conclusion

The findings of this study indicate that the relinquishment of power in nursing is not a uniform or one-dimensional concept; rather, it is interpreted by participants in different and sometimes conflicting ways. Some participants viewed it as a negative phenomenon and a sign of the weakening of nurses’ professional status and their exclusion from decision-making processes. In contrast, others considered the relinquishment of power, under certain circumstances, to be a rational and adaptive strategy for managing conflict, maintaining organizational stability, and reducing structural pressures.

The results indicate that the factors influencing the exercise of power among nurses play a dual role. Some structural and organizational factors, including hierarchical culture, medical dominance, lack of resources, and restrictive upstream policies, directly contribute to the relinquishment of power. In contrast, factors such as scientific governance, the definition and implementation of specialized nursing roles, institutional support, and meaningful participation in decision-making can prevent the relinquishment of power and strengthen the exercise of professional power.

The findings also show that nurses’ responses to power inequality do not always lead to the relinquishment of power and, depending on the organizational context and the level of institutional support, may result in covert resistance, maintaining control over limited professional domains, or attempts to exercise knowledge-based power. These findings suggest that the relinquishment of power is not merely a consequence of external pressures, but rather the outcome of a dynamic interaction between inhibiting and facilitating factors operating within different organizational and professional contexts.

Overall, the findings of this study emphasize that understanding the relinquishment of power in nursing requires a context-based and multilevel perspective. Policies and managerial interventions should be designed to reduce the factors that contribute to the relinquishment of power and to create conditions that strengthen the exercise of professional power among nurses.

# Limitations:

Like any qualitative study, this research has several limitations that should be considered when interpreting the findings. First, the participants were selected from nursing managers working in teaching hospitals affiliated with universities of medical sciences in selected cities of Iran. Although maximum variation was sought through purposive and snowball sampling in terms of gender, work experience, managerial level, and geographical location, the findings may not fully reflect the experiences of nursing managers working in private hospitals, Social Security hospitals, or underserved areas of the country. Second, the voluntary nature of participation and the sensitivity of issues related to power within healthcare organizations may have influenced the openness and depth of some participants' responses. To minimize this effect, the researchers sought to establish a trusting environment, ensure confidentiality, and emphasize the professional independence of the participants. Third, data were collected at a single point in time, making it impossible to examine changes in perceptions and strategies over time. Therefore, longitudinal studies are recommended to explore how the relinquishment of power and related coping strategies evolve throughout the professional careers of nursing managers. Finally, although Lincoln and Guba's criteria were applied to enhance the trustworthiness of the findings, the interpretive nature of qualitative research does not permit statistical generalization. Nevertheless, the rich description of the research context, participants, and analytical process enables readers to assess the transferability of the findings to similar settings.

# Declarations

**Ethics approval and consent to participate:**

All procedures performed in this study involving human participants were conducted in accordance with the ethical standards of the institutional research committee and with the Declaration of Helsinki and its subsequent amendments or comparable ethical standards. This study was approved by the Research Ethics Committee of Tehran University of Medical Sciences (Ethics Code: IR.TUMS.FNM.REC.1403.158). Written informed consent was obtained from all participants before data collection. Participants were assured that their participation was voluntary and that they could withdraw from the study at any time without any consequences. Confidentiality and anonymity were maintained throughout the data collection, analysis, and reporting processes. Audio recordings and interview transcripts were stored on a secure university server with encrypted access and will be destroyed after the required retention period in accordance with university regulations.

**Consent for publication**:

Not applicable.

**Availability of data and materials:**

The qualitative data of this study (interview transcripts) are not publicly available due to confidentiality agreements with participants and ethical restrictions. However, anonymized excerpts are available from the corresponding author upon reasonable request.

**Competing interests:**

The authors declare no competing interests.

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**Authors' contributions**

**Z.H.M.:** Conceptualization, Data curation, Formal analysis, Writing – original draft, Writing – review & editing, Project administration, Supervision.

**M.E.:** Conceptualization, Methodology, Validation, Supervision, Writing – review & editing.
**M.F.:** Conceptualization, Methodology, Validation, Supervision, Writing – review & editing.

All authors read and approved the final manuscript.

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