CULTURE AND MEDICAL SOCIAL WORK PRACTICE IN SAUDI ARABIA

NAWAF ALTHUMALI

A thesis submitted in partial fulfilment of the
requirements of Nottingham Trent University
for the degree of Doctor of Philosophy

December 2021

COPYRIGHT STATEMENT

ACKNOWLEDGEMENTS

I extend my sincere thanks to Dr Bowpitt Graham and the second supervisor Dr Arnull, Elaine, for their unlimited support, excellent advice, and valuable guidance, all of which helped me complete this work. I would also like to thank my former supervisor Dr Chak Kwan. I also thank the teaching staff who supported me for their assistance and support.

I would also like to extend my thanks to the one who taught me the determination to seek knowledge, to the light of my life, my mother, whom I ask Allah to protect. And my great thanks to my father, may Allah the Almighty have mercy on him, who passed away before completing this work; how happy would I have been if I had presented these pages to you with my hands.

I am also pleased to extend my profound thanks and gratitude to my wife, Afaf, my companion, who walked with me towards achieving my goal step by step. And all my children, the pure, kind hearts and the light of the path, you are my honour and pride. They endured and worked on creating a suitable atmosphere for the completion of my studies. My thanks and gratitude go out to my entire family, who were excited to see me achieve this goal, encouraged me, and stood by my side. Finally, thanks also to everyone who guided or assisted me in my studies and research preparation.

ABSTRACT

The practice of social service in any society is determined by the distinct social and cultural characteristics of each particular country. This study explores tensions between professional social work roles and the cultural and religious context of hospitals in the Kingdom of Saudi Arabia. The Purnell model of cultural competence was the organising framework for this qualitative study. The researcher used the qualitative technique of thematic analysis to interpret the results. The researcher gathered data via semi-structured interviews with a convenience sample of social workers (n=24) and patients (n=20) from hospitals in Taif, Saudi Arabia, on their perceptions of medical social workers' roles and responsibilities.

The findings indicate tensions between social work roles and patient expectations, particularly regarding the role of women, respect for religious practices, beliefs about the nature of illness and how it should be treated. The results suggest that although social workers identified various specialised and non-specialised roles, The vast majority of these roles were unknown to the majority of the patients. There may be a lack of appreciation for social workers' efforts and functions as a result of a lack of awareness and knowledge about the social worker's role in the healthcare sector. A significant finding was the need for cultural competency among social workers. Issues occur when patients or their families impose their religious and social values on staff when receiving treatment. Patients agreed on the importance of their cultural and spiritual values when receiving the social worker's help. Most patients reported that the social workers complement Saudi cultural and Islamic religious customs. The study's findings also indicated that a non-supportive organisational environment, including a shortage of offices, training, and financial support, was a major barrier that medical social workers faced. Therefore, this study recommends adding domains and themes to the Purnell model of cultural competence to ensure that social workers are culturally competent.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

TERMINOLOGY

Culture: "Culture is that complex whole which includes knowledge, beliefs, arts, literature, morals, law, customs, and any other capabilities and habits acquired by a human as a member of society" -Edward Burnett Tylor (1832-1917).

Efficient/Effective Healthcare: Healthcare that is easily accessible, affordable and enhances patient outcomes.

KSA: Kingdom of Saudi Arabia

Mixed Research Method: A study method that combines both qualitative and quantitative research types.

MOH: Ministry of Health

MSW: Medical Social Work

Qualitative Research Methodology: A descriptive type of research that deals with non-numeric data, particularly people's opinions, views, and perceptions of the topic of discussion.

Quantitative Research Methodology: A scientific research method that uses statistical tools to analyse and interpret numerical data.

Social Work Practitioners: Professionals who support the needs of individuals, families, and individuals who are marginalised, disadvantaged, have special needs, or experience various physical health needs.

CHAPTER 1. INTRODUCTION

1.1 INTRODUCTION

Saudi Arabia has recently witnessed rapid development in the healthcare field based on the Western medical model. Western medicine is a system in which doctors and other healthcare professionals see patients and treat their symptoms through the use of prescription medications, surgical operations, various forms of therapy and radiation (Vandegrift, 2017). The Western model of healthcare incorporates multi-disciplinary teams. Disciplines such as medicine, social work, nursing, and other allied health professionals comprise inter-professional teams in the Saudi healthcare sector (Alagalni 2006; Albrithen 2009; Al Fahidi 2012; Albrithen and Yalli 2013; Aljadhey et al. 2014; Albrithen and Yalli 2015). Payne (2005) and Woodruffe (1962) detail the history and origins of the Western model of social work practice in the UK from a philanthropic activity to an organised profession.

Social workers play a vital role in ensuring successful healthcare services (Saleh 2002; Lymbery and Butler 2004). To ensure the efficiency and effectiveness of the healthcare sector, cooperation between medical staff and social workers is essential given the current environment, in which standard practices can conflict with established social and behavioural norms (Albrithen and Yalli 2016; Davies and Connolly 1996). Social workers can bridge the gap between patients' social, cultural, and economic needs and medical treatment while providing regular support in managing life events (Van Der Laan 1998; Quezada 2007; Ryan 2012; Arafa 2015; Yalli and Albrithen 2016).

There is a clear connection between the social workers' willingness to adapt to limitations imposed by cultural norms and positive caregiver-patient results. Social workers routinely provide patients with support in managing life events (Bywaters and McLeod 2003; Quezada 2007; Ryan 2012; Arafa 2015; Yalli and Albrithen 2015; Alotaibi et al. 2020).

This study examines social workers' roles in a multidisciplinary hospital team from the social worker and patient perspectives. This study increases the actual knowledge of the perceived role of social work practitioners in Saudi Arabian hospitals while paving the road for further studies on similar topics by other academic researchers. Therefore, understanding social workers' roles and tasks in a multidisciplinary team can lead to developing effective performance-enhancing training programs while at the same time improving healthcare outcomes. As such, this study identifies and examines the cultural and social values in Saudi Arabia that may represent critical barriers to the delivery of healthcare services by social workers.

1.2 BACKGROUND

Social work education in Saudi Arabia has lagged behind the rapid development in the healthcare sector, forcing the system to rely on foreign medical professionals. Studies have demonstrated that the number of trained social work practitioners graduating from various social work training institutions is insufficient to meet demand in Saudi Arabian hospitals (Walston et al. 2008; Yalli 2008; Al-Ahmadi 2009; Wahabi and Alziedan 2012). Accordingly, the significant challenges to developing the social work profession in Saudi Arabia may include 1) socio-cultural and religious factors, 2) the perceived low status of social workers in Saudi Arabian hospitals, 3) a scarcity of training resources, 4) high patient: staff ratio (Yalli 2008; Yalli and Albrithen 2015; Yalli and Albrithen 2016; Yuen et al. 2020).

Islamic culture guides daily life in Saudi Arabia; it is not merely an optional religious allegiance, as in Christian countries. Islamic culture considers men and women morally equal in duties and rights, and they must fulfil the same obligations of worship and belief. Islamic practises encompass behaviour, language, food, and other social customs. According to Islam, anything related to illness, health, and death come from Allah (Al-Ahmadi, 2009). Saudis

believe that sickness is an atonement for sins, rather than a punishment from God. This perception challenges healthcare providers as some patients fail to participate in the treatment process. Socio-cultural beliefs shape social workers' practise in Saudi Arabia (Tumulty 2001). According to Islam, male social workers cannot provide social care for female patients, in the absence of their husbands or other close male family members. To enhance patient outcomes, social workers must respect Islamic cultural mores (Elzubeir et al. 2010). The cultural aspects of verbal and non-verbal communication influence social work treatment (Northouse & Northouse, 1998). *Health communication strategies for health*. Saudi Islamic culture has strict guidelines on providing treatment when the patient's gender is different from the caregiver's gender (Hodge 2005; Ragab 2016). In addition, because of confidentiality constraints in Saudi culture, social workers face other challenges regarding inquiring about patient information on emotional topics such as sexuality (Al-Makhamreh and Lewando-Hundt, 2008; Almutairi, 2015). Low status and lack of staffing lead to social workers having multiple roles, including secretarial and administrative duties. The addition of these roles impacts patient care. Al-Ahmadi (2009) recommended that hospitals allow social workers to focus on their professional responsibilities by removing all non-specialised duties.

The Saudi Arabian government has tried to retain and attract many medical and healthcare professionals, particularly in social work. The government has taken various measures to train new social workers. Higher education institutions have expanded social service departments in universities by offering social work training, particularly in a medical setting. Moreover, the Saudi government has allocated funds to provide Saudi students with advanced, social work training in many foreign countries (Slama 2012; Ministry of Health Saudi Arabia 2016; Saudi Arabian Cultural Mission in Australia 2021; Royal Embassy of Saudi Arabia in USA 2021). This initiative seeks to improve social workers' expertise and decrease the turnover rate in healthcare. In line with this, Purdy (2010) concluded that the recruitment and training

of new social workers would partially resolve the existing challenges confronting the healthcare system in Saudi Arabia.

Examining patients and social workers' views about these roles helps create new methods to address the issues affecting the social work profession in Saudi Arabia due to the multiple challenges that social workers encounter.

1.3 STUDY SIGNIFICANCE

Based on studies by Ellingson (2002), Ryan (2012), Ambrose-Miller and Ashcroft (2016), and Abrithen and Yalli (2015), various roles and functions of hospital social workers can include: 1) coordinating treatment plans, 2) advocating for patients, 3) addressing psychological issues, 4) decision making and 5) helping to resolve behavioural problems and risky behaviours. Other more universally recognised functions include: 1) community organising, 2) capacity building, 3) assisting patients to recognise and receive entitlement benefits such as medical assistance, 4) providing techniques for risk management, and 5) aiding and educating the medical team on psychological health issues (Bridget and Meagan 2019). However, few studies have investigated the roles of social workers in Saudi hospitals. Albrithen and Yalli (2015) explored social workers' roles and functions in hospitals in the Western region of Saudi Arabia. They raised several concerns about social workers' perceptions of their roles and Saudi culture's impact on healthcare outcomes. This study expands this research by exploring social workers' and patient' perceptions of hospital social workers' roles and functions in Saudi Arabia. This study helps develop new strategies based on Saudi society's social, behaviour and cultural expectations to improve social worker performance and enhance patient outcomes.

1.4 RESEARCH QUESTIONS

The following research questions guided this inquiry: The primary research question of this study is "What are the implications of culture and values on social work professional practice in the healthcare sector in Saudi Arabia?" From this central question, the following sub-questions were developed:

R_1: How do hospital social workers perceive their roles and functions?

R_2: How do patients perceive the roles and functions of hospital social workers?

R_3: How do Saudi cultural values influence social work practice in hospitals?

R_4:What are the challenges and obstacles to social work practice in hospitals?

1.5 STRUCTURE OF THE STUDY

The study is divided into the following chapters:

Chapter 1 introduces the problem under investigation and the relevant background of this problem. Chapter 1 also outlines the statement of the problem, the purpose of the study and its significance. The chapter also delineates the research questions, definitions of terms and assumptions, limitations and delimitations.

Chapter 2 comprises the literature review. The search procedures of the study are also described in this section. The review is organised by theme, including the background of the Kingdom of Saudi Arabia, cultural values in Saudi society, the social work profession in Saudi Arabia, the healthcare sector in Saudi Arabia, and medical social work. Barriers to effective medical social work practice recommendations and limitations complete the chapter.

Chapter 3 outlines the methodology of the study. The chapter discusses the research design and the rationale for its choice. The research questions guiding the study are identified, and the research process of sampling, data collection, and data analysis are described.

Chapter 4 presents the results of the data analysis. The research questions provide a framework for the presentation of the results. Furthermore, the data from semi-structured interviews, organised by social worker and patient participants, is reported.

Chapter 5 discusses the findings reported in Chapter 4, and is organised by research question. The chapter summarises the findings and discusses the implications for medical social work practice in Saudi Arabia.

Chapter 6 presents the conclusions of the study. Furthermore, the chapter presents recommendations for medical social service providers in Saudi hospitals, as well as social workers and patients.

1.6 SUMMARY

This chapter delineates the main points of the study, including the significance of the study, the research questions, aims and objectives of the study, the adopted research methods, and the organisation of the entire study. The following chapters specify these points.

CHAPTER 2. SOCIAL CARE IN THE SAUDI HEALTH SECTOR

2.1 INTRODUCTION

This chapter articulates an in-depth discussion of the literature concerning culture and the medical social work profession in Saudi Arabia. Previous research was reviewed to reduce the scope of the research topic, and a methodological study was conducted to answer the research question. This is consistent with academic researchers' statements defending the procedure of performing a literature evaluation to confirm the study project's legitimacy. (Ghauri et al., 2005; Morse et al. 2006; Creswell 2009; Saunders et al. 2012).

Consequently, this chapter includes a background discussion of the Kingdom of Saudi Arabia while specifying the impact of oil discovery on economic growth. The following sections explore the cultural values of Saudi society. Additionally, the definitions of culture in the literature and the implications of culture in Saudi Arabia as well conceptions of as health and illness in Islam were examined. The following sections of the literature review include a discussion of the social work profession in Saudi Arabia, the healthcare sector, medical social work in Saudi Arabia, barriers to effective medical social work practice, and effective social work practice recommendations. The chapter concludes by discussing the limitations cited in the literature and specifies research gaps.

2.2 BACKGROUND OF THE KINGDOM OF SAUDI ARABIA

Figure 2.1. Geographic regions of Saudi Arabia

Source: Encyclopaedia Britannica, Inc.

As depicted in Figure 2.1, the Kingdom of Saudi Arabia is located in Western Asia and is approximately 2,149,690 km^2 in area. The country is bordered by the Red Sea to the west, Jordan and Iraq to the north, the Sultanate of Oman and Yemen to the south, and Qatar, Kuwait, and the United Arab Emirates (UAE) to the east. Saudi Arabia is connected to Bahrain via the King Fahd Causeway. Saudi Arabia is the main gateway connecting Europe, Asia, and Africa (Ministry of Higher Education 2015). The population of Saudi Arabia reached 31,787,580 in 2016, with a population growth rate of 2.55% and a population density of 15.3 (Ministry of Higher Education 2015).

Saudi Arabia consists of 13 administrative units, each with its own capital city. The country's western region is the most developed and dynamic area, with a host of cities, including the Holy City of Makkah, Jeddah, Taif and Madinah. The latter is the second holy city in the KSA (Ministry of Commerce and Investment 2015). Each region and city varies in population, infrastructure, and public services (e.g., hospital facilities). Although the Ministry of Health manages all government hospitals, these hospitals vary in size, number of employees, type, and specialisations. However, these government hospitals are identical in terms of the healthcare services they provide. Social workers operate in the social care divisions of hospitals, where they provide social services connected to enhancing health care and offer advice on healthcare policy and services. As a result, social workers' roles and duties are nearly the same in all public hospitals in Saudi Arabia.

According to the General Authority for Statistics of the Kingdom of Saudi Arabia (2016), a significant percentage (36.82%) of the Saudi Arabian population consists of foreigners or non-Saudi residents. This indicates a wide diversity in nationality and cultural backgrounds in the Saudi population. Most Saudi Arabian residents are of Islamic heritage, and accordingly have strong cultural traditions, such as strong relationships between family members, including daily and frequent visits by several relatives to a sick family member.

Arab and Islamic traditions have influenced Saudi Arabia’s cultural environment. The culture is intensely religious, traditional, conservative, and family oriented. Saudi customs and attitudes appear to be ancient and originated from the Islamic history of the Arab empire. However, the rapid changes of the modern era have also influenced the country’s culture, although many challenges have arisen previously. However, the discovery of oil has drastically altered daily life, turning the country’s economy into a valuable source of welfare for its citizens (Hamdan 2005).

2.2.1 Impact of the Discovery of Oil

The discovery and development of oil in the 1930s transformed Saudi Arabia from an impoverished nomadic community into a wealthy commodity producer in just a few years (Abdullah 2001). Oil-generated revenue initiated large-scale reforms in society, including the opening up of schooling for boys and girls in the early 1970s, education abroad and lifestyle transitions (Habashi 2015). Saudi Arabia has the second-largest global oil reserves in the world and is the largest international exporter of oil, which led to its prosperous economic status. The economy began flourishing in the 1970s, concurrently doubling its oil returns. Total economic production has increased more than 33 times during the past 28 years. Other productive sectors have also seen significant growth, such as agriculture, industry, and mining, increasing the Saudi economy to fifteenth globally (Habashi 2015).

Many challenges, transformations and changes have driven the renaissance and improvement of information in the KSA. The Saudi Ministry of Education has sought to improve the quality of higher education. Universities developed programs to support students in scientific disciplines and enhance their competitive world marketplace skills. Today, there are 34 universities, 24 government universities, and ten private universities in the KSA, with at least five of these universities considered among the best international universities (Ministry of Higher Education, 2015).

However, the discovery of oil and accompanying rapid economic development have exacerbated economic inequalities and social segregation and hence expanded the need for social work in Saudi Arabia (Albrithen and Yalli, 2015). The rapid economic growth led to urbanisation, with areas around the oilfields evolving into urban centres. Similarly, this period witnessed the rise of informal settlements, which mainly consist of the urban poor who could not find employment at the oil refineries. This urban expansion was also accompanied by the

rise in social vices such as prostitution and substance abuse. Social workers thus provide care to the disadvantaged and address these social issues.

Moreover, the Saudi government's significant involvement in providing social services in the KSA was critical in expanding the profession. As the largest employer of social care workers, the government set up social care training schools to equip students with the necessary skills, in line with international standards and best practices (Albrithen and Yalli 2015; Habashi 2015). Yalli (2008) argues that the discovery of oil was a turning point in Saudi Arabia's history, leading to vast socioeconomic changes. The revenues from oil exportation allowed the government to undertake various infrastructural development programs across different sectors such as health, transport, education, telecommunication, and housing. An increase in military spending led to its modernisation and expansion. The booming oil industry led to a trickle-down effect of expanding other petroleum-based industries (Abu-Alia 1986; Metz 1992). As a result, increased revenues from oil exportation have also led to the growth of the healthcare sector.

2.3 CULTURAL VALUES IN SAUDI SOCIETY

2.3.1 Definition of Culture

Many scholars have approached defining the concept of culture from a variety of different perspectives, leading to a multiplicity of definitions. Tylor (1871) defined culture as the sum total of knowledge, belief, art, law, morals, custom, and any other habits and capabilities acquired by a person as a member of society. Linton (1936) referred to culture as any society with its entire ideas and patterns of habitual behaviour. According to this definition, culture conditions the emotional responses acquired by members of society. Keesing and Strathern (1981) defined culture as indicating a particular social group's socially transmitted patterns and behavioural characteristics. Brumann (1999) defined culture as the entirety of the

complicated themes of traditional behaviour developed by the human race and learned by each successive generation. In this definition, it is clear that the definition of culture is not precise while reflecting the general idea of habitual behaviour.

Other scholars (Brumann 1999; Birukou et al. 2013) have considered the implications of globalisation in defining the term culture, whereas global contact blurs cultural boundaries, and such connection requires culturally aware administrators and professionals. Recent anthropology textbooks contain a broader definition of culture as the socially transmitted knowledge and behaviour shared by a group of people.

In summation, one can consider culture as the total socially acquired lifestyle or way of life of a group of people. It contains the patterned, feeling, repetitive ways of thinking and acting characteristic of the members of a particular society or segment of society. This definition aligns with the argument of Harris (1997). Given this, culture consists of something shared and/or learned by a community of people. However, it is still necessary to explore the specific theme of culture in Saudi Arabia since it is the primary concern of this project.

2.3.2 Culture in Saudi Arabia

Saudi Arabia's cultural environment is a unique mix of Arabic and Islamic influences. Arabic tribal practices and customs combined with the Islamic worldview to define the attitudes of the Saudi people. Therefore, the numerous expatriate health professionals, who have minimal awareness of Saudi culture, may exacerbate the problem of delivering high-quality treatment and cause possible cultural tensions, thereby contributing to patient dissatisfaction (Al-Makhamreh and Lewando-Hundt 2008; Almutairi 2015; Saudi Arabian Cultural Mission in Australia 2021).

In one study conducted by Alshammari et al. (2019) on hospital healthcare professionals' perceptions toward patients' safety culture in Saudi Arabia, they discovered a significant positive association between patient safety characteristics and the participants' cultural profiles. This is consistent with the Saudi Arabian Ministry of Health's vision (2016). Ministry of Health strives to guarantee safer healthcare for everybody by developing and distributing patient safety best practises and assisting all healthcare institutions in the Kingdom in implementing them (Ministry of Health of Saudi Arabia 2016)

Most healthcare staff are expatriates from countries with different cultural backgrounds, such as the Philippines, India, Australia, Malaysia, the United Kingdom, the USA, and other Middle Eastern countries. Many professionals in medicine, allied health professions, and social workers come from Western-developed codes which define social workers' role in Saudi healthcare (Albrithen and Yalli 2015).

Therefore, Arabic, and Islamic traditions have profoundly influenced Saudi Arabia's cultural environment. The culture of the Kingdom is thus intensely religious, traditional, conservative, and family-oriented. Many of these traditions and attitudes are centuries old, originating from the Islamic history of the Arab empire (Ministry of Health of Saudi Arabia 2016). However, the rapid pace of change of the modern era has also influenced its culture. The Middle East, specifically the Gulf nations, have experienced significant difficulties in the past 50 years. Oil and its resulting riches have greatly affected Saudi Arabia (Hamdan 2005; Al-Makhamreh and Lewando-Hundt 2008; Almutairi 2015).

Family is considered a significant component of Saudi society and the cornerstone of citizens' identity. Islam encourages Muslims to maintain relations with their family members by visiting them, celebrating with them, providing them with financial assistance, helping them when in need, showing sufficient respect, and practising compassion. Relatives prefer to live

close to each other in large cities, promoting family interaction and socialisation. Close connections and relationships exist between extended and immediate family members (Al-Makhamreh and Lewando-Hundt 2008; Almutairi 2015). Grandparents are held in high regard in Saudi society and have substantial decision-making authority concerning family matters. Al-Shahri (2002) thus concluded that healthcare workers should treat elderly people gently and in a soft-spoken, respectful, and compassionate manner.

The well-being of the Muslim population is one of the central teachings of Islam. The holy Qur'an is not a book of medicine but does contain guidelines that promote health and well-being. The traditions of the Prophet Muhammad inform the Muslim community about general well-being and the prevention of disease (Ragab 2016). Islam encourages constructive practices that promote health and well-being, such as meditation, ablution, bathing, fasting, and breastfeeding. In particular, Islam is concerned with cleanliness. Therefore, the religion encourages all Muslims to practise activities such as nail cutting, teeth brushing, and depilation of auxiliary and pubic regions.

Furthermore, Islam prohibits unhealthy eating, eating carrion, consuming alcohol, drinking blood and intoxicants, homosexuality, and sexual promiscuity. Muslims do not consider sickness from Allah (Almighty God) to be a form of punishment; instead, they view it as atonement for sins. Islam motivates Muslims to seek medical assistance and care (Ragab 2016). By exercising patience and saying prayers, Muslim patients ask Allah for support and forgiveness. Charity is one of Islam's recommended positive deeds; therefore, the patient is encouraged to donate to charity, increase God's remembrance, and spend time reading or listening to the holy Qur'an (Padela et al 2018; Ragab 2016).

2.4 THE SOCIAL WORK PROFESSION IN SAUDI ARABIA

2.4.1 Development of the Social Work Profession in Saudi Arabia

The beginnings of the social work profession can be traced to the United Kingdom and other European countries, as well as the United States and Canada in the latter half of the 19th century (Weiss-Gall and Welbourne 2008). Since then, social work has spread to more than 144 countries and has become a global profession. In Britain, the first medical social workers were called 'hospital almoners', or sometimes 'lady almoners'. In the 1960s, the term 'medical social workers' began to be commonly used. In the United Kingdom, social workers must undergo thorough training to become registered professionals. The social worker must maintain work-specific qualifications, and they are typically employed in the public sector by local authorities (Leutz 1999). The British government spends a considerable amount of its local expenditure funds on social service departments, hiring numerous social workers. In the United Kingdom, all social workers, including medical social workers, are licensed and abide by regulations. In April 2005, the title 'social worker' became protected in England (Cree and Myers 2008). Egypt was the gateway of the social work profession to the Middle Eastern region (Soliman 2013). Soliman (2013) postulated that social work educators from the United States and Britain who travelled to Egypt in the 1950s and 1960s established the profession in this country. As in America during the beginning of the 20th century, social work initially confused most people in Egypt. Many could not understand the role of social workers in society. Although imported from the West, there is evidence that social work responded to existing needs. Awad (2010) wrote that social work in Egypt initially concentrated on providing care to the elderly and creating social centres for the homeless.

Many researchers have attempted to determine the historical origin of social work in the Kingdom of Saudi Arabia. Albrithen and Yalli (2015) argued that a rudimentary form of the profession has existed since 1962 to respond to the needs of some disadvantaged persons in society. Social welfare in Saudi Arabia entailed providing food, clothing, and other subsidies to underprivileged groups like orphaned children, the poor and persons with disabilities. According to these authors, a developed welfare system in Saudi Arabia, coupled with the profession's presence in other Islamic countries like Egypt, led to the social work practice in Saudi Arabia. The authors further explain that Saudi Arabia relied heavily on social care professionals from neighbouring Islamic countries such as Egypt, Jordan, and Palestine, who migrated to Saudi Arabia and helped expand the profession in healthcare centres, schools, and social welfare programs. These foreign social work professionals trained not only social work students, but also established professional standards. With an increase in the number of higher learning institutions in the country, the number of trained social workers again rose. Integrating social work education into the curriculums of higher education institutions meant that students recognised the profession's importance, which increased public awareness of the profession in the KSA. There was also a genuine interest by social care educators to modernise the profession following international standards, which also contributed to its growth (Almaizar and Abdelhamed 2018).

According to Al-Shahrani (2003), social work in Saudi Arabia began in 1954 when a juvenile care centre opened. In 1955 social work was introduced to schools. There were no health care facilities or other forms of treatment available in rural and urban areas until 1980. However, the introduction of modern techniques only dates back to the establishment of the Ministry of Labour and Social Affairs in 1960. Social work education began at the assistants' level when an intermediate institute was opened in 1962 by the Ministry of Labour and Social Affairs. However, other researchers have asserted that social work started in Saudi Arabia in 1955

(Almaizar and Abdelhamed 2018). This date is justified through the significant employment of two specified social workers to supervise schools' social activities during this period.

Yalli (2008) explained that social work services that began in the 1960s culminated in creating the Ministry of Social Affairs (MoSA). The MoSA presently supervises more than 60 medical centres that provide social care services to individuals with physical and health challenges and disadvantaged members of society. The author also stated that there are currently five social care homes across the KSA supervised by the MoSA, providing social and psychological care services to children with special needs (Yalli 2008). Moreover, the ministry also offers social care services under the Alternative Care Programme to orphaned children, children of prisoners and those who lack proper social upbringing for various reasons. The Alternative Care Programme gives monthly aid to a select number of families who care for orphaned children. Regarding children with special needs, Islamic culture and religious beliefs state that those who assist the less-privileged and less fortunate in society will earn a reward from Allah. This belief motivates people to volunteer and provides social care services to orphaned children.

Soliman (2013) traces the development of the social work profession in Islamic countries in the Middle East while stating that it must obtain aid from religious organisations and state governments for the social work profession to develop. The government and social gatherings, such as religious groups, play a critical role in the societal acceptance of social work. The profession must mediate and build the trust of various religious groups, political affiliations, and ethnicities in a given region. Soliman (2013) asserted that a combination of cultural, religious, historical and ideological factors led to the development of the social work profession in the region. These considerations created favourable conditions for the profession to succeed in the region. For instance, the dominant Islamic religion's values match

those espoused by the profession, contributing to the acceptance of social work (Soliman 2013). The establishment of social work schools and professional associations heralded the beginning of the profession in this country. Therefore, social work education started in Saudi Arabia during the 1960s when a secondary social work institute began for the intermediate school certificates holders. Secondary education institutions supported students with social work courses (Almaizar and Abdelhamed 2018). Awad (2010) postulated that social problems and injustices led to the foundation of social welfare institutions. The social work profession was first practised in schools during the third stage of development (1952–1979) and later moved to hospitals and factories. The Arab-Israeli Conflict of 1967 caused many people to recognise the importance of social workers, who provided housing, healthcare, and food to the displaced. The profession then spread to the rural regions of the country. This early development of social work in Saudi Arabia encourages us to explore its current status and implications in the Kingdom.

2.4.2 Current Status of Social Work in Saudi Arabia

As a reaction to the significant importance of social work, the Kingdom of Saudi Arabia adopted a corresponding education system in 1955. According to Almaizar and Abdelhamed (2018), the Saudi Ministry of Education sought the assistance of two social workers from other countries (from Egypt) to carry out the specified plans of managing education and social activity. This, in turn, led to the recognition of the critical role played by social workers for Saudi students (Almaizar and Abdelhamed 2018). Consequently, social work began to take its essential place in social, educational, security, and medical institutions in Saudi society. Given this, fundamental factors impacted the development of the social work profession in the country, such as the social work movement at the end of the 19th century. However, such changes had many impacts for accepting the need for a significant profession that appeared

with a solid capacity to practically handle many social issues (Almaizar and Abdelhamed 2018).

To increase the number of Saudi Arabian social workers, universities in the Kingdom have developed social science departments. Graduates from these social science departments work in all areas of social work (Alotaibi et al. 2020). The intermediate institute of social work education accepts Intermediate Competency Certificate graduates. Despite the cultural disparities between American society and less developed countries, the American system primarily influenced social work in Saudi Arabia. According to Al-Shahrani (2003), Saudi Arabia has accepted and implemented reform policies, social service systems and social work preparation frameworks and credentials used by Western industrial society in general and American culture specifically. The Centre for Social Development in Addiriyah, founded in 1960, offered the opportunity to acquire three leading social work practice methods. Since then, eight groups of students, totalling 189 practitioners, have graduated from this program. There are currently five KSA higher education institutions teaching social work: King Saud University, Princess Nora Bent Abdul Rahman University, Umm Al-Qura University in Makkah, King Abdulaziz University in Jeddah, and Imam Mohammed Bin Saud Islamic University in Riyadh (Albrithen and Yalli 2013; Alotaibi et al. 2020).

Social workers in Saudi schools appeared to work closely with students and their families while linking the environment of home to schools. Therefore, social workers undertook permanent roles and activities involving solving problems students face, which might impede them from achieving their academic degrees. Social workers in the Kingdom perform tasks connected to educating all students and workers in the schools through transferring social skills. This is relevant to discussing the healthcare sector in Saudi Arabia and medical social work practices more broadly (Almaizar and Abdelhamed 2018; Alotaibi et al. 2020).

2.5 HEALTHCARE SECTOR IN THE KINGDOM OF SAUDI ARABIA

The growth of the healthcare sector is a sign of the KSA's development process. The Ministry of Health as well as the primary, secondary and tertiary healthcare services run by the Saudi government provide healthcare services (Statista 2021). The KSA has provided accessible healthcare facilities for its citizens and residents at a hefty price tag. Statista (2021) estimates that Saudi Arabia has the highest healthcare expenditure in the Arab region at around $38 billion annually.

On the other hand, the private expenditure on healthcare is considered the highest in the Gulf, at over $9 billion (Statista 2021). Settling on this figure, the government constructed new public medical centres, bought new facilities, and hired more medical staff. Most hospitals have begun providing modern medicine rather than traditional treatment methods, resulting in better disease management and lower mortality rates to improve health standards in line with international standards (USSABC 2019). One distinctive feature of the Saudi Arabian healthcare system is the low degree of private insurers involved in healthcare provision.

The health sector comes second only to education in the KSA budget. The KSA 2019 budget allotted $46 billion or 15.5% of the total budget for the health and social development category (USSABC Economic brief 2019). While the MOH is responsible for the entire population's healthcare, other governmental and private facilities also provide health services (Statista 2021). Since the 1960s, Saudi Arabia has invested in new medical advancements like screening and testing equipment and immunisation programmes to solve healthcare challenges (Ministry of Health Saudi Arabia 2019). The government of Saudi Arabia has continuously emphasised the enhanced role of the private sector via the nationalisation and financing of job creation and investment-related activities. The private sector accounts for at least 30% of the Saudi healthcare industry. The healthcare market has opened to multinational

healthcare firms, encouraging greater competition. In recent years, procedures for foreign investors have eased. Hospitals in Saudi Arabia may now be owned and run by foreigners. To allow businesses to recruit skilled health practitioners, experienced staff can move unrestrictedly between organisations.

According to Statista (2021), in 2018 total inpatient visits to private-sector hospitals in Saudi Arabia reached 1.6 million, representing a compound annual growth rate (CAGR) of 5.4% since 2014. The increasing demand for inpatient services in hospitals in the private sector exceeds the growth rate of inpatient visits in the Ministry of Health (MOH) and other government sectors. They accounted for 2.8% CAGR over the five years. Private sector outpatient visits have risen by 5.4% from 2014 to 2018, reaching 60 million patients and increasing to 1.6% CAGR outpatient growth for MOH and other government sector visits (Statista 2021). Furthermore, the total number of hospitals rose, while hospitals in the private sector reported significant growth. In 2018, MOH beds approached 43,680, private sector beds approached 18,883, other government sector beds approached 12,583 (USSABC Economic brief 2019). However, even while the Kingdom's healthcare sector has made great progress, there is still a need to work faster.

Yuen and Skibinski (2012) reported that the weak operational methods for inpatient screening reflect the health sector's poor management and regulatory system. The Ministry of Health (MoH) also perceived a deficiency in the well-being structure, emergency and referral administrations, and additional preventive care (Yuen and Skibinski 2012). According to its Vision 2030, the Saudi government aims to increase the private sector’s participation rate in all industries. One of the focal points of Vision 2030 is the healthcare sector. The disparity between hospital bed demand and current supply shortages poses significant challenges for the government. The MOH expects to become less of an operator and concentrate on

regulatory supervision within the sector. Although the demographic population of Saudi Arabia skews towards younger age groups, these citizens' long-term healthcare needs require changes today to meet potential future healthcare demand (USSABC 2019).

Furthermore, the government has employed more doctors, nurses, pharmacists, paediatricians and medical social care personnel to work in the new medical centres (Ministry of Health Saudi Arabia 2019). A report published by the Ministry of Health of Saudi Arabia (2019) estimates 3.5% growth in the number of physicians and dentists, 0.7% growth in the number of nurses and 3.2% change in the number of pharmacists. This reflects the importance of occupying healthcare professions in the Kingdom. However, there is still a need to employ different types of medical personnel to work in the newly built centres to meet the various and changing healthcare needs (Al-dossary et al. 2021). In line with increasing medical personnel, it is necessary to increase awareness to the necessity of arming those healthcare providers with specific cultural and moral training to cope with various social and structural changes.

Yalli (2008) notes that economic development in KSA has led to various social and structural changes that prompted government intervention. The author explained that the expansion of education led to an increase in the number of females who qualified for employment in different professions within medicine, social work, engineering, the financial sector and academia (Yalli 2008). This corresponds to the fact that more women entering the workforce entails a disruption of women's traditional roles of taking care of household chores in Islamic culture (Sharma and Reimer-Kirkham 2015). Rapid urbanisation and industrialisation have also exacerbated rural-to-urban migration. As people moved to urban areas searching for employment, there was a disruption of the tradition of extended families and the emergence of single nuclear families (Yalli 2008; Al-Ghamdi 2021). Other challenges include terminal

lifestyle diseases such as heart and liver diseases, kidney problems, and cancer, as well as the spread of the COVID-19 pandemic, all of which necessitate increased medical social care services (Al-Ghamdi 2021).

Additionally, Saudi Arabia emphasised the importance of health care in its welfare and community sustainability, especially in light of cultural values and societal concerns. It's easy to see the consequences of this kind of engagement, given the burgeoning oil sector that drew employees from neighbouring and developed countries. (Hodge 2005; Ragab 2016). The interaction with foreign nationals and exposure to Western culture and media has led to social vices contrary to Islamic culture, such as substance abuse and sexual immorality. The Saudi government developed new social care programs in hospitals to mitigate social problems caused by the socioeconomic changes in the KSA. For instance, with the booming oil industry, social issues such as parental disobedience, family differences, substance abuse, and violence became rampant due to the influx of locals' interaction with expatriates. The Saudi government has established social care departments at newly constructed hospitals to help solve these new social challenges (Al-dossary et al., 2021). Despite these issues, one still must admit the importance of medical social work in the Kingdom.

2.6 MEDICAL SOCIAL WORK IN SAUDI ARABIA

2.6.1 Development of Medical Social Work

Mary Richmond, one of the founders of social work, outlined the main functions of social workers. These functions include serving as a social caseworker, solving problems regarding people and families, being an agent of social reform through social propaganda and legislation, and conducting social research (Agnew 2004; Trevithick 2011). Since the turn of the 20th century, social workers have served the healthcare needs of individuals and communities (Cree & Myers 2008). The title of books for social workers published more than

100 years ago, such as *Social Work in Hospitals: A Contribution to Progressive Medicine* (Cannon 1913) and *Social Work: Essays on the Meeting-Ground of Doctor and Social Worker* (Cabot 1919), capture the essence of how the profession has connected social and environmental conditions to physical health outcomes. Today's literature is equally compelling in emphasising the importance of the social determinants of health and the significant role social workers play in addressing people's complex and often intersecting needs (Parrott 2001).

Based on ecological systems theory, elements of a human, emotional, biological, psychological, and social identity interact, and illness affecting one of these elements affects other elements (Awad & Ride 2010; Bint Mughais 2006; Carlton 1984; Mahnaz 2016). Medical social care treats the patient's psychological, emotional and social needs in a physical care setting. For the therapeutic process to be successful, the social worker must collaborate with many different professionals involved in the patient's care (Bomba et al., 2010; Elzubeir et al., 2010; Mahnaz 2016). The social worker's core responsibilities are to the patient and his family and the specialist support team. The success of social services is contingent upon the social worker's capacity to maintain constant and constructive contact with other team members and his ability to conduct accurate evaluations of people in their environments. (Atheb 2012; El-Meligy and Zayed 2012; Mahnaz 2016). The Los Angeles County Department of Public Health (2013) suggested that 'A population's health is shaped 10% by the physical environment, 20% by clinical healthcare (access and quality), 30% by healthcare behaviours (themselves largely determined by social and physical environments), and 40% by social and economic factors' (p. 4). Medical social workers collaborate with other human service workers to help severely ill patients suffering from physical and psychological issues. Throughout the many difficult struggles of patients, medical social workers and other professionals meet people's common and severe needs regarding physical and mental illnesses. In this regard, Andrews et al. (2013) states:

> ‘Social workers are familiar with the complex and overlapping systems that must negotiate to ensure that social, psychological and economic needs of individuals and groups are addressed in a way that underscores optimal health’ (p. 67).

Once the patient discusses their core issues with the medical social worker and other medical staff members at the hospital, physicians, nurses, and medical social workers can give patients’ positive feedback about their health and well-being. Medical social workers interact with each other for the patient’s safety. Medical social workers network with other organisations and agencies in discussing their plans about patients’ discharge from the hospital and aftercare program. Case managers work with medical social workers as a team, helping patients meet their goals and help patients connect with other organisations for physical, mental, and social productivity. Andrews et al. (2013, p. 68) stated:

> ‘Social workers historically have targeted their services to such disenfranchised groups, including those who do not have a stable place in society, may lack housing and other basic services, and have no or irregular contact with the health system’.

2.6.2 Medical Social Work in Saudi Arabia

Social work is a dynamic profession, and medical social work has a long tradition of service and achievement. The definition of a social worker in Saudi healthcare stems from Western industrialised countries’ professional practices (particularly the United Kingdom and the United States), including allied healthcare professions, medicine, and social work. Empirical studies from those countries have identified the overall role of social workers in hospitals and factors in the workplace affecting practitioners’ ability to perform their duties effectively (Albrithen and Yalli 2015). The role of social work developed by reacting to particular needs in healthcare settings. Resolving the psychosocial difficulties that patients and families bring to the healthcare system or that arise due to their interactions with the healthcare system and with interlinking community services remain consistent features of the role of social work. This shed light on defining the term ‘health social work’.

Charlton (1984) defined health social work as professional contributions intended to ensure good health and eliminate illness. These professional contributions include institutional and community social functions resulting from physical and mental ailments, disabilities, and other injuries (Yuen and Skibinski 2012; Bridget and Meagan 2019). According to CASW (2003), the social work profession has moved towards an emphasis on health promotion and illness prevention and the management of chronic diseases. The current empirical literature demonstrates that social networks play a critical role in improving the lives of individuals, families and communities. Social workers in medical centres apply an ecological approach to delivering healthcare services within patients' settings. The ever-changing relationships between all variables are the focus of a social work practice that uses an ecological framework.

Another definition of the term 'health social work' refers to professional efforts in health and disease. This involves practice relating to the community's social functioning and institutional clients precipitated or aggravated by an actual or possible mental or physical disorder, injury or disability. Many contributors describe the social work profession's potential to improve the primary health paradigm by focusing on health promotion, chronic disease management, and disease and injury prevention (CASW 2006; Yuen and Skibinski 2012; Bridget and Meagan 2019). Empirical evidence indicates that social networks and social support play a significant role in the health of communities, groups, families and individuals. Social workers have a strong tradition focused on the ecological approach and incorporate service provision in a wide range of environments (CASW 2006).

The liberal policies and opening to Western countries of the 1960s and 1970s led to the development of medical social work in Saudi Arabia (Yalli 2008). The rapid economic growth caused by the discovery of oil, an influx of immigrants and the subsequent social changes

necessitated government intervention to manage societal disruptions caused by these social changes. Therefore, the Saudi government needed to guarantee these social changes according to Saudi Islamic culture. As a result, government-sponsored social and youth programmes were created during the 1960s. The KSA also created the Ministry of Labour and Social Affairs. Their responsibilities include addressing existing inequalities, improving living standards and quality of life, providing care and assistance to the less-privileged members of society and encouraging Saudi citizens' participation in community development initiatives. One study by Al Fahidi (2012) investigated the historical development of the profession in Saudi Arabia. In the beginning, social work grew in response to indigenous needs. However, in the absence of trained Saudi social workers, the ministry hired professionals from other countries. During the 1960s, medical social workers only worked in psychiatric and thoracic diseases hospitals (Al Fahidi 2012). The medical social work profession developed in Saudi Arabia as the Ministry of Labour and Social Affairs established social work institutions and sent students abroad to acquire the necessary skills to improve the domain in the KSA (Al Fahidi 2012). During the historical development of the social work profession, the ministry hired non-Saudi nationals to work in various medical centres. These foreign nationals established medical social workers' roles, the professional code of conduct, and standard procedures. In the past, such recruitment of non-Saudis was a reaction to significant indigenous needs. However, the Saudi government recently issued related regulations to regulate such work (Yuen and Skibinski 2012; Bridget and Meagan 2019).

However, a review of the current international literature on healthcare problems and hospital social workers revealed that not all research is relevant or comparable to Saudi practitioners' experience. Saudi Arabia has a complex socio-economic, political, and cultural climate, influencing clinical practice and healthcare. It is essential to understand the working context for social work practitioners in Saudi hospitals. Healthcare requires professionals to work

effectively and efficiently to improve individuals and communities' capacities, respond to the nation's development goals, and resolve unwanted circumstances that result from the rapid changes in the social and health conditions of the KSA (Atheb 2012)

On a global scale, the profession began to emphasise the societal consequences of diverse diseases. Similarly, in Saudi Arabia, the profession's perception has improved to the point where it is now required in all hospitals, not only those who treat psychiatric and thoracic problems. Economic development and social work experts from neighbouring nations both contributed significantly to the profession's development. One of the engines for job growth in the KSA was the introduction of social work training schools. The expansion of social work institutions enabled more trained personnel to be sent to hospitals in rural locations outside of Taif and Riyadh (Al Fahidi 2012).

Alagalni (2006) surveyed psychiatric hospitals in Saudi Arabia to clarify the professional skills that social work specialists in psychological health need. The comprehensive case study included about 60 hospitals in Riyadh and Dammam and Taif. The sample included 15 specialists, male and female, and used the statistical programs (SPSS). The hospital's responsibility is to ensure that social work specialists meet professional requirements. This study's significant finding is the complex diversity in medical social services in Riyadh. This study also offered recommendations about overcoming barriers related to professional requirements for medical social work (Yuen and Skibinski 2012; Bridget and Meagan 2019). Yalli and Albrithen (2015) concluded that The Ministry of Health is a significant employer of social workers in the country and employs most hospital social workers. The purpose of incorporating social workers' knowledge into the Saudi medical sector was to contribute to the country's health and social development initiatives by offering free social services to address patients', families', and communities' psychosocial needs. Additionally, the purpose

was to collaborate with other health care providers in various SMoH settings to maximise the delivery of quality services by addressing and resolving psychosocial issues. Social workers in Saudi Arabia operate in various sorts of governmental hospitals located all around the nation (Yalli and Albrithen 2015). General hospitals, specialist hospitals, and psychiatric hospitals. Many other government institutions, such as the Ministry of the Interior, the Ministry of Education, the Ministry of Defense and Aviation (the National Guard), and even private hospitals, employ social workers to help care for their staff. SMoH hospitals employ over 80 percent of social workers, with 11 percent employed by semi-public hospitals, seven percent employed by other governmental organisations, and roughly two percent working by the private-for-profit sector (Yalli 2008).

Social work employees perform many significant functions and duties in Saudi hospitals (Albrithen and Yalli 2015). Some of these tasks include regular visits to internal wards and outpatient areas and, when needed, joining physicians' rounds, evaluations of the psychosocial aspects of wellbeing, advice and rehabilitation facilities, and other assigned tasks by the hospitals' administration. Social services emerged as a significant and complementary medical initiative when physicians found that psychological and social issues led to the decline and delay of patient treatment (Atheb 2012; El-Meligy and Zayed 2012; Mahnaz 2016). Due to the dynamic nature of their professional work, social workers must update their professional skills for the benefit of their clients (Albrithen and Yalli 2015). Social work thus has defined goals, methods, ethics, and research that help address problems that face Saudi individuals, groups, and communities to realise their potential (Atheb 2012; El-Meligy and Zayed 2012).

According to Abdul Aziz (2014), Ministerial Decree No. 3510 on the 26th of December 1973 formalised medical social work in Saudi Arabia. This decree established a medical social

work department under the Directorate of Therapeutic Medicine. The Supreme Commission for Administrative Reform established a General Administration of Mental and Social Health to supervise psychological and social medical services at health centres. The Medical Social Work Procedures and Policies Manual of 2008 (MSWPPM) classifies and governs medical social care services in the KSA. The social work profession's importance in the health sector prompted the government to create independent social work departments in public hospitals. In most government hospitals, medical technical departments house social work departments (Abdul Aziz 2014). Rather than the Ministry of Civil Service, the Ministry of Health directly employs medical social work graduates. Creating a medical social work department and independent divisions in all public hospitals under the medical technical department's jurisdiction is a testament to the development of the profession in the country and the government's recognition of its importance.

2.7 BARRIERS TO EFFECTIVE MEDICAL SOCIAL WORK PRACTICE

2.7.1 The Relationship between Social Workers and Medical Services

Albrithen and Yalli (2015) highlighted the continued growth of social work within the Saudi healthcare system. They also indicated that social workers consider their primary job roles as communicating directly with patients and families while they are at the hospital. Practitioners are highly conscious of the human condition's social, emotional, and intellectual aspects. Practitioners confirmed that the care team and hospital administration does not work well with them for patient social care, which highlights the importance of their role. According to the specialists, social work roles outside of the hospital setting are not applied in Saudi society, they do not tend to do these roles. Lack of social follow-up of patients outside the hospital is an implicit concern for physicians. Social workers believe that this role may conflict with the culture of patients, and it is a completely new role for Saudi society.

According to their perspective, comparing professionals in developing countries to those in more developed countries is unjust. Because of this, they are in a state of relative isolation from healthcare experts. Social workers believe their contributions to healthcare cooperation in a hospital are underappreciated. Practitioners who have access to more educational and training options can significantly impact public hospitals (Albrithen and Yalli 2015). According to Ellingso (2002), collaboration encompasses 'cooperation in planning and working together, sharing goals and coordinating individual actions, problem-solving, planning, decision-making and accountability.' Two people from different fields can collaborate on a project (Ellingson 2002). Interprofessional teams may only succeed if each team member recognises and appreciates the contributions made by the others.

In the history of the medical profession, doctors dominated the care of illnesses. It is a tradition that the attending physician should have the final, definitive opinion about patient care (El-Meligy and Zayed 2012). As a result, doctors' views of social workers are complicated. Many doctors only see these practitioners as individuals with compassionate hearts who strive to do good work for patients through social support. However, one study conducted by Ryan (2012) contradicted this finding. Accordingly, the author argued that the successful work of a hospital's interprofessional team historically relies on nurses (Ryan 2012). However, social workers and nurses' roles sometimes overlap in hospitals, placing them in competition for more desirable positions. For instance, while discharge planning is typically the responsibility of a social worker, some hospitals appoint lead discharge coordinators to nurses. Initially, social workers also performed patient counselling in hospitals (Almaizar and Abdelhamed 2018; Alotaibi et al. 2020), but over time psychiatric nurses claimed that role as well. A nurse and social worker will be more successful in fulfilling their individual roles if positive contact and cooperation are present. Understanding the complexity of collaboration between nurses and social workers may result in an increase in collaboration

between the two, which is critical in a hospital setting. In general, social workers and nurses collaborate effectively in Saudi hospitals, however time management is frequently an issue (Alotaibi et al. 2020). Social workers have observed that management was critical to how hospitals value social workers. There is a need for more research on management's role in fostering interprofessional collaboration between social workers and nurses to enhance the quality of patient care (Ryan 2012; Alotaibi et al. 2020). In addition, one study conducted by Alagalni (2006) surveyed psychiatric hospitals in Saudi Arabia to clarify the professional skills that social work specialists in psychological health need. The comprehensive case study included about 60 hospitals in Riyadh, Dammam and Taif. The sample included 15 specialists, male and female, and used the statistical programs (SPSS). Many of these medical social workers did not possess the required special skills, experience, and training (El-Meligy and Zayed, 2012). Some medical institutes see social workers as being concerned with assisting the needy and resolving social welfare issues. It is the hospital's obligation, however, to guarantee that social work professionals satisfy all of the necessary professional standards. They lacked the skills to advocate for their patients and interface with other areas of the medical institution. This study's significant finding is the complex diversity in medical social services in Riyadh. This study also offered recommendations about overcoming barriers related to professional requirements for medical social work. In this regard, some medical institutions see social workers as supporting the needy and settling social welfare cases.

2.7.2 Multi-disciplinary Teams in Medical Social Work

Social workers are in a distinctive position to educate and empower patients and their families. They are often the only professionals involved with patients and their families from beginning to end (Nicholson and Matross 1989). On the multidisciplinary team, the social worker is the expert in facilitating communication between the patient, families, and the rest of the healthcare team, and is expected to be the catalyst amongst the interdisciplinary team by

promoting the interactions amongst the team (Dugan-Day, 2012). Reese and Sontag (2001) reported practices that may undermine the interdisciplinary team and offered solutions to ensure success. One example of a barrier and associated solution relates to the perception that social work in healthcare is secondary to medicine by other team members or social workers themselves (Berkman 2006). Suggested solutions included orienting the team, either at orientation or continuing education, to each professional's role in order to fully understand and appreciate each profession (Reese and Sontag 2001; Ellingson 2002; Hale and Fields 2007; Ambrose-Miller and Ashcroft 2016; Al-dossary et al. 2021.). In line with this, El-Meligy and Zayed (2012) argue that the medical social worker requires close working relationships with nurses. Regular interaction with patients contributes to patient wellbeing and psychological responses and the implementation of treatment plans. The social worker may rely on nursing staff to better understand patient attitudes and reactions to various circumstances. Nurses regularly observe whether the patient has visitors and the effect of these visits. Just as social workers rely on nurses to observe and describe patient behaviour or problems, nursing professionals often seek social workers' assistance to solve problems (Ellingson 2002; Hale and Fields 2007; Ambrose-Miller and Ashcroft 2016; Al-dossary et al. 2021.). On the other hand, a medical social worker's success depends on the strength of their relationship with the management of the medical institution. If the administration appreciates the importance of social workers, they will receive all the facilities and resources required to carry out their mission and, in turn, ensure the benefit of patients (El-Meligy and Zayed 2012).

Social workers in the healthcare sector struggle for recognition and acceptance. Ambrose-Miller and Ashcroft (2016) enumerated six obstacles to cooperation: 1) self-identity, 2) culture, 3) decision-making, 4) role clarity, 5) power dynamics and 6) communication. These factors have significant repercussions for interprofessional cooperation in clinical practice with social workers. This research highlights many areas of concern for social workers on

interprofessional teams, including the conflict between a specifically established responsibility of social work and the need for the fluidity of interprofessional team roles (Ambrose-Miller & Ashcroft 2016). Many hospitals are in the process of phasing out social work departments and combining services. In some instances, programs vary in their perceptions of social workers, contributing to difficulties in the professional recognition of social workers. Furthermore, without departmental frameworks, decision-makers discuss forming connections with other disciplines. This is because organisations did not develop formal structures for disciplines to meet together (Globerman et al. 1996; Ellingson 2002; Hale and Fields 2007; Ambrose-Miller and Ashcroft 2016; Al-dossary et al. 2021).

El-Meligy and Zayed (2012) discuss medical institutions' capacity limitations, the level of appreciation by the administration for the medical social services' efforts, the cooperation of medical team members, the nature of the administrative work, and the extent of work-related stress. In some institutions, there is not sufficient cooperation necessary for effective teamwork. For instance, some doctors do not believe that social and psychological factors influence patient care, and some doctors believe that they understand patients' psychosocial needs better than social workers (El-Meligy and Zayed, 2012).

2.7.3 Compassion Fatigue

Figley (1995) proposed the term compassion fatigue to describe the long-term cumulative stress resulting from the ‘cost of caring’. Compassion fatigue was a broad term intended to encompass burnout, in addition to emotional contagion and secondary victimisation (Figley 1995). He articulated a comprehensive description of the cognitive, emotional, behavioural, spiritual and somatic symptoms that can manifest in compassion fatigue and how it can negatively influence one’s relations and work performance.

Broadened monetary subsidies have prompted case managers to work with more patients with various, more extreme health issues and disabilities. In the 2007 National Association of Social Workers Membership Workforce Study (Salsberg et al. 2017), 16% of respondents rated seeing a specialist as a significant activity stressor. Social workers reported heavy workloads associated with abnormal levels of occupation-related anxiety. However, compassion exhaustion also assumed a role in the stress levels of some social work specialists. Compassion exhaustion, otherwise called ‘auxiliary traumatic anxiety’, presents as a progressive diminishing empathy for others' anguish. Although emotional exhaustion among social workers is not unique to Saudi Arabia, uncooperative patients and a lack of proper language communication and cultural harmony exacerbate it.

2.7.4 Gender

In Saudi society, gender-based segregation is socially sanctioned and implemented by the government. There is no mixing of the sexes in public places, and there are separate physical places allocated to males, females and families. The rights and responsibilities of women in Saudi development is a controversial debate among both progressives and conservatives since women in most environments are not permitted to communicate and work with unrelated men, except out of necessity (Al-Makhamreh and Lewando-Hundt 2008; Ettner et al. 2016).

Saudi women typically (although not exclusively) work in universities, women's social work and development projects, banks, and the healthcare sector. The law prohibits women from driving cars and riding bicycles in public places. Saudi women rely on their close male relatives, such as their dads, brothers, and spouses, to provide transportation to and from their destinations. Men carry the financial responsibility of the home, even if their women work unless they come to a consensus on alternatives and their wives agree to make compromises on their part. On the other hand, Saudi women are permitted to start enterprises, own property,

and make financial investments. Due to the division of the school system in Saudi Arabia based on gender, there is very little interaction between males and females. The educational system developed for female students varies from male students, but the curriculum's content is the same. Because of cultural values, Saudi female nurses tend not to interact with male patients. Male nurses provide care to male patients, and female nurses care for female patients. Tumulty (2001) reported that about 25% of nurses in Saudi Arabia are male. However, if there is a staff shortage, both male and female nurses may need to care for both (Tumulty 2001). There are also religious implications regarding this issue. Islamic views on abortion, homosexuality, and gender norms are other areas that may conflict with medical social workers' values (Hodge 2005; Ragab 2016). In general, Islam, founded on the law of Sharia and the good of society, affirms the sanctity of human life throughout the life cycle from conception to natural death, heterosexuality, and complementary gender roles in the family system. Medical social workers who advocate for abortion rights, homosexuality, and egalitarian gender roles need to monitor their own and their clients' reactions to ensure that they avoid implicitly imposing their beliefs on others (Hodge 2005). As a result, KSA's health framework is gender segregated. Almost no data is accessible regarding how the administrative planning of well-being neglects gender.

2.7.5 Traditional Cultural Attitudes, Beliefs and Practices

Medical professionals in Saudi Arabia face various difficulties regarding cultural diversity, beliefs, and the context of delivering medical and social care. A universal law exists amongst the medical professions which dictates that access to medical services is a human right, and thus patients have the right to access social care organisations (Leininger and McFarland 2002). Beliefs about physical and psychological diseases in certain cultures contribute to feelings of anxiety, ridicule or shame, leading patients to conceal their disease for fear of public disclosure. This secretiveness prevents medical social services from accessing the

required information to provide the necessary treatment (El-Meligy and Zayed, 2012). Shyness and modesty are key for individuals who live in the Saudi setting. Shyness refers to behavioural characteristics exemplified by the exercise of modesty and decency, particularly in terms of personal appearance and proper use of language by dressing appropriately, not being excessively outgoing, and speaking about things that cause embarrassment by humiliating themselves or others. Women more commonly express shyness than men, particularly women who are not yet married.

Honour and shame are two other concepts that affect modern Saudi culture. To be respected in society, people must maintain their reputation, dignity and principles. Tarnishing an individual's honour embarrasses both the individual and their family. Factors contributing to shame include (but are not limited to) rude behaviour, the exploitation of older or vulnerable persons, being passed over for special favours, and immoral sexual activity of a female member of the family (Almutairi and McCarthy 2012). Awareness of these principles helps one understand and appreciate Saudi behaviour (Ragab 2016). Both honour and shame have a broader meaning, with similar influences for many people in Middle Eastern, Asian and Latin American countries.

Hall (1989) classified societies as either high or low context societies. This categorisation provides some insight into the variations between cultures. The critical element in Hall's theory is context. Context has a significant influence on people's attitudes and communication in some communities. Hall (1989) describes a culture of high context (HC) as ‘one in which individuals are deeply involved with each other’. In a high context society, there is a social hierarchy structure as a result of intimate relationships between individuals. There is also strict self-control of inner emotions, and simple messages with deep meaning communicate knowledge. A high context culture prevails in the Middle East, Africa, and South America.

In general, individuals in these societies believe in saving face, which means addressing issues that avoid public humiliation or lack of respect for others.

People in high context cultures are indirect in their communication and use implicit messages with meaning embedded in the socio-cultural context. This communication style uses a mixture of verbal and non-verbal messages to convey meaning. People who use this type of indirect communication frequently avoid direct interactions that may cause conflict. These communities typically cope with conflict by using a third party to practise passive resistance or privately address the problems.

A culture of low context (LC) is 'one in which people are highly individualised, somewhat alienated, divided, and have relatively little contact with others' (Hall 1989). Low context culture occurs in Western countries such as the United States, Germany, Switzerland, and Scandinavia. Low context culture allows individuals to be more straightforward in their conversation, choosing to use more explicit forms of communication. Words can express the entirety of the meaning of the message in these societies. This communication style is more context-free, emphasising the literal and precise meaning of the mentioned words. People who use a more direct contact style candidly address disagreements, usually by face-to-face interactions, believing that discussions can solve the issue. The perception of high and low background cultures is vital to this debate due to the volume of multicultural in Saudi Arabia (Almutairi and McCarthy 2012).

2.7.6 Religion

The overly religious nature of Saudi society may likewise influence therapeutic service organisations and women's wellbeing. For example, in an examination conducted at a Saudi college, 40% of instructors and 50% of understudies, half of whom were women, believed

that ownership of *jinn* (also known as evil spirits) induces epilepsy (Yuen and Skibinski 2012). The use of religious beliefs to interpret illness has certain adverse effects; it can cause a lack of patient cooperation with the services offered, and a negative emotional and psychological state as the patient blames themselves for the illness. An unwillingness to cooperate with the services provided and a negative psychological state undermines medical social workers' ability to achieve the desired healthcare outcomes.

Saudi people practice spiritual healing for terminal illnesses, poisonous stings, jinn possession, and the evil eye's harmful influence. In these instances, the care includes reading the Noble Qur'an and Prophet Mohammad's (peace be upon him) sayings, eating honey, black cumin and Zamzam water obtained from Zamzam well in the Holy Mosque in Mecca. Zamzam's water is a renewable source from underground, approximately 20 metres from the Holy Kaaba. The well is a popular pilgrimage destination for pilgrims seeking to drink from the holy water. It is believed to be the world's oldest well, with water flowing there for over 5000 years. The assumption is that Zamzam water can cure many diseases. Many Saudis also believe in black magic and the evil eye. They believe that a wicked and jealous person causes illness by a sting of an evil eye. Jealousy may result from admiration for the riches, health, appearance, or other positive characteristics of another person (Hodge 2005; Ragab 2016).

It may be challenging for some social workers to imposing their special values which differ from the values of some patients. One example is the Islamic veiling practice, hijab, in which the dominant meta-narrative is the consequent abrogation of the client's right to self-determination. However, many women within the Islamic meta-narrative perceive the hijab differently, viewing the hijab as an essential part of worship and a practice that generates inner peace and tranquillity.

2.7.7 Language

Saudi Arabia's official language is Arabic, while the compulsory second language in schools is English. However, most Saudi individuals cannot speak English, particularly those who do not have a tertiary education. Since language barriers negatively affect patient satisfaction and medication compliance, some Saudi government hospitals provide translation services between non-Arabic-speaking healthcare providers and patients. El-Gilany and Al-Wehady (2001) argued that the language barrier might be an obstacle to delivering healthcare for Saudi citizens, as most nurses are expatriates who do not speak Arabic. Saudi hospital interpreters only translate from the native language (Arabic) to English between the service provider (physician, nurse) and the recipient (patient) of the service (Mahfouz 2006). Expatriate nurses also only work for short periods, reducing their role in health education and maintaining adequate patient communication**.**

2.8 RECOMMENDATIONS FOR EFFECTIVE SOCIAL WORK PRACTICE

2.8.1 The Relationship between Social Work and Medical Services

A medical care organisation's primary objective is to provide the highest possible quality of healthcare to patients. Doctors, nurses and social workers have various cultural traditions and values when working with patients to apply their cultural backgrounds and history. This practice is advantageous because social workers will bring in a vast spectrum of skills from past and personal experiences in dealing with their own and other cultures to promote the wellbeing of medical facilities and respectful engagement with patients. This is according to multiple experts' recommendations (Ellingson 2002; Hale and Fields 2007; Ambrose-Miller and Ashcroft 2016; Al-dossary et al. 2021).

One can consider the importance of healthcare professionals in communities, focusing on values added to economic growth. On the other hand, one can consequently admit the importance of social workers in the healthcare sector. Social workers are an essential part of the healthcare system in the United States. According to Steketee et al. (2017), the person-in-environment approach and unique abilities of the social work profession address the needs of patients, individuals and the community and can be beneficial for achieving cost control, disease prevention and community health objectives. This is particularly true in addressing social determinants of health by improving health and cost outcomes (Yuen and Skibinski 2012; Bridget and Meagan 2019).

Consequently, there is an eminent need for innovative methods beyond cost reduction to express the real added value of social work. More research is necessary to test the effect of social work prevention and intervention activities on vulnerable populations' health and well-being while assessing social costs and benefits (Steketee et al., 2017). Given the scarcity of appropriate medical services in Saudi society, such as the lack of a sufficient number of medical institutions, the lack of a particular function for convalescence, the limited capacity (or lack thereof) of vocational rehabilitation institutions and the lack of physicians, technicians and nursing bodies compared to the number of patients is a cause for concern (El-Meligy and Zayed 2012).

2.8.2 Compassion Fatigue

The experience of compassion fatigue among social workers results from the physical, mental and emotional wear associated with providing empathic patient care. Resiliency training and mindfulness-based interventions are effective in mitigating compassion fatigue. Self-recognition of compassion fatigue by the social worker and organisational involvement

enhances the effectiveness of interventions (Al-Sahli 2009; Bomba et al. 2010; Hartman-Shea et al. 2011; Al Fahidi 2012; Mohammed and Bin Sanad 2013).

Current strategies and interventions to mitigate compassion fatigue rely on personal and institutional factors. Providing educational seminars on the identification of compassion fatigue for hospital personnel who are at risk can better equip them to deal with stressors that can facilitate the development of compassion fatigue (Al-Sahli 2009; Bomba et al. 2010; Hartman-Shea et al. 2011; Al Fahidi 2012; Mohammed and Bin Sanad 2013). Organisations have essential roles in the treatment and prevention of compassion fatigue. Initiating meaningful recognition programs should be considered a means to acknowledge social workers' value and address high levels of turnover, burnout, and secondary trauma (Kelly and Lefton, 2017). Implementing hospital-wide policies on protective and preventative strategies to promote wellness among social workers can ensure equal access to resources and address decreasing compassion satisfaction and increasing compassion fatigue levels.

2.8.3 Traditional Culture, Attitudes and Beliefs

The medical social care profession is a rapidly growing field due to the rise in the global population and the advent of new diseases (such as obesity and cancer). Middle-income countries in the Middle East can lack adequate human capital, such as nurses and social workers, to meet the health and social needs of the increasing population and migrants. As a developing country, Saudi Arabia is at risk for such diseases, and thus they need to recruit medical practitioners from neighbouring and distant countries. In Saudi Arabia, medical social workers from other Islamic nations have no difficulty practising their profession. Nevertheless, even within Islamic nations, there may be variations in culture that require learning about these new cultures. Due to the strong impact of Islamic culture on delivering health and social services, social workers from non-Muslim countries face various challenges

while performing their service in the KSA (Al-Sahli 2009; Bomba et al. 2010; Hartman-Shea et al. 2011; Al Fahidi 2012; Mohammed and Bin Sanad 2013). Culture has a major impact on the practice of medical social work in Saudi Arabia. Islamic culture influences health, economic activity, education, marriage, and social relationships. Social workers who work in healthcare organisations, for example, must have a thorough awareness of Islamic cultural practises, including its traditions, beliefs, qualities, and religious rites, to do their jobs effectively. As a result, there are small splits within the field due to a lack of basic knowledge.

According to Almutairi, McCarthy and Gardner (2015), Saudi Arabia uses a different approach by conducting semi-structured interviews to assess potential employees' comprehension of Islamic culture. Most international social workers report difficulties acclimating to the cultural differences in the KSA (Almutairi, McCarthy and Gardner 2015). In Islamic countries such as the KSA, the diversity of patients requires medical professionals to be familiar with and adapt treatment to deal with patients from diverse cultural and religious backgrounds while also delivering quality services in healthcare facilities. Medical social work's primary objectives are helping medical institutions and assisting patients to overcome the obstacles and difficulties they face. Medical social workers see patients as an integrated unit of social and psychological factors. There is scant literature on how social work connects with the principles of Islamic teachings as an influencing factor (Abdel et al. 2006). Medical social workers must understand the importance of family and community among Muslims (Abdel et al. 2006). Medical social work offers care to all people, including patients and their families, responsibility to family affects health care (Awad 2010).

According to Islam's teachings, one must balance transparency and accountability in meeting the needs of people and communities. This teaching defines the roles of a medical social worker in Saudi Arabia and other Islamic nations. Islam attaches greater importance to family

relations, community support, and spiritual processes. However, there is no existing literature on how medical social workers in these nations can navigate conflicts (Hodge 2005; Ragab 2016; al-Sahli 2009).

Islamic culture affects the practice of the field of social work in the KSA in many ways. Understanding these cultural values may assist social workers in designing effective methods of action. Islamic culture prompts public hospitals in Saudi Arabia to implement time schedules to assign relatives defined durations for visitation (Seago 2000). For example, the Intensive Care Unit (ICU) limits visits to one hour for relatives. Medical workers must display the utmost respect for older generations by giving healthcare suggestions to their family members (Mutair et al. 2014). Almutairi and McCarthy (2012) suggest that nurses should demonstrate respect and establish beneficial relationships with patients and their families when facing certain beliefs and behaviours, such as dressing, eating, frequent visits, or reading religious supplications

These difficulties are due to the environment's sensitivity and excessive misunderstanding of the nature of some diseases (e.g., venereal, thoracic, psychological and mental) (El-Meligy and Zayed 2012). The diversity of culture in the KSA is due to its large area, and the influx of Arab immigrants in particular, and professionals need to consider the cultural values and practices of each person or community. Culture plays a role in how a person's attitudes about the nature of the specific disease and its general significance, which in turn affects healthcare delivery. Ho (2010) interviewed five nurses to evaluate cultural awareness to investigate the different cultures present in Saudi Arabia. The author found that understanding the cultures of patients affected the delivery of nursing care. Hospitals may find it prudent to implement orientation programmes to address these barriers based on cultural beliefs and values (Ho 2010).

Expatriate medical staff working in Saudi Arabia and other countries could improve their skills and quality of work via training in their respective host countries' values and cultural traditions. Williams and Richardson (2007) claimed that the concept of cultural safety originated in New Zealand and usually implied not participating in an assault on personal identity and works to provide culturally safe healthcare by respecting the attributes and beliefs of each culture. In Saudi Arabia, social workers rely on their experiences and values since, in most cases, they are similar to patients' values. However, non-Saudis and others may find it challenging to apply the concept of cultural safety due to cultural differences.

2.8.4 Religion

Health providers should be mindful of the religious and moral needs of a patient. Faith assuages patient anxieties during healthcare struggles. Health practitioners should provide patients with an opportunity to express their religious and moral views and customise their assessment and counselling to suit their individual needs (Hodge 2005; Ragab 2016). Healthcare organisations need to provide their healthcare personnel with a sense of understanding of the religions of the world and their possible effects on patient care through education and training. Provider education helps their patients have a healthy conversation about their faith and its impact on diagnosis and treatment (Swihart and Martin 2020). An increase in religious diversity could be crucial to healthcare. The strong religious values of Islamic communities require doctors and nurses to adapt to improve healthcare quality. Omu and Reynolds (2014) conducted a study on the correlation between healthcare practices and religion, irrespective of the religious differences between Muslims and Christians. According to this research, the presence of religion bases patients' overall strength, confidence, hope, and courage to overcome unforeseen circumstances.

Subjective well-being correlates with religious and moral values and provides resources to deal with disability, give meaning to life, minimise distress and provide social support (Omu and Reynolds 2014). Islamic religious beliefs may determine the choice of treatment programs available and the date and time of therapy sessions, among other factors. Religious beliefs often determine the perceptions of patients. Consequently, religious-based care approaches can help achieve desirable health outcomes by enhancing patients' psychological and emotional wellness. Therefore, social workers must involve patients while providing care by seeking their opinion on their cultural beliefs regarding therapeutic processes. However, in cases where patients' beliefs or opinions contrast with established best practices, social workers must educate the patients to help them make an informed decision.

Omu and Reynolds (2014) conducted a study evaluating health practitioners' views on the effect of Muslim religious values on Kuwaiti patients' self-efficacy in stroke recovery. Results indicate health professionals believed that the religious beliefs of Muslim stroke patients positively affected their self-efficacy for recovery. Respondents felt that their religious patients drew strength, energy, hope and inspiration for success from their relationship with God. There was an assumption that religious observance enhanced a sense of relation with the unimpaired moral self, improving self-efficacy. Many of those interviewed, particularly nurses, found it essential to invoke patients' religious faith and encourage patients in their religious observances, believing that this helped enhance their sense of self-efficacy. The Kuwaiti community is unique, with very high levels of professed religiosity among the Muslim civilian population and traditional social values. Whether the results generalise to other Arabic communities or multicultural contexts of recovery in the West remains unclear. However, a greater understanding of the power of religious beliefs to affect self-efficacy in recovery can lead to culturally competent treatment that harnesses the faith of patients and families (Omu and Reynolds 2014).

Social workers who are not familiar with patients' cultural and religious values or those who choose to disregard these beliefs may encounter interpersonal conflicts. In these cases, discrepancies between patients' cultural beliefs and social work principles can occur. Professionals must explain evidence-based practices by demystifying cultural concepts. Medical professionals must respect patients' cultural beliefs and understand them to effectively persuade patients to accept established rules (Hodge 2005; Ragab 2016). In Islamic countries such as the KSA, the diversity of patients requires medical professionals to be familiar with and adapt treatment to deal with patients from diverse cultural and religious backgrounds while also delivering quality services in healthcare facilities. While all social workers need to build positive relationships with their patients, Muslim patients' sensitivity to their beliefs, traditions, and virtues relative to other patients is crucial in Islamic countries such as Saudi Arabia. Muslim patients react positively when working with staff who practise Islamic values like equity, empathy, honesty, and justice. Therefore, medical social workers must follow certain principles. Failure to follow these principles can lead to uncooperative and unsupportive patients, putting social care outcomes at risk. Additionally, social workers need to ensure that their activities help build a stronger relationship between patients and their families (Bint Mughais 2006; Awad and Ride 2010; Bomba et al. 2010). Another function of medical social workers in Islamic culture is patient assessment. In this regard, social workers must understand the concept of *qawmah,* which can be translated as 'awakening or becoming conscious' derived from the teachings of Islam. Medical social workers in Saudi Arabia have a primary duty to help patients understand their health conditions and treatment. Therefore, according to Islamic teachings, it is a duty for all social workers to possess counselling knowledge and skills that respect the Islamic faith (Almaizar and Abdelhamed 2018; Alotaibi et al. 2020).

The first step in the healing process is to overcome psychological barriers. Social workers in Saudi Arabia cannot produce meaningful results without recognising the effect of Islamic and local culture on patients' attitudes, values, and views on the sickness and treatment process. al-Sahli (2009) argued that some patients believe that disease is a sign of a curse. It is the responsibility of medical social workers to ensure that patients recognise the value of care and consent for diagnosis and treatment. Social workers must counteract the patients' views of illness as a curse by educating them that diseases do not correlate with religion. Therefore, recognising cultural values that might pose psychological barriers to the recovery process helps patients reduce these challenges.

The disorganisation of patient families may fracture the family bond, a central element in Muslim culture. Mohammed et al. (2013) state that medical social care professionals must describe the disease to the patient and their family in detail. In addition, they assist families in making patient healthcare decisions and treatment planning. Medical social workers in Saudi Arabia also provide grief-counselling services to families (Saleh 2009). Medical social workers share roles and ethics no matter what culture, country, or region (Bell & Hafford-Letchfield 2015; Reamer 2017). This means that medical social workers in Saudi Arabia help obtain different health services, for example, encouraging patients to collaborate with medical insurance companies and community health organisations. They help patients understand the benefits they are eligible to receive as well as aid in completing applications for the most suitable medical insurance. When providing social services, observing Islamic cultural traditions increases the effectiveness of medical social workers in Saudi Arabia and other Islamic countries (Saleh 2009). Referring to a correlate to this argument, Albrithen and Yalli (2013) concluded that it is essential to recognise the religious and cultural aspects that inform social work practice in Saudi Arabia. Social work as a profession encourages professionals to have a deep commitment to their job, fostering a high degree of satisfaction from addressing

the needs of people and the community in which they are involved. Social work contributes to helping others, which is a central theme in Islamic culture. Social work is commonly viewed as a rewarding task because Allah appreciates and rewards assisting those in need, regardless of the quality and amount of aid. This approach may not be exclusive to Islamic practitioners or Islamic culture (Albrithen and Yalli, 2013).

2.8.5 Language

The current literature addresses effective communication between patients, healthcare providers and medical social work. Challenges also cause mistakes, low-quality treatment and even death among patients and social work specialists. The findings include research demonstrating that patients and medical social workers have a correspondence problem (Zuhur 2012). Accordingly, unpleasant interactions occur when the professionals' dialect clashes with those of patients. These differences influence the essence of social services (e.g., adherence to data on illness and reaction to treatment regimens when providing the information). Zuhur (2012) indicated a need to enhance the harmonisation of correspondence among patient and social healthcare specialists in the KSA to achieve safe, high-calibre social services. Addressing the correspondence issue can reduce healthcare costs. The fundamental solution to managing this problem is to survey the dialect and correspondence needs of the population (Beresford et al. 2007).

Some studies suggest healthcare workers generally struggle with dialect differences (Zuhur 2012). This is a significant barrier to building a quality patient-medical worker relationship. Medical attendants portrayed their patients as anxious to talk in their particular dialect despite the fact that they realised that the attendants did not comprehend them (Aljahdhey et al., 2020). Zuhur (2012) recognised dialect boundaries in an explorative subjective investigation about the correspondence between therapeutic services experts and multilingual patients.

Wahabi and Alziedan (2012) found that dialect differences affect communication between patients' families and non-Arabic attendants concerning asthma administration (i.e., utilising inhalers and spacers for paediatric patients). A cross-sectional analysis by Binsalih et al. (2011) analysed patients' experience and level of satisfaction in a tertiary health facility among healthcare professionals. The study found that Saudi patients who could converse with them in the local dialect under Saudi doctors' guidance displayed a higher degree of satisfaction than those who interacted with specialists who could not communicate with them in Arabic.

2.8.6 Transcultural Medical Care

Transcultural medical care focuses on the influence of beliefs and values of specified cultural groups on behaviour patterns in illness, health and caring (Leininger 1993; Leininger and McFarland 2002). According to a study by Lovering (2006), transcultural healthcare aims to provide culturally congruent treatment while applying such knowledge in planning and provisions of culturally convenient care. With a combination of education and field experience, transcultural healthcare workers provide experienced, professional and secure treatment to people from different backgrounds. Their analysis investigated the symbols, gestures and meanings of cultural therapy. Specialists, generalists, and consultants are transcultural healthcare providers (Murphy 2006; Purnell 2012). Serving in different clinical practice environments, they help others become receptive to and informed about diverse cultures. They may recognise neglected or misunderstood cultures and help healthcare systems determine how different cultures in a group are represented or fail to be represented. Transcultural healthcare providers encourage cultural self-awareness and the ongoing learning of transcultural skills (Murphy 2006; Purnell 2012).

Despite the advantages achieved by healthcare practitioners using transcultural methodologies into their practises, there is still a misunderstanding of the traits that are required to successfully incorporate this notion. Thus, according to the findings of Chang et al. (2018), training healthcare workers in core transcultural attitudes, knowledge, and abilities is essential for the development of cultural competence.

2.8.7 Social Work Education and Professional Training

The level of education amongst healthcare professionals influences cultural knowledge and skills through the ability to adapt to new cultures when conducting quality healthcare practices. A study conducted by Mareno and Hart (2014) in the US found a positive relationship between a medical practitioner's level of education and cultural awareness, knowledge and competency, among other factors. This study measured the levels of cultural competence amongst nurses with undergraduate versus post-graduate qualifications. Corresponding to this study, Majid et al. (2011) found that nurses with post-graduate qualifications scored higher on cultural understanding, knowledge, beliefs, and values of different people than nurses with a basic undergraduate degree. Regarding the relationship between these factors and basic university education, a close partnership between the professionals and family members was crucial in promoting healthcare quality. More information relating to the patient's medical history provides an avenue for establishing more research on various diseases. Islamic culture strongly influences the practice of the social work profession in Saudi Arabia, thus necessitating that social work professionals learn the culture and integrate it into care provision. More on-the-job training sessions may improve the cultural competency of social workers in the KSA (Elzubeir et al. 2010; Atheb 2012; El-Meligy and Zayed 2012; Mahnaz 2016). Medical social workers need to enhance their professional knowledge and mastery of Arabic and Islamic culture and beliefs to deliver high-quality medical care and social services (Almaizar and Abdelhamed 2018; Alotaibi et al.

2020). The concept of cultural competence has attracted the attention of many authors (Purnell 2000; National Association of Social Workers, 2001; Ridley et al. 2001; Campinha-Bacote 2002; Jirwe et al. 2006; Loftin et al. 2013; Almutair et al. 2015). Its vast implications reflect the novel appreciation for considering the culture of both corresponding parties, chiefly the healthcare professionals and the patients, and particularly while handling mental illness cases (Al-Sahli 2009).

2.9 RESEARCH QUESTIONS

Addressing the gap in the previous literature review, the researcher aimed to explore the impact of Saudi Arabian culture on social work and discuss the current state of the social work profession in Saudi Arabia. While the research paid attention to the implications of culture, habits, and religion on the performance of social workers in Saudi Arabia, many challenges that might cause other barriers to social work tasks in the healthcare sector's progress were found. Given that, the primary research question is: *'What are the implications of culture and values on social work professional practice in the healthcare sector in Saudi Arabia?*'. Based on this primary research question, the following sub-questions emerged:

- What are the roles of medical social workers in Saudi Arabia?
- In what ways do Saudi culture and values influence social work professional practice ?
- What challenges do social workers and patients face that affect the hospital's social care delivery?

To answer these questions, the researcher conducted an empirical study to fulfil the aims and objectives of the study.

2.10 LIMITATIONS

Barriers were not addressed in full due to a scarcity of related references. Corresponding to this restriction, the number of texts covered by the review cannot determine or speak for the entire KSA, contributing to the investigation's limited focus (Cannon 2013). Nevertheless, the matter requires further evaluation on the actual situation to find the ideal means by which such barriers can be mitigated, particularly concerning the interactions between patients and healthcare workers. More precisely, future research should investigate the clinical practice of more medical social workers around the country to assess the impact of Islamic culture on the obstacles to the profession and correspondence between patients and social workers. This review identified barriers that affect communication between patients and medical social health workers in the KSA. In the future, addressing these challenges and enhancing the nature of human services will be relevant.

2.11 SUMMARY

The social work profession in Saudi Arabia originated in neighbouring Islamic countries such as Egypt, and originally from educators from the United Kingdom and United States. The extant literature indicates that the profession developed rapidly in the KSA due to 1) the already existing comprehensive social welfare programmes in the country, 2) the establishment of training institutions and professional associations for social work, 3) the Saudi government's intense involvement in social work programmes and 4) the modernisation of the profession by educators. The recruitment of social work educators from neighbouring countries and other developing countries was also crucial to the KSA's development. Islamic culture may affect social work through healthcare practice preferences, spirituality, religious traditions, communication, family roles and organisation, childbirth practises, nutrition and pregnancy. Consequently, when providing their services to patients, social work practitioners are confronted by several challenges. Islamic culture affects professional practice via close

family relations because social workers must regularly include the patient's family in the care process and even seek their support in making important decisions.

Awareness of Islamic teachings and beliefs is necessary for KSA social workers and influences the therapeutic options as well as the psychosocial and emotional state of patients. Because of the prevalent Islamic culture, Arabic language, and plurality of Arabic dialects, the literature review demonstrates that social workers are likely to face communication barriers with their patients. The variety of concerns are also increasing, regardless of how the administration assigns tasks to social welfare specialists. The nature of social welfare and the well-being of patients and social health workers are also at risk (Cannon 2013). In Saudi Arabia, medical social workers have low social competence and require extra instructive and introductory programmes. The Ministry of Health may also require Arabic and English language skill tests for experts applying for work in hospitals. However, in addition to language tests, the prevalent issue of cultural communication demonstrates that Islamic cultural competency tests are necessary for social workers in the KSA.

Although the literature review indicates that social workers' roles are similar in other countries, Islamic culture strongly affects health and social services by social work practitioners and other healthcare professionals. The current literature explains how Islamic culture affects social work professional practice; however, it does not address how cultural influence affects social workers and patient’s perceptions of their roles in hospitals across the KSA. This literature review sought to understand this literature gap by elaborating on how the prevailing Islamic culture influences the professional practice of medical social workers in KSA. This gap provides a strong rationale for the current research.

The social services have undergone many changes in history as it has changed according to society's cultural determinants. There is an interest in developing social service globally,

particularly in the Kingdom of Saudi Arabia. Social services need continuous development, designing specialised programs to improve organizational regulations and structure. The hospital administration monitors how social workers and specialists adhere to the tenets of professional behaviour, fulfil responsibilities and obligations towards the rights and dignity of their patients and respect their sensitive information.

The literature review traces the development of medical social work in the Kingdom of Saudi Arabia. As the social work profession becomes more visible in Saudi hospitals, social workers and patients must adapt to the medical and cultural environment.

The multiple cultural and tribal backgrounds of patients present challenges for social workers and patients. In addition, the lack of a specialised reference in social work tasks is problematic and ambiguous. A new practice arises from the ambiguity of technical tasks with social workers' cultural and religious needs, which needs to be supported and reviewed. The literature points to the gap in understanding the social worker's role in Saudi hospitals from both the social worker and the patient perspectives. Therefore, the current study aims to fill that gap.

CHAPTER 3. METHODOLOGY

3.1 INTRODUCTION

This chapter details the study's research design and methods to explore social workers' and patients' perceptions of medical social workers' roles and functions in Saudi Arabian hospitals. The research aims to determine how cultural and religious beliefs influence medical social work in the KSA and obstacles confronted by healthcare providers while their work. This chapter provides a comprehensive overview of the research questions, sampling procedures, data collection methods and procedures, and the strategies used to analyse the data to achieve the research objectives.

3.2 RESEARCH METHODOLOGY

3.2.1 The Rationale for Qualitative Inquiry

Although its roots lay in the tenets of the Elizabethan Poor Laws of 1601, social work is a product of modernism (Payne 2005). With social work's move towards post-modernism, social constructionism developed a new way of understanding knowledge (Payne 2005). One channel of knowledge development in social work is the interpretive approach embedded in qualitative research (Grinnell and Unrau 2011). The interpretive approach places a focus on subjective reality (Carey 2012; Creswell 2013; Grinnell and Unrau 2011; Padgett 2008; Martin et al. n.d.) In other words, since human beings are so diverse, there is more than one way to view the world (Payne 2005). This perspective seeks to understand the feelings and meanings of people's experiences and the reasons for their actions (Carey 2012; Grinnell and Unrau 2011; Padgett 2008). Unlike the quantitative approach, the qualitative approach defines reality from a phenomenological perspective (Ernst 2003; Taylor 2005). The foundation of qualitative research is how the participants express their reality (Creswell 2009; Denzin & Lincoln 2003; Ghauri & Gronhaug 2005; Saunders et al. 2012).

This study uses a qualitative research method to address the research questions. Percy et al. (2015) state that qualitative methods investigate subjective opinions, attitudes, beliefs, or reflections on the subjects' experiences. Qualitative study methods are aimed at exploring a specific community's ideas, views, behaviours, and social background regarding the subject under investigation.

Creswell (2008) described a qualitative study as one in which, without performing quantitative analysis, the researcher asks broad questions that are descriptive and analyses the collected information. Qualitative studies are typically employed in the social sciences to gather non-numerical data and explain the significance of the data collected to help the researcher understand the participants' social life. This form of research appeals to social scientists because it enables them to explore the meanings assigned to the beliefs, views, experiences, behaviours, and perceptions of the study participants regarding phenomena under investigation. Strauss and Corbin (1998) added that these qualitative studies do not collect results by statistical processes. This study applies a qualitative research approach, following all qualitative research features, including non-numeric data and examining the participants' expectations and views. Quantitative research varies from qualitative research in that it deals exclusively with numerical data and uses qualitative statistical approaches to assess the causal and correlative relationships of the examined variables.

However, as this analysis does not ascertain the statistical associations between the variables under review, this study is not suited to quantitative research. In this study, this flexibility is essential because it allows the researcher to explore additional social workers and patients to develop a rich exploratory study of the topic.

Although there are numerous forms of qualitative methods of analysis, this study applies a phenomenological research approach. Heidegger and Dahlstrom (2010) explain that

phenomenological studies describe an activity, event, or phenomenon, while Giorgi (2009) states that phenomenology focuses on answering the question "what is it?" Qualitative research such as phenomenology tries to describe the phenomenon, while quantitative analysis attempts to explain why it occurs regularly. Therefore, it does not oppose quantitative research; rather, it asks a different question to understand the phenomenon better. The phenomena under investigation are perceptions of the role and function of hospital social workers in Saudi Arabia. This research also explores the impact of cultural and religious traditions on medical social work and the challenges affecting the profession.

Phenomenological studies also use various data collection approaches to understand better the participants' meanings and perceptions, such as conducting interviews, reading documents about the events under investigation, and visiting the events' locations. In other words, phenomenological studies seek perspectives and observations on the subject from participants. Accordingly, there is usually no well-informed hypothesis (Heidegger and Dahlstrom 2010), but rather the researcher discovers emerging themes from multiple interviews. The researcher performed two separate sets of interviews with social workers and patients to develop the common themes regarding social workers' functions in Saudi Arabian hospitals.

3.3 THEORETICAL FRAMEWORK

The researcher adopted the Purnell model of cultural competence to explore a workforce in which social workers are culturally different from each other and their patients. Because Saudi society's culture is highly traditional, belonging to a tribe is seen as a power source for individuals. The researcher considers that during the daily tasks of the professionals, they will have to deal with various cultures. Due to the multinational and multilingual nature of the hospital staff in Saudi hospitals, the standard language in use in hospitals is English. As a

result, many misunderstandings are entirely due to lack of effective communication. Whatever the justifications, the language barrier between the patients and the hospital staff constitutes a psychological barrier; even with interpreters, intimate comprehension in one language is more trustworthy and effective.

Therefore, cross-cultural differences will be considered. Given this, this conceptual model guides the research and frames the research questions. The Purnell model of cultural competence is thus use as an organising framework to guide cultural competence among multidisciplinary healthcare team members.

Increasing one's consciousness of cultural diversity improves the possibilities for healthcare practitioners to provide culturally competent, and therefore enhanced, care. Cultural competence is a conscious process and not necessarily linear. To add to the complexity of learning a culture, no standardised terminology related to culture and ethnicity exists (Purnell 2005).

The purposes of the Purnell model are as follows:

- Provide a framework for all healthcare providers to learn concepts and characteristics of culture.
- Define circumstances that affect a person's cultural worldview in the context of historical perspectives.
- Provide a model that links the most central relationships of culture.
- Interrelate characteristics of culture to promote congruence and to facilitate the delivery of consciously sensitive and competent health care.
- Provide a framework that reflects human characteristics such as motivation, intentionality, and meaning.

- Provide a structure for analysing cultural data.
- View the individual, family, or group within their unique ethnocultural environment (Purnell 2005).

In the current study, the Purnell framework provides a descriptive power, as it integrates some of the subtler nuances of cultural behaviour and beliefs. The model explains different exogenous and endogenous variables that determine individuals' cultural patterns regarding the social work profession. The study illustrates various culturally diverse practices and beliefs that could inform the concept of cultural knowledge.

The Purnell model of culture competence (2000) consists of 12 domains, ranging from general to specific phenomena. For religiously devout people, the care provider may need to start with spirituality rather than one of the other domains because their religion (e.g., Islam and Judaism) prohibits certain nutritional and communication practices. The 12 domains are listed below, accompanied by a brief description:

1) Overview/heritage involves concepts of the country of origin, current residence, the effects of the topography of the country of origin and current residence, politics, economics, occupations, educational status, and reasons for emigration.
2) Communication involves concepts of dominant language and dialects, contextual use of the language, and paralanguage variations such as tone, voice volume, intonations, willingness to share thoughts and feelings, and reflections.
3) Family roles and organisation involves concepts related to the head of the household and gender roles; priorities, family roles, and developmental tasks of children and adolescents; roles of the aged and extended family members; and child-rearing practices.

4) Workforce issues involve acculturation, autonomy, gender roles, assimilation, health care practices from the country of origin, and ethnic communication styles.
5) Biocultural ecology involves differences in specific ethnic and racial origins such as skin colouration and physical variations in body stature; hereditary, genetic, endemic, and topographical diseases; and how the body metabolises drugs.
6) High-risk behaviours involve the use of alcohol, tobacco, and recreational drugs; increased calorie consumption; lack of physical activity; engaging in risky sexual practices; and non-use of safety measures such as seatbelts and helmets.
7) Nutrition involves the meaning of food, having adequate food for satisfying hunger; food choices, taboos, and rituals; how food and food substances are used for health promotion and wellness and during illness; and enzyme deficiencies.
8) Pregnancy and childbearing practices involve culturally sanctioned and unsanctioned birth control methods; views toward pregnancy; fertility practices; and restrictive, prescriptive, and taboo practices related to pregnancy, birthing, and postpartum.
9) Death rituals involve how the culture and the individual view behaviours to prepare for death, death rituals, and burial practices.
10) Spirituality involves religious practices and prayer, individual sources of strength and behaviours that give meaning to life.
11) Health care practices involve the focus of health care such as acute or preventive; traditional, biomedical beliefs, and religious magic; self-medicating practices; individual responsibility for health; and views regarding chronicity, organ donation and transplantation, and mental illness.
12) Health care practitioner concepts involve the use, status, and perceptions of traditional, magico-religious, and Western biomedical health care providers.

The researcher formulated the interview questions based on these 12 domains (see Appendix C).

3.4 POPULATION AND SAMPLING

Yalli (2008) reported that in 2003, there were about 810 social workers employed in different hospitals across Saudi Arabia. Since 2003, the number of social workers has risen dramatically as the SMoH built new hospitals. This study's population consists of licensed social workers and patients in King Abdul Aziz and King Faisal hospitals in Taif, Saudi Arabia. Taif, in the province of Makkah, is located on the eastern slope of the Al-Sarawat Mountains. As depicted in Table 3.1, Taif has 15 hospitals. The researcher chose King Abdul Aziz and King Faisal hospitals as the sites for the current study. With a cumulative 1000 patients and 57 social workers, these two hospitals provide an ample population from which to draw a sample. Although the Mental Health Hospital has more beds and the highest number of social workers, this study only included medical social workers; it did not include mental health patients and their corresponding social workers.

Table 3.1. Hospitals in Taif, KSA

	Hospital	Opening Date	No. Beds	No. Social Workers	Information about the hospital
1	King Abdulaziz	2002	500 Beds	38	Referral and educational hospital provide specialised health services for all patients. Includes 21 medical specialities and a dialysis centre.
2	King Faisal	1934	500 Beds	19	Referral and educational hospital provide specialised health services for all patients. Includes 18 medical specialities, a gynaecology and obstetrics tower and a dialysis centre.
3	Mental Health Hospital	1958	780 Beds	38	Specialised in mental health.
4	Children's Hospital	1970	200 Beds	7	Specialised hospital for children.

5	Obstetrics and Gynaecology Hospital	1970	200 Beds	11	Specialised in obstetrics and gynaecology.
6	10 peripheral hospitals	2008	50 Beds each	-	Rural hospitals that serve the villages of Taif.

3.4 SAMPLE

This study sample consisted of patients (n=20) and social workers (n=24) from King Abdul Aziz Hospital and King Faisal Hospital in the city of Taif. The researcher chose these hospitals because each facility has a fully functioning social work department. All participants are Saudi nationals and Muslim, as it is compatible with the study's aims of dealing with Saudi culture and Islam. The sample size for this study is relatively small but meets the study's objectives. As Creswell (2009) indicated, a qualitative study sample size should meet the study objectives. This sample represents the Taif community well. The researcher deemed this sample size (N=44) sufficient to meet saturation requirements in assessing perceptions of the role of a medical social worker in Saudi Arabian hospitals.

Social workers participating in the study had to meet specific criteria, including working in either the surgery or internal medicine department, so they were likely to have interacted with patients for a considerable amount of time. Moreover, the participants had to be qualified social workers and professionally licensed by the Saudi Commission for Health Specialities. Social workers at both King Abdul Aziz and King Faisal hospitals all have obtained bachelor's degrees. Social workers who met these conditions were randomly selected to participate in the study. The researcher conducted interviews with the 24 social workers, and Tables 3.2 to 3.5 list their characteristics.

The following characteristics were regarded as inclusion criteria for participant patients: 1) hospitalised until the social worker dealt with them 2) used social care services 3) were older than 21 years of age. There was an equal number of males and females in the patient sample.

Table 3.2. Characteristics of the social worker sample (N=24)

Participant Number	Name Code	Gender	Years of Experience	Education Level	Specialisation	Religion	National Origin
1	SA1-KM	Male	1	Bachelor	Social Work	Muslim	SA
2	SA10-MNS	Male	11	Master	Sociology	Muslim	SA
3	SA11-NAJ	Female	1.6	Bachelor	Social Work	Muslim	SA
4	SA2-HZ	Female	3.6	Bachelor	Sociology	Muslim	SA
5	SA3-MM	Female	1	Bachelor	Social Work	Muslim	SA
6	SA4-RRA	Male	31	Bachelor	Social Work	Muslim	SA
7	SA5-RS	Male	18	Bachelor	Social Work	Muslim	SA
8	SA6-SA	Male	11	Bachelor	Social Work	Muslim	SA
9	SA7-ST	Male	16	Bachelor	Sociology	Muslim	SA
10	SA8-AW	Female	1.8	Bachelor	Sociology	Muslim	SA
11	SA9-MA	Female	5	Bachelor	Social Work	Muslim	SA
12	SF1-SH	Male	6	Bachelor	Sociology	Muslim	SA
13	SF10-HMQ	Male	16	Master	Sociology	Muslim	SA
14	SF11-NWS	Male	7	Bachelor	Psychology	Muslim	SA
15	SF12-AMB	Female	10	Bachelor	Sociology	Muslim	SA
16	SF13-IAD	Female	28	Bachelor	Sociology	Muslim	SA
17	SF2-OK	Male	4	Master	Social Work	Muslim	SA
18	SF3-AAO	Male	10	Bachelor	Social Work	Muslim	SA
19	SF4-NAH	Male	1.6	Bachelor	Psychology	Muslim	SA
20	SF5-MMS	Male	4	Bachelor	Social Work	Muslim	SA
21	SF6-YAZ	Female	3.6	Bachelor	Social Work	Muslim	SA
22	SF7-MAJ	Female	4	Bachelor	Social Work	Muslim	SA
23	SF8-NGS	Female	3	Bachelor	Social Work	Muslim	SA
24	SF9-FHQ	Female	8	Bachelor	Sociology	Muslim	SA

3.5 DEMOGRAPHIC CHARACTERISTICS OF THE SOCIAL WORKER SAMPLE

Table 3.3. Summary Characteristics of Social Worker Sample (N=24)

Variable	N	%
Age		
21-30	6	25
31-40	11	45.8
41-50	5	20
51-60	2	8.3
>60	0	0
Gender		
Male	15	62.5
Female	9	37.5
Experience		
<2 years	5	20.8
2-<5 years	6	25.0
5 -<10 years	6	25.0
>10 years	7	29.1
Education		
Bachelor	21	87.5
Master	3	12.5
Doctorate	0	0.0
Field of Study		
Social Work	12	50
Sociology	9	37.5
Psychology	2	8.3
Other	1	4.2
Religion		
Muslim	24	100.0
Christian	0	
Other	0	
Nationality		
Saudi	24	100.0
Other	0	

As depicted in Tables 3.2 and 3.3, the average profile of social work participants was male, age <40, with 2-10 years of experience and a bachelor's degree in social work. 50% (n=12) of the social workers interviewed in the study majored in social work: 37.5% (n=9) specialised

in sociology, 8.3% (n=2) specialised in psychology, while 4.2% (n=1) social workers had an undefined specialisation (Figure 3.1).

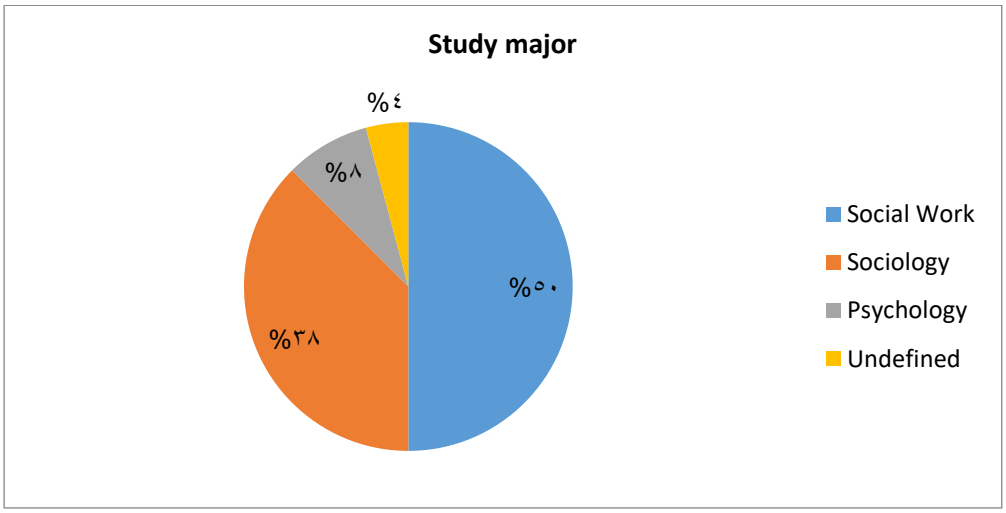

Figure 3.1. Study majors of social worker participants

The population for the patient sample were patients in the general surgery department of two hospitals at the time of the study (N=55). The patients' sample consisted of 20 patients, ten from each hospital. Inclusion criteria included: 1) patients hospitalised for a month or more, since they must have interacted with the social workers during their stay and 2) 21 years or older. There was an equal gender representation of males and females in the sample. However, the rescheduling resulted in a sample of nine females and eleven males. Because there are two separate sections, a women's section and a men's section, patients who met the study conditions participated in the study. The researcher gave patients advance notice of the time and location of the interviews. The face-to-face interviews occurred on the hospital premises, particularly in inpatient rooms. Interviewing patients is necessary to achieve the second study objective of obtaining patients' perceptions of social workers' roles in hospitals.

The researcher assigned each participant a code name to conceal their original identity when analysing and recording their responses to the interview questions. Table 3.4 displays the demographic characterisation of the participants.

The exclusion criteria for patients included the following:

- Patients thought to be at risk of being harmed by participating in the study (based on their health conditions).
- Patients who are unaware, unconscious, or suffering from a mental state.
- Patients who have not agreed to a social work referral

Table 3.4. Demographic characteristics of patients (N=20)

Patient code	Age	Gender	Marital Status	Religion	Educational level	Duration in hospital	Hospital
R.SM	40-49 years	Male	Married	Muslim	Primary School	6 weeks and more	King Abdulaziz
H.KA	30-39 years	Male	Married	Muslim	Secondary School	2 weeks to less than 4 weeks	King Abdulaziz
S.AH	40-49 years	Male	Widower/ Widow	Muslim	Middle School	4 weeks to less than 6 weeks	King Abdulaziz
A.NO	50-59 Years	Female	Divorced	Muslim	Secondary School	6 weeks and more	King Abdulaziz
N.AM	50-59 Years	Male	Divorced	Muslim	Graduate School	2 weeks to less than 4 weeks	King Abdulaziz
M.RM	50-59 Years	Female	Married	Muslim	Middle School	4 weeks to less than 6 weeks	King Abdulaziz
M.SA	60 years and over	Male	Married	Muslim	College	4 weeks to less than 6 weeks	King Abdulaziz
B.DA	20-29 Years	Female	Single	Muslim	Graduate School	4 weeks to less than 6 weeks	King Abdulaziz
A.JM	50-59 Years	Female	Divorced	Muslim	Graduate School	2 weeks to less than 4 weeks	King Abdulaziz
I.FA	40-49 years	Male	Married	Muslim	College	4 weeks to less than 6 weeks	King Abdulaziz
O.GL	30-39 years	Female	Single	Muslim	Graduate School	Less than 2 weeks	King Faisal
A.KH	60 years and over	Female	Widower/ Widow	Muslim	Uneducated	4 weeks to less than 6 weeks	King Faisal
A.MA	50-59 Years	Male	Divorced	Muslim	Primary School	4 weeks to less than 6 weeks	King Faisal
M.OT	Less than 20 years	Female	Single	Muslim	Secondary School	Less than 2 weeks	King Faisal
S.SN	40-49 years	Male	Married	Muslim	Graduate School	6 weeks and more	King Faisal
R.KA	Less than 20 years	Male	Single	Muslim	College	4 weeks to less than 6 weeks	King Faisal
M.WA	50-59 Years	Female	Married	Muslim	Secondary School	6 weeks and more	King Faisal

Patient code	Age	Gender	Marital Status	Religion	Educational level	Duration in hospital	Hospital
A.HJ	Less than 20 years	Female	Single	Muslim	Secondary School	2 weeks to less than 4 weeks	King Faisal
T.SN	20-29 Years	Male	Married	Muslim	Graduate School	Less than 2 weeks	King Faisal
S.QR	40-49 years	Male	Married	Muslim	Middle School	2 weeks to less than 4 weeks	King Faisal

Table 3.5. Summary demographics for patient sample (N=20)

Variable	N	%
Gender		
Male	11	55.0
Female	9	45.0
Age		
< 20	3	12.5
20-29	2	8.3
30-39	2	8.3
40-49	5	20.8
50-59	6	25.0
> 60	2	8.3
Marital Status		
Single	5	20.8
Married	9	37.5
Divorced	4	16.6
Widowed	2	8.3
Length of Hospital Stay		
< 2 weeks	3	12.5
2 weeks to < 4weeks	5	20.8
4 weeks to < 6 weeks	8	33.3
> 6 weeks	4	16.6
Education Level		
Uneducated	1	4.1
Primary School	2	8.3
Middle School	3	12.5
Secondary School	5	20.8
College	3	12.5
Graduate School	6	25.0

All patients were Muslim. The average patient profile was male, age 40-60, married, with at least a secondary education. The majority were in hospital for four-six weeks.

3.6 SAMPLING TECHNIQUE

Wolf et al. (2016) states that two types of sampling techniques exist: probability and non-probability sampling. All population members can be chosen in the probability sampling process, and thus results are more likely to represent the entire population. Some examples of probability sampling techniques are simple, systematic, stratified and clustered (Daniel 2012). The researcher implemented a non-probability method of purposeful sampling to select study participants. In this form of sampling, the researcher selects participants based on their availability or the researcher's judgement. This sampling approach allowed for cost and time savings. Non-probability sampling is more convenient and cost-effective than probability sampling. However, the findings of the non-probability sampling technique may not be generalisable. Examples of non-probability sampling strategies are quota, ease, haphazard and snowball (Daniel 2012). Therefore, the sampling method continues until no additional data or new themes, or key points appear in the interview (Javadi and Zarea, 2016).

3.7 RESEARCH QUESTIONS

This study aims to examine the perceptions of social workers' roles in Saudi Arabian hospitals. The following questions guided the design of this study:

R_1: How do hospital social workers perceive their roles and functions?

R_2: How do patients perceive the roles and functions of hospital social workers?

R_3: How do Saudi cultural values influence social work practise in hospitals?

R_4: What are the challenges and barriers to social work practise in hospitals?

3.8 DATA COLLECTION

3.8.1 INSTRUMENTATION

The researcher used semi-structured interviews for data collection. This type of interview method allows flexibility in questioning to obtain as much information as possible (Wengraf 2001). This form of interview is ideal for qualitative studies. Wengraf (2001) explains that while semi-structured interviews allow the investigator to follow a template or guide for the interviews, they also enable the researcher to 1) tailor interviews according to the desires and personal styles of the respondents, 2) encourage a two-way communication process, 3) provide an opportunity for learning and 4) help the interviewer become acquainted with the respondents. According to Galleta (2013), semi-structured interviewing requires excellent interviewing skills, sufficient preparation to avoid leading questions and sufficient data processing skills.

Experts reviewed the questions to eliminate ambiguous and guiding questions. A pilot study was carried out with two participants from each sample to examine the questions' appropriateness and ease of completion. Subsequently, the researcher carefully studied the results to answer the research questions to ensure that the responders understood the questions.

Both social workers and patients completed the demographic questions. There were two interview schedules, one for social workers and one for patients. The interview schedule for social workers covered three topics: 1) perceptions of their current role, 2) how to manage the cultural and religious values of patients when providing social care, and 3) obstacles in medical social work practice. The interview schedule for patients focused on two topics: 1) the current roles of social workers and 2) obstacles in medical social work practice. The question to social workers about managing the cultural and religious values of patients while

providing social care was eliminated from the patient interview schedule due to its irrelevance, as patients do not provide social care.

The researcher collected data questions defining socio-demographic characteristics and a semi-structured interview form (See Appendix C) prepared in line with Purnell's Cultural Competence Model (Purnell 2008). The Purnell domain of Overview/Heritage influenced the socio-demographic questionnaire with items related to religion and nationality added to typical demographics.

Topic 1 of the interview schedule for social workers relates to perceptions of role and derives directly from Purnell's domains of Healthcare Practitioners and Workforce Issues. Topic 2, which is encompassed by the question 'How do social workers in hospitals manage the cultural and religious values of the patient when providing social care?', spans three of the Purnell domains, namely Family Roles, Healthcare Practices and Spirituality. Topic 3 concerns identified obstacles to healthcare and relates directly to the Healthcare Practices and Workforce Issues domains.

The interview schedule for patients parallels that of the social worker. Topic 1 relates to the perceptions of patients of the role of the social worker, based on Purnell's domain of Healthcare Practitioners. Topic 2 for patients is the identification of obstacles in medical social work practice. This topic encompasses multiple domains, including Communication, Healthcare Practices, Family Roles, Spirituality and Workforce Issues.

A female research assistant attended an interview with the female participants who were uncomfortable being questioned by a male researcher due to strict adherence to Islamic cultural practises that prohibit one male from meeting with one female. All the healthcare

institutions in KSA follow the practice of having a female nurse present when male physicians meet with female patients. The availability of this assistant corresponded to practices of the health institutions in the area and fostered trust and security among the participants.

The researcher trained the female research assistant in the interviewing skills outlined above, qualitative methodology, and the study's purpose, significance and methodology to ensure the integrity of the data. Despite training the female research assistant to attend the interview, female participants were unwilling to disclose their personal information due to cultural customs. This is because women in Saudi society typically cannot tell their personal information to strangers without a male counterpart present.

Some participants were also uncomfortable with tape recording. This may be because the use of a tape recorder to conduct research in Saudi Arabia is a rarity. When the participant did not consent to tape recording, the researcher took notes during the interviews and then transcribed the interview content after completion of the interview. The researcher transcribed interview notes in full.

The short time to perform the study was another problem. Having to reschedule interviews owing to the participants' job obligations exacerbated the difficulty of limited time.

3.8.2 PROCEDURES

The researcher invited social workers and patients who met the inclusion criteria to participate in the study. The researcher maintained a list of potential participants who responded to the invitation. Interviews commenced on August 10, 2017 and continued for over four weeks. Interviews for social worker participants took place in the social work department office at each hospital. Patient’s interviews were conducted inside each hospital in a private office. The researchers conducted all interviews in Arabic, as all the participants were Saudi nationals

fluent in the Arabic language. The researcher audio-recorded interviews when patients gave consent to be interviewed in this manner, and also took notes to ensure continuity in the comments and mitigate potential audio-recording difficulties. For interviews of patients who did not consent to be recorded, the researcher took copious notes of the content. The interviews lasted from 45 minutes to an hour. The researcher halted recruitment upon reaching saturation, the point at which interviews no longer reveal new data (Padgett 2008).

3.9 DATA ANALYSIS

3.9.1 Statistical Analysis

Data were evaluated using the descriptive analysis method. The notes and voice recordings recorded during the interviews were transferred to the computer. During the transfer, all interviews were separated in accordance with 12 themes determined based on Purnell's model. Under the themes, the statements of the participants were included. Speech texts were represented in italics.

A thematic analysis of the semi-structured interview data was conducted after data collection. Thematic analysis is a qualitative research method that can be widely used across a range of epistemologies and research questions. It is a method for identifying, analysing, organising, describing, and reporting themes found within a data set (Braun & Clarke 2006). One of the advantages of thematic analysis is that it is a flexible method which one can use both for explorative studies, in which one does not have a clear idea of what patterns are being searched for, as well as for more deductive studies.

The data analysis included the transcription of the tape-recorded interviews using the Microsoft Word programme. The researcher then translated the transcription into English, which is the academic language of the researcher and the supervisors of the research. Based

on the phenomenological method, data analysis began after transcription and translation to explain the perception of the social work profession in the country and the impact of Islamic cultural and religious traditions on the profession.

The researcher sorted interview responses into themes. Coding refers to the assignment of a word or phrase to a salient attribute. To create a repetitive pattern, similar answers from the respondents received the same codes. The codes were then grouped into categories that were used to construct a theory to explain how Islamic culture and religion affect the professional practise of social work in Saudi Arabia. Grbich (2007) defines codifying as the method of applying and reapplying codes to the qualitative data to enable the data to be 'segregated, grouped, regrouped and relinked to integrate meaning and explanation'. The researcher organised the collected data into parts according to the research questions. The researcher serialised each respondent's transcript and assigned similar codes to similar responses by all respondents in each segment. Lincoln and Guba (1985, 347) state that researchers should use their classification reasoning in addition to their tacit and intuitive senses to evaluate the 'look alike' and 'feel alike' data when grouping them. The researcher grouped encoded information into categories and further divided it into subcategories. For example, some of the key sections include: ‘social workers' perceptions of their roles’, ‘patients' perceptions of social workers' roles’, ‘challenges facing social workers’, and ‘how social workers are influenced by Islamic cultural practises’. The researcher divided sections into smaller sections and classifications into sub-classifications based on the study participants' responses.

To establish themes, concepts and theories, the researcher contrasted and combined categories. Richards and Morse (2007) clarify that data categorisation aids in the transition from data diversity to data types. Concepts are how the classified data can achieve a more general, higher-level abstract hypothesis (Richards and Morse 2007). The researcher's ability

to illustrate the systematic interrelation of themes and concepts contributes to developing a theory (Corbin and Strauss 2008). The study thus identified the interrelationship between the different categories to understand how Islamic culture and religion influence clinical practice in medical social work in Saudi Arabia.

3.9.2 Validity

Trustworthiness

This study applied Lincoln and Guba's (1985) criteria for evaluating the trustworthiness of a research study to ensure the validity of the study findings. According to Lincoln and Guba (1985), four factors determine the trustworthiness or validity of a study: credibility, transferability, reliability and confirmability. Credibility refers to confidence in the reality of the outcomes. Transferability means demonstrating that it is possible to apply the results in other contexts. Reliability, the consistency and replicability of the study results, is the third criterion. The last criterion is confirmability, which refers to a degree of neutrality or how participants influence study outcomes, rather than the researcher's bias, interests, or motivations.

Credibility

The researcher sought to ensure credibility by audio recording interviews. In addition, the Microsoft Word programme was utilised to transcribe the verbatim recordings, ensuring accuracy. An accredited translation centre's team assigned the translation process according to the request of the University's Research Department to translate the interviews from Arabic to English. A professional translation specialist verified the correctness of the meanings and the rest of the translations. The translation specialist is from a translation office accredited and trusted by the Ministry of Higher Education to translate government research and

documents while observing confidentiality. The respondents confirmed via telephone the accuracy of the information they provided. Thereby, this study ensured the credibility of the research findings through rigorous verification of the collected data.

Transferability

The study adhered to the rigorous professional and educational requirements for participant social workers to ensure transferability. The fact that only social workers approved by the Saudi Health Specialties Commission participated in the study indicates generalisability to other regions of the country.

Reliability

To ensure the reliability of the study findings, the researcher performed transcription and translation and coding procedures multiple times.

Confirmability

This study used phenomenological data analysis by examining participants' perceptions of the roles of medical social workers and the influence of the Saudi culture on social services provided in Saudi Arabia Hospitals. The primary researcher coded the answers of the participants to grow common topic categories for the themes. Initially, the researcher summarised accounts to identify main points, memos constructed, and initial open codes labelled by comparing versions and using selective coding themes been built with an overarching core concept. The primary researcher translated the Arabic transcripts and notes into English to facilitate reporting and determine themes derived from the accounts. Additionally, separating the research diary from field records allowed the target of data gathering in areas of interest, resulting in a series of inductive reasoning data.

Ethical Considerations

The researcher obtained informed consent before conducting all interviews. The consent forms contained information about the study risks and benefits (see Appendix A). The researcher informed participants about the approximate length of the interview and the general topics to be discussed. Participants were also informed that they could opt out of the interviews at any given time without reprisal. Since permission had to be obtained from the hospital administration, many social workers could have been under pressure to participate, which may have affected their behaviours, reactions and responses to the study.

This study strictly adhered to confidentiality laws to alleviate these challenges:

1. The researcher informed participants about the study purpose, goals, methods and how the interview material will be protected. The researcher gave a written informed consent (Appendix B) to each study participant to explain their rights and assure their anonymity and confidentiality. Participation in the study was entirely voluntary, and the right to withdraw at any time was well-maintained.

2. Since the researcher had to contact the hospitals' management and seek their authorisation, many social worker participants may have been under pressure to participate, influencing their attitudes, reactions, and responses to the study. The researcher explained that participation was voluntary and that the hospitals' management would not know whether they eliminated this scenario.

3. The researcher informed participants that they were free to withdraw from the study for whatever reason without facing any consequences or revealing the causes.

4. The researcher assured the participants that all the information shared is strictly confidential and only used for academic purposes.

5. The researcher did not collect personal details of participants and used pseudonyms to conceal their identities. The participants also assumed that the researcher would not share interview materials with other parties apart from transcribing, translating, and analysing.

6. The researcher was responsible for all the records, which were destroyed after completion of the study. To maintain the confidentiality of the research participants, the researcher stored study data on a password protected university account.

7. Although the only role of the research assistant was to be available to female participants during the interviews, she did not survey the literature related to the project, data collection, and data analysis. The researcher had signed an agreement, written in Arabic, with the research assistant to maintain the confidentiality of all female participants who attended the interviews. The agreement prohibited sharing information with anyone but the principal researcher of this project and prohibited informing any third party about the contents. Participant identities were protected while prohibiting any related documents concerning this project to other third parties.
8. The College Research Ethics Committee (CREC) of Nottingham Trent University reviewed and approved this study to interview the study participants on the 10th of August 2017 (Ethics Approval) to ensure compliance with ethical research procedures.

9. The researcher obtained approval from the Saudi Ministry of Health to conduct this study in various hospitals (Appendix A).

3.11 ROLE OF THE RESEARCHER

Researcher positionality is an important factor in collecting and interpreting unbiased data. During the study, the researcher worked as a social worker in the Ministry of Health of KSA. Therefore, I clarified my position as a researcher, rather than a social worker, to the research participants. My education shaped my research knowledge, skills and methodologies. I was an insider in this study who understood the social workers' situations and experiences. I acknowledged that participants might not be comfortable discussing their experiences. The purpose of the research was also explained to build trust (Qu & Dumay 2011). The participants understood there were no right or wrong answers. Honest disclosure about the researcher and the research agenda helped establish a rapport and gain the trust of study participants.

3.12 LIMITATIONS

Some social work participants did not appear for their scheduled interview; others did not complete the interview. Social workers cited busy schedules and emergencies as reasons for not fully participating. As a result, the researcher rescheduled some interviews, while others occurred multiple times.

Despite training female researcher to attend with the female interview participants, some participants did not want her to attend. The country's cultural traditions dictate that women cannot reveal their personal details to strangers without the presence of a male counterpart. Despite assurances of the study's compliance with confidentiality laws, most female patient-participants remained uncomfortable except in the presence of another female, which is the assistant's role in the research. It is also a rarity to use a tape recorder to perform research in Saudi Arabia. These limitations may have skewed some answers from female participants.

The limited time to conduct the research was another challenge. Having to reschedule interviews due to the participants' work commitments compounded the challenge of limited time.

3.13 SUMMARY

This chapter discussed the stages of research planning and execution. It has highlighted all the research procedures, beginning with the study questions and objectives and progressing to the population of interest, research methodologies and design, sample tactics, data gathering methods, and data analysis. It also discusses how the study assured the validity and reliability of the findings.

CHAPTER 4. RESULTS

4.1 INTRODUCTION

In this chapter, the results of the study are presented, the researcher divided it into two main sections: 1) social workers participants and 2) patient-participants.

4.2 THEMATIC ANALYSIS OF INTERVIEWS WITH SOCIAL WORKERS

The current chapter deals with the findings of semi-structured face-to-face interviews conducted by the researcher with social workers (n=24) and patients (n=20) in two hospitals in Taif: King Abdulaziz Specialist Hospital and King Faisal Hospital. To achieve the study's aims and address the research issues, the researcher created the interview questions using the Purnell model of cultural competence. The researcher performed a thematic analysis of interviews focused on the key topics raised by participants. Four main themes emerged for the social worker sample and two main themes emerged from the patient sample. The social workers' sample findings are presented first, followed by the patients' sample. The structure of the displayed data are organised by theme.

4.3 DEMOGRAPHIC CHARACTERISTICS OF THE SOCIAL WORK SAMPLE

The demographic data included the gender, nationality, and years of work experience of social worker participants in Saudi Arabia. All 24 social worker participants were Saudi residents and Muslims. Aggregating the data on social work participants, 45.8% (n=11) of the sample were female and 54.1% (n=13) male. 46% (n=11) have one to five years of experience, 16.6% (n=4) have five to ten years of experience, and 37.5% (n=9) have over ten years of experience. Females have an average of 5.6 years of experience, while males have an average of 10.5 years of experience. Over 91% (n=22) of the sample have a direct qualification in social work.

4.3 MAIN THEMES

The thematic analysis of participant responses, statements, ideas, and clarifications determined themes. Four main themes emerged from analysis of the social worker interviews:

1. **Perceptions of social workers towards their functions, responsibilities and duties in the hospitals (Purnell domains: Healthcare Practitioners, Healthcare Practices, Workforce Issues).**

This theme includes the following sub-themes:

- Daily tasks.
- Work procedures and policies.
- The importance of information for work.
- The development required for work.
- The desire of employees to make changes to their working environment.

2. **Impact of Islamic cultural and religious values on the professional practice of social workers in hospitals (Purnell domains: Communication, Spirituality, Family Roles, Healthcare Practices).**

This main theme includes the following sub-themes:

- Being affected by the cultural and religious values of the patient when providing service.

- The influence of cultural elements on the nature of the medical social services provided in the hospital.

- The impact of cultural elements on the relationship between medical social services providers and patients.

- Difficulties regarding the process of providing medical services as a result of cultural elements.

3. **The need for staff to develop and train in their working lives (Purnell domains: Healthcare Practices, Workforce Issues)**

This main theme includes the following sub-themes:

- The Medical Social Work Procedures and Policies Manual and its conformity with the current work task.
- Work policies: between reality and perspective.
- Workers' need for training and professional development.

4. **The challenges that social workers face and that obstruct the provision of social care in hospitals (Purnell domains: Communication, Family Roles, Spirituality, Workforce Issues).**

This main theme includes the following sub-themes:

- Challenges arising from labour policies.
- Challenges arising from patients' behaviour.

This chapter provides a thorough overview of these key themes and sub-themes. The researcher cites textual quotes from the interviews as evidence of the subjects.

4.4 PERCEPTIONS OF SOCIAL WORKERS REGARDING THE FUNCTIONS, RESPONSIBILITIES AND DUTIES OF SOCIAL WORKERS IN HOSPITALS

Social worker participants agreed on their tasks during daily rounds and the challenges patients face during their hospital stay. They describe the nature of these problems and whether they originate within the hospital system or the environment, such as family problems, social problems, and so forth. Social worker participants mentioned the challenges of writing patient reports. Some social worker participants referred to the psychological examination activities they conduct. Some social worker participants discussed the process of coping with procedural issues in the job. Social worker participants felt it was a challenge to access procedures to mitigate the lack of resources to deal with social problems exacerbating patients' health. Some spoke positively and shared their satisfaction with the manual and work procedures, while others spoke otherwise. The examples listed in the following section demonstrate this. Most social worker participants suggested that the administration does not enforce specific policies and procedures for the work. Based on these interviews, it is evident that some hospitals, such as the King Abdul Aziz Hospital, are developing some work policies to improve patient-supplied social services.

Results indicate that social worker participants regularly obtained information from patients through a variety of structured procedures. The patient's initial social evaluation includes gathering information on the psychological, social and health status and the family situation. These data are the basis for the development of work policies and accompanying procedures. Some participants discussed the employees' job satisfaction and their satisfaction with the nature of their work and the tasks they perform. Some shared a moderate level of satisfaction with their work, while others favoured neutrality and did not express their opinion. Social worker participants also spoke of the need for the social services sector to fund, improve and enforce the policies and procedures established in Saudi hospitals. Some social worker

participants stated that, in reality, organisations do not use the experiments they perform. Research stops at the end of analysis or when the responsible authorities send a request for reinforcement. Table 4.1 provides a list of responses by social worker participants regarding the sub-themes of the first main subject:

Table 4.1. Social Worker Participants' Responses to the Sub-Themes of the First Main Theme

Theme	F	%
Daily tasks	24	100.0
Work procedures and policies	6	25.0
Work procedures and policies are not successful	8	33.3
The importance of information for work	4	16.6
Developments required for work	3	12.5
The need to support and fund social work in hospitals	11	45.8
Satisfaction with work and work environment	6	25
The need to apply the procedures in practice	6	25
Promoting and benefiting from social studies	4	16.6
The desire to make changes in the work environment	2	8.3

Social worker participant opinions differed on everyday activities and acceptance of job practises. All 24 social worker participants spoke about this. Four social worker participants discussed the significance of data for the job and its position in creating work. 11 participants emphasised the need to support and finance the hospital's social service and include some of the required material needs for patients. Six of the social worker participants shared their satisfaction with the working environment and the essence of the task. Finally, two social worker participants spoke of the ability to make improvements in the work environment.

The social worker participants (N=24) indicated a familiarity with the assigned tasks.

One (SA2-HZ) specialist stated:

> *For me, I'm a social worker in the Intensive Care Unit (ICU). I manage social cases and help with any inpatient issues. I do a case study with the patient and address any social issues. We can do nothing with some medical patient concerns; we have no means to help them. This is for the patient. There are three parties: you have a manager to communicate with; you have a patient to communicate with; in addition to the doctor, you may have someone to contact. We communicate with them in the interest of the patient.*

The specialist (SA3-MM) gave a standard overview of the tasks demanded of him and all the specialists in the same hospital, adding that they are supported in their daily duties by the attending physician:

> *The daily round with doctors to patients [consists of] conducting each patient's initial social evaluation and writing a psycho-social case-based report, psychological and moral support to patients, researching the patient's economic, social, and psychological aspects, resolving problems with the patient refusing treatment, discussing the patient's state with the doctor, and planning the patient's discharge strategy.*

The specialist (SA5-RS) pointed out the various tasks according to the departments in which the specialists operate and clarified the educative position of the hospital specialists:

> *Naturally, the tasks differ depending on where the specialist is located, whether in rehabilitation departments or outpatient clinics. There's a difference in my function at outpatient clinics, for example, when I go to the clinics and ask the physicians if a social worker is necessary. [I] refer patients who refuse to enter medical treatment or experience social difficulties that obstruct the treatment plan to the social worker and take appropriate action for each case. There is also an educational role, such as presenting lectures or seminars to patients; this is the specialist's function. These are virtually the most significant activities in outpatient clinics.*

The specialist (SF6-YAZ A) presented a complete and detailed description of the tasks performed by the specialists, both supervisory and executive, by describing the order of administrative tasks, the measures they perform every day, work processes and so forth:

> *We meet at our office to begin; some cases discussed by colleagues. Then I do a preliminary review of the patient's social situation, the reason for his entry, and if he has an accompanying person or not. We make an initial estimate of all patients and each age group, and then we pass this detail to the statistics department.*

After completing the daily trip and check-up patients, the specialist (SF6-YAZ A) proceeds to delineate his duties:

> *We do a regular round in the men's inpatients' section. We check out new patients and then enter their details into the files; I have about twenty-four patients in the section. We gathered details about their marital status, whether the client has social issues, or*

a complaint about hospital care, and so on. I call the families of patients with problems or needs, such as the patient's need for a family member to accompany him or an invitation for his family to visit him. Also, I occasionally must tell the patient's family that his treatment has come to an end; they have to come to pick him up. When the patient requires surgery, someone from his family must either sign the consent form or stay with him during the surgery. Furthermore, for verification and disclaimer, we record in the daily report that we have contacted the patient's family, mainly if he is a psychiatric patient. In addition, psychiatric patients need more care, regular follow-up by a professional, and contact with their families to provide help after their treatment.

The specialist (ST12-KS) pointed out the different roles of the specialists according to the department in which they work, in addition the changes made in the form (Social Assessment-Case Study), and explained their stance on this change:

After the last Eid, a new form (Social Assessment-Case Study) for patients came to us and differed from the previous one in little details, a new updated form that came to be used, adjusted by some of the colleagues in the department or they did so in collaboration with the specialists. Some changes to the policies and procedures have come. I used them with patients; all my colleagues in the department reported their data in a new form and placed it in the patient's register. The nurse and the doctor use some of the social details in the file, for example, the number of family members, the job or the economic status. The information we receive from the patient here in the surgery department varies, for example, from the information we receive from the patient in the clinics or the emergency department. The patient is the first beneficiary, of course.

Concerning the professional information and latest news of the speciality, the social worker participant (SA3-MM) explained how specialists obtain it:

We seldom have our courses as social workers, rarely get details about professional courses in the newspapers or some of our colleagues. With personal effort, sometimes we know about them in other hospitals or from websites.

The social worker (SF2-OK) stated that no clear data source existed and that the Internet was the primary source of information for them:

Knowledge outlets are open to all now. There is more than one source, and there is no clear source for social service information to be given to you. The best way to access information and be educated on social work is mostly through Internet

information sources. Social networking sites are one of the simplest things to do and provide a huge amount of data simultaneously.

Most social worker participants emphasised that they do not want to make changes in their work as much as they want to master what they are currently doing. Social worker participant (SF3-AAO) explained:

I'm not searching for improvements; what I'm looking for is better comprehension, belief, and encouragement for what I'm doing now.

The social worker participant (SF6-YAZ) reiterated, in terms of his willingness to improve himself, what most of his peers said:

For my own sake, I don't want to adjust. Our job, moreover, is excellent. At the core of our job is what we do; [what] we do as social workers is known to be at the core of our jobs. I see nothing that needs to be changed. Maybe, as I told you, we need different things. We have to get the authorities to pay for insurance. For us, these things are important.

About the need to encourage and finance social work in hospitals, most social worker participants agreed on the value of providing patients with material resources and providing them with the requisite medical facilities, as noted by one participant (SF7-MAJ):

Material or in-kind assistance to patients such as oxygen cylinders, wheelchairs, and medical devices used by the patient was one of the items I was interested in.

The therapist advises that:

Some patients should not leave until they provided an oxygen tank in their homes. They complain that they are unable to provide such a device.

25% (n=6) of social worker participants expressed satisfaction with their work and offered their support to others who want to study and work in social service. Some social worker

participants indicated their willingness to enhance their work environment. Some social worker participants indicated less than complete satisfaction, as illustrated by participant (SA1-KM):

> *For satisfaction, it is not outstanding, but rather good, almost acceptable. Some needs are missing.*

The social worker participant (SF12-AMB) expressed her dissatisfaction with the current situation due to a lack of material resources, which reflects her desire to provide comprehensive patient care:

> *I'm convinced of the work, but I'm unsatisfied with the current situation due to a lack of resources and support.*

Four social worker participants (16.6%) discussed the promotion and utilisation of social studies. The social worker participant (SA11-NAJ) claimed that to obtain a better understanding of their needs as well as their psychological and physical comfort, in-depth analyses of patient cases were necessary :

> *As a social worker, based on my perspective, we follow a fixed schedule every day. My work not just in one unit. I sometimes visit the Physical Therapy section. Rarely do we obtain a case that necessitates a comprehensive social investigation that the patient needs to study; these circumstances must be explained and analysed during several interviews: the first interview, the second interview, and the third interview.*

4.5 IMPACT OF ISLAMIC CULTURAL AND RELIGIOUS VALUES ON THE PROFESSIONAL PRACTICE OF SOCIAL WORKERS IN HOSPITALS

Saudi culture and the Islamic religious spirit influenced the social worker participants' answers. Goodness, generosity, tolerance, and concern for the patients' psychological and health characterised social worker behaviours. These attributes derive from Islamic teachings, which parallel the principles of professional social work. Social workers also recognised and respected the ethnic and cultural diversity of the patients and their families.

The responses of the participants also demonstrated how tribal affiliation influenced interactions between patients and social workers. Social work participant responses indicated a familiarity with the customs, traditions, and religious beliefs of the hospital's social services provision. They emphasised the need for flexibility in working and accepting others, regardless of their customs, beliefs, religions and communicating with all patients. At the same time, social workers appreciate the need to communicate with the individual, familial, tribal, and societal environment. As social workers, they work to eliminate bias in their work.

While social work's values acknowledge and respect the patients' religious views on health and illness, the social work participants shared some concerns about the impact of gender on their work. However, they support what is consistent with the cultural beliefs and practises of patients. For example, male patients usually oppose working with a female social worker. This represents the patient's religious need that he only be served by other males. Similarly, because of tribalism, customs, and religion, some female patients reject male social workers and insist on females performing the service.

The interviews also revealed that social workers invoke religious tenets for therapeutic purposes. Social workers may counter patient thoughts of suicide and desperateness by reminding patients of Allah and divine providence. Regarding religious beliefs, starting

where the client is consistent with professional social work values and skills is foundational. What would not be acceptable is for the worker to negate or impose religious beliefs upon the patient.

In the interviews, the social worker participants emphasised that personal relations do not influence service provision. Social workers treated all patients fairly and equitably in service delivery. The interviews revealed that patients frequently resort to religious healing, such as Ruqia (a sort of reading therapy on the patient), Qur’an reading, and prophetic medicine (authentic hadiths on medicine narrated by the Prophet Muhammad, peace be upon him) often involving herbs. In some instances, the interference of a member of the patient's family, particularly the father and relatives concerned about their privacy, affect the service and harm the patient's condition.

Table 4.2. Social Worker Participants' Responses to the Sub-Themes of the Second Main Theme

Theme	f	%
Being affected by the cultural and religious values of the patient when providing the service.	24	100
The influence of cultural elements on the nature of the medical social services provided in the hospital.	8	33.3
The impact of cultural elements on the relationship between medical social services providers and patients.	5	20.8
Difficulties regarding the process of providing medical services as a result of cultural elements.	7	29.1
The influence of the gender of the social worker on providing the patient with the service	19	79.1
The influence of the gender of the social worker on the patient's acceptance of the service	8	33.3
The intervention of the patient's family or relatives and its impact on the provision of the service	6	25
The use of religious healing at work or to achieve a goal	6	25
Quality of service affected by the patient's affiliation to a tribe	4	16.6

Table 4.2 highlights the variety of ideas and themes concerning the effect of cultural and Islamic religious beliefs on the clinical practice of social workers in hospitals. All 24 social worker participants discussed the impact of the patient's cultural and religious beliefs upon service delivery. Eight staff (33.3%) addressed the effect of cultural elements on the nature of medical social care offered in the hospital. Five social worker participants (20.8%) discussed the theme of cultural elements' impact on the relationship between medical social services providers and patients. Seven social worker participants (29%) discussed the challenges of delivering medical social services due to cultural elements. Gender concerns were a pattern as nineteen social worker participants (79%) discussed it. Twelve social worker participants (50%) mentioned that the social worker's gender affects providing the patient's service, particularly in family cases. Six social worker participants (25%) shared their opinions on this subject, and four social worker participants (16%) concentrated on the

patient's affiliation. Some social worker participants agreed on the importance of cultural principles concerning the patient's cultural and religious values when delivering the service. According to the participant (SA2-HZ):

> *When working, it is a double-edged sword: Traditions and customs are a double-edged sword. It can be positive, and it can be unfavourable. How can it be like that with customs and traditions? Just as I told you earlier. If a patient wishes to be treated here and he is affected by some of his family and tells him we have a better folk healer than the hospital.*

There are traditions and practises that influenced him. Many social worker participants expressed a spirit of tolerance in dealing with patients and the importance of providing social service despite bias around customs, traditions, principles, or external factors. The (SA4-PRA) participant says:

> *Any custom or tradition should not be dismissed in any way, even though he's not a Muslim. We treat him like any patient, and like any patient, he is granted his full rights. But if any things are there. In his customs and traditions, for instance, he has everything. We explain to him what, as an opinion, is wrong with it. We're not forcing our views, and this is indirect.*

Social worker participant (SA5-RS) stressed the importance of coping with various cultures, traditions and customs:

> *Yeah, it cannot be dismissed or forged in any way. Each society has values, cultures, and customs of its own. Of course, the care of cases [should be] by age group, at the cultural level, and the patient's environment.*

The spirit of sincerity in work was evident among social workers in Saudi hospitals as per social worker participant (SA9-MA). He demonstrated respect for the practises and beliefs of various sects as well as respect for religions. He focused on providing patients with medical social services, regardless of other social factors. The social worker participant demonstrated:

> *Patients in Saudi Arabia turn to religious and folk healing, as well as prophetic medicine, which is a component of many tribes' tradition and practice. And how much alternative medicinal, religious, and folk therapy he wants. It is vital to consider the patient and his age, the religious component, the breadth of his culture, and his level of education. To provide the patient with meaningful information, you should visit him on the first day to organise your ideas. When I was employed in 1984, I learnt a maxim: 'Let him speak if you want to know someone.' You'll learn about his education, religion, interpersonal connections, and life experience.*

(SF13-IAD) indicates that the client must accept the specialist or his social counselling would be useless and that he interacts with senior patients skilfully due to his specialised understanding of Saudi culture and tribal traditions, as well as his advanced age:

> *If you can't accept the customer as is, he won't accept you. There's a chance that a customer doesn't want me; as a result, I'm delegating the task to another co-worker, this is not always the case, the client's first perception and notion may evolve. If the customer sees and accepts me, he will view me in that light. It might be psychological comfort because of my personality. Perhaps it is my advanced age that aids me. That's why paired with the elderly, and it is a gift from God. We work with people who hold master's degrees. However, the first is God's blessings and the internalisation of the desire to help the people. The second point to mention is that you love your job.*

Social worker participant (SF10-HMQ) confirms that the explanation for his workplace success is his religious affiliation and how faith influences the workplace's intentions, perceptions, and actions .

> *God Almighty, this is by God's blessing. I mean, when I came, there were people older than me, had services more than me, and had been social workers since their graduation, and I am a person whom you might feel weak. However, they failed in a case, but by Allah's blessing, I managed to handle it.*

The social worker participant (SF1-SH) talked about the challenges they face due to the patient's rituals, traditions, and culture:

> *The patient may have a preconceived notion, a religious conviction, or something else. He rejects the medication, as well as the social worker's advice and the nurse's advice. He, for example, does not always follow hospital rules, such as wearing hospital uniforms. As a matter of tradition, he refuses to follow these rules, particularly for the elderly people, they dislike wearing this outfit.*

The social worker participant (SF1-SH) stresses that some Saudi patients comply further because they know that the social worker is of Saudi nationality and that he is aware of customs and rituals:

> *The patient doesn't like to be obliged to do a certain thing. But this is rare and simple. On the contrary, once the patient sees that the social worker is Saudi and understands his dialect and way, he cooperates with him greatly. On the contrary, we faced many cases in which they don't get along with the doctors from other nationality's; they don't cooperate or help. Still, once the social worker explains to them, they accept easily and with conviction.*

In some cases, a specialist may have a problem resulting from the patient's awareness and lack of understanding of the nature of the social work and must present themselves and explain their services to the patient. The participant (SF2-OK) says about the patient's impact on the service provided:

> *Yes, it affects his understanding; what can you offer him, what is your job. The low level of awareness of the patient is the responsibility of the social worker. They must introduce themselves and their role in medical facilities.*

Social worker participant (SF1-SH) described the patients' expectation of the nature of the service and the way they deal with the specialist in this way:

> *Honestly, as soon as the patients see the social worker, they explain both their issues and conditions. Once patients embrace him, they can explain all the issues and situations they have, inside and outside the hospital, so that he will support them. We persuade them to bring people who accompany them. They're looking for a lot of things, and we genuinely provide them with fantastic services.*

Social worker participant (SF9-FHQ) clarifies the nature of the service expected by the patient:

> *The patient expects me to solve his problem, from A to Z. If he explained his problem to me, he expects me to solve his problem, whether it can be solved or not, all medical, social and material problems, everything.*

Many patients have reservations about the medical service given to them if the specialist was from a different gender than them due to the traditions of the tribe and culture in line with the religious life prevailing. Participant (SF5-MMS) says:

> *Women often refuse, but men may accept me as a female to walk in on them. Yes, they may accept me. I do not refuse this. It's normal for the interest of the patient. On the contrary, this is my duty. I take the lead and go to deal with the patient. He may not accept to meet the social worker. But the women, no. They don't want men to provide the service. Maybe 90% because of customs and tradition. Maybe it's not because of religion. But let me say we have customs and traditions which forbid men from walking in on women. Men may make a fuss for him; how come men walk in on women. Knowing that there are no religious contraindications.*

Social work participant (SF11-NWS) addressed the culture of shame common in Eastern societies in general and Saudi Arabia. Meaning men do not accept to be advised by a woman because this is considered derogatory :

> *No problem, however, some patients will not accept this because of the shame culture, and they will question why a female specialist is educating, guiding, or advising him. It also relies on the patient's knowledge and ethics, as well as whether or not someone accompanying him.*

Social work participant (SF7-MAJ) summarised the obstacles or problems facing hospital social service due to the patient or his family:

> *Numerous impediments exist. Specific individuals discontinue treatment because they are unsure of its efficacy, which could result from his family. Several of them don't follow up the advice. When you inquire why you don't dress in medical garb, he states that he will not, even if you inform him that it is sterile. You bring this clothing with you from the outside. He may, however, remain unconvinced. They believe it may irritate their skin and cause blisters.*

Many social worker participants had little trouble providing social services to patients. Social worker participant (SF4-NAH) stated:

> *Thankfully, not all the specialist is facing difficulties providing social services. Some patients may refuse to accept the specialist's and medical staff's recommendations because he thinks they intrude on his privacy. On the contrary, I see that all medical personnel are cooperative. When you leave the patient, you pray for him and ask Allah to heal him. You psychologically support him so that he begins to feel confident and accept your direction.*

Social worker participants noted that they pay attention to the impact of the tribal affiliation of the patient on the specialist. In some cases, participants consider this in the interest of the patient. In this regard, one participant (SF4-NAH) stated:

> *The social worker must sometimes take into consideration the tribal values of the client he is meeting. For example, a tribal patient may sometimes have customs that prevent, for example, circumcision early.*

The interviews revealed that social workers sometimes resort to religious healing (or psychological support using religion), particularly when there is a need for psychological support and to improve the level of treatment provided to the patient. The Islamic religion is the most significant, although not the exclusive, factor that generates Saudi culture. Therefore, religious healing is an integral part of the Saudi people's customs, traditions, and beliefs. Stimulating the patient's religious sentiments, such as patience in calamities and asking for a reward from God, is a tradition of Prophet Mohamed (PBUH). Here, one social worker participant (SA9-MA) explains this, stating:

> *Religious healing doesn't mean treatment by ruqyah (legislated duas), but rather strengthening the religious beliefs. If the patient is old, I will focus on the religious side. God willing, may God bless you. You have signs of religion. God willing, you are devout. You know that the pillars of Islam are five, and the pillars of faith are six. Among the pillars are that you believe in fate, whether good or bad. One must accept what God has allotted for you. Allah now rewards you for all of this. You have the final say of whether to accept this medical decision or not because your delay will negatively affect your health. But we won't carry out any medical procedure without your approval.*

Furthermore, the patient may be embarrassed by his condition, or the site of his injury may be sexual, leading him to deny medical treatment or inspection. Although one of the values of the Islamic religion is that necessities make forbidden things permissible, it is also common that some husbands will not accept a male doctor examining his wife, even if it greatly affects her health condition. This is all connected to the prevalence of ‘shame culture’ and the lack of understanding of religion. This was something mentioned by participant (SA9-MA):

> *Religious care for the sick is mostly used with elderly people and doesn't work with young people. In other words, approach people in their understandable language. I found a young man who rejected a traffic crash wound care. It was in the genitals of men. In this case, he was upset. "You have to believe in fate," I told him, "My brother. Allah has foreshadowed for you; this is your destiny. There will be a detrimental impact if you postpone the clearance of medical intervention or surgery. We are going to permit you to protect your positions. The injury was in its thigh. However, Islam permitted necessity.*

4.6 NEED FOR EMPLOYEE WORK DEVELOPMENT AND TRAINING

Social worker participant interviews demonstrated an immediate need to improve the hospital social services sector in tandem with the fundamental improvement of the policies and procedures adopted. It was found that the policies and practices are appropriate for some hospitals but not suitable for others. The interviews demonstrated the social worker participants' insistence on providing support and material resources to enhance patients' social care.

Hospital management directly impacts social workers and their jobs. Some social worker participants are frustrated with their work environment, reporting a lack of incentives and management's lack of cooperation. Results indicated that staff needed training, qualification, and new skills to complete their requisite tasks.

Table 4.3. Social Worker Participants' Answers to Sub-Themes of the Third Main Theme

Theme	F	%
Medical Social Work Procedures and Policies Manual and its conformity with the current work tasks	22	91.6
Labour policies and their impact on them	17	70.8
Need for training and development	14	58.3
Tips for those interested in working in the field of social work	11	45.8

As depicted in Table 4.3, 22 social worker participants (91.6%) addressed issues relating to the Manual on Medical Social Work Procedures and Policies and their relation to current work activities. In contrast, 17 social worker participants discussed labour policies and their effect on them. 14 social worker participants (58.3%) discussed the value of training and learning. 11 social worker participants (45.8%) addressed a variety of tips for those wishing to work in the field of medical social work. The tasks of medical social workers are described in the Manual of Procedures and Policies for Medical Social Work by the Ministry of Health, but they must always keep up to date with the current state of affairs. The existence of the manual is in itself an accomplishment. However, the greatest challenge for social workers is no accepted official uniform guidelines define a social worker's job description. Some participants addressed this manual's importance to their work efficiency and progress when changing personal efforts to accommodate the workflow. In contrast, others feel it needs refinement and that it might be sufficient for some hospitals but not suitable for other medical facilities, such as the mental health hospital. Social worker participant (SA1-KM) remarked:

> *The guide is excellent but lacks some things. Almost the same tasks in general, no explained procedures in the policies; for example, we make rounds and discover cases. It mentions the rounds on patients without clarifying what to do. We changed that indeed with personal efforts, but it needs an official guide and support. The round now is defined as sitting and talking with the patient, learning about his needs in terms of social issues and problems within the hospital. The problem inside the hospital may be an extension of a social problem outside the hospital. Here, we provide support and assistance.*

Social worker participant (SA7-ST) disagrees with him as he thinks that almost all policies are not applied and contradict the work assigned to them:

> *'Well, most of the policies are different than daily work. Now there are about fifteen or sixteen policies. Our department used to be the patient relationship department but split up now. There were a lot of policies shared with others. However, only sixteen of the thirty-two policies are currently in use. You can imagine how these departments work on varied and unclear roles'.*

Social worker participant (SA2-HZ) supports this observation:

> *Not very successful. Not identical at all. There are some administrative procedures in which I don't perform the tasks: accompanying and statements. They take up the time of the specialist instead of his work with the patient in the department. These tasks jeopardise him and make him an administrative rather than technical employee. They also added administrative functions in the Manual. I can say without exaggeration that they are at least 40% of the roles of the social specialist. They do not match my tasks.*

Seventeen specialists (70.8%) responded similarly concerning work policies and their effect on specialists. Some believe that the organisation should create and design approaches in conjunction with the actual job requirements. Others think that they can work within the policies to some extent.

14 social worker participants (58.3%) agreed that they need training and material incentives because of their role in increasing efficiency and employment. They also referred to the importance of more versatile policies to increase creativity and encourage professional participation.

Social worker participant (SF3-AAO) referred to their need for training in university courses:

> *Training is needed, specialisation is required. The world is changing, science is evolving, and information and social theories are changing. We need training in general and specific aspects (e.g., social terminology, social worker role with violence cases and suicide cases).*

Social worker participant (SA4-RRA) supports this opinion:

> *Training and support are vital because they play an essential role in the specialist's job growth, such as lectures on case studies and external organisations that offer services to individuals' function. We miss as specialists because we cannot communicate with external institutions, such as social and charitable institutions; this doesn't exist in the hospital. I mean, I cannot, for example, refer to comprehensive rehabilitation or social welfare because of the absence of a clear mechanism. I mean, I was also a trainee in Jeddah. There are also problems therein communicating with external institutions.*

Social worker participant (SA8-AW) stressed the importance of training in the English language as well as other courses:

> *We asked for the development of the English language for most social workers. All of them do not speak well. This causes us a problem in not understanding those who speak English in the medical team (SW).*

The social worker participants discussed the issue of employment in social work. Many of them entered this field to help patients and the poor to receive God's reward in this world and the afterlife. They confirmed their love for this job and belonged to it. Social worker participant (SA2-HZ) describes the humanitarian work, stating:

> *For me, social service is humanitarian work. How is it humanitarian work? It has a noble goal. You provide humanitarian services seeking reward from God. a Prayer or supplication from a patient is enough and better than everything else. Nothing is greater than this; It makes me feel comfortable and takes grief away from you (SW).*

Social worker participant (SA1-KM) SW explained that the work is good but entails some obstacles:

> *It's a good field and interesting work. It has some problems and lack of order, but there is no work without problems.*

Social worker participant (SF7-MAJ) emphasised the importance of social work and his passion for it, but outside of the hospital setting, explaining:

> *I recommend specialising, perhaps in an environment other than the hospital, because it is a nice and humane speciality. However, there are some difficulties and obstacles in the work environment and the social worker or the social researcher in juvenile homes, Comprehensive Rehabilitation, and other social welfare institutions. I think he can able to work more successfully and professionally (SW).*

4.7 CHALLENGES CONFRONTING SOCIAL WORKERS AND HINDERING THE PROVISION OF SOCIAL WORK SERVICES IN HOSPITAL

The profession of medical social care, like all professions, entails many challenges and barriers that emerge either from the policies, the nature of the work or from patient treatment. The interviews revealed that staff face challenges arising from relationships with hospital management, such as not including them in decision-making, failing to build suitable facilities for their work and dissatisfaction with the hospital management's policies. The sub-themes displayed in Table 4.4 emerged from these conclusions.

Table 4.4. Social Worker Participants' Answers to Sub-Themes of the Fourth Main Theme (N=24)

Theme	F	%
Challenges arising from work policies	16	66.6
Challenges arising from the inexperience of specialists	3	12.5
Challenges arising from patients' behaviour	9	37.5

Table 4.4 displays that 66.6% of social worker participants (n=16) addressed the challenges raised by job policies, while 37.5% (n=9) of social worker participants discussed the challenges of working with patients. This data highlights the importance of hospital administration's support of research in medical social work and stresses the need for these administrations to make additional efforts to help social workers resolve obstacles and challenges.

Social worker participant (SF3-AAO) commented on the role of hospital management and the medical team in dealing with them and emphasised the role played by managers:

> *Thank God, I have thirty years of experience; I've worked with different managements, several departments have changed, and I've worked with a range of managers in the hospital. Some managers understand the social worker's role, believe in him, and support him, while other managers make the rule of the specialist secondary. Even some managers make the social worker works on things other than his speciality (SW).*

He further commented on the challenges arising from specialists' negligence:

> *There are some social workers who do not do their part because of feeling frustrated with the management. The lack of an appropriate work environment, lack of cooperation with the social worker, and lack of management understanding for the nature of the work of the social worker hinder the work of the social worker. Lack of familiarity with behaviours, lack of adequate training, adequate practice and training, lack of vocational training institutes. I mean the direct contact, the lack of exchange of experience among social workers, and lack of reference such as a professional association, managed by social workers, that protect their rights and clarify their roles (SW).*

As for the challenges posed by management, social worker participant (SF2-OK) observed:

> *As far as management is concerned, I see marginalisation. There is no interest in the social service or the specialist. They see their role as marginal and unimportant so far. I have worked with more than one management, and the same concept exists in management so far. Medically, for me, no. Medically, there is understanding even in decision making. The social worker has a role in decision making. Mostly, it's more with doctors or medical team, but in general, the medical team does not affect like management (SW).*

Social worker participant (SA1-KM) addressed a mixture of challenges resulting from the lack of experience and management underestimating social workers. He supported his opinion with a real example from his work:

> *Well, the current hospital administration knows that our work is of value and benefit to the patient, but it does not estimate that the current hospital director is a doctor in origin. He gives doctors incentives and allowances, for example on the National Day holiday we should not work for three days, which is an official leave from the*

government, he summoned some specialists, including myself, to cover the work of the Patient Affairs Department, because they have some people waiting at the counter, there were not enough employees, and they couldn't explain to them. Someone is needing an ambulance; another needs a medical device and another needing a bed (SW).

Social worker participant (SA8-AW) clarified that the specialist might be the cause of the challenges facing him:

He may be the cause of the problem, which disrupts the provision of social service through the lack of knowledge. He does not have a background. Some of them don't know the patient and have no information.

Social worker participant (SA10-MNS) shared his opinion and covered the theme adequately, observing how the specialist could be the cause of the challenges:

Some individuals work in social care who are unaware of the profession's ethics. Also, some specialists lack professional integrity as well as good courtesy. The social worker may be inexperienced and new to the job, which affects his performance, as well as many sick cases and work pressure, which may lead to a lack of understanding of the proper professional perception. The specialist is often disappointed by others' lack of respect for his efforts. These feelings will gradually transform into resentment of his profession; this is the most serious problem (SW).

Social worker participant (SA6-SA) asserted that the practitioner might be the source of the issue at times, obstructing the delivery of social services due to a lack of expertise, or he may lack the personal characteristics and skills required for social work:

The problem may be in the specialists themselves, sometimes among each other, and sometimes with the patients. It is normal. If he does not understand society's social and cultural background, he won't accept the patient, not aware of social workers' ethical obligations as specialists. Social service because most of those who join it wants to be called specialists, but they are not technically really specialists. One must reconcile with himself, his past and his present. I feel that the past and our education method have a role besides other things such as personal traits (SW).

Regarding the challenges arising from patients and their desire to see an improvement in people's perceptions, one participant (SF5-MMS) stated:

> *I don't want to change my job; instead, I want to change people's views on the importance of social work. Our work is essential, but some people do not respond to us. In addition, nurses ask about our occupation and believe that we don't have a benefit. I mean, they don't recognise our role as social workers. They don't recognise the importance of social work, not only here in the hospital but also society's perceptions (SW).*

It is evident from the previous evidence that the prevailing Saudi customs and traditions impact patients and pose challenges in dealing with patients and providing medical services. The social worker participants split the challenges into two significant factors: 1) the extent to which management and the medical team assimilate to the social worker's job; and 2) the social workers' lack of knowledge, experience and their need for appropriate training.

4.9 PERCEPTIONS OF SOCIAL WORKERS REGARDING THE FUNCTIONS, RESPONSIBILITIES AND DUTIES OF SOCIAL WORKERS IN HOSPITALS

4.7.1 Daily Tasks

Responses concerning the duties, responsibilities of social workers in hospitals indicate that all interviewees are familiar with their daily tasks, the most important of which are the following:

1. Make rounds to the patients' places in the wards daily.
2. Conduct case studies to ascertain the eligibility of the patient for help.
3. Prepare the social reports periodically for the hospital management about activities carried out by the social work department.

4. Build professional relations with medical personnel working in hospitals to fully understand the medical cases and identify mechanisms to deal with them and solve their problems.
5. Work on the exit plan for patients.

This agreement indicates a clear job description of Saudi hospitals' social workers' functions (Ministry of Health 2016). The results of this research support the findings of Al-Saif (1999), which defined the most significant tasks performed by social workers in hospitals, such as seeing patients regularly during rounds, providing patients with assistance, writing patient case studies, and communicating with medical staff on patient needs. This result supports previous research (Al Fahidi, 2012; Shahry, 2005). Ben Sanad (2013) found that the hospital specialist's most important role is developing solutions to patients' problems and recommending practical solutions for them, agreeing with the findings of Jawair (2001) and Jebreen (2002). However, Sahli (2009) indicated that medical staff do not understand or appreciate the hospital's medical social worker's role. Therefore, there is a need to clearly describe the medical social worker's role to facilitate a complete understanding and delineation of the social worker's tasks. Medical social workers primarily concentrate on providing service to enhance the quality of patient care, which greatly benefits the patient recovery process.

In this regard, social worker participant (SF1-SH) stated:

> *Although social workers have limited authority, we are keen to help patients, as I have told you. We're calling the doctors for them; we're calling the Patient Affairs Office if they had some concerns. When they need more, we call the nurses for them. We're getting their family to join them (SW).*

4.7.2 Work Procedures and Policies

It is necessary to analyse work procedures and policies from an employee's point of view, which helps establish procedures and policies that serve the job's interests and increase service quality. Two thirds (n=16) of the 24 participants believed that job practices and policies are neither appropriate nor efficient.

Social worker participant (SA1-KM) commented:

> *'The policies in the guidebook are general. We applied them to our work with some modifications; for example, there is a policy regarding patients, but the procedure that the specialist should follow is unclear. Patient rounds are a broad concept that can take up a lot of a specialist's time and effort' (SW).*

This finding supports the results of Awad and Nimr (2010), which found that social service administrative procedures and policies hinder social workers' success and called for a simple manual of policies and procedures. Shibani (2006) found discontent with the hospital procedures and policies regarding the social worker's position in the medical system. Al Fahidi (2012) also observed that the social work respondents agree with the social worker's responsibilities as set out in the Executive Regulations for the practice of the social service profession. Bint Mughais (2006) pointed to the diversity in several fields of services provided by the Department of Medical Social Services, including the operational aspects, informative aspects and services for people with special needs.

Each person's different level of charisma, characteristics, and individual tendencies may explain the disparity in findings. Some specialists have the ambition and desire to perform their role and believe that policies and procedures restrict them. Authoritarian and autocratic hospital management styles, which do not engage social workers in the treatment planning or process, may influence the perception of policies and procedures.

4.7.3 Academic Preparation

The interviews revealed that many social workers do not perceive that they are contributing a valuable service, making the patient a secondary issue.

Social worker participant (SA2-HZ) stated:

> *Instead of being 90% in the field, the specialist is occupied for 40%–50% as an administrative employee with work he has nothing to do with and 60% in the field. The specialist should be totally free 90% for the social work, with the need for an administrative officer in the department to perform administrative functions (SW).*

This finding agreed with Al Fahidi (2012), which demonstrated that social workers believed their role was purely administrative, indicating a lack of awareness of the importance of social factors in inpatient treatment. The results of this study also supported Awad and Nimer (2010) study, which suggested that social workers are not prepared to work in the medical sector due to inadequate academic training in medical social work. These curricular inadequacies contribute to the lack of knowledge of social work's importance in the medical field. This study's findings were further consistent with the results of Al-Shaibani (2006), which suggested a gap in expertise and analytical foundations when dealing with cases. Social workers need to embrace the profession's knowledge, values, and skills to achieve optimal therapeutic outcomes. A complete understanding of the social worker's roles leads to all areas of interaction with patients.

4.7.4 Developments Required for Work

When speaking of frustration with processes and policies, social worker respondents did not focus on physical infrastructure and office equipment.

Social worker participant (SF3-AAO) observed:

> *Development is required. Also, the specialisation is an excellent thing and allows us to provide high-quality services. For example, a social worker responsible for the violence should take courses on violence and the causes of violence. In some cases, the social worker is responsible for following up with the patient and his family, home visits, changing the surrounding environment and family therapy (SW).*

This result varies considerably from the results of Al Fahidi (2012), which suggested that the most significant factors that obstruct social service are lack of equipment and development. This finding is also consistent with Al-Qaood (1993), which found that social workers believe that lack of action and logistical support contributed to a broad difference between the current role of social work and what is needed. This finding also corresponds with Al-Shahid (1992), which indicated that the most critical challenges to social work in hospitals were the lack of means and the neglect of the development of work. Al-Otaibi (2011) also concluded a lack of resources available to specialists in social work. This variation may be because the two hospitals included in the study had modern buildings and facilities, suggesting the Ministry of Health's increasing capacity to meet these material needs and supplies (such as computers, offices, and furniture). Hospitals may not understand what is required for social workers to carry out their roles.

4.8 THE DESIRE OF EMPLOYEES TO MAKE CHANGES IN THEIR WORK ENVIRONMENT

The lack of promotions, incentives and insufficient allowances and the hospital's allocation of scarce funding to other areas reduced social workers' motivation to work and develop. 33% (n=8) of respondents expressed satisfaction with the job and the work environment.

Social worker participant (SA8-AW) remarked:

> *Change may involve learning foreign languages. We hope that English courses will be held at the expense of the hospital or the ministry. We want to take courses and develop. We cannot. There is nothing to motivate the social worker (SW).*

Social worker participants also discussed the need to introduce protocols to improve their work. In addition to carrying out additional studies to strengthen the work environment and enhance experts' work, enforcing protocols is recommended. The results indicate that there is a difference between what the specialists expect and what is occurring. This result is consistent with Qaood (1993), who found that social workers believe that there is a difference between expectations and observations in the work environment. The results also agree with Shehri (2005) findings, who found that there are challenges in obtaining advancement and low wages and material benefits, as they directly influence the success of social workers. Finally, views of social workers regarding the roles, duties and tasks in hospitals indicate a need for action and the development of realistic strategies for developing the work environment to increase staff efficiency and enhance the implementation and application of specialist and patient studies.

4.9 IMPACT OF ISLAMIC CULTURAL AND RELIGIOUS VALUES ON THE PROFESSIONAL PRACTICE OF SOCIAL WORKERS IN HOSPITALS

4.9.1 Impact of Cultural and Religious Values in Service Provision

Saudi society is highly concerned with Islamic religious values when providing services to patients. Gharabia (2010) suggested these values have a tangible impact on the nature of the services offered. He noted that the ethical or religious practices carried out by social workers in one country would not be appropriate for use in another country (Gharabia 2010). This corroborates the study's finding on the influence of religious views. For instance, a social worker will combat suicidal and futile feelings in a patient by reminding him of Allah and the virtues of persistence and tolerance, regardless of what happens to him. On interactions between the health provider and patient, all social worker participants agreed regarding the significant impact of religion and spiritual beliefs on patients' care and treatment. They usually respond to their religious thoughts and resort to this type of idea and beliefs to recover.

The findings also demonstrated that cultural beliefs and medical methods such as health education by professionals or physical therapy at specific times have a minor impact on the relationship between service providers and the patients; it is less influential from the religious side.

Almutairi (2015) found a lack of Saudi cultural and civilisational efficacy among non-Muslim health practitioners, causing a culture shock between service providers and patients. The patient's values and cultures do not often influence service providers. Rather, there is neutrality in the provision of services. Sheppard (2006) suggested that variations in principles and beliefs may lead to challenges in reacting to the relationship between the service provider and the patient. The findings revealed challenges regarding the availability of social, medical facilities expected by patients or their relatives.

Gharabia (2010) suggested that linguistic, social and class disparities as well as value differences negatively impact medical care.

19 (79%) social worker participants stated that the gender of social workers impacts the provision of medical social work. There are a few rules that should be followed whenever feasible. Understanding of these concerns is critical for healthcare providers to deliver culturally appropriate treatment. such as avoiding direct eye and physical contact between a healthcare practitioner and a patient of the opposing gender when providing healthcare.

Participants saw an influence of Asian and Middle Eastern culture on dealings between specialists and patients. However, the tradition of taboos and shame and the principles of lawful meeting in private between individuals of different genders may affect the professional relationship. Family members also always demand to accompany their children while they receive medical care (Almutairi 2015). Social worker participant comments revealed that the

gender of patients does not influence the type service provided. This was compatible to a certain extent with the Al-Sahli study (2009), which found no impact on the gender of social workers in the practice of their responsibilities and duties or their commitment to professional values. Research indicates no relationship between the gender of social workers and their duties or commitment to professional principles (Abu Soso 1991; Al-Shaibani 2006; Al-Sahli 2009).

However, 33% (n=8) of social worker participants stated that some patients refuse service from a social worker of a different gender. Gender is a sensitive issue in determining the professional relationship with the patients. Gender influences relationship formation, understanding and ensuring smooth and flexible care. A female social worker may be more receptive to other women's emotional and psychological needs, particularly in Saudi society.

4.9.2 Medical Social Work Procedures and Policies Manual

Current Work Tasks

100% of social worker participants (n-24) discussed the Medical Social Work Procedures and Policies Manual (Ministry of Health Saudi Arabia 2016) and its conformity with the current work tasks. Some of them believed that the manual is good and conforming for their current work, while others objected to the components. There is an expressed need for the Ministry of Health to regularly update and specialise the manual to fit each hospital and speciality. Social work participants found the manual to be too general, blurring medical social work practices. A shortage of training programmes and learning sources, which are the backbone of employee's guidance in all institutions, exacerbated the problem.

4.9.3 Work Policies: Between Reality and Perspective

According to 33% (n=8) of the social worker participants, there is a need to continuously update the social worker's manual issued by the Ministry of Health. There is a gap between the policies expected of the social workers and those imposed and applied. This finding is consistent with the results of Al Fahidi (2012) and Aljuwair (2001). They pointed to the large gap between curricula and application in hospitals and mixing social worker tasks with other specialities.

4.9.4 Workers' Need for Training and Professional Development

Most of the workers agreed regarding the need for training, development, and follow-up on recent developments in their field. Shibani (2006) suggested that social workers use the expertise gained from their work experience, training and development to offer their best

services possible. These workers also have a significant role in mitigating social challenges in Saudi society, dealing with patient populations and their families.

4.10 BARRIERS TO THE PROVISION OF MEDICAL SOCIAL WORK SERVICES

During interviews with social worker participants, two-thirds (n=16) responded that a lack of involvement in creating care plans for patients and medical professionals led to challenges in service provision. Not being involved made social workers feel that their role in hospitals was minor, marginal and meaningless.

Research indicates that the lack of a clear explanation of social workers' responsibilities in the clinical team contributed to misunderstanding their roles (Al-Sahli 2009). The lack of independence of social workers, the right environment for interviewing patients, and benefits for workers significantly impact social workers willingness to work. Moreover, the daily work schedule presented a challenge to the function of workers in hospitals due to inadequate institutional policies. Almost 21% (n=5) of social worker participants acknowledged that their lack of expertise is the primary source of their challenges. They attributed this to the lack of diverse and comprehensive training in the complexities of practice in hospitals. Shaibani (2006) suggested that there were insufficient courses on the reality of medical social work. Gharabia (2010) proposed a lack of expertise in specific fields of social work within the hospital. Ahmed (1992) found a correlation between experience and efficiency of medical social workers. Alquaib (1986) agreed, indicating the experience of workers and department heads in performing their social work tasks, as evidenced by a large number of patients (14 out of 20 patients) seeking psychological, social or physical help from workers.

Patients cause some challenges, which is an obstacle to the profession in general. Al-Sahli (2009) supports this finding, indicating a great challenge due to the lack of patients and their

families' understanding of the social worker's role. This study suggests the possible reason for this is precisely the blurring about the worker's role in hospitals, including among patients. The current study confirms this finding as 60% (n=12) of patient participants were not aware of the role of social workers, causing a state of uncertainty about how social workers add to the patient's treatment process. To ensure that social workers continue to provide comprehensive service, their unique role in the multidisciplinary teams must be recognised and understood.

Aljuwair (2001) also demonstrated that patients did not know the function of the social workers and had limited interaction with them. points out that the challenges faced by workers result from the lack of expertise for some of them and their need for training and development. The lack of benefits and low wages affects their morale, and it is essential to improve the social worker's personal, moral, and material conditions.

The current global population is estimated to be around 6 billion people; there are 191 countries, more than 6000 languages, and thousands of different cultures, depending on how culture is defined. Cultural competency, defined as an ongoing and interactive process based on respect for others' beliefs and practices, has crept into the professional literature with several studies over the last decade (Purnell 2000; National Association of Social Workers, 2001). It is known that culture impacts health and health care, and therefore on health professions education, but how society affects the ability to define practice competency globally is less understood. Competence is a valuable commodity in the healthcare sector today. It brings traditional connotations that can be difficult to overcome, particularly when discussing new professional development models and ways to regulate professional performance. Competences are the functional component or 'what' that goes with it. The characteristics of capability or the 'how' of competence are referred to as competencies. When

viewed as a whole, all these ideas contribute directly to the growth of successful and long-term performance in an individual (Bruno et al. 2010). All social work participants in the study agreed that professional development should be part of a competency framework.

4.10.1 Thematic Analysis of Patient Responses

This section presents the results of the interviews conducted directly with 20 patients in the hospital. The researcher conducted thematic analysis for written interviews based on the patients' main themes after designing semi-structured interview questions.

4.11 DEMOGRAPHIC CHARACTERISTICS OF PATIENTS IN THE STUDY

All 20 patients in the sample were Muslim. Aggregate data show that the average patient profile was male (55%, n=11); age 40-60 (45.8%, n=11); married (37.5), and had either a secondary (20.8%, n=5) or graduate education (25%, n=6). The majority were in hospital two-four weeks (20.8%, n=5) or four-six weeks (33.3, n=8). For detailed information, see Tables 3.2-3.5.

4.12 MAIN THEMES

Thematic analysis identified two main themes: 1) the patient's perception of the role of the medical social worker and 2) patient perceptions of the impact of customs and traditions on medical social work.

First Theme: The patients' perception of the role of the social worker in the hospital. This main theme has the following sub-themes:

- Patients' awareness of the presence of the social worker in the hospital.
- Patients' expectations of the role of the social worker in providing economic assistance.

- Patients' expectations of the services provided by the social worker to the patients.

This theme is in line with Purnell's theme of perceptions of healthcare practitioners

Second Theme: Impact of customs and traditions perceived by patients in medical social work. This main theme contains the following sub-themes:

- Being affected by the cultural and religious values of the patient when providing the service.
- Problems or challenges facing the provision of social service to patients related to the social worker.
- The complementarity of roles between the social worker and the medical staff.
- Obstacles facing patients in following the instructions and advice of the social worker.
- Complementarity and harmony between social service and the specific nature of Saudi society.
- Tools and facilities that can help the social worker to develop services.
- The possibility of communicating with a social worker of the opposite sex.
- The relationship of social service to the development of the role of women in Saudi society.
- The role of alternative medicine and traditional medicine.

This section provides a detailed description of these central themes as well as sub-themes. Quotations from the interviews support this discussion, identifying common factors and focusing on repetition of participant comments. The following is a detailed analysis of each of the aforementioned themes.

4.12.1 Theme One: Patients' perception of the role of the social worker in the hospital (Purnell domains: Healthcare Practitioners, Healthcare Practices).

Results found consensus among patients about the role of the social worker. The identified roles included: 1) procuring financial aid; 2) procuring durable medical equipment, expensive treatments; and 4) facilitating transportation and transfer to medical centres by dedicated cars or ambulances. The majority of patients did not expect a social worker at the hospital. Indeed, most of the participants predicted that nothing would change if there were no social services.

The themes are sequential and complement each other around one axis. 25% (n=5) of patients expected that the social worker refers to charities or organisations for medical equipment. 20% (n=4) of patients thought it was useless to visit the social worker due to their financial needs. However, 15% (n=3) of patients thought social work services benefitted them since they helped them gain psychological comfort and build a good relationship with doctors, nursing staff and other patients. They thought that if the social workers did not exist, the service would be inadequate. There was general agreement that the social workers, whether male or female, check all of them out. 55% (n=11) reported that they had no idea about social work services in the hospital. The following examples illustrate this data.

Patients felt that the social worker's role involved periodic visits by the social worker to the patient. If the patient needed his assistance, the social worker reports on his situation and makes regular rounds. 20% (n=4) of patients also said that nothing changes whether or not the social worker visits them and that his job does not help. 40% (n=8) of patients stated they did not expect a social worker's involvement because they did not know much about this profession.

Table 4.5. Patients' Responses to the Sub-Themes of the First Main Theme

Sub-Theme	N	%
Patients' awareness of the presence of the social worker in the hospital	9	45
Patients' expectation of the role of the social worker in providing economic assistance	5	25
Patients' expectation of the services provided by the social worker to the patients	8	40

Data indicated that patients expected the social worker to only provide economic support to those in need; otherwise, he is useless. Patient (S.SN) stated:

> *Yes, the social worker came, wrote a social case study and put it in the medical file. From his title, I expected him to refer to charities or Zamzam Association which helps the patient get medical equipment such as wheelchairs or crutches. He told me it's received from the department's medical supply.*

One patient (S.AH) gave a detailed description of the type of economic support he expected from the social worker:

> *Yes, the social worker came three days after entering [the hospital], filled out a sheet, and placed it in the medical file only. From his title, I expected that he could refer to charities or Zamzam Association which helps the patient get medical devices because I need oxygen equipment and maybe an oxygen cylinder. Still, he cannot refer to any association or charity.*

Some reported that they did not know about the social worker or their role. Patient (R.SM) stated:

> *Yes, the social worker came by to see me a couple of days after entering the hospital. His questions were about my presence in the hospital and my health. He introduced himself and the services he provides to the companions and us. However, before I meet the worker, I expected nothing from the worker. Frankly, the worker is not known, at least to some people. His job is not like that of the doctor and nurse, but if I have a problem, I can tell the worker as the worker said to me.*

He also added:

> *The services are that he comes by to see us. He does not come short. He checks if we need something. Even at the visit time, he sometimes comes by to talk to my brother, who comes here as a companion with me. He brought a companion paper for my brother to provide to his work to give him leave and does not record his absence. However, I asked him to talk to the doctor to refer me to the specialised hospital in Mecca for radiography and tests not available here. He talked to the doctor, but the doctor said we should wait for the consultant to diagnose my condition, although I have been waiting for their reply for nearly a month.*

The patient (B.DA) praised the presence of the social worker. She said:

> *Yes, the social worker, [the identity of the social worker was deleted] comes by to see us. Before I met her, I did not expect how much support I would get from her. Now, I feel very comfortable with her presence and support for me on all levels. It would be different if I did not meet because she helped me have an excellent positive relationship with those around me, whether the medical staff or other patients.*

Another patient (A.KH) knew about the social worker, her importance and her role. She remarked:

> *Yes, I met the social worker every day or two. She came by to see us in this department, and I know that she works to help patients and fulfil their needs. If the social worker is not here, the service will be inadequate.*

However, one patient (T.SN) expressed his indifference to the presence of the social worker. He stated:

> *Yes, I met the social worker after I entered the hospital. I had no idea about the presence of the social worker in the hospital. Nothing, in my opinion, would be different if I did not meet him.*

He also added:

> *The worker came to check on me when I came in, offered suggestions and help and talked to me about my social status, but these services are unnecessary for me. He wrote me a social report in my file about my social status.*

There also seems to be a difference between male and female patients' acceptance of the social worker's role. The female patients expressed an evident appreciation of the psychological support from the social workers. In contrast, the male patients exhibited an apparent lack of acceptance of the social worker's psychological and social support. Almost 73% (n=8) of males were not aware of social workers' presence in the hospital. This discrepancy could be due to the male patients' low culture and awareness of the social worker's role and assistance.

Many participating patients reported that one of the most critical social worker roles is translating the nurses' explanations about treatment and instructions because they do not understand their language. This translation is an essential role for the social worker

In this regard, patient (M.OT) stated:

> *Yes, she explained to me my health condition. The doctor is from India, and I cannot understand the Filipino nurses. She explained how to take the treatment and when the doctor and nurses check on me before the operation.*

Another patient (M.WA) expressed the same sentiment:

> *Yes, she explained to me my health condition. I do not understand the doctor or the nurses. I do not know their language. She explained to me how to take the treatment and when the doctor and the nurses check on me before the surgery.*

The patient (H.KA) reported that the type of services provided by the social worker is not helpful for him. He stated:

> *The worker offered suggestions and help, but these services are not necessary for me. He wrote me a social report in my file about my social status, and frankly, there is no need for that.*

The patient (S.QR) also agreed with him, stating:

He does not provide anything to me. He asks about my health, the services provided and whether I need anything. He helped me bring the nurses to ask them for some services, like changing some tools.

In terms of the type of support provided by the social worker to patients, their families and those accompanying them, the vast majority expressed that the social worker fulfils a social and psychological role. However, there are a few who do not think his role social support at all.

He did not provide any service to me, and it's social support (S.AH).

No, he has nothing to support me socially (M.RM).

I consider it support for the hospital (S.QR).

All patients but one stressed that there were no problems or conflicts with the social workers in the hospital as their primary concern was the patient's welfare and comfort.

However, one patient (M.SA) reported a problem or conflict:

The conflict was that the vehicle transporting me here should be a private car, not the centre's bus. I spoke with the social worker to put my name on the transporting list, but he said the place is far away and the other patients will be late. I wrote a letter to the hospital director, and I wait for his answer. I'm still a patient, the state guarantees all rights of patients, and I want them to treat me equally to others.

Some patients confirmed that the social worker has a vital and influential role in obtaining psychological comfort and reassurance. Patient (R.SM) stated:

[He cares for] the comfort of patients after the doctor. That's right; the worker can help the inpatient stay in the hospital for a long time, reassure him and introduce him to services in the hospital.

Patient (B.DA) stated:

Yes, the social worker plays an important and essential role in the comfort of patients and the provision of social services and psychological support for them. Standing with the patient, checking on, arranging his exit, and helping the patient solve his social problem give him a sense of assurance and comfort. Hence, the patient devotes himself full-time to the patient recovery and the health aspect, which expedites recovery time. This is thanks to God and then to the support and advice of the social worker. This happened with me in weight-loss operation, and the social worker stood by me.

Patient (S.SN) stated:

He cares about any observations or problems and facilitates exit procedures, procedures of facilities paperwork, etc. He may take care of the procedures of providing some medical devices for patients. He helps them, as he explained to me previously. I can communicate with him if there are any comments about the room or nursing or problems from some companions with their patients. He informs patients to go out if the doctor decides so and works to provide some medical devices.

Data revealed that some patients fear that the social worker is a substitute for the doctor. They clearly expressed that the social worker's presence is comforting in some other things, but the doctor's visit and follow-up are indispensable, and the social worker cannot replace him. If this happens, it will not be acceptable to them. Patient (T.SN) clearly expressed this:

The social worker filled the social report for me and put it in the file. I did not need the worker in anything else, but he comes by to see me in the room from time to time, makes suggestions only and checks on me, so you cannot say whether he comforts patients or not. Maybe some of them, yes, and maybe some of them do not feel comfortable with the presence of the social worker as they feel with the doctor, for example.

Most participating patients felt that the social worker has no right to interfere in medical decisions; his role is limited to the social aspect, facilitating procedures, and so forth. Patient (R.SM) stated:

Praise be to God, the worker only talked to the doctor about referring to the oncology hospital, and we wait for the response of the Medical Consultant. He can follow up the response of King Abdullah City Specialist Hospital to check up on the indicated case and response to involve in treatment.

These patients are not aware of the social workers' role. Here, the patient praises the social worker for his help in mediating a case transfer for treatment in another hospital. This task may be outside of the social worker's competence. Therefore, there is an urgent need to clarify the social worker's role and clarify the difference between social work tasks and tasks of other disciplines.

Patient responses indicate the need for clarification about the social worker's role in helping the patient make medical decisions:

> *I do not think even if he has some suggestions, but the medical decision is related to my health, and he cannot impose his opinion on acceptance or rejection (H.KA).*
>
> *No, the worker did not happen to suggest anything (M.RM).*
>
> *No, the worker helps me with education and explains some health tips to me (A.JM).*
>
> *No, I do not think he has the right to do this. He only gives advice (O.GL).*
>
> *I have no medical decisions. I have regular dialysis, and the worker can only advance and delay (M.SA).*
>
> *I do not think even if he has some suggestions, but the medical decision is related to my health, and he cannot impose his decision on acceptance or rejection like the doctor (T.SN).*

One patient (A.MA) also reported that the presence of the social worker is significant for him. He stated:

> *He does not help me, but he brings us essential papers such as the accompanying certificate or social report and asks about any problems we have with either nursing or maintenance. This is a good thing, and may God bless him.*

4.12.2 Theme Two: Impact of customs and traditions perceived by patients in the practice of medical social work (Purnell domains: Healthcare Practices, Communication, Family Roles, Spirituality and Workforce Issues).

The results revealed that Saudi religious Islamic culture affected participating patients; this is demonstrated by, among other things, the lack of mixing between men and women. Islamic instructions give the patients the freedom to choose the treatment method that leads to their recovery and safety. Islamic culture allows male doctors to treat men and female doctors to treat women, except for necessity. The Kingdom of Saudi Arabia hospitals separates male from female patients. Islamic teachings and adoption of the *sunnah* (traditions) of the Prophet (PBUH), including the Prophetic instructions related to medicine. It is a collection of advice reported about the Prophet Muhammad (PBUH) on the treatment and general health, which he used and prescribed and advised to others. These instructions and advice reached us in the form of prophetic *hadiths* (sayings of the Prophet), some of which are related to therapeutic and preventive medicine. They deal with the cure of illnesses of the hearts, souls and bodies, including natural medication and spiritual therapies, prayers and the Holy book (Qur'an). Early scholars compiled these teachings, the most important of whom is Ibn Qayyim al-Jawziyah, and later scholars added other books. They also use *Hijama* (cupping) treatment, one of the branches of alternative medicine in which cups made of glass, bamboo or pottery are applied to the skin to create suction. *Hijama* therapists believe in cupping and its importance in activating blood circulation and blood flow and treating many diseases. The origins of this science date back thousands of years ago to the ancient Egyptians. Ancient historical records document that ancient Egyptians used the cupping treatment. This reflects the Saudi people's attachment to traditional Saudi culture and the teachings of the Islamic religion, and the customs of Saudi society.

Positivity and good interaction characterised participating patients' interaction with the social worker. Patients' responses also reflected the predominance of community traits and tribal customs experienced by patients and social workers.

The patients' responses also indicated their familiarity with Saudi women's practises, traditions, and religious behaviours. They praised banning the mixing of men and women. This often arose from their opinions on and attachment to prophetic medicine. They also emphasised that practises and beliefs did not grant women equal opportunities to engage in jobs involving male patients, even the social work profession. Although there is no relation between women's freedom and employment as social workers or other specialisations, social work is like any other work in which women can engage in. General cultural rules apply to everyone in all circumstances and fields, whether the employee is a woman or a man. Because of the influence of some customs and traditions and commitment to obedience and loyalty to some of the cultural components that constitute collective behaviour, social workers, whether male or female, cannot compete for this right. They are equally committed to these limitations.

The patient may decline to comply with the social worker based on gender (i.e., the female patient refuses to cooperate with a male social worker, talk to him about private and social matters, express her thoughts, and ask that a female worker provide the service). This is the outcome of tribal rigidity, customs and practices that regulate them. These customs and traditions derive from the essence of culture and the dominant mindset of most Islamic or Middle Eastern countries. Saudi history, customs, social practises, culture, and Islamic practices all constitute a distinct identity for the Saudi people. The culture of the Saudi people is profoundly Islamic in both the older and younger generations. This illustrates the extent to which Islamic rulings, law, heritage, belief and prophetic medicine influence individuals' opinions in the sample.

Throughout the interviews, it appeared that many patients often rely on religious therapy such as *Ruqyah*, Qur'an reading, and prophetic medicine. Prophetic medicine includes herbs and *Hijama* (cupping), cauterisation (branding with fire), new cupping therapy and others.

Table 4.6. Patients' Responses to the Sub-Themes of the Second Main Theme (N=20)

Theme	n	%
The patient is affected by the Saudi and religious culture when receiving assistance from the social worker.	20	100
Problems or challenges facing the provision of social service to patients are related to the social worker.	12	60
Complementarity of roles between the social worker and the medical staff.	15	75
Obstacles facing patients in following the instructions and advice of the social worker.	2	10
Complementarity and harmony between the social service and the specific nature of Saudi society.	13	65
Tools and facilities that can help the social worker to develop services.	14	70
Possibility of communicating with a social worker of the opposite sex.	9	45
Relationship of the social service to the development of the role of women in Saudi society.	9	45
Impact of alternative medicine and traditional medicine.	16	80

15 patients (75%) discussed the complementarity of roles between the social worker and the medical staff. Only two (10%) of the patients addressed obstacles following up with the social worker's instructions and advice. 13 (65%) patients discussed complementarity and harmony between social work and Saudi society. 14 patients also addressed a central issue (i.e., the tools and facilities to assist the social worker in developing services). 9 participants (45%) were concerned about communicating with a social worker of the opposite sex because of the nature of Saudi culture's customs and practices. Communication would happen only in the presence of a family member. Furthermore, nine participants explored the relationship between the social sector and the advancement of women's role in Saudi society. Additionally, 17 patients addressed the influence of complementary medicine and conventional medicine, which is attractive to all those who know it.

Patients agreed on the importance of their cultural and religious values when receiving the social worker's help. Many patients reported that the social worker's work complements the

Saudi cultural and Islamic religious customs because the social worker is a member of the Saudi society.

Patient statements confirm the absence of conflict:

> *I think there is no conflict. The social worker is supposed to be a member of the society and knows the customs, traditions and how to speak with the community members (R.SM).*
>
> *The social worker should be observant, advise according to religious guidance, and be careful about our customs and traditions (H.KA).*
>
> *The social worker is often a member of the community. He certainly knows the customs and traditions of the community, so I expect he can understand the patient's customs and cultural backgrounds (S.AH).*
>
> *Praise be to God; there are complementarity and harmony between the customs and religious traditions of the society and the work of the social worker (B.DA).*

The subjects' responses, particularly those of patient (B.DA), demonstrate that the patients' notion of the social worker's role is material assistance or religious counselling with or without psychosocial support. This notion underscores the need to raise awareness of the social worker's role in hospitals and Saudi society in general.

According to one participant (A.JM), the level of complementarity between the function of the social worker and Saudi society's norms and religious beliefs, according to one participant (A.JM), depends on the social professional's grasp of his realisation of Islamic faith and society's culture.

> *By preserving the religious fundamentals and Islam, which is what distinguishes us, as well as adhering to the inherent customs and traditions.*

Participant (M.WA) confirmed the need to preserve Islamic traditions and customs and the need for the social worker to be a Muslim, Saudi citizen or a Muslim who knows and maintains the traditions of Saudi society. Fulfilling the rules and provisions of Islamic Law,

the Saudi traditions derived from it and Islamic heritage are the basis for accepting the social worker and his role by Saudi patients.

The majority of patients reported two main elements of problems and challenges. The first is the lack of designated office space. Patients must wait for the social worker to drop by, delaying the solution of any immediate issue. The second element is the lack of sufficient resources for social workers to directly provide economic and financial assistance or assign it to charities specialised in delivering it and the medical supplies they require. Many participants reported this challenge.

The patient (R.SM) reported in detail the second element:

> *I mean, he should have the ability, for example, for financial assistance. Some patients have financial problems. I wish he can transfer to social security to increase the monthly allowance. The allowance for a pensioner, like me, does not cover home and children's expenses. Sometimes, we get indebted and have nothing left before the superannuation is paid. Nowadays, everything is expensive, and prices have doubled (e.g., gasoline, electricity, water, food and drinks). The age and the monthly allowance from social security do not cover all these expenses.*

The patient (R.KA) confirmed this as an issue. Individuals in the sample did not understand the role of a medical social worker and the type of support he can provide to the patient. There is confusion between being a psycho-social supporter and being a social institution that adopts cases that need financial and material help. Allaying this confusion requires a robust, transparent and consistent initiative to educate patients and explaining the social worker's function straightforwardly and clearly in a manner acceptable to all classes in society at all levels of education and community, different age groups and beliefs.

Patient (M.SA) stated:

The unavailability of the worker sometimes, especially in the afternoon, and there is no one to cover his place.

Another patient (B.DA) added that the lack of a dedicated office and a particular phone number to communicate directly with the social worker is a major problem for them, saying:

In my opinion, there are no problems, but the worker does not have a permanent office. Her presence in the nursing room requires that I contact the nursing to give me the social worker. Otherwise, there are no problems.

Some patients believe that there is no room for any problems because the worker's role is not likely to cause any problems. His role does not go beyond just advice and guidance. Patient (S.SN) stated:

He does not have anything but advice and guidance or health education. Some patients may need advice on health education and familiarising themselves with healthy habits or healthy foods.

Another patient (R.SM) confirmed that there are no problems with the worker and that he helps:

If you mean problems from the specialist, then there are no problems caused by the worker here, but sometimes we need some services from the nursing or doctor, so we ask the worker to be present.

Patients felt that granting the social worker more extraordinary financial assistance powers and medical aids would develop social work services. 14 participants (70%) addressed this issue in the same clear and frank manner. Participant (R.SM) reported:

I mean, he should have the ability, for example, to provide financial assistance. Some patients have financial problems. I wish he can transfer to social security to increase the monthly allowance.

This expectation is far from reality, clearly showing how patients misunderstand the social worker's role and tasks. Awareness campaigns would help patients not blame social workers for avoiding responsibilities that are not theirs.

Patients spoke about the complementarity and harmony between social work and Saudi society. The social worker appears to support some activities and events of interest to Saudi society, such as the celebration of health days and national events. Some patients consider these events useless and a waste of money, which could help patients who need additional economic support or medical equipment. The patients stated:

> *It is better to serve the patient, educate the community and help patients who cannot find beds or treatment (N.AM).*
>
> *If these are the ones in the markets, they are useless because they do not benefit patients. It is a waste of money and needless efforts (M.RM).*
>
> *No, because it is not appropriate. The activities that take place in the Urology Centre are known to all patients and do not benefit people (M.SA).*

Others said that these activities are helpful, and many segments of Saudi society need them as they develop health and nutritional awareness in a way that suits the specific nature of the Saudi society. Patients who expressed the same meaning stated:

> *On the contrary, they are useful to introduce health events, especially for inpatients (S.AH).*
>
> *Yes, they are appropriate and valuable to teach everyone, for example, about the prevention of a particular thing or disease (A.MA).*
>
> *On the contrary, they are useful to introduce health events, especially for inpatients or diabetics (S.SN).*

Patient (R.SM) presented a clear objection to the behaviour of mixing that happens in these events, which is contrary to customs and traditions of Saudi society and religious teachings, stating:

> *I know nothing about what happens inside the hospital. Still, I saw some health campaigns in markets such as the blood donation campaign, the awareness of some conditions such as diabetes and vaccination, and mixing and things not part of our customs and tradition. But God saves us.*

Patient (A.JM) emphasised that compatibility with tradition and Sharia is the most important thing for all, and then comes any other benefit:

> *If it is within the limits of Sharia and tradition, it will be undoubtedly helpful.*

Patient (A.HJ) required that they should commit to religious teachings and the traditions of Saudi society to be accepted:

> *This is a finished basic matter and out of the question.*

Patient (I.FA) indicated a general agreement that they accept any social event or celebration of any occasion as long as it does not violate the customs and traditions of Saudi society and the teachings of Islam:

> *Yes, if there is not mixing in the hospital here.*

4.13 COMMUNICATING WITH A SOCIAL WORKER OF THE OPPOSITE SEX

Most of the patients agreed on the relationship of social work to the development of the role of women in Saudi society. They thought that women's work does not raise their societal status or promote equality between men and women. The Islamic religion and related

teachings provide a solid foundation for Saudi society's traditions and rules that guaranteed women's status, dignity and freedom. Patient statements illustrate this belief:

Patient (A.MA) stated:

> *Women do not need equality. They do not lack anything. They have all their rights, and what you read on social media about the oppression of Saudi women is not valid. They are the mother, the sister, the daughter, and half the society. The parents have the 2030 Vision, which will be the new Saudi Arabia.*

Additional statements supported this view:

> *Women are dignified and honoured, and their status does not need improvement because it's already improved (S.SN).*
>
> *Working under Islamic Sharia and the Qur'an, not social work, guarantees justice and equality (A.KH).*
>
> *Women in society have full rights and are not treated poorly or inadequately (I.FA).*
>
> *Women, whether in the hospital or the government, are dignified and honourable (M.SA).*
>
> *No, religion and Sharia gave women their full rights (N.AM).*

Some social work participants agree with this view while others do not, as illustrated in the first part of the thematic analysis of social workers' responses. Patient (R.SM) indicated that society has changed and developed. There are more opportunities for women to participate in social activities and perform active roles in society like men. He wrote in his answer:

> *Of course, every hospital has male and female workers. Now, society changes, and women take the best chances. Now, they drive cars, and they enter movie theatres. They attend in stadiums. Everything developed regarding women: the social worker should promote equality between men and women, of course, within the limits of Islamic Sharia and without excesses.*

However, 20% (n=4) of patients oppositely answered this question. In their opinion, social work, like any other opportunities offered to women, allows them to prove themselves, their abilities and their skills. Other people can depend on them when they hold appropriate positions, particularly leadership and effective roles suitable for their nature as women.

One patient (M.OT) added:

> *Yes, I expect that, especially with the current state trends in providing and helping women to find jobs and give them their rights.*

There was a positive response to alternative and traditional medicine by 90% (n=18) of participants. A minority (10%; n=2) felt that drug treatment in hospitals is necessary since they are not aware of this type of treatment.

One patient (R.SM) confirmed this majority sentiment:

> *We used them all. For example, Ruqyah and cauterisation from a knowledgeable and capable sheikh benefit, God willing. The treatment of evil eye and envy is Ruqyah; the hospital has no medicine for it. Some ailments in the foot are treated by cauterisation twice or thrice. As for traditional medicine, we used it, and sometimes it works and sometimes not. It should be through an old healer with experience and knows about the traditional therapies such as herbs and ointments, which our father and our ancestors used for treatment.*

Other patients also confirmed this:

> *Yes, traditional medicine, as well as Ruqyah from the Prophetic medicine, can be a treatment, God willing (H.KA).*
>
> *Yes, our fathers were treated with cauterisation and Hijama or traditional drugs, and they were healthy and well (N.AM).*

One patient (M.RM) provided a detailed answer on this subject:

> *Yes, it is beneficial. Prophetic medicine, which was used in the old days, benefited many people, such as dialysis, cauterisation, and Hijama or even Ruqyah. This is part of our religion and the Quran, so it's sure better than hospitals. However, there are no traditional healers now, except in remote areas.*

Another patient (B.DA) confirmed this by listing some health problems clearly and directly in her answer:

> *Yes, I believe in traditional medicine, and it may be more beneficial to me, such as Ruqyah or herbal medicines that help in the loss of appetite and less eating. There are also some treatments for diabetes, such as gum Arabic, as it's very beneficial in reducing blood sugar. My mother has been using it.*

This response views traditional medicine as complementary to clinical medicine, which corresponds with the statement of participant (B.DA):

> *Yes, it's certainly helpful in many cases . . . But of course, medicine comes first. It is more important than going to the traditional healer; it has many efforts and is in constant evolution.*

The patient (A.MA) confirmed this although his health condition is not subjected to the effectiveness of this type of treatment:

> *For my condition, no, but generally, it is helpful for other cases, and I was once treated at (Name). He is a man who fears God and has experience and understanding of diseases, the method of cauterisation (with fire), medicine and reciting the Qur'an on drinking water. He does not require you to pay a specific amount of money or anything. All his work is for God's sake.*

However, this did not prevent some patients from receiving the service from a person of the same gender. Female patients chose to receive the service from a female service provider for psychological satisfaction and more reassurance in explaining the social side.

The patients felt that firmly established Saudi customs and beliefs affect adopting social programmes, social care and even therapy approaches. These customs and beliefs can affect

the social worker's performance and the social work department at the hospital in fulfilling their function as part of the provision of medical services. The members of Saudi society consider the behavioural direction that follows the Islamic teachings and popular traditions emanating from the Islamic religion and faith as a condition for the acceptance of any new social roles for fear of violating the social stability associated with Saudi Islamic culture.

CHAPTER 5. DISCUSSION

5.1 INTRODUCTION

The study proposed to answer the following research questions:

1. What are the perceptions of social workers (towards) the functions and responsibilities of social work in hospitals?

2. What are the perceptions of patients regarding the functions and responsibilities of social work in hospitals?

3. What is the influence of Saudi cultural values on the professional practice of social work in hospitals?

4. What are the challenges and obstacles to providing social care in the hospital from the perceptions of social workers and patients?

Establishing a competency framework for medical social workers sets a benchmark for healthy and efficient practice in Saudi Arabia. The framework describes the expertise, knowledge and values needed for social workers to work in specialized healthcare sectors. The study attempted to determine the role of medical social workers in Saudi Arabia and how Islamic culture and values affect the clinical practice of social work. The study also described the challenges that social workers encounter in their professional practice due to Islamic culture. Findings resulted in four main themes related to the study objectives: 1) the perception of social workers regarding the duties, functions and responsibilities in the hospital; 2) the impact of Islamic culture and religious values on the professional practice of social workers in hospitals; 3) need for staff development and training; 4) challenges facing social workers during their provision of hospital services. Based on the theories and studies

described in the literature review, this chapter compiled observations from medical social workers and patients. The discussion exemplifies the range of emotions that this multifaceted issue elicits in both patients and medical social workers. Rather, it provides insights into the professional practice of medical social work and the issues that practitioners face. Social workers frequently collaborate with other healthcare professionals in hospitals, and patients' view on social workers and their interactions with other medical professionals is essential for the hospital's smooth operation.

Research identifies the social worker as a key agent within the health care framework by hospital healthcare providers, who recognized that the social worker's role and connection to the community were critical components of good hospital practice (Davies and Connolly 1995). The social worker relates to the medical, emotional, and psychological needs of patients. A lack of appreciation for the social worker's efforts and functions may be due to a lack of awareness and knowledge of the social worker's role in the health sector, as was the case in this study.

5.2 PARTICIPANTS

Among the social worker participants (n=24), 45.8% (n=11) were female and 54.1% (n=13) were male. 22 (91.6%) have direct qualifications in social work. 11 (46%) of the social workers have one to five years of work experience, while four (16.6%) have five to ten years of work experience, and nine (37.5%) have more than ten years of work experience. Females have an average of 5.6 years of experience, while males have an average of 10.5 years of experience.

A review of peer-reviewed journal databases found no published studies on gender disparities in professional practice in social work. However, detailed studies in other health-related professions indicate that specific gender disparities affect practice (Yuen and Skibinski 2012).

Gender differences may affect the therapeutic interaction within the framework of social work. The ultimate aim of the social work counselling partnership is to strengthen the client's intrinsic capabilities and capacity to access external resources. People view the therapeutic interaction within each gender community as being affected by individual beliefs, values, and experiences.

Social worker participants with over 20 years of experience as medical social workers had a different perspective than those with fewer than 20 years of experience. There is an inverse relationship between years of experience and the likelihood of contributing to professional development and evaluating patient outcomes. However, these results are not generalisable due to the small number of participants. It is difficult to ascertain why these differences exist without further research. The social workers' practice environment has changed significantly in the last 20 years, as have the expectations for social work professional development. Participants with more than 20 years of experience may perceive less need for such activities, particularly as they have extensive practice wisdom. When they were novice practitioners, social work qualifications were only just becoming readily available. The majority of social workers entered the profession without formal social work qualifications.

5.3 THEME ONE: SOCIAL WORKER ROLES

5.4 Social Worker's Perception of Their Role As Medical Social Workers

Moghis (2006), in the study entitled 'Factors Affecting the Performance of Workers in the Department of Social Work in the Medical Sector', aimed to classify factors affecting the performance of social workers in the Department of Social Work in the Riyadh Medical Complex. One of the most significant results of this study was the wide variety of services offered by social workers in the Department of Medical Social Work at the Riyadh Medical Complex. These services included practical, educational and recreational elements, with most

emphasis on the practical components. Social workers in the Social Care Department are mainly involved in delivering care to people with special needs. This service is often available and other types such as child cases, emergencies, various cases of abuse, special cases, surgery and cases of kidney failure. Social work in the medical field is one of the most critical areas of professional practice in the country.

The social worker plays an active part in complementing the rest of the medical staff, the nursing team and the technical team, whether in the clinic, radiology or physical therapy, eventually leading to outstanding health services and improved social care for patients. The data demonstrates that social workers perceived their role of facilitator and liaison as important. This role encompasses enabling the communication between patients, families and the multidisciplinary team to help the hospital team understand the patient's and the family's perspectives. The social worker liaises with the doctor to ensure that the patient diagnosed as disabled receives all the information and supporting documents needed to apply for a disability grant. Participants described additional roles of attending family conferences and providing supportive counselling to a family during diagnosis.

One of the sub-themes that arose from the data discussed by the social worker participants in this study is the educator's role. As educators, social workers have a vital function in enhancing hospital communication, interaction, relationships and understanding. Social workers believed that their position as educators was important in delivering psychosocial education and conducting therapeutic group therapy sessions. This is a key finding within the mesosystem of social workers' interaction with patients, families and the multidisciplinary team (MDT). Social workers have an essential role in educating the patients and families on medical terminology and the different options for available care.

They also strive to improve the communication and understanding among the multidisciplinary team members, the patients, the family and the caregivers (Purnell 2002). Social worker participants discussed their role as educators, educating the doctors and other multidisciplinary team members on the importance of involving the social worker at the point of diagnosis.

Social work participants found patient involvement difficult when they have not received their medication when bedridden or at the end of life. Their role is to educate communities about their various roles and responsibilities, and services from social workers' viewpoints. These results are consistent with previous studies that explored social workers' role in strengthening coordination between the multidisciplinary team (Hartman-Shea et al. 2011). The study found that participants discussed their role as brokers, linking patients and their families with the required resources or referring them to such resources. This role is helpful for those patients who are no longer able to support themselves and their families. Social workers serve as brokers, providing patients and their families with information and linking them with funding sources (WHO 2016). This interaction (i.e., linkage) between social workers and patients is the outcome of an interpretive process. Social workers try to understand the patient in the context of the ecology of different approaches, such as the broker's role in linking patients with resources at the macro level, help social workers realize and appreciate other realities.

This study revealed that the social worker role as an assessor is critical in healthcare provision. This study showed that social workers in health care environments (i.e., hospitals) play a vital role in carrying out holistic assessments, which means that they must assess the patient as a whole (physical, emotional, social and spiritual). This is consistent with the literature, which describes the assessment as a core feature of social workers delivering healthcare (WHO

2016; McCormick et al. 2010). The meaning of the assessment varied for each respondent. Those who considered medical social workers to be discharge planners perceived assessment as a means to 1) establish the reason for referral to the social worker; 2) assess the support systems of patients; 3) investigate the social backgrounds of the patients; 4) help the family in decision-making about the patient's care and treatment options and 5) determine what is needed to discharge the patient. To others, assessment meant a method for evaluating the patient's 'state' ('state' refers to the patient's physical, emotional, social and spiritual dimensions). Social workers' role in carrying out assessments can also include deciding whether patients need a disability grant. Other respondents described it as a means of recognizing how the family accepts the patient's condition and what they should do to support and provide for the patient. These definitions of assessment were consistent with the literature (Hartman-Shea et al. 2011). Social worker participants viewed and addressed their role as advocates as essential for better patient care. This result is in agreement with McCormick's work (2011). This finding from the participants means that social workers with diverse backgrounds, knowledge, expertise and commitment to social justice can act as advocates and champions for the most vulnerable. Additionally, their patients are repositories with stories of courage and resilience in the face of life-limiting diseases. Social workers encourage self-determination and patient control and deliver health services and assistance from a strength's perspective. Social workers evaluate the medical culture respectfully and constructively and advocate on behalf of patients and their families. Often in the hospital, patients may be too weak to express their opinion on the treatment process. The patient and family may feel intimidated by the multidisciplinary team and the professional language and atmosphere. Through advocacy, social workers in primary care settings help the patients and the family articulate their needs and wishes and find ways to reconstruct normalcy after the major disruption of a life-threatening illness.

The in-depth interviews of the social workers revealed that the most prominent role identified as providing significant psychosocial support and counselling to patients and helping patients and their families solve problems that hinder the treatment process. The consensus of all social worker participants was that social workers identified themselves to patients as counsellors and support persons. Social worker participants responded to questions about the role and function of social workers by saying that they are aware of them and are familiar with their daily activities. Still, that specific work-related policies and processes are ineffective. They also mentioned a lack of funds and moral support and a desire to improve their working environment. Their role as counsellors is significant when they are sitting with hospitalized patients and families (Abdel et al., 2006). Listening to patient narratives and offering help during difficult periods is crucial to providing appropriate health care. The study found that the social work participants perceived role as counsellors included helping patients cope with the diagnosis of a life-limiting illness. This finding focuses on the acceptance of a diagnosis, forgiveness, self-worth and positive thinking medication adherence.

5.4.1 Patients' Perception of The Role of The Social Worker in The Hospital

25% (n=5) of participating patients believe that a social worker's job is related to economic aid. While 40% (n=8) of the patients were not expecting services from a social worker, 45% (n=9) of them were aware of a social worker's function. The lack of familiarity with the social worker's function was evident through the answers of the patients. This may be because the social worker's job is new to them, or they have not met a social worker before. However, 90% (n=18) of the patients agree found the social worker helpful. This finding indicates that the social worker is a supportive and acceptable factor for patients and may contribute to their emotional and psychological recovery.

Participating patients found the social worker to be a grief and spiritual counsellor, preparing the patient and the family on death and dying issues. Social workers provide bereavement counselling, which helps the patient and the family cope with a loved one's death (WHO 2016; Reith and Payne 2009). Reith and Payne (2009) argued that the social worker could facilitate the therapeutic process to promote emotional healing and closure for the patient and the family through the loss and transformation of the grief process. Navigating the grief process involves psychosocial assistance, meeting patients' physical, emotional, social and psychological needs. This also corresponds with the findings of the WHO (2016), which indicated that social workers promote treatment coordination by evaluating and promoting psychosocial education. In addition to assisting patients and their families, two of the patient respondents in this study highlighted the role of medical social workers in providing support to the medical staff, confirming Al-Sahli's (2009) findings. The study showed that the main functions of liaison and facilitator between the patient, family, and staff to enhance contact suggested by both patients and social workers in the current study are compatible with previous studies (Al-Sahli 2009; Hartman-Shea et al. 2011).

The findings from the analysis of the participants' responses are consistent with Ibtisam (2008), which found the social worker's role in medical institutions and the facilities to support the performance of his role. The main findings of the study (Neil 2009) were:

1. The social worker has a vital role in forming a good relationship between the patient, the medical staff, and the nursing team.
2. Working on integrating the patient in the medical community and improving the social relationship between the hospital segments.

Human behaviour is the outcome of several forces, physical, emotional, social and moral. Man is an integrated unit. Social work is a profession of integration, dealing with

psychological and emotional dimensions as medical professionals take care of the physical dimension of patients. Thus, the close relationship between the social work and the medical profession embodied by the social worker is confirmed. It strongly affects the patient who embraces any medical systems that he may object to or fear, such as advanced surgeries or rehabilitation strategies with substantial side effects. There is a clear correlation between social work and medicine. Some patients have clarified that physicians do not devote enough time to patients to engage in appropriate discussions about their health status. Such conditions and circumstances necessitate the participation of the social worker in promoting communication between the doctor and the patient, as well as the patient's nursing staff. It is not just the social worker's responsibility. Still, it can assist in resolving a patient's problem (e.g., interacting with the doctor and nursing staff), addressing the patient's medical and health difficulties, clarifying the necessary surgical procedures and their benefits, and clarifying all aspects.

5.5 THEME TWO: IMPACT OF CULTURE ON MEDICAL SOCIAL WORK PRACTICE

This study found that Saudi society's dominant social practices and traditions, such as respecting the prevalent ethics, culture and teachings of the Islamic religion by forbidding the mixing between men and women, impacted social work services. These findings were also in line with the previous section results, which confirmed gender differences as one of the obstacles social workers face during service provision.

Study results indicated a prominent theme of (a) religious practise and use of prayer, (b) religious festivals, and (c) the Saudi religious system, including the religious police. Purnell (2012) clarified the theme of 'spirituality as something more than formal religious practises related to faith and affiliation and the use of prayer’. An important initial theme concerns the

practise of religion and the use of prayer. As Purnell (2012) points out, a healthcare provider who is aware of the patient's religious tradition and spiritual needs is in a stronger position to facilitate culturally responsive healthcare. This observation is consistent with Jirwe et al. (2006), who stated that cultural awareness indicates a self-awareness that requires understanding one's attitudes towards patients from other cultural backgrounds. Without such understanding of one's attitudes, healthcare staff may impose their own culture on others.

Issues occur when patients, families or staff impose their religious values on non-Muslim staff. One example from the research is a male doctor who believed he had the right to impose his spiritual values on female social workers. This imposition resulted in bad feelings and impacted working relationships. According to participants, there is a firm connection between Saudi culture and faith, unlike other cultures. Belief affects people's perception of the Saudi ethnic community. It is difficult for Saudi people and social workers to abide by people who have no faith or lack knowledge about various religions, creating barriers. For instance, medical social workers feel that some Saudi and Muslim communities who took prayer breaks to fulfil Islamic ritual requirements were avoiding work. These findings are consistent with Amutairi et al. (2015), who suggested that the attitudes of some Saudi staff compromise patient care. Expatriates complain that in Saudi Arabia it is more acceptable for staff (such as smokers) to take unscheduled breaks during the day. This departure from the Western tradition of short breaks during the workday may cause tensions among staff members.

There is an essential need for non-Muslim groups to acknowledge Muslim cultural and religious requirements and practice to facilitate their working relationships. Issues can also arise between staff from different sects of the same religion (e.g., Sunni and Shia Muslims, Catholic and Protestant Christians). Social worker participants described a need to show

respect and not let this affect working relationships. Learning about other religions might facilitate improved connections, as well as increase knowledge about different cultures.

It is necessary to teach Islamic and cultural practises practices to specialists to mitigate challenges and issues. The theme of 'religious festivals' can also become a barrier amongst workers. An example is the imposition of the Muslim tradition of fasting during Ramadan on non-Muslim team members. However, organisations can provide a cafeteria and coffee shop available to non-Muslim workers, although it is not permissible to eat or drink in public during Ramadan.

Cultural context or the ethnicity of healthcare professionals affects the perception of that culture (Seago 2000; Staten et al. 2003). UK healthcare decision-makers have started to consider the need to meet the religious and cultural interests of minority communities in healthcare organizations (Vydelingum 2006). As a result, the strict application of the 'Saudi religious system, including the religious police', is an indirect barrier to non-Saudi staff within the Saudi system. Religious men have the authority to comment on others (e.g., to ask the female social workers not working with patients who are male). According to Percot (2006), social workers generally like living in the Gulf region, except in Saudi Arabia. The laws of this country adversely affect women and Christians. Religion encompasses public and private social life and everyday activities in politics, economics, fiscal policy and working life (Almutairi, McCarthy and Gardner, 2012). Religion plays a vital role in Saudi society and requires the attention of the multicultural workforce. Demonstrating the various aspects of Saudi Arabia's way of life and how the strict application of the religious system affects multicultural workers in hospitals is essential to promoting understanding and tolerance in society (Almutairi et al. 2012).

Chapter Three indicates that the Purnell model of culture competence (2000) consists of 12 domains, flowing from general to more specific phenomena. In line with the Purnell model of culture competence domains, participants reported on the theme of healthcare practitioners. There is an interconnection between healthcare, family, organisation, and spirituality. Responses reflected this interconnection and were consistent with the themes of 1) traditional versus biomedical practitioners and 2) status of the healthcare provider.

The researcher considered that the gender of the social worker was a critical and influential factor in communicating with patients. 55% (n=11) of patients stated that there is comfort with the same gender in understanding and narrating the health, social and psychological problems flexibly and smoothly. Female patients may feel that a female social worker will understand their psychological and emotional needs. Gender differences are an influential and sometimes disruptive factor in the medical process.

Purnell (2012) also viewed the gender of the healthcare provider as significant. Saudi cultural traditions sometimes interfere with social work practice and cause barriers to patient care. A Saudi Arabian female social worker's refusal to touch a male patient affects her role as a social worker. This refusal may lead to conflict with other colleagues. A similar situation may arise with female patients and a male social worker. The female patient's cultural values influence the relationship. Purnell (2012) demonstrated that not all ethnocultural groups accept care from someone of the opposite gender, and patients may feel uncomfortable and refuse care as a result. Participants mentioned organisational barriers when male-to-female assignment restrictions are in place. There is a role limitation for male social workers in Saudi organisations. As a result, participants described the 'Status of Health Care Provider' as a significant barrier between medical social workers and patients. Participants agreed that Saudi hospitals' hospital culture, headed by doctors and males, is similar to other organisations.

Hospital culture influences the interaction between social workers and patients, as patients and their families listen to doctors, even though the social worker knows more about patients' conditions. Junco, Dutschke and Petrucci (2008) refer to the social system in Saudi Arabia that perceives men as responsible for both the family and community. According to Purnell (2012), patients' respect for social workers is comparable to their respect for physicians. This is the reverse of participants' perception of the Saudi view of social workers. Participants saw social workers as being of lower status, influencing the level of collaboration. Social work is a relatively new profession in Saudi Arabia. This finding may reflect a lack of awareness of the role of the social worker in hospital settings.

Similarly, many articles indicate that cultural differences related to assertiveness influence how healthcare colleagues view each other and act in the workplace. Specifically, Harner et al. (1994) found Western social workers to be more assertive with physicians and males than others. The concept of social workers being dependent on physicians and men is inseparable from the Muslim idea of a woman being subject to the husband, fathers and elder brothers (Harner et al. 1994). The findings demonstrate the dominant male culture and a doctor's role in their culture, as seen in a leadership position. This impacts their performance and creates conflict with social worker colleagues. Western social workers are seen as assertive and firm since they challenge rather than simply follow, leading to tension between Western social workers and Arab male managers. Cultural norms influence leadership style, and therefore that conflict may be due to the cultural diversity between social workers and their hospital managers (Carland 2008; Hale and Fields 2007). Based on the participants' responses, the significant observation is that Western social workers can self-facilitate cooperation and respect physicians and male staff by speaking out and standing up for themselves and their patients. Doctors and male staff value this trait in Western social workers. According to Wilson (2007), the qualifications, skills or competence of a social work professional have

minimal impact on the likelihood of experiencing racism in the workplace. Generally, study responses of the patients indicate satisfaction with social workers. This study's findings align with the conclusions of Kuokkanen and Leino-Kilpi (2001) regarding what makes an empowered practitioner. They found that the following components promote empowerment: 1) moral values, 2) considering others with respect, 3) acting justly, 4) personal integrity, 5) looking after your health, 6) challenges to speak and work, 7) operating efficiently under pressure, 8) acting flexibly and proficiently, 9) making decisions, 10) acting independently, 11) discussing and communicating with colleagues, 12) finding creative explanations, 13) encouraging new ideas, 14) sociability, 15) working for a common goal and 16) solving problems. These qualities are essential for collaboration and empowerment. Findings from this study indicate that social workers in Saudi Arabian hospitals were not as assertive as their Western counterparts.

5.6 PATIENT VIEW OF THE IMPACT OF ISLAMIC CULTURE ON SOCIAL WORK PRACTICE.

The study interviews provide evidence of the cultural competence of the social workers. Patients agreed on the importance of their cultural and religious values when receiving the social worker's help.

The majority of patients reported that the social worker's work complements the Saudi cultural and Islamic religious customs. The social worker supports some activities and events of interest to the Saudi society, such as the celebration of health days and national events.

Social work participant responses indicated a familiarity with the customs, traditions and religious beliefs of the hospital's social services provision. They emphasised the need for flexibility in working and accepting others, regardless of their customs, beliefs, religions and communicating with all patients. In this regard, one participant stated that *'The social worker*

must sometimes take into consideration the tribal values of the client he is meeting' (participant SF4-NAH). At the same time, social workers appreciate the need to communicate with the individual, familial, tribal and societal environment. Saudi culture and the Islamic religious spirit influenced the social worker participants' answers. Goodness, generosity, tolerance and concern for the patients' psychological and health characterised social worker behaviours. The social work participants shared some concerns about the impact of gender on their work. They support what is consistent with the cultural beliefs and practises of patients.

Aiken et al. (2012) indicated a correlation between positive nursing outcomes and a supportive work environment (i.e., positive doctor-social worker interactions, social worker involvement in decision-making, administrative respect for social workers and organizational objectives quality of care). In this regard, the organization and nature of the colleague relationship differed according to staff background.

5.7 THEME THREE: NEED FOR TRAINING AND PROFESSIONAL EVELOPMENT

The study participants highlighted boundary concerns with staff and social workers being unrecognized and unappreciated. The conditions defined by the participants include 1) failure to recognise the qualifications and role of medical social workers; 2) the role of social workers in delivering counselling; 3) psychosocial support; assessments; 4) preparation of discharges and management of heavy caseloads. A multidisciplinary care team tends to distinguish health provider functions. For example, medical social workers have different roles than nurses, doctors, administrators, or dieticians (Yuen and Skibinski 2012). Clear separation of responsibilities prevents miscommunication in delivering treatment to patients and promotes successful teamwork.

On the other hand, some health social workers favour supervisors and supportive managers who understand social workers' time and needs in healthcare environments. Supervisory support allows participants to address critical issues with their managers, process cases and brainstorm about activities. Teamwork is a core aspect of patient care and fills the gap in training within the multidisciplinary team. Teamwork enables each member to adequately address and respond to the different psychosocial needs of the healthcare patients.

The study noted that job overload, misunderstanding of the social worker's role, heavy caseloads, and insufficient resources negatively affect study participants' well-being, leading to social workers feeling stressed and over-extended.

1. The current research results were consistent with the findings of Arafa (2015), which sought to recognise the challenges encountered by the social worker in the hospital and the motivation for success as one of the aims of the study. The lack of social workers in the hospital summarises the multiple observations found in this study.
2. Most social care practitioners have prior work backgrounds in specialities other than social work, such as sociology.
3. Lack of training programs that develop the skills of the social worker

5.8 CHALLENGES FACED BY SOCIAL WORKERS

One of the research objectives was to identify factors that hinder social workers' ability to deliver quality healthcare to patients. This study finds that social workers in primary care environments encounter a variety of challenges, including 1) their role as social workers; 2) lack of health education and training; 3) lack of in-service training; 4) lack of continuing education and health research; 5) obstacles to communication; incomprehensible medical jargons; 6) lack of specialized medical social workers and their workloads; 7) the well-being of social workers; 8) lack of supervision, 9) lack of debriefing and management support; 10) lack of respect for the role of social workers in the provision of health services; 11) lack of

hospital beds and other factors that hinder the ability of social workers to provide proper healthcare.

Some findings agreed with the results of the analysis of the responses of the patients in this study. Hospitals focused on providing comprehensive medical and therapeutic facilities, including psychiatric and social support, as an additional therapeutic benefit for hospitalised patients. It focuses on enhancing the quality of therapeutic care for patients and supplying them with adequate services in compliance with Saudi culture's customs and traditions and the teachings of the Islamic religion, and the sense of social responsibility and humanity that social workers display. In this regard, Saudi society seeks to fulfil Saudi Vision 2030 (a strategic framework to reduce Saudi Arabia's dependence on oil, diversify its economy, and develop public service sectors such as health, education, infrastructure, recreation, and tourism) to promote the health of Saudi Arabian society.

Caring about a patient who is going through the dying process impacts those involved emotionally. It is possible to interpret role overload as contributing to the stressful circumstances in which social workers operate. Social workers can experience burnout because of the ongoing medical challenges (Zuhur 2012). Social workers experienced role stress when doctors and other healthcare professions do not consult them around patient treatment planning. Participants had feelings of inadequacy about the level of treatment they can offer due to role overload. Therefore, it is crucial to ensure that social workers take on proactive educational tasks concerning social workers' roles. The medical social workers noted the need for more time and fewer cases to improve their healthcare functions.

Since there is no clear description of social work among members of Saudi society, they often confuse it with financial assistance and solve the general problems that obstruct their medical care, including economic issues. For example, (H.KA) claim that *'one of the principles of*

medical social work is to address the problems of patients in the hospital, whatever their sort, even their financial problems, and not offer the care they need'. There is a consensus that medical social care is one of the most relevant fields of social work. Medical social work enables the patient's capacity to resolve the challenges that impede the success of their social role. It deals with the social worker's clinical efforts in the medical institution and with the various contexts of the patient to improve and reach optimal social efficiency as soon as possible (Judith et al. 2016).

The participants indicated that medical social workers enhance medical practice. Communication breakdowns between healthcare professionals occur for many reasons. The literature addresses professional communication breakdown (Beresford et al. 2007). This study indicates that efficient communication and teamwork enhances effective patient treatment. Differentiation of roles in the multidisciplinary team helps define individual responsibilities. The results of this study indicate that the lack of consultation with the social worker on discharges of patients and late referrals from doctors contributes to inadequate health care for patients with life-limiting diseases. Participants experienced a lack of social worker involvement and gaps in referrals to the social workers from the doctors and nurses. These considerations hindered the ability of social workers to provide sufficient treatment. All of the participants experienced some communication difficulties in delivering healthcare. They also experienced heavy caseloads due to the shortage of staff, as one social worker participant (SA3-MM) commented:

> *In terms of communication, I think . . . it can be that sometimes we got too busy here given our workloads.*

Many cases assigned to each of them represents another barrier to effective communication in the team. Because of their customs and traditions, some Saudi tribal patients had issues

with social workers. The social worker in these cases needed to emphasise the importance of adhering to existing health protocols and doctors' instructions. This study discovered a communication gap among healthcare professionals at various levels and suggested communication training for the multidisciplinary team.

5.9 IMPLICATIONS FOR PRACTICE

The researcher used the Purnell model of cultural competence as the theoretical framework to explore a workforce where social workers are culturally different from the patients for whom they care. At the start of the research, the theoretical framework seemed efficient to guide the research and examine the research problem. The cultural differences among the social workers and patients could be due to different origins as some of the patients are non-Saudi.

The Purnell framework conveys an explanatory power in the study, as it integrates some of the subtle nuances of cultural behaviour and beliefs. The model explains different exogenous and endogenous variables that determine individuals' cultural patterns and social work profession. The study illustrates a variety of culturally diverse practices and beliefs that could inform cultural knowledge. For example, the nonverbal communication component, such as body language clues, may have different contextual implications depending on the culture; this corresponds to the Purnell domain of Communication. Purnell's domain of Family Roles includes the family structure which entails the gender roles (i.e., head of the family), family role (i.e., collective versus individual family members) and the extended family network which may be different among cultures. The Purnell domain of Spirituality and Healthcare Practices speaks to social work and healthcare practises, such as folk practises and health response. These emerging themes are essential factors in understanding the professional

practice of medical social care and the many cross-cultural barriers that arise, as reflected in the domain of Inhabited Location in the Purnell model.

There is considerable diversity among the social worker participants in how medical social workers in Saudi Arabia provide healthcare in the primary care setting. Responses were vague when discussing medical care as the basis for work. This study evaluated the social worker's role in the provision of healthcare, which was in line with the first research objective of the study. In interpreting the findings on the implications for healthcare practice, this study found that only a tiny proportion of their work focused on healthcare. The majority of the social worker participants' daily tasks did not include a specialised focus on medical care. This may be due to a shortage of social workers in Saudi Arabia, a lack of resources for specialisation as medical social workers, and multidimensional roles as social workers in hospitals, communities, and medical care, confirming the influence of the domain of Workforce Issues in the Purnell model.

The Workforce Issues domain of the Purnell model continues to impact discussions of time and workload constraints; many social workers stressed that it was challenging to meet the competency requirements. There have been few studies on the time and workload pressures that medical social workers face (Yamatani et al., 2009). High workloads lead to high employee turnover, burnout, feelings of frustration and demoralisation (Yamatani et al., 2009). Social worker workload concerns remain unchanged despite significant social work services provision (Douglas et al. 2014). De Kerckhove and Vens (2014) suggest that social workers do not get a reprieve in their day-to-day routine from dealing with people at their most vulnerable. Demoralisation and burnout may result from the stress of working with vulnerable people. Additionally, De Kerckhove and Vens (2014) believe that persistent stress

arises from perceptions of loss of control and feelings of ineffectiveness. Such feelings can prevent social workers from perceiving positive results from their work.

Heavy workloads and insufficient time to complete tasks influence a social worker's ability to meet practice standards. Workload complaints are symptomatic of feeling dissatisfied, demoralized or ineffective. It is difficult to determine how the workload and time pressure affect professional practise standards because of the lack of research into social work in the health sector, particularly in Saudi Arabia. The comments made by social worker participants indicate that they feel compromised by heavy workloads and time pressure. Some of the respondents could have job dissatisfaction, and different performance expectations contribute to being under pressure. There is an expectation that social workers have up-to-date knowledge and skills to practise social work. Without learning and sustaining these attributes, they cannot purposefully work with clients. Knowledge and skill maintenance, and therefore competence, is not a static method. Ongoing professional development has to be a lifetime mandate if social workers claim to be a profession. De Kerckhove and Vens (2014) proposed that an intrinsically inspiring, effective change agent is professional development. Schools for social work do not provide social workers with all the experience and expertise they need for the lifetime of their career (Loftin et al. 2013). Therefore, the need for professional development allows social workers to stay up-to-date with the latest products and improves essential skills in reflective practice, self-awareness, and client understanding (Loftin et al. 2013).

Competence does not solely mean social workers possessing the necessary knowledge and skills to perform the work, but the quality of their practice as well. Continuous professional development is essential for developing high-quality, skilled practice (Mareno and Hart, 2014). It allows some social workers in clinical practice to be actively interested in

postgraduate study, research activities and writing for peer-reviewed publications to improve the social work profession. However, to ensure their practice is of high quality, individual social workers do not always need to undertake these activities. All social workers participants in the study agreed that professional development should be part of a competency framework.

Five social worker participants expressed dissatisfaction with nurses and doctors who do not adequately assess or diagnose, confirming the importance of the domain of communication in the Purnell model. Moreover, doctors do not often refer patients to social workers, which adversely affects social workers' time and workload. Another aspect that adversely affects medical social work is the lack of sufficient bed space in the hospital. This lack of capacity leads to the discharge of patients with advanced life-limiting illnesses or at the end of life to die at home without consulting the social worker and family members. Social workers perceived this as a factor affecting the ability to provide appropriate care, resulting in a lack of necessary guidance and support for the patient and the family, as indicated in the healthcare practices domain of the Purnell model.

In the event that social workers and family members are not consulted prior to the patient's discharge, lack of proper referrals and inappropriate teamwork is a healthcare system issue. Participants in this study encouraged doctors to consult with social workers before discharge and refer patients to them, as reflected in the communication domain of the Purnell model. Based on the findings related to the challenges facing the social workers in hospitals, this study advocates that the Saudi Arabian government dedicates special medical care or social care unit to patients.

Additionally, the study's findings establish an inconsistency in healthcare practice and confirms Purnell's findings in the domain of Healthcare Practices. Social worker participants

who worked at the national referral and the intermediary hospitals expressed satisfaction and positivity about healthcare management in their respective settings. They reported having specialised, trained healthcare professionals in their MDTs providing care. Some social worker participants, for example, discussed a comfort level on their perceived confidence when delivering healthcare. Whereas 79% (n=19) of the participants felt competent to provide healthcare, 20.8% (n=5) of the participants had a varied comfort level about healthcare provision; for example, one of the participants did not receive palliative care training

This study indicates a difference in the levels of education and training of social workers in primary health care environments and a gap in confidence in social workers providing healthcare. Mareno and Hart (2014) found that healthcare training increased the performance of medical social workers. Further research is needed to understand better the effects of healthcare training for medical social workers. The purpose of improved medical care training is to limit inconsistencies in the social work of healthcare in the field. Critical issues presented and analysed in Chapter Four and further interpreted in this chapter of this thesis include: 1) participants' perceptions and satisfaction with the provision of healthcare services and with the role of the social worker in the provision of healthcare, 2) perceptions on interactions with patients and family, and 3) perceptions about interactions with the multidisciplinary team and skills needed as medical social workers.

There is an agreement between social workers and patients. They agree that social workers need to: 1) apply the regulations; 2) reach the goals; 3) follow the programs of quality control; 4) maintain the levels of safety, environment and infection control standards of each department; 5) speed up the provision of direct social care to patients; 6) identify their problems related to the health and social situation and their relationships with other patients, nursing staff and medical staff; 7) find appropriate solutions to them; study, analyse and

evaluate the information contained in the medical treatment plan and match it to social service programs to develop the appropriate treatment program for each patient to the maximum benefit possible; 8) determine patient eligibility for free treatment or access to means and devices, assist or providing an appropriate transportation; 9) raise awareness among patients of the nature of the disease, the prescribed medicine, its effects, its consequences and how to take or apply it; 10) assist patients in understanding, accepting and following the prescribed treatment system and medical recommendations; 11) work with patients, doctors and nurses in the hospital and the staff of external institutions cooperating with them in the preparation and implementation of health treatment plans to be followed when the patient exits the hospital; 12) identify and use the resources available to help patients with health needs to resume their everyday lives in the community; 13) teach them how to live, accept and interact positively with their conditions to reach the required recovery; 14) prepare official reports required by the management of the hospital in the field of social work; 15) and review and maintain the monthly, quarterly and annual statistics when appropriate.

Participants generally agreed with Bridget and Meagan (2019), who state that social workers should continue education and stay current with practice innovations in social services.

5.10 SUMMARY

The chapter presented an in-depth interpretation of the data gathered on patient and medical social worker views on the role and challenges for medical social workers in providing healthcare to patients. The Purnell model of cultural competence is a practical approach to determining competencies for operating in a multicultural environment and ensuring that medical social workers are culturally competent.

This study suggests that the model should incorporate additional themes, such as fairness and injustice in the workplace, empowerment and disempowerment, and cultural differences. The

studies show that in creating a constructive grounded model of the roles of medical social workers in healthcare provision, the multidimensional roles of social workers within the healthcare system should be outlined. Medical social work in the KSA can build on the national government's commitment towards the global resolution of healthcare by the World Health Assembly (WHO 2014). The WHO (2014) called upon WHO and member states, to which Saudi Arabia is a signatory, to improve primary healthcare access as the central aspect of health systems, focusing on primary healthcare and community care. Medical social work seeks to 'help individuals to live and die well', and it envisions an 'integrated social and healthcare' strategy (Department of Health 2010). According to this study, social work, with its culture, ideas, and patient experience, is qualified to fulfil this role in fostering social and therapeutic integration. It is also worth mentioning that several of the issues raised in this study are not specific to social workers. For Saudi and non-Saudi patients, the cultural barriers to providing healthcare to the opposite sex, particularly female patients, could be challenging topics. Therefore, this study recommends that health care administrations consider developing policies and rules to resolve these challenges.

Social workers play several responsibilities in primary care settings, and this research showed them to be multidimensional. They can be an assessor or an advocate or a discharge planner or a liaison or a facilitator or an educator or a therapist. Other healthcare professionals do not recognize that social work roles hinder social service delivery, with social workers receiving insufficient support in these fields. At the social work undergraduate level, there are limited healthcare practice opportunities for social work students. The study uses the required building blocks to strengthen the concentration of practical social work opportunities in medical social work to enhance continuing education. Cultural competence is essential for effective collaboration among medical social workers through acknowledgement, awareness of cultural differences and sustained sensitivity to Saudi Arabian patients' needs.

Finally, the study advocates for policy guidelines and asserts a need for research to identify approaches for improving medical social work. This study has added to the current literature by identifying variables for a comprehensive understanding of medical social workers' skills and roles perceived relevant to the job. Appreciation of the medical social workers in their environment is essential (Bomba et al. 2011).

As medical social work begins to evolve, social workers in Saudi Arabia will be required to be on the frontlines by providing administrative duties, care and effective policy on the macro-level. The next chapter offers general conclusions and recommendations for the entire study.

CHAPTER 6. CONCLUSION

6.1 INTRODUCTION

This chapter provides a summary of the essential findings and recommendations and concludes the discussion. The study aimed to determine the roles of medical social workers in Saudi Arabia and determine how Islamic culture and values influence social work professional practice. The study also sought to understand the challenges that social workers face in their professional practice due to the influence of Islamic culture. As a researcher, I obtained rich and meaningful data, owing to the qualitative nature of the methodology, which opened up new avenues for discovery along the way. The findings of this study produced original and authentic data. The thematic analysis discussed in Chapter 4 and interpreted in Chapter 5 explains how multiple layers of meaning emerged throughout the inductive research process.

6.1.1 OBJECTIVES OF THE STUDY

The study's first objective was determining how social workers perceive their role in providing care to patients in primary care settings in Saudi Arabia. For the most part, key findings from the research demonstrate that social workers' various roles are imperative in providing care to patients. In this study, social workers perceived their roles to be multidimensional. They perceived their roles as counsellors who provide counselling and psychosocial support to the patient and the family in coping with a life-limiting illness; facilitators who provide information around the patient’s treatment and care options; context interpreters; and discharge planners for the patients. Social workers also serve as liaisons between the patient, the family and the multidisciplinary team; refer patients to the next level of care; serve as brokers who link the patients and the family with internal and external resources; and educators to the patient family on life-limiting illnesses. They educate the staff

on different social issues as well. Above all else, social workers advocate on behalf of patients and their families.

The study's second objective was to determine the effect of Islamic culture on the professional practice of medical social care. The Purnell (2002) framework that guided this objective suggests that cultural background forms the individual. Cultural background relates to concepts such as the country of origin, current residence, the impacts of the topography of the country of origin and current home, economics, politics, reasons for emigration, educational status, and occupation (Purnell 2002). In Saudi culture, the family's role, which is also a domain in the Purnell model, is a significant factor in the care facility, as their family-oriented nature can interfere with inpatient care.

Moreover, in this study, participants indicated cultural stereotyping towards certain ethnic groups. Some participants did not accept this attitude, which affects teamwork and collaboration, which influences care. Issues also occur when patients, families, and staff impose their religious values on non-Muslim staff. Ramadan can create barriers to working; while Muslim staff are expected to not work hard during Ramadan, non-Muslim staff can view this as ‘taking it easy', which suggests a lack of cultural sensitivity toward Muslims.

The theme of ‘folk practices’ is evident from this study's results, including practices based on social workers’ spiritual beliefs, such as staff changing medication dose based on mother’s instinct or giving water to patients who should not receive anything by mouth. This is a dangerous practice and is sometimes against hospital policy. The Saudi people generally consider the reason for the illness to be predestination or fate and that this results from God's will (Al-Ghamdi 2010; Lovering 2006). Other cultural attributions of disease are a consequence of supernatural powers such as the evil eye or *Jinn* (evil spirits) possession (Al-Ghamdi 2010).

The Purnell model of cultural competence is a valuable means of identifying competencies for working in a multicultural setting. The study discussion suggests adding domains and themes to the model to ensure that social workers are culturally competent. These include cultural differences, empowerment and disempowerment, and workplace justice and injustice.

The final objective of the current study was to determine the challenges faced by medical social workers. This study found that other healthcare professionals in the hospital do not sufficiently understand social workers' roles. Factors that hinder the ability of social workers to provide care include: 1) the lack of social care in-service training; 2) lack of continuous education and research on social care in Saudi Arabia; 3) communication barriers (e.g., medical jargon used by the doctors); 4) shortage of specialised medical social workers and heavy workloads; 5) multidimensional roles as being generic rather than specialized; 6) the wellbeing of the social workers, 7) lack of supervision; 8) lack of debriefing and support from management; 9) lack of appreciation for the role of the social worker in the provision of social care and 10) lack of hospital bed space. The study established that social worker require several essential skills: 1) clinical skills training, 2) relationship-building skills, 3) understanding of the clinical environment, 4) understanding family dynamics, 5) empathy, 6) listening skills, 7) patience, 8) good communication, 9) organizational skills, 10) self-awareness, 11) knowledge of resources and laws and 12) investigative skills.

6.1.2 RECOMMENDATIONS

This study recommends that organisations with medical social workers adopt the revised Cultural Competence framework to guide social workers' multicultural training and development. The framework can help healthcare institutions manage the multicultural social work profession's complexities, allowing local and international social workers in Saudi Arabian hospitals to continue to collaborate effectively. The study's outcome calls on the

medical social worker workforce to understand that ethnocultural and subcultural populations exist. Sexual orientation, education, socioeconomic status, language and other factors characterise cultural groups. A professional translator with a good understanding of ethics is vital to secure the integrity of social workers and patient safety in KSA hospitals. As such, the study recommends using well-trained translators who could utilise their Arabic skills and foreign language to provide services to medical social workers and patients.

Globally, there is a wide range of training opportunities in medical care social work that provides training for social workers interested in or working in healthcare. From social work students to practitioners, such resources help enhance the competency of social workers who provide healthcare. However, as a medical social work practitioner, educator, researcher, and personal experience, I found that the residual taboo against speaking about death and illness hinders medical care training in Saudi Arabia.

This study found that many patients still visit traditional healers before consulting professionals trained in Western methods; thus, patients present themselves to the doctor at an advanced stage of their illness. Additional education, training, awareness, and research are necessary to eliminate this practice. This study found that most participants indicated the need for in-service training, continuing education, and conferences on medical care for social workers, and logistical support for social workers' offices.

Based on the key findings of this study, the following recommendations and modes of implementation are suggested:

Recommendation 1*: A clear understanding of the role of the social worker among the medical team, the nursing team, and patients should be promoted.*

Implementation:

1. The medical institution develops awareness and education activities within the medical institution.
2. Planning and conducting seminars and workshops that explain the social worker's role in the medical field for doctors, patients, and technical and administrative staff in hospitals and medical institution.
3. Engaging the media in introducing social work and medical social workers to the public.
4. Educating patients and the public about the social worker’s role in the hospital and trying to harmonise with Saudi culture and society

Recommendation 2: *The working environment should be improved and the necessary equipment for the success of the tasks of social workers should be provided.*

Implementation:

1. Create a special social work department within the Ministry of Health to develop social work skills and review the work of social workers in hospitals.

2. Give attention to the incentive and reward systems that allow social workers to obtain psychological comfort and confidence and give them a great incentive to pay attention to social work's success in the medical field and achieve its objectives.

3. Periodically amend and develop the Policies and Procedures Manual, with the need to adopt the latest trends in healthcare to increase the therapeutic and diagnostic specialisation, thus constituting specialized groups in the social work
4. Revise the allowances and entitlements of social workers in medical services and equality with other medical groups

5. Grant the social worker more administrative and financial powers to care for patients.
6. Provide dedicated space for social workers to maintain privacy and confidentiality and allow them to engage clients quickly without delay or harm.

Recommendation 3*: Enhance communication between medical team members and the medical centre.*

Implementation:

1. Create a unique and secure electronic system to register patients' data to facilitate the social worker's work, save information in an archived electronic manner, and accelerate handling and processing.
2. Create a sound and robust system of evaluation and follow-up.
3. Conduct more research on the role of the medical social worker.

Recommendation 4: *Practice medical social services in a culturally sensitive manner.*

Implementation:

1. Ensure that religious and cultural beliefs do not affect them when providing medical social services while strictly respecting them inside and outside the workplace.
2. Accept all patients' groups, understand their situations under any circumstances, and ensure the provision of medical social services to them promptly.
3. Respect the patients' opinions and views if this will contribute to the treatment's acceleration.

Recommendation 5: *Increased attention to continuing education for social workers on current best practices.*

Implementation:

1. Utilise latest research to develop educational and health awareness plans for social workers.
2. Develop a program of evidence-based workshops and trainings on current professional social work best practices.
3. Develop trainings on the impact of Saudi culture on medical social work practice.
4. Develop trainings on the use of the Procedures and Policy Manual.

Critically, all these recommendations are important for those interested in healthcare and medical research, such as health institutions and the research department of the Saudi Ministry of Health. In addition, these recommendations are valid for use by other academic researchers in their future studies.

REFERENCES

Abdullah, H.M., 2011. *Economics of Environmental Resources,* 3rd ed., Scientific Publishing House, Riyadh, Saudi Arabia.

Abed Rabbo, I.Y.B., 2008. *Planning indicators to increase the effectiveness of professional performance for the social worker in the school field*. M.A. thesis.

Abramson, J.S. and Mizrahi, T., 2003. Understanding collaboration between social workers and physicians: Application of a typology. *Social work in health care*, *37*(2), 71-100.

Agnew, E.N., 2004. *From charity to social work: Mary E. Richmond and the creation of an American profession*. Urbana: University of Illinois Press.

Aiken, L.H., Sermeus, W., Van den Heede, K., Sloane, D.M., Busse, R., McKee, M. and Moreno Casbas, M.T., 2012. Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *BMJ*, 344, e1717.

Alagalni, O.A., 2006. *Evaluation of social workers' professional skills*, Riyadh: Naif Arab University for Security Sciences.

Al-Ahmadi, H., 2009. Factors affecting performance of hospital nurses in Riyadh Region, Saudi Arabia. *International Journal Health Care Quality Assurance*, 22, 40-54

Albrithen, A.A., 2009. *Perceptions of formulaic behaviour: An Arabic Constitution for Social Service*. Kingdom of Saudi Arabia: King Saud University.

Albrithen, A. and Yalli, N., 2013. A discussion of professional issues of hospital social workers in Saudi Arabia. *Social Work in Health Care*, *52*(1), 20-42.

Albrithen, A. and Yalli, N., 2015. Hospital social workers in Saudi Arabia: characteristics and functions. *Social work in health care*, *54*(2), 158-176.

Albrithen, A. and Yalli, N., 2016. Social workers: peer interaction and hospital integration. *International Social Work*, *59*(1), 129-140.

Al-dossary, H., Alumran, A., Al-rayes, S., Althumairi, A., Aljanoubai, H., Alhuseini, M., Alkhaldi, O., Al-Fayez, A. and Alanzi, T., 2021. An overview of health information management education in Saudi Arabia. *Informatics in Medicine Unlocked*, 23, 1-5.

Al Fahidi, M., 2012. *Assessment role social medical service primary healthy welfare from the point of view socialists and specialists and patients*. M.A. thesis [unpublished], Naif University for Security Sciences, Riyadh, Saudi Arabia.

Al-Ghamdi, K.M., 2010. Beliefs and perceptions of Arab vitiligo patients regarding their condition. *International Journal of Dermatology*, 49 (10), 1141-1145.

Al-Ghamdi, N. A. 2021. Ideological representation of fear and hope in online newspaper reports on COVID-19 in Saudi Arabia. Heliyon, 7(4), e06864. https://doi.org/10.1016/j.heliyon.2021.e06864

Aljadhey, H., Mahmoud, M.A., Hassali, M.A., Alrasheedy, A., Alahmad, A., Saleem, F., Sheikh, A., Murray, M. and Bates, D.W., 2014. Challenges to and the future of medication safety in Saudi Arabia: A qualitative study. *Saudi Pharmaceutical Journal*, *22*(4), 326-332.

Aljuwair, S. F., 2001. Obstacles facing the social worker in health care units in the State of Kuwait: a field study. *Journal of Gulf and Arabian Peninsula Studies*, 103.

Almaizar, H. and Abdelhamed, Kh.A., 2018. Research Trends in Social Work in Kingdom of Saudi Arabia. *Journal of Sociology and Social Work*, 6(2), 18-26.

Al-Makhamreh, S.S. and Lewando-Hundt, G., 2008. Researching 'at home' as an insider/outsider – gender and culture in an ethnographic study of social work practice in an Arab society. *Qualitative Social Work*, 7(1), 9-23,

Almutair, A.F., McCarthy, A. and Gardener, G.E., 2015. Understanding cultural competence in a multicultural nursing workforce: registered nurses' experience in Saudi Arabia. *Journal of Transcultural Nursing*, 26 (1), 16-23.

Almutairi, A. and McCarthy, A.L., 2012. A multicultural nursing workforce and cultural perspectives in Saudi Arabia: an overview. *The Health*, 3 (3), 71-74.

Almutairi, K.M., 2015. Culture and language differences as a barrier to provision of quality care by the health workforce in Saudi Arabia. *Saudi Medical Journal*, *36*(4), 425.

Alotaibi, A.Sh., Mohamad, M.S., Saim, N.J. and Zakaria, E., 2020. The practice of school social workers in the Kingdom of Saudi Arabia. *European Journal of Molecular & Clinical Medicine*, 7(6), 607-620.

Al-Qabandi, S.A., 2004. Evaluation of medical social work in public and specialized hospitals and planning. *Social Sciences Journal*, 32(3), 253.

Al Qatari, Gh. and Haran, D., 1999. Determinants of users' satisfaction with primary health care settings and services in Saudi Arabia. *International Journal for Quality in Health Care*, 11(6), 523-531.

Alquaib S., 1986. Professional obstacles for a social worker in the school, an unpublished master's thesis, King Saud University, Riyadh, Saudi Arabia.

Al-Sahli, M., 2009. *Evaluation of the social worker's role in Al-Amal Mental Health Complex.* Naif Arab University for Security Sciences, Riyadh, Saudi Arabia.

Al-Shahrani A. S., 2003. The professional practice of social work in hospital settings in Saudi Arabia. Ph.D. thesis, University of Wales, Cardiff.

Al-Shahri, M.Z., 2002. Culturally sensitive caring for Saudi patients. *Journal of Transcultural Nursing*, *13*(2), 133-138.

Alshammari, M.H., Susanto, T., Villareal, S., Indonto, M., and Gonzales, F., 2019. A survey of hospital healthcare professional's perceptions toward patient safety culture in Saudi Arabia. *International Journal of Africa Nursing Sciences*, 11, 1-6

Al-Zahran, S.K., 2011. Social constraints faced by women working in the health sector. Ph.D. thesis, King Abdul-Aziz University, Jeddah.

Ambrose-Miller, W. and Ashcroft, R., 2016. Challenges faced by social workers as members of interprofessional collaborative health care teams. *Health & Social Work, 41*(2), 101-109.

Arafa, A.A., 2015. *The impact of obstacles on the performance of social workers in government hospitals in Sudan*. Khartoum, Sudan.

Atheb, H., 2012. *The social specialist practising in the medical field*. Riyadh: Naif Arab University for Security Sciences.

Awad, H. Ride, N., 2010. The reality of application of the profession of social work in the medical field and its obstacles in Qalqilya and Tulkarm hospitals. *Social Science Magazine Palestinian*, 3 (12), 36-50.

Bell, L. and Hafford-Letchfield, T., 2015. *Ethics, values, and social work practice*. Open University Press.

Beresford, P., Adshead, L. and Croft, S., 2007. *Palliative care, social work and service users*. London: Jessica Kingsley Publishers.

Berkman, B., 2006. *Handbook of social work in health and aging*. Oxford University Press.

Binsalih, S.A., Waness, A.O., Tamim, H.M., Harakati, M.S. and Al Sayyari, A.A., 2011. Inpatients' care experience and satisfaction study. *Journal of Family and Community Medicine*, *18*(3), 111.

Bint Mughais, N., 2006. Factors affecting the performance of workers in social service departments in the medical field. *Journal of Studies in Social Work and Human Sciences – Egypt, 9*, 150-175.

Birukou, A., Blanzieri, E., Giorgini, P. and Giunchiglia, F., 2013. A formal definition of culture. In *Models for intercultural collaboration and negotiation* (pp. 1-26). Springer, Dordrecht.

Bomba, P., Morrissey, M. and Leven, D., 2010. Key role of social work in effective communication and conflict resolution process: medical orders for life-sustaining

treatment (MOLST) program in New York and shared medical decision making at the end of life. *Journal of Social Work in End-of-Life & Palliative Care*, 7, 56-82.

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77–101. doi:10.1191/1478088706qp063oa

Bridget, S. and Meagan, L., 2019. *Palliative care: a guide for health social workers*. Oxford: Oxford University Press.

Brumann, C., 1999. Writing for culture: Why a successful concept should not be discarded. *Current anthropology*, *40*(S1), S1-S27.

Bruno, A., Bates, I., Brock, T. and Anderson, C., 2010. Towards a global competency framework. *American Journal of Pharmaceutical Education*, *74*(3).

Bywaters, P. and McLeod, E., 2003. Social care's impact on emergency medicine: a model to test. *Emergency Medicine Journal*, 20, 134-137.

Campinha-Bacote, J., 2002. The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of transcultural nursing*, *13*(3), 181-184.

Cannon, I., 1913. *On the social frontier of medicine*. Cambridge: Harvard University Press.

Carland, M.P. and Faber, C., 2008. *Careers in international affairs*. Georgetown University Press.

Carlton, T.O., 1984. *Clinical social work in health settings: A guide to professional practice with exemplars*. New York: Springer Publishing Company.

Chang, L., Chen, Sh-Ch. and Hung, SH-L. 2018. Embracing diversity and transcultural

society through community health practicum among college nursing students. *Nurse Education in Practice,* 31, 156-160.

Corbin, J.M., Strauss, A.L., and Strauss, A.L., 2008. *Basics of qualitative research: techniques and procedures for developing grounded theory*. Los Angeles, CA: SAGE.

Cree, V.E. and Myers, S., 2008. *Social work: making a difference*. Bristol: Policy Press.

Creswell, J.W., 2008. Educational research: Planning, conducting, and evaluating quantitative and qualitative research. 3rd ed. Upper Saddle River, NJ: Pearson Education, Inc.

Creswell, J.W., 2009. *Research design: qualitative, quantitative, and mixed methods approaches*. Los Angeles: SAGE.

Daniel, J., 2012. *Sampling essentials: practical guidelines for making sampling choices*. Los Angeles: SAGE.

Davies, M. and Connolly, J., 1995. The social worker's role in the hospital seen through the eyes of other healthcare professionals. *Health & Social Care in the Community*, *3*(5), 301-310.

Davies, M. and Connolly, J., 1996. Hospital social work and discharge planning: an exploratory study in East Anglia. *Health & Social Care in the Community*, *3*(6), 363-371.

De, K.C., Kerckhove, C. and Vens, E., 2014. *Social work in an international perspective: history, views, diversity and human rights*. Antwerp: Garant.

Department of Health., 2010. Supporting people to live and die well: A framework for social care at the end of life. NHS. *National End of Life Care Programme*. Crown Publications.

El-Gilany, A. and Al-Wehady, A., 2001. Job satisfaction of female Saudi nurses. *EMHJ-Eastern Mediterranean Health Journal, 7 (1-2), 31-37*.

Ellingson, L.L., 2002. Communication, collaboration, and teamwork among health care professionals. *Communication research trends*, *21*(3).

El-Meligy and Zayed., 2012. *Rehabilitation medical care in the perspective of social work*. Cairo, 9-68

Elzubeir, M.A., Elzubeir, K.E. and Magzoub, M.E., 2010. Stress and coping strategies among Arab medical students: towards a research agenda. *Education for Health*, 23 (1), 355.

Ernst, A., 2003. *Comparison of qualitative and quantitative research*. Munich: GRIN Verlag GmbH.

Ettner, R., Monstrey, S. and Coleman, E. eds., 2016. *Principles of transgender medicine and surgery*. Routledge.

Galletta A., 2013. *Mastering the semi-structured interview and beyond: From research design to analysis and publication. Qualitative studies in psychology*. New York, NY: NYU Press.

General Authority for Statistics of the Kingdom of Saudi Arabia, Population in Saudi Arabia by Gender, Age, Nationality (Saudi / Non-Saudi) - Mid 2016 A.D.

Ghauri, P.N. and Gronhaug, K., 2005. *Research Methods in Business Studies*, 3rd ed., Great Britain: Pearson Education Limited.

Giorgi, A. 2009. *The descriptive phenomenological method in psychology*. Pittsburgh: Duquesne University Press.

Globerman, J., Davies, J.M. and Walsh, S., 1996. Social work in restructuring hospitals: Meeting the challenge. *Health & social work*, *21*(3), 178-188.

Grbich, C., 2007. *Qualitative data analysis: An introduction*. London: SAGE.

Guba, E.G. and Lincoln, Y.S., 1989. *Fourth generation evaluation*. Newbury Park, London; New Delhi: SAGE.

Habashi, M., 2015. *Vision of Saudi Arabia in 2030*. Makkah: Um Alqura University.

Hale, J.R. and Fields, D.L., 2007. Exploring servant leadership across cultures: a study of followers in Ghana and the USA. *Leadership*, 3 (4), 397-417.

Hall, E.T., 1989. *Beyond culture*. New York: Anchor Press–Doubleday.

Hamdan, A., 2005. Women and education in Saudi Arabia: Challenges and achievements. *International Education Journal*, *6*(1), 42-64.

Harris, M., 1997. *Culture, people, nature: An introduction to general anthropology*. Addison-Weley Educational Publishers, Inc.

Hartman-Shea, K., Hahn, A., Kraus, J., Cordts, G. and Sevransky, J., 2011. The role of the social worker in the adult critical care unit: A systematic review of the literature. *Social Work in Health Care*, 50, 143-157.

Heidegger, M. and Dahlstrom, D.O., 2010. *Introduction to phenomenological research*. Bloomington, IN: Indiana University Pres.

Ho, Y.C., 2015. Investigating internationally educated Taiwanese nurses training and communication experiences in the United States. *Journal of Continuing Education in Nursing*, 46 (5), 218-227.

Hodge, D.R., 2005. Social work and the house of Islam: Orienting practitioners to the beliefs and values of Muslims in the United States. *Social work*, *50*(2), 162-173.

Ibrahim, T., Zayyan, O. and AlBorie, H., 2013. *The economics of the health service: a reference to the economics of the Saudi health system*. Jeddah: Scientific Khwarazm.

Jirwe, M., Gerrish, K. and Emami, A., 2006. The theoretical framework of cultural competence. *Journal of Multicultural Nursing & Health*, 12 (3), 6.

Judith, L.M., McCoyd and Tob, S.K., 2016. *Social work in health settings: Practice in context*. New York: Routledge.

Keesing M. and Strathern, A.J., 1981. *Cultural anthropology: a contemporary perspective.* New York (CBS).

Leininger, M., 1993. Towards conceptualization of transcultural health care systems: Concepts and a model. *Journal of Transcultural Nursing*, *4*(2), 32-40.

Leininger, M. and McFarland, M.R., 2002. *Transcultural nursing: Concept theories, research and practice*. 3rd ed. New York: McGraw-Hill.

Leutz, W.N., 1999. Five laws for integrating medical and social services: lessons from the United States and the United Kingdom. *The Milbank Quarterly,* 77 (1), 77-110.

Linton, R., 1936. *The study of man: An introduction*. New York: D. Appleton-Century.

Loftin, C., Hartin, V., Branson, M. and Reyes, H., 2013. Measures of cultural competence in nurses: an integrative review. *The Scientific World Journal, 2013.*

Lovering, S., 2006. Cultural attitudes and beliefs about pain. *Journal of Transcultural Nursing*, 17 *(*4), 389-395.

Lymbery, M. and Bulter, S., 2004. *Social work ideals and practice realties*, New York,

NY: Palgrave Macmillan.

Mahfouz, T., 2006. *Speak Arabic instantly*. Lulu. com.

Mahnaz, H.S., 2016. Medical social work: Connotation, challenges and prospects. *Pakistan Journal of Social Sciences,* 36, 495-504.

Mareno, N. and Hart, P.L., 2014. Cultural competency among nurses with undergraduate and graduate degrees: Implications for nursing education. *Nursing Education Perspectives*, *35*(2), 83-88.

McTighe, J.P., 2018. *Narrative Theory in Clinical Social Work Practice*. Springer.

Ministry of Health Saudi Arabia., 2016. Medical social work procedures and polices manual.

Ministry of Health of Saudi Arabia, 2019. Health Indicators Report. [online]. Available at: https://www.moh.gov.sa/en/Search/Pages/Default.aspx?k=health%20indicators. [Accessed 10 May 2021].

Ministry of Higher Education Saudi Arabia., 2016. Saudi universities accepted more students. Umm-alqura University in Saudi Arabia.

Moghis, N., 2006. Factors affecting the performance of workers in the social work departments in the medical field. *Journal of Studies in Social Work and Human Sciences*, Egypt.

Mohammed, S., 2013. *Evaluation of the social worker role in the infectious diseases departments at the government hospitals from the standpoint of patients*, Riyadh: Naif Arab University for Security Sciences.

Mooney, M., 2007. Professional socialization: the key to survival as a newly qualified nurse. *International journal of nursing practice*, 13 (2), 75-80.

Morse, J. M. and Richards, L., 2006. *Readme first for a user's guide to qualitative methods*. Thousand Oaks: SAGE.

Murphy, S.C., 2006. Mapping the literature of transcultural nursing. *Journal of the Medical Library Association*, *94*(2 Suppl), p.E143.

Mutair, A.S.A., Plummer, V., O'Brien, A.P. and Clerehan, R., 2014. Providing culturally congruent care for Saudi patients and their families. *Contemporary Nurse*, 46 (2), 254-258.

National Association of Social Workers, 2001. *NASW standards for cultural competence in social work practice*. National Association of Social Workers.

Neil, B., 2009. *Advocacy skills for health and social care professionals*. London: Neil Bateman.

Noor. M.A., 2006. Medicine, society and basic study in medical meeting. Areiad: Dar Alewa.

Northouse, L.L. and Northouse, P.G., 1998. *Health communication strategies for health professionals.* 3rd edition. Stamford: Appleton & Lange. NY: Palgrave Macmillan.

Omu, O., and Reynolds, F., 2014. Religious faith and self-efficacy among stroke patients in Kuwait: health professional views. *Disabilities and Rehabilitation*, 36 (18), 1528-1535.

Padela, A. I., & Zaidi, D. 2018. The Islamic tradition and health inequities: A preliminary conceptual model based on a systematic literature review of Muslim health-care disparities. *Avicenna journal of medicine*, 8(1), 1–13.

Parrott, L., 2001. *Social Work and Social Care*, 2nd ed. Gildredge Social Policy. Routledge.

Payne, Malcolm. 2005. *The origins of social work: Continuity and change*. Palgrave Macmillan.

Percy, W.S., Kostere, K. and Kostere, S. 2015. Generic Qualitative Research in Psychology. *Qualitative Report*, 20(2), 76-85.

Purdy, N., Spence Laschinger, H.K., Finegan, J., Kerr, M. and Olivera, F., 2010. Effects of work environments on nurse and patient outcomes. *Journal of Nursing Management*, 18 (8), 901-913.

Purnell, L., 2000. A description of the Purnell model for cultural competence. *Journal of Transcultural Nursing*, *11*(1), 40-46.

Purnell, L., 2012. *Transcultural health care: A culturally competent approach.* 2nd ed.: FA Davis.

Quezada, M., 2007. The experiences of public child welfare social workers: Exploding factors related to job satisfaction: M.S.W., California State University, Long Beach.

Ragab, I.A., 2016. The Islamic perspective on social work: A conceptual framework. *International Social Work,* 59(3), 325-342.

Reith, M. and Payne, M., 2009. *Social work in end-of-life and palliative care*. Bristol: The Policy Press.

Ridley, C.R., Baker, D.M. and Hill, C.L., 2001. Critical issues concerning cultural competence. *The Counseling Psychologist*, *29*(6), 822-832.

Ryan, B., 2012. *A Qualitative Study of Medical Social Workers' and Nurses' Perceptions on Effective Interprofessional Collaboration* [online]. Minnesota, USA: St Catherine University. Available at: https://sophia.stkate.edu/msw_papers/84 [Accessed 15 August 2019].

Saleh, A., 2002. *Social Work and Fields of Practice*, Alexandria, Egypt: Darul.

Salih, A., 2009. *The basics of social medical service and rehabilitation*, Egypt: Dar Al Marifa.

Salsberg, E., Quigley, L., Mehfoud, N., Acquaviva, K.D., Wyche, K. and Silwa, S., 2017. *Profile of the social work workforce*. USA, George Washington University.

Saudi Arabian Cultural Mission in Australia, 2021. *Culture traditions and art* [online]. The Saudi Arabian Cultural Mission website. Available at: https://sacm.org.au/culture-traditions-and-art/ [Accessed on 23 March 2020].

Saunders, M., Lewis, P. and Thornhill, A., 2012. *Business Research Methods*, ed 6. Pearson.

Seago, J.A., 2000. Registered nurses, unlicensed assistive personnel, and organizational culture in hospitals. *Journal of Nursing Administration*, 30 (5), 278-286.

Sharma, S. and Reimer-Kirkham, Sh., 2015. Faith as social capital: Diasporic women negotiating religion in secularized healthcare services. *Women Studies International*, 49, 34-42.

Slama, S.A., 2012. Developing the healthy section and effecting on economic growth in Saudi Arabia, that research is presented to going to complete the bachelor degree, Are aid.

Soliman H., 2013. *Social work in the Middle East*. New York, NY: Routledge.

Soumen, A., 2018. The study of medical social worker how was this evolved in India and how medical social service officer in AIIMS can changed the problem faced by patients. *Acta Scientific Medical Sciences*, 2.6, 19-30.

Staten, D.R., Mangalindan, M.A., Saylor, C.R. and Stuenkel, D.L., 2003. Staff nurse perceptions of the work environment: a comparison among ethnic backgrounds. *Journal of Nursing Care Quality*, 18 (3), 202-208.

Statista Research Department, 2021. Healthcare in Saudi Arabia – statistics & facts. *Statista*. [Online]. Available at: https://www.statista.com/topics/4807/healthcare-in-saudi-arabia/#dossierSummary [Accessed 23 May 2021].

Steketee, G., Ross, A.M. and Wachman, M.K., 2017. Health outcomes and costs of social work services: a systematic review. *American journal of public health*, *107*(S3), S256-S266.

Strauss, A. and Corbin, J., 1998. *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks: SAGE.

Swihart, D. L., Yarrarapu, S., and Martin, R. L. 2021. Cultural Religious Competence in Clinical Practice. *In StatPearls*. StatPearls Publishing.

Taylor, G.R., 2005. *Integrating quantitative and qualitative methods in research*. Lanham, MD: University Press of America.

The Canadian Association of Social Workers., 2006. Social Workers in Health: Working Conditions and Related Topics Literature Review.

The Ministry of Commerce and Investment, 2015. *The Kingdoms Regions*. Retrieved from The Saudi Network (n.d.). *Taif City profile*. Retrieved from http://www.the-saudi.net/saudi-arabia/taif/Taif%20-%20Saudi%20Arabia.htm.

The Embassy of Kingdom of Saudi Arabia at USA, 2021. About Saudi Arabia [online]. The Embassy website. Available at: https://www.saudiembassy.net/culture-art [Accessed on 23 March 2020].

Trevithick, P., 2011. *Social Work Skills and Knowledge. A practice handbook, 3rd ed*. McGraw-Hill Education (UK).

Tumulty, G., 2001. Professional development of nursing in Saudi Arabia. *Journal of Nursing Scholarship,* 33 (3), 285-290.

Tylor, E.B., 1871. *Primitive culture: Researches into the development of mythology, philosophy, religion, art and custom* (Vol. 2). J. Murray.

USSABC (US-Saudi Arabian Business Council) Economic brief, 2019. Saudi Arabia's healthcare update.

Van Der Laan, G., 1998. The professional role of social work in a market environment', *European Journal of Social Work* 1(11), 31-40.

Vandergrift, T., 2017. *Comparing and contrasting eastern vs. western medicine*. https://www.fsunews.com/story/life/2017/01/15/comparing-and-contrasting-eastern-vs-western-medicine/96617364/ [Accessed on 28 April 2020].

Vydelingum, V., 2006. Nurses' experiences of caring for South Asian minority ethnic patients in a general hospital in England. *Nursing Inquiry*, 13 (1), 23-32.

Wahabi, H.A. and Alziedan, R.A., 2012. Reasons behind non-adherence of healthcare practitioners to pediatric asthma guidelines in an emergency department in Saudi Arabia. *BMC health services research*, *12*(1), 1-9.

Walston, S., Al-Harbi, Y. and Al-Omar, B., 2008. The changing face of healthcare in Saudi Arabia. *Annals of Saudi medicine*, *28*(4), 243-250.

Weiss-Gal, W., 2008. The professionalization of social work: a cross-national exploration. *International Journal of Social Welfare*, 17 (4), 281-290.

Wengraf, T., 2001. *Qualitative research interviewing: Biographical narrative and semi-structured methods*. Thousand Oaks, CA: SAGE.

Williams, T. and Richardon, S., 2007. Why is cultural safety essential in health care? *Medical Law,* 26 (4), 699-707.

Woodroofe, K., 1962. *From charity to social work in England and the United States*. Routledge and Kegan Paul.

Wolf, C., Joye, D., Smith, T.E., Smith, T.W. and Fu, Y.C. eds., 2016. *The SAGE handbook of survey methodology*. New York: SAGE.

Wolfram, W. and Friday, W.C., 1997. The role of dialect differences in cross-cultural communication: Proactive dialect awareness. *Bulletin VALS-ASLA, 65*, 143-154.

World Health Organization, 2006. *Health system profile Saudi Arabia*. Regional Health Systems Observatory.

World Health Organization, 2016. *Planning and implementing palliative care services: A guide for programme managers*. Geneva: World Health Organization.

Yalli, N., 2008. *Hospital social work in Saudi Arabia: an investigation of practitioners' perceptions of the common workplace issues that influence their position and role in health care*. Ph.D. dissertation, University of East Anglia.

Yalli, N., 2008. *Social work in Saudi Arabian hospitals: an exploration of practitioners' perceptions of the profession's position in the delivery of healthcare services*. Ph.D. thesis, University of East Anglia.

Yalli N. and Albrithen, A., 2015. Hospital social workers in Saudi Arabia: characteristics and functions. *Social Work in Health Care*, 54, 158-176. DOI: 10.1080/00981389.2014.972532.

Yalli, N. and Albrithen, A., 2016. Social workers: Peer interaction and hospital integration. *International Social Work*, 59 (1), 129-140.

Yuen, F. and Skibinski, G., 2012. *Family health social work practice*. Hoboken: Taylor and Francis. Zawawi, A.N. and Al-Rashed, A.M., 2020. The experiences of foreign doctors in Saudi Arabia: A qualitative study of the challenges and retention motives. *Heliyon*, *6*(8), p.e03901.

Zuhur, S., 2012. *Saudi Arabia* [electronic resource] Sherifa Zuhur. Santa Barbara, Calif: ABC-CLIO.

APPENDICES

APPENDIX A.1 PERMISSION FROM MINISTRY OF HEALTH AT TAIF TO CONDUCT THE STUDY (ENGLISH VERSION)

Kingdom Of Saudi Arabia
Ministry Of Health
Directorate Of Health Affairs–Taif
Mental and Social Health Department

وزارة الصحة
Ministry of Health

المملكة العربية السعودية
وزارة الصحة
مديرية الشئون الصحية بمحافظة الطائف
ادارة الصحة النفسية والاجتماعية

07-02-2017
To: Nottingham Trent University

As per the request of Mr. Nawaf W. Althumali about the approval to conduct a Ph.D research entitled (Culture and Medical Social Work Practice in Saudi Arabia).

Therefore, Directorate of Health Affairs in Taif, confirm that the researcher has a permission to conduct this study and it will be supervising on conduct the research by Mental and Social Health Department.

Yours sincerely,

Talq M. Al otaibi
Head of Mental and Social Health Department in Directorate Of Health Affairs–Taif
dmhs-Taif@moh.gov.sa
Al Khaliyydiah, Qurwa, Taif 26521, Saudi Arabia
Phone: +966 12 736 6200

APPENDIX A.2 PERMISSION FROM MINISTRY OF HEALTH AT TAIF TO PERFORM THE STUDY (ARABIC VERSION)

المملكة العربية السعودية
وزارة الصحة
مديرية الشئون الصحية بمحافظة الطائف
إدارة الصحة النفسية والاجتماعية

وزارة الصحة
Ministry of Health

الرقم : .....
التاريخ : .....
المشفوعات : .....

(لمن يهمه الأمر)

السلام عليكم ورحمة الله وبركاته

إشارة الى موافقتنا على الطلب المقدم من الباحث / نواف وصل الله الثمالي وذلك لإجراء دراسة الدكتوراه بعنوان:

The Perception of Social Workers and Patients of The Current Role of Social Workers in Saudi Hospitals

عليه فأن إدارة الصحة النفسية والاجتماعية بمديرية الشئون الصحية بالطائف هي الجهة التي أشرفت على إجراء هذه الدراسة اعتبارا من ١٤٣٨/١١/١٨هـ الموافق ٢٠١٧/٨/١٠ ، وحتى ١٤٣٩/٤/٢٧هـ الموافق ٢٠١٨/٠١/١٤

وتقبلوا اطيب تحياتي،،،

مدير إدارة الصحة النفسية والاجتماعية
بالشئون الصحية بالطائف

طلق محماس العتيبي

APPENDIX B. INFORMED CONSENT FOR SOCIAL WORKERS

The perceptions of social workers and patients of the current role of social workers in Saudi hospitals

Dear Social Worker,

About the researcher:

My name is Nawaf Althumali, I am a research student in School of Social Sciences, Nottingham Trent University- UK, I have a research project entitled "The perceptions of social workers and patients of the current role of social workers in Saudi hospitals" as part of my PhD requirements.

About this study:

At this time, I am collecting data and conducting interviews with social workers and patients on this subject, and you are invited to participate in an interview. The interview will be about the perceptions of practitioners and patients regarding social worker duties in the hospital and the expected professional practice under local customs and traditions in the Kingdom of Saudi Arabia. The research aims to uncover the challenges facing the provision of social care in the hospital. Results of this research will help to improve the work of social workers, the development of medical social care and the provision of appropriate services to patients.

Ethical issues and the interview procedures:

Your signature below will be taken as consent to conduct an interview with you as a volunteer and to allow the researcher to use the information you provide only for the purposes of study and scientific analysis. The expected length of time for the interview is about one hour, you can withdraw from participating within six months after the interview date, with no requirements to explain your reasons. All data will be confidential and can only be accessed by the researcher and his supervisors. However, the researcher has legal commitments to share the information with the relevant authorities if it is about your safety or the others.

All your personal data, including your name and workplace, will be removed from the research documents. The coding will be used for interviews, and all recordings and texts will not have any indication of your identity.

The data will be stored securely, and all records and files will be destroyed after being transcribed and analysed. If you would like to see the results of the study, please contact the researcher on means of communication set forth below.

If you feel discomfort, boredom, or inconvenience from the length of the interview or certain questions, you can take a break, or you can postpone/ not complete the interview if you wish.

Thank you.

For more information, to make a change to your responses or if you have any questions please contact:

The Researcher: Nawaf Althumali	Director of Studies:
Taif	Email: .....@ntu.ac.uk
Tel: 0217366200	Phone: +44 (0) …….
SA Mobile: 00966…….	School of Social Sciences
UK Mobile: 0044……..	Nottingham Trent University
.....@my.ntu.ac.uk	UK

CONSENT FORM – SOCIAL WORKERS		
Please carefully read the following and mark the appropriate options, taking into account that by signing below, this means that you agree to its content:		
1	I understand the purpose of the research.	☐
2	I understand that my participation is entirely voluntary and does not entail any material or any work-related obligations.	☐
3	I understand that I can withdraw from participating within six months after the interview date, with no requirements to explain my reasons.	☐
4	I understand that I have the right to answer or not to answer any interview question.	☐
5	I understand that this interview will be oral and I give permission for it to be audio recorded.	☐
6	I understand that the researcher maintains confidentiality and will not publish my personal information.	☐
7	I agree to participate in this study.	☐

Participant's Name: ……..…….……

Participant's Signature: Date: ……..…….…… ……..……

You will receive a copy of this form.

☐ I confirm that the participant has been notified of the information above.

Researcher's Signature: Date: ……..…….…… ……..……

INFORMED CONSENT FOR PATIENTS

The perceptions of social workers and patients

of the current role of social workers in Saudi hospitals

Dear Patient,

About the researcher:

My name is Nawaf Althumali, I am a research student in School of Social Sciences, Nottingham Trent University- UK. I have a research project entitled "The perceptions of social workers and patients of the current role of social workers in Saudi hospitals" as part of my PhD requirements.

About this study

At this time, I am collecting data and conducting interviews with social workers and patients on this subject, and you are invited to participate in an interview. The interview will be about the perceptions of practitioners and patients regarding social worker duties in the hospital and the expected professional practice under local customs and traditions in the Kingdom of Saudi Arabia. The research aims to uncover the challenges facing the provision of social care in the hospital. Results of this research will help to improve the work of social workers, the development of medical social care and the provision of appropriate services to patients.

Ethical issues and the interview procedures:

Your signature below will be taken as consent to conduct an interview with you as a volunteer and to allow the researcher to use the information you provide only for the purposes of study and scientific analysis. The expected length of time for the interview is about one hour, you can withdraw from participating within six months after the interview date, with no requirements to explain your reasons. All data will be confidential and can only be accessed by the researcher and his supervisors. However, the researcher has legal commitments to share the information with the relevant authorities if it is about your safety or the others. All your personal data, including your name and workplace, will be removed from the research documents. The coding will be used for interviews, and all recordings and texts will not have any indication of your identity.

The data will be stored securely, and all records and files will be destroyed after being transcribed and analysed. If you would like to see the results of the study, please contact the researcher on means of communication set forth below.

If you feel discomfort, boredom, or inconvenience from the length of the interview or certain questions, you can take a break, or you can postpone/ not complete the interview if you wish.

Thank you.

For more information, to make a change to your responses or if you have any questions please contact:

The Researcher: Nawaf Althumali	Director of Studies:
Taif	Email: .....@ntu.ac.uk
Tel: 0217366200	Phone: +44 (0)
SA Mobile: 00966	School of Social Sciences
UK Mobile: 0044	Nottingham Trent University
.....@my.ntu.ac.uk	UK

CONSENT FORM - PATIENTS		
Please carefully read the following and mark the appropriate options, taking into account that by signing below, this means that you agree to its content:		
1	I understand the purpose of the research.	☐
2	I understand that my participation is entirely voluntary and does not entail any material or any other related obligations	☐
3	I understand that I can withdraw from participating within six months after the interview date, with no requirements to explain my reasons.	☐
4	I understand that I have the right to answer or not to answer any interview question.	☐
5	I understand that this interview will be oral and I give permission for it to be audio recorded.	☐
6	I understand that the researcher maintains confidentiality and will not publish my personal information.	☐
7	I understand that the services I receive at the hospital will not be affected by my participation in this research.	☐
8	I agree to participate in this study.	☐

Participant's Name: ……..…….……..…….

Participant's Signature: Date: ……..……..……
……..……

You will receive a copy of this form.

☐ I confirm that the participant has been notified of the information above.

Researcher's Signature: Date: ……..……..……
……..……

APPENDIX C. INTERVIEW SCHEDULE

Interview Schedule: **Social Workers**

Date:		Interviewee Code:	
Topic 1: The perceptions of social workers of the current role of social workers			
1.1	What are the daily tasks that you currently undertake in the hospital?		
1.2	How do you see the policy and procedure manual for medical social care, and its match to your current business tasks?		
1.3	How you feel about your current role in the hospital? Why?		
1.4	In your opinion what are the tasks that you wish to do and consider to be within the work of the social worker?		
1.5	How do you receive new information about medical social work and social workers' tasks?		
1.6			
1.7			
1.8			
1.9			

Interview Schedule: **Social Workers**

Date:		Interviewee Code:	
Topic 2: How do social workers in hospitals manage the cultural and religious values of the patient when providing social care			
2.1	How do you view the cultural and religious values of the patient when providing social care in hospitals?		
2.2	How far affect the cultural and religious elements of social workers' services for patients?		
2.3	What do you think of providing care to a patient of a different gender? Do you think the patient accepts this? Why?		
2.4	When does a social worker use religious therapy? How do you see the patient's acceptance of religious advice and guidance? Why?		
2.5	Do you think that the patient's tribal affiliation obliges you to change the way you treat them or the type of service you offer? How is this done, in detail?		
2.6	Talk about some of the habits, traditions or beliefs that the patient has which affects the patient's understanding /acceptance of advice and guidance from the social worker? What has the most impact?		
2.7	What help does the patient or his family expect from you?		
2.8	What are the obstacles and issues facing provide the social services equally among the patients which may be caused by the patient or his family?		

Interview Schedule: **Social Workers**

Date:		Interviewee Code:	
Topic 3: The obstacles identified by social workers and patients in medical social work practice.			
3.1	What are the obstacles or issues facing the provision of social services in the hospital that relate to the social worker?		
3.2	Describe how do you perceive (understand /deal with) the hospital administration and medical teams treat social workers in hospitals? What is the impact of this treatment?		
3.3	What are the obstacles and issues facing the provision of social services in the hospital that may be caused by the patient or his family?		
3.4	In your opinion, what is the impact of the current work environment on the performance of the social worker? If any, how is this impact classified according to the provision of social care?		
3.5	What policy and working guide do you need to make your job more effective?		
3.6	What other training and support do you think could develop the medical social work practice?		
3.7	Are there any other additional comments would you like to mention?		
3.8			
3.9			
3.10			

Interview Schedule: **Patients**

Date:		Interviewee Code:	
Topic 1: The perceptions of patients of the current role of social workers.			
1.1	What are the social workers' current tasks and their role in the hospital?		
1.2	What tasks do you think are not the task of a social worker?		
1.3	What are the services you receive from dealing with a social worker? What did you expect from him?		
1.4	From your experiences, how would you describe the aid provided by the social worker to you? Do you classify this as social support?		
1.5	Do you think the job of social worker is important and necessary in the hospital? Why?		
1.6	Did they experience some conflicts with social workers' suggestions? How did they respond to the conflicts?		
1.7			
1.8			

Interview Schedule: **Patients**

Date:		Interviewee Code:	
Topic 2: The obstacles identified by social workers and patients in medical social work practice.			
2.1	What are the obstacles or issues facing the provision of social work in the hospital that relate to the social worker?		
2.2	Do you think the social worker's job is necessary and important to the patient? Why?		
2.3	What are the obstacles and issues facing the social worker in the hospital that can be related to the patient or his family?		
2.4	Describe how do you perceive the attitude of the medical team and hospital administration towards the social worker? What is the impact of this attitude from your point of view?		
2.5	In your opinion, what is the impact of the current work environment on the performance of the social worker? If any, how is this impact classified according to the provision of social care?		
2.6	What tools or facilities do you think help the social worker in developing the services which are provided to the patient and his family?		
2.7	Are there any other additional comments would you like to mention?		
2.8			

Date:		Interviewee Code:	
Topic 3: Participants (Patients)			
No.			Code
3.1	What is your age? a. ☐ 21 to less 30 b. ☐ 31 to less 40 c. ☐ 40 to less 50 d. ☐ 50 to less 60 e. ☐ 60 and above		
3.2	What is your gender? a. ☐ Male b. ☐ Female		
3.3	What is your nationality? a. ☐ Saudi Arabian b. ☐ Other (specify) ……..……		
3.4	What is your religion? a. ☐ Muslim b. ☐ Other (Specify) ……..……		
3.5	What is your marital status? a. ☐ Single b. ☐ Married c. ☐ Widowed d. ☐ Divorced e. ☐ Other (specify) ……..……		
3.6	How long have you stayed in hospital?		
3.7	What is your education level? a. ☐ Uneducated b. ☐ Primary School c. ☐ Middle School d. ☐ Secondary School e. ☐ College f. ☐ Graduate School j. ☐ Other (specify) ……..……		

Date:		Interviewee Code:	
Topic 3: Participants (Social Workers)			
No.			Code
3.1	What is your age? a. ☐ 21 to less 30 b. ☐ 30 to less 40 c. ☐ 40 to less 50 d. ☐ 50 to less 60		
3.2	What is your gender? a. ☐ Male b. ☐ Female		
3.3	What is your nationality? a. ☐ Saudi Arabian. b. ☐ Other (specify) ……..……		
3.4	What is your religion? a. ☐ Muslim b. ☐ Other (Specify) ……..……		
3.5	What is your marital Status? a. ☐ Single b. ☐ Married c. ☐ Widowed d. ☐ Divorced e. ☐ Other (specify) ……..……		
3.6	How many years of your experience? a. ☐ Less than 2 years b. ☐ from 2 years to less 5 years. c. ☐ from 5 years to less 10 years. d. ☐ from 10 years and more.		
3.7	What is your education level? a. ☐ Bachelor b. ☐ Master c. ☐ Doctorate d. ☐ Other (specify) ……..……		
3.8	What is your educational background? a. ☐ Social Work b. ☐ Sociology c. ☐ Other (Specify) ……..……		