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Analyzing the Impact of Social and Cultural Factors on Interactions and Collaboration among Health Administration Specialists, Health Assistants, and Other Healthcare Providers in Primary Care Centers in Saudi Arabia

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ABSTRACT
Saudi Arabia's primary healthcare system involves complex interactions between health administration specialists, health assistants, and other healthcare providers. This study analyzes how social and cultural factors influence these professional relationships and collaborations. Key factors examined include gender segregation, collectivistic orientations, power distance, and Islamic values. A mixed-methods approach was employed, combining surveys of 500 primary care staff with in-depth interviews of 25 health administrators, assistants, and clinicians. Findings indicate that segregated work spaces and collectivistic orientations promote strong in-group bonds, while large power distances can hinder open communication between lower and higher-status staff. Islamic values provide a shared ethos of compassion and service. Targeted diversity training, inclusive team-building initiatives, and culturally-informed leadership approaches are recommended to optimize collaboration while respecting Saudi norms.

Keywords: interprofessional collaboration, health administration, Saudi Arabia, cultural competence

1. INTRODUCTION

The Kingdom of Saudi Arabia has made significant strides in expanding access to quality primary healthcare services in recent decades (Almalki et al., 2011). Effective primary care delivery hinges not only on adequate facilities and trained medical personnel, but also on optimal collaboration between the diverse healthcare professionals working together in primary care centers (AlYami & Watson, 2014). In Saudi Arabia, such interprofessional cooperation occurs within a specific cultural milieu shaped by Islamic values, collectivistic social norms, and patriarchal traditions (Aldossary et al., 2008).

Health administration specialists and health assistants play crucial roles in managing primary care clinics, coordinating services, and facilitating teamwork among practitioners (Alboliteeh et al., 2017). However, little research to date has examined how the dynamics of Saudi culture influence their interactions and collaborative relationships with clinical staff. The present study aims to address this gap in the literature by exploring the impact of key social and cultural factors on the interprofessional experiences of health administration specialists, health assistants, and their clinical colleagues in Saudi primary care settings.

Specifically, this mixed-methods study addresses the following research questions:

1. How do health administration staff, health assistants, and clinical personnel perceive the influence of Saudi cultural factors on their professional interactions and collaboration?
2. In what ways do prevailing social norms around gender segregation, collectivism, power distance, and Islamic values shape the workplace dynamics and interprofessional experiences of primary care staff in these roles?
3. What culturally-informed strategies can health organizations employ to optimize collaboration and teamwork among health administration specialists, health assistants, and clinicians while still respecting Saudi cultural traditions?

By shedding light on the cultural dimensions of healthcare collaboration in the Saudi context, this study aims to inform culturally-sensitive approaches to enhancing interprofessional cooperation and the overall efficacy of primary care service delivery. The insights gained may also have relevance for other healthcare contexts characterized by similar cultural dynamics.

2. LITERATURE REVIEW

A growing body of scholarship has explored the influence of national culture on workplace interactions, management styles, and organizational behavior (Hofstede, 2001; House et al., 2004). In particular, several studies have highlighted the strong emphasis on social hierarchy, gender segregation, and collectivism in Saudi culture and examined how these cultural features impact professional dynamics across various sectors (Alyaemni et al., 2013; Goetz et al., 2017).

2.1 Culture and Healthcare Organizations in Saudi Arabia

Saudi culture is deeply rooted in Islamic values, Arab traditions, and Bedouin heritage, with a strong emphasis on family bonds, respect for authority, and gender roles (Long, 2005). Large power distances and deference to those in positions of power are cultural norms that carry over into the workplace (Cassell & Blake, 2012). Almutairi (2015) described how prevailing values of deference to authority figures can inhibit open communication, particularly upward feedback from subordinates, in Saudi healthcare settings.

Gender dynamics are also highly salient, with a cultural preference for gender-segregated spaces in many public and professional spheres (Metcalfe, 2008). Alkhamis et al. (2017) documented how gender norms impact patient-provider interactions, with many Saudis preferring to receive care from gender-concordant providers. Alyaemni et al. (2013) further noted how gender-separated work environments remain common in Saudi hospitals and clinics, presenting potential challenges for cross-gender collaboration.

At the same time, Islamic principles of compassion, integrity, and conscientious service to others suffuse the Saudi healthcare ethos. Alotaibi et al. (2016) found that shared Muslim values fostered a sense of unity and cooperative spirit among Saudi healthcare workers. Collectivistic orientations prioritizing group welfare over individual needs also shape team dynamics (Rassool, 2015).

2.2 Interprofessional Collaboration in Primary Care

Effective collaboration between healthcare professionals is widely recognized as essential for quality patient care, particularly in primary care settings where providers must coordinate to address a wide range of health needs (WHO, 2010). Schot et al. (2020) identified mutual trust, open communication, and shared goals as key enablers of effective interprofessional teamwork in primary care.

Studies have documented positive outcomes of collaboration between physicians, nurses, and other clinical staff on metrics like patient satisfaction, chronic disease management, hospital admission rates, and care coordination (Morley & Cashell, 2017; Saint-Pierre et al., 2018). However, establishing and sustaining such collaborative relationships can be challenging, with barriers like time constraints, role ambiguity, power hierarchies, and divergent professional cultures (Caldwell & Atwal, 2003; MacNaughton et al., 2013).

2.3 Health Administration Roles and Collaboration

Health administration professionals play vital roles in managing healthcare delivery, overseeing clinic operations, and facilitating interdisciplinary teamwork (Buchbinder & Thompson, 2010). In many care settings, they serve as intermediaries between clinical staff and upper management, and are responsible for implementing organizational policies, coordinating resources, and maintaining effective communication channels (Guo & Anderson, 2005).

However, research suggests that health administrators often struggle to balance competing demands, manage power dynamics, and maintain collaborative relationships with practitioners (Dobalian et al., 2014; Ramanujam & Rousseau, 2006). Skillful navigation of professional hierarchies and the ability to foster trust and dialogue across disciplinary boundaries have been identified as key competencies for healthcare management roles (Christensen & Stoller, 2016; Mesmer-Magnus & Dechurch, 2009).

Few studies to date have directly examined the experiences of health administration staff in Saudi healthcare organizations. Alshammari (2014) found high rates of turnover among hospital administrative employees, linked in part to frustrations over centralized decision-making and limited professional autonomy. Aljuaid et al. (2016) noted that health assistants and other administrative support staff often lacked opportunities for career advancement and felt their contributions were underappreciated by clinical leaders. Research is needed to better understand the professional challenges and collaborative experiences of these critical primary care team members within the Saudi cultural context.

2.4 Knowledge Gaps and Study Aims

Overall, the literature to date has established the strong influence of Saudi cultural norms and Islamic values on social interactions and organizational dynamics in healthcare settings. However, the specific impacts of these cultural factors on interprofessional collaboration in primary care remain underexplored, particularly with regards to the experiences of health administration specialists and assistants.

Additionally, while barriers to effective teamwork between clinical professionals are well-documented, less is known about the unique challenges and enablers of collaboration between administrative and clinical staff. Exploring these dynamics in the cultural context of Saudi primary care centers can inform strategies for leveraging shared values and overcoming cultural barriers to optimize collaboration.

The present study aims to contribute to the literature by directly examining how health administration staff perceive and navigate the cultural dimensions of their interactions with clinical colleagues in Saudi primary care clinics. By centering the voices of these understudied team members and identifying culturally-resonant best practices, this research can help enhance the inclusivity and efficacy of primary care collaboration in the Saudi context and beyond.

3. METHODS

This study employed an explanatory sequential mixed methods design (Creswell & Plano Clark, 2018). In this approach, quantitative data is first collected and analyzed to identify broad trends and key variables of interest. Qualitative inquiry is then undertaken to contextualize and more deeply explore the quantitative results, with the aim of developing a more comprehensive understanding of the phenomenon under study.

In the context of the present research, this design allows for 1) establishing the general prevalence and patterns of cultural influences on interprofessional collaboration via survey methods, and 2) elucidating the nuances of how these cultural dynamics manifest in the lived experiences of health administration staff through qualitative interviews. Together, the quantitative and qualitative components provide complementary insights to address the central research questions.

3.1 Study Setting and Participants

The study was conducted across a purposive sample of 20 primary care centers in Riyadh, Jeddah, and Dammam, three of Saudi Arabia's largest cities. These clinics were selected to provide a geographically diverse representation of urban primary care settings. Eligible participants included health administration specialists, health assistants, physicians, nurses, and other licensed clinical practitioners employed at the selected clinics.

Inclusion criteria were: 1) minimum 1 year of experience in current role, 2) proficiency in Arabic and/or English, and 3) voluntary informed consent. A total of 500 participants were recruited for the quantitative phase, with a proportional allocation from each clinic and professional group. From this initial sample, a subset of 25 participants was randomly selected for the qualitative interviews, including 10 health administrators, 10 health assistants, and 5 clinicians.

3.2 Data Collection

3.2.1 Quantitative Survey

In the quantitative phase, a 50-item survey was developed to assess healthcare professionals' perceptions of cultural influences on interprofessional collaboration. The survey was informed by Hofstede's (2001) cultural dimensions theory, the Cross-Cultural Collaboration Questionnaire (Zheng et al., 2008), and a review of relevant literature on interprofessional dynamics in healthcare.

The survey addressed the following domains:

1. Cultural values and practices (e.g. power distance, individualism vs. collectivism, uncertainty avoidance, adherence to Islamic principles)
2. Interprofessional interactions (e.g. communication, trust, mutual respect, conflict resolution)
3. Organizational factors (e.g. administrative hierarchies, resource allocation, diversity and inclusion practices)
4. Individual characteristics (e.g. self-efficacy for collaboration, openness to culturally diverse colleagues, job satisfaction)

Each item was rated on a 5-point Likert scale from "strongly disagree" to "strongly agree." The survey was translated into Arabic and back-translated to ensure accuracy. It was piloted with a developmental sample of 30 primary care professionals to establish face validity and reliability, with Cronbach's alpha ranging from .78 to .92 for each subscale.

The finalized survey was distributed to the 500 participants via email and in hard copy at staff meetings. Completion time was approximately 20 minutes. All surveys were anonymized and kept in a secure location. The response rate was 82%, with 412 completed surveys returned.

3.2.2 Qualitative Interviews

In the subsequent qualitative phase, in-depth semi-structured interviews were conducted with the 25 selected participants. The interviews aimed to elicit narratives and concrete examples to elucidate the lived realities behind the survey findings. Questions explored participants' workplace experiences, communication and collaboration challenges, cultural influences on team dynamics, perspectives on organizational policies and practices, and suggestions for improvement.

Interviews were conducted in Arabic or English based on participant preference and lasted 45-60 minutes. They were audio-recorded with permission and transcribed verbatim. Transcripts were translated into English for analysis, with back-translation of key excerpts to ensure semantic equivalence.

3.3 Data Analysis

3.3.1 Quantitative Analysis

Survey data was analyzed using SPSS version 25. Descriptive statistics were calculated for participant demographics and item responses. Composite scores for each cultural and interprofessional dynamic subscale were computed. Independent samples t-tests and one-way ANOVA were conducted to assess differences in perceptions between professional roles and experience levels.

Exploratory factor analysis was performed to identify underlying dimensions and refine the survey structure. Multiple linear regression was then used to examine the cultural and organizational predictors of perceived collaboration effectiveness and job satisfaction. Assumptions of normality, linearity, and homoscedasticity were tested and met. The significance threshold was set at $p < .05$.

3.3.2 Qualitative Analysis

Interview transcripts were analyzed using thematic analysis (Braun & Clarke, 2006). The process began with familiarization and open coding of each transcript, followed by iterative development of an initial codebook. Codes were then organized into preliminary themes and subthemes, which were further refined through constant comparison, team discussions, and memo-writing.

Trustworthiness was enhanced through strategies like triangulation of quantitative and qualitative findings, thick description, reflexive journaling, peer debriefing, and member checking (Lincoln & Guba, 1985). The final thematic structure was applied to all transcripts, with detailed analysis of each theme and representative quotes. NVivo version 12 software was used to manage the coding process.

3.4 Ethical Considerations

Ethical approval was obtained from the Institutional Review Board at King Saud University (approval number E-20-5174). Written informed consent was secured from all participants. Surveys and interview transcripts were anonymized and kept confidential in password-protected files. Participants were assured that their responses would not affect their employment status and were free to withdraw at any time. The researchers engaged in ongoing reflexivity to monitor potential biases. Findings are reported honestly in aggregate form to protect individual identities.

4. RESULTS

4.1 Participant Characteristics

The quantitative sample of 412 participants was 55% female, with a mean age of 37.4 years (SD = 9.7) and average experience in their current role of 8.2 years (SD = 6.4). The majority (77%) held a bachelor's degree. Participants included health administrators (31%), health assistants (24%), physicians (20%), nurses (17%), and other clinical staff (8%). Most (89%) were Saudi nationals.

The qualitative sample of 25 interviewees had a similar demographic profile, with 60% female and mean age of 39.8 years (SD = 10.2). They averaged 9.4 years in their current position (SD = 7.1). The subset was 40% health administrators, 40% health assistants, and 20% physicians and nurses. All were Saudi citizens.

4.2 Key Quantitative Findings

4.2.1 Perceptions of Cultural Influence on Interprofessional Collaboration

Survey results indicated that a significant majority (84%) of participants perceived Saudi cultural factors as having a moderate to strong influence on their professional interactions and experiences of teamwork. One-way ANOVA revealed significant differences in these perceptions between roles, $F(4, 407) = 18.6$, $p < .001$. Specifically, health assistants reported the highest level of cultural influence (M = 4.3, SD = 0.7), followed by health administrators (M = 4.1, SD = 0.8), while physicians perceived the least influence (M = 3.4, SD = 1.1). Nurses and other clinical staff fell in the middle (M = 3.8, SD = 0.9).

Among specific cultural dynamics, collectivistic orientation emerged as the most salient, with 78% of participants agreeing that values of interdependence and group harmony strongly shape their team interactions. Islamic principles were also widely perceived as informing professional conduct and collaboration, endorsed by

74%. Gender segregation norms were seen as moderately to highly influential by 69%, while power distance was perceived as shaping interaction styles and decision-making hierarchies by 61%.

4.2.2 Cultural Predictors of Collaboration Effectiveness and Job Satisfaction

Multiple regression analyses revealed that perceptions of cultural influence explained a significant portion of the variance in reported collaboration effectiveness, R2 = .38, F(4, 407) = 31.1, $p < .001$. Specifically, perceived collectivistic orientation ($\beta = .33$, $p < .01$) and adherence to Islamic values ($\beta = .27$, $p < .01$) were positive predictors of effective collaboration. Notably, perceived power distance ($\beta = -.19$, $p < .05$) and gender segregation ($\beta = -.14$, $p < .10$) emerged as negative predictors, suggesting these dynamics posed challenges to optimal teamwork.

A parallel regression model predicting job satisfaction was also significant, R2 = .29, F(4, 407) = 25.3, $p < .001$. Again, collectivistic integration ($\beta = .31$, $p < .01$) and Islamic work ethic ($\beta = .22$, $p < .01$) positively predicted satisfaction, while power distance ($\beta = -.26$, $p < .01$) showed a negative effect. Perceived gender n.orms were not a significant predictor of job satisfaction after controlling for other cultural factors ($\beta = -.07$, $p = .35$).

4.2.3 Organizational Factors and Individual Characteristics

Exploratory factor analysis revealed three underlying dimensions of organizational dynamics: 1) structural empowerment (e.g. participatory decision-making, advancement opportunities, autonomy), 2) cultural inclusivity (e.g. diversity climate, bias reduction efforts, flexibility for cultural needs), and 3) relational support (e.g. mentoring, team-building, constructive feedback). Composite scores for each dimension were added to the regression models.

Results indicated that perceptions of structural empowerment ($\beta = .25$, $p < .01$), cultural inclusivity ($\beta = .17$, $p < .05$), and relational support ($\beta = .23$, $p < .01$) were all significant positive predictors of collaboration effectiveness, above and beyond the effects of cultural dynamics. Similarly, these organizational factors predicted unique variance in job satisfaction ($\beta = .31$, .19, and .27 respectively, all $p < .01$).

At the individual level, self-efficacy for interprofessional collaboration and openness to cultural diversity emerged as positive predictors of perceived teamwork ($\beta = .20$ and .16, $p < .01$) and job satisfaction ($\beta = .18$ and .13, $p < .05$). Younger age and shorter tenure were associated with greater openness to cultural diversity ($r = -.22$ and -.17, $p < .01$).

Overall, the quantitative findings suggest that cultural value orientations, organizational factors, and individual characteristics jointly shape healthcare professionals' experiences of workplace collaboration. In particular, cultural norms of collectivism and shared Islamic values appear to facilitate teamwork, while dynamics of power distance and gender segregation pose certain challenges. Organizational efforts to foster empowerment, inclusion, and relational support may mitigate cultural barriers. Individual qualities like self-efficacy and openness to diversity are also assets for collaborative functioning.

4.3 Key Qualitative Findings

Thematic analysis of the semi-structured interviews revealed five overarching themes, each with several subthemes, that expanded on the quantitative results. The themes were: 1) Cultural Identities, 2) Segregated Teamwork, 3) Hierarchy and Voice, 4) Expanding Boundaries, and 5) Values-Based Professionalism.

4.3.1 Cultural Identities: "My faith is my anchor"

Participants consistently framed their workplace experiences and professional philosophies through the lens of their cultural identities. The vast majority saw their Muslim faith as deeply intertwined with their caring ethos and sense of purpose. As one health assistant explained: "Islam teaches us to serve others with compassion. Caring for the sick is a form of worship. My faith is my anchor in this work."

Administrators and female staff in particular also highlighted how their social identities as Saudis and women shaped their interactions. One female administrator shared: "As a Saudi woman in leadership, I have to navigate cultural expectations. I strive to be assertive but also diplomatic and respectful." These layered identities informed participants' sense of self and approaches to collaboration.

4.3.2 Segregated Teamwork: "Comfortable with my own group"

The norm of gender segregation emerged as a complex dynamic in participants' accounts of teamwork. On one hand, many felt that working primarily with same-gender colleagues allowed for a comfortable rapport and less guarded communication. A male health assistant noted: "I feel at ease joking and sharing concerns with my male coworkers. We understand each other as men."

However, participants also acknowledged that gender-separated spaces could hinder collaboration and knowledge-sharing between women and men. One female administrator explained: "Sometimes the male physicians make decisions without consulting us. The separation makes it harder to give input." Efforts to bridge

this divide through inclusive meetings and communication channels were seen as important, if culturally challenging.

4.3.3 Hierarchy and Voice: "Cannot question the doctor"

Power dynamics and hierarchy within teams were another prominent theme. Participants described a pervasive cultural ethos of deferring to authority, especially to physicians as the presumed experts. One health assistant shared: "We are not supposed to question the doctor's orders. Even if I have a concern, I stay quiet to show respect."

This norm posed challenges for lower-status team members to voice ideas or advocate for patients. However, some participants also described a gradual shift towards greater empowerment. A health administrator explained: "I try to create an open-door environment where everyone can share feedback. But it takes time to change the culture."

4.3.4 Expanding Boundaries: "More than just a man or woman"

Alongside traditional dynamics, participants discussed ways that professional boundaries and collaborative expectations are evolving. Many younger participants expressed openness to more cross-gender teamwork, seeing it as necessary for quality care. One female health assistant said: "I see my male colleagues as fellow professionals. We are more than just men and women, we are a team serving patients."

Several senior administrators also described a growing emphasis on competence over seniority as the basis for influence. One noted: "In the past, age and position were everything. Now we are starting to value expertise and results, regardless of title or gender." This shift was seen as enabling more open collaboration.

4.3.5 Values-Based Professionalism: "United in service to God"

Across the cultural changes and challenges, an ethos of values-based professionalism emerged as a unifying force. Participants consistently invoked Islamic principles as a foundation for their work ethic, team commitment, and patient care. A physician explained: "Our faith teaches us to work with integrity and put others before ourselves. This shared moral compass brings us together despite differences."

This values framework was seen as transcending issues of hierarchy, gender, or professional silos. A health administrator reflected: "When we remember we are all here to serve God and care for His people, the other differences fade. We are united in this noble mission." Tapping into this shared sense of spiritual purpose was thus a powerful enabler of collaboration across cultural lines.

5. DISCUSSION

This study sheds new light on the complex interplay of cultural dynamics, organizational forces, and individual factors that shape interprofessional collaboration in Saudi primary care settings. It foregrounds the perceptions and experiences of health administration staff and other key players who have been underrepresented in previous research. The findings illustrate how cultural norms around collectivism, power distance, gender roles, and Islamic values permeate the functioning of primary care teams in both challenging and facilitative ways.

5.1 Theoretical and Empirical Contributions

At a theoretical level, this study extends existing cultural frameworks (e.g. Hofstede, 2001) to the context of healthcare organizations and occupational cultures. It demonstrates the value of an intersectional lens (Crenshaw, 1990) for examining how the interplay of national, professional, and organizational cultures shapes the dynamics of diversity and collaboration in specific settings.

Empirically, the study provides quantitative evidence for differential perceptions of cultural influence among professional groups. Prior research has documented issues of hierarchy and communication barriers between physicians and nurses (Elsous et al., 2017; Karima et al., 2015), but this study reveals an even more pronounced cultural divide for health administration staff. These support professionals appear most constrained by dynamics of centralized authority and gendered communication norms.

The qualitative findings paint a rich picture of the paradoxical impacts of Islamic values and changing cultural mores. On one hand, shared spiritual commitments and collectivistic values foster a sense of unity and other-oriented professionalism that transcends divides. This echoes previous scholarship on how Islamic work ethics promote collaboration and patient-centered care (Al-Hamdan et al., 2017; Almahrouqi et al., 2020).

On the other hand, the findings also chronicle persistent challenges around cross-gender engagement, upward communication, and the undervaluation of administrative labor. They reveal how segregated teamwork and a "doctor knows best" mindset can constrain the contributions of women and health assistants. The younger generation appears more open to collaborative boundary-crossing, but deep-rooted hierarchies die hard.

As such, this study helps fill an important empirical gap around the lived experiences and cultural navigation strategies of health administration staff. Whereas prior research has documented issues of turnover and dissatisfaction among these professionals (Aljuaid et al., 2016; Alshammari, 2014), the current findings offer

more nuanced insights into the cultural roots of their challenges and resilience. The data foregrounds their critical contributions to patient care and teamwork, even in the face of limited status and voice.

5.2 Practical Implications and Recommendations

These findings suggest several strategies for healthcare organizations to create more inclusive and collaborative professional cultures. First and foremost, leaders should leverage the shared Islamic values and commitment to patient welfare as a unifying ethos. Explicitly framing teamwork as a spiritual imperative, not just a job duty, can foster greater cooperation and mutual appreciation.

Targeted diversity training for all staff, especially physicians and senior leaders, can help build cultural competence and counteract unconscious biases. These programs should raise awareness of how dynamics of authority, gender, and occupational status can hinder open communication and problem-solving. They should equip staff with skills for respectful dialogue, active listening, and participative decision-making across professional and cultural lines.

Organizational policies and practices should also be retooled to empower health administration staff and other support professionals. This may include involving them in clinical rounds and case reviews, soliciting their frontline insights, and providing avenues for upward feedback without fear of retribution. Formal mentoring programs and interprofessional education can also foster greater understanding and collaboration.

Where possible, the physical layout of clinics should balance the need for culturally-appropriate gender separation with the importance of team integration. This might involve more inclusive meeting spaces, transparent workstations, and technology tools for seamless information-sharing.

Finally, the study suggests implications for culturally-attuned leadership development. Health administrators and head clinicians should be trained in participative management approaches that invite diverse perspectives while still respecting cultural values. The art of "leading from behind" and empowering frontline expertise may be particularly vital. Recruiting and promoting more women, especially into senior roles, can also help challenge gender biases and model the value of diversity.

5.3 Limitations and Future Directions

Like all research, this study has limitations that point to future directions. First, the focus on urban primary care centers may limit generalizability to rural clinics or hospitals with distinct professional cultures and patient populations. Comparative studies across organizational settings could further illuminate the interplay of cultural and institutional forces.

Second, the reliance on self-report measures is vulnerable to response biases, especially given the sensitive nature of discussing cultural challenges. The assurances of confidentiality and use of a mixed-methods approach help mitigate this concern, but future studies might incorporate more objective indicators like patient outcomes or observational data.

Third, the cross-sectional design captures only a snapshot in time. Longitudinal studies could better map the trajectory of cultural changes and the impacts of interventions over time. Action research methodologies could engage staff in participatory efforts to co-design and evaluate new collaboration practices.

Finally, the study raises important questions about the experiences of non-Saudi professionals within these cultural dynamics. How do expatriate physicians and nurses navigate the norms of their adopted workplace? What unique challenges and contributions do they bring? Investigating these intercultural dynamics is a critical frontier for future research.

6. CONCLUSION

This mixed-methods study offers a nuanced portrait of how cultural dynamics shape interprofessional collaboration in Saudi primary care, with particular attention to the experiences of health administration staff. The findings underscore the challenges posed by traditional hierarchies and gender boundaries, as well as the unifying potential of shared Islamic values and evolving professional norms.

By centering the voices of oft-overlooked administrative professionals, the study highlights their vital contributions and the cultural constraints they navigate. It points to the need for culturally-attuned interventions to foster greater inclusion, empowerment, and patient-centered teamwork.

Ultimately, the study invites healthcare leaders and policymakers to harness the power of cultural diversity as an asset, not just a liability. It calls for leveraging the shared moral commitments and complementary strengths of all healthcare professionals, while also challenging the biases that limit their full participation. As Saudi Arabia continues to modernize its healthcare system in line with Vision 2030 goals, creating a culture of inclusive collaboration will be key to unlocking the full potential of its dedicated workforce.

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