The Nature and Structure of Teams: A Case Study of Interdisciplinary Teamworking in Primary Care

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Abstract

Considerable attention has been placed on how interdisciplinary teams can improve quality of care, professional relationships and collaboration. Consequently, improved teamwork is becoming an aspiration of health and social care practitioners, managers and organisations. In order to better understand teamwork in health care and how they function in a segregated organisation, a study of perception, structure of interdisciplinary primary health care teams and human resource practices was conducted. The thesis goes through an intensive programme of qualitative research in Riyadh City the capital of Saudi Arabia. It covers six cases, drawing on 47 interviews of teams in interdisciplinary primary care centres that varied in their Ministry of Health administrative standards evaluation. The research critically examines the HRM system and it links to teamwork policy, which resulted in tension between interdisciplinary members in the team. The key contribution is that there is little research on how health professionals work under segregated conditions and how they function.

The research explores and emphasizes the traditional nature of management and HRM within the Saudi Arabian public sector. HRM practices have historically been concerned with tight managerial control through close direction. Control in this perspective is mostly focused on performance systems, performance management and tight control over individual activities. The objective of tight control, historically, has been to reduce direct labour costs and improve efficiency, through requiring employee compliance with specified procedures and rules and basing

rewards on some measurable output criteria. Thus, managerialism in the Saudi context remains highly influenced by Taylorist scientific management concepts, in which standardization and efficiency by the separation of execution and conception of tasks are emphasised. Maximum control over employees has been achieved through narrowly specified jobs supported by task focused training, payment systems and selection.

The thesis reveals how some healthcare teams may exist as teams in name only, showing little actual evidence of collaborative working. Such inequitable payment and reward systems, and on-going perceived hierarchical differences between team members.

Furthermore, the thesis explores in detail the implementation of teamworking within workplaces that remain segregated by gender, and examines the crucial role of the female supervisor, as line manager to female team workers in healthcare settings, to the implementation and success or failure of teamworking.

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Abbreviations

HRM	Human Resource Management
MOH	Ministry Of Health
CBAHI	Central Board for Accreditation of Healthcare Institutions
PHC	Primary Healthcare Centre

Chapter 1: Introduction

1.1 Introduction to the Central Debates of the Thesis

This thesis examines the nature of inter-disciplinary teamworking in healthcare in Saudi Arabia. It explores the relationship between teamworking and HRM, and the rhetoric and reality of inter-disciplinary teamworking within a context where gender segregation remains a defining feature of society and workplaces. Drawing on intensive qualitative research, comprising 47 interviews with senior managers, medical specialists, nurses, female team supervisors, and other team members, the thesis explores inter-disciplinary teamworking in six primary care centres in Riyadh City, the capital of Saudi Arabia. The thesis unpacks the synergies, tensions and contradictions between teamworking and HRM, examines different perceptions and meanings of teams amongst team members, and highlights the crucial role of the female supervisor to teams in the Saudi Arabia context, an aspect of teams that has been unexplored in research to date.

Over the past thirty years, there has been considerable attention paid within the fields of Human Resource Management (HRM) and the sociology of work to the operation of teamworking within organisations. Much of this literature has been quite prescriptive in nature, assuming that teamworking is an essential element of HRM within organisations and can have a positive impact upon individual and organisational performance. However, critical strands of the teamworking literature have examined the reality of teams,

questioning the extent to which such positive effects can and do occur in practice. Examining the contested meanings of teams, varied management rationales for implementing teamworking and the realities of how teamworking operates within Saudi Arabian healthcare settings, the thesis sheds important new light on how, why and when teamworking is successful, and when it fails.

Inter-disciplinary teamworking, in which teams are configured to span across functions, groups and departments that have traditionally worked separately has become increasingly important across a range of sectors and settings over recent years. It is commonly viewed as a means through which boundaries within organisations can be broken down, tasks and processes improved, and performance and service levels increased. Within healthcare, with complex organisational structures and traditionally strong occupational and departmental boundaries and divides, inter-disciplinary teamworking has been advocated as a means of improving performance, promoted by governments and professional bodies in a range of settings as a means of achieving improving quality of care, professional relationships and collaboration. Consequently, improved inter-disciplinary teamworking is an aspiration of health and social care practitioners, managers, organisations and governments across a range of settings (Reeves et al. 2010; Nancarrow et al, 2013).

In the interdisciplinary teamworking in healthcare literature, and within the teamworking literature more generally, critical studies have highlighted the

importance of context to understanding the operation of teams, the implementation of teamworking, and its effects on individuals and organisations. In sharp contrast to research that has identifies steps and guidance for achieving successful inter-disciplinary teamworking, and where it is assumed that teamworking can be implemented effectively in every situation, these critical studies have highlighted how context matters. These contextual based studies have paid attention to different meanings, configurations and effects of teamworking, and of inter-disciplinary teamworking in particular in different countries, sectors, and within organisations of different sizes. Common to all of these studies is a recognition that the nature of teamworking cannot be understood without close attention to these contexts, and that an analysis of contexts can help progress our conceptual and theoretical understanding of the operation of teams, as well as providing rich empirical insight into the realities of teamworking. Yet, there still remains a relative lack of research on teamworking within specific contexts, where organisational, institutional and societal levels factors may impact profoundly upon the operation of teamworking.

This thesis explores the operation of interdisciplinary teams in healthcare settings in Saudi Arabia, progressing theoretical, methodological and empirical understanding of the nature of teamworking through a qualitative study conducted within six healthcare centres based in the capital of Saudi Arabia, Riyadh. The Saudi context provides a unique, and to date underexplored lens, through which to understand the nature of

interdisciplinary teamworking in healthcare. Gender segregation exists within society and within workplaces in Saudi Arabia, and impacts profoundly upon working practices, HRM and management. Close consideration of this aspect of Saudi society is vital to gain an understanding of how inter-disciplinary teams work in practice, and the constraints on their operation, which in term can shed new light on dominant theories and models of teamworking. The thesis explores in detail the implementation of teamworking within workplaces that remain segregated by gender, and examines the crucial role of the female supervisor, as line manager to female team workers in healthcare settings, to the implementation and success or failure of teamworking.

Alongside this, there are other important aspects of work in Saudi Arabia that merit attention, analysis of which can progress our theoretical, conceptual and empirical understanding of teams. Healthcare in Saudi Arabia, similar to other areas of the public sector, has traditionally been highly bureaucratic and hierarchically organized, with sharp divisions between units and groups. Inter-disciplinary teamworking has been advocated over recent years as a means of developing effective patient focused care and is increasingly a part of quality improvement agendas and initiatives within health. These new approaches to teamworking are predicated on changes to traditional modes of working, yet their implementation may create a range of challenges. The thesis examines this implementation in detail and shows that success of interdisciplinary teamworking cannot be assumed in advance. Structures and systems of HRM vary markedly across healthcare practices, facilitating teamworking in

some circumstances, and constraining it in others. This thesis explores these conditions in detail, highlighting a strong HR strategy, fit between HR practices, and informal leadership from female line managers, within traditionally male dominated organisational hierarchies as key elements to the success of inter-disciplinary teams.

1.2 Aims and Research question

The aim of the thesis is to develop a better understanding of the nature of inter-disciplinary teams in healthcare and how they function within the gender-segregated setting of Saudi Arabia. The specific research questions addressed by the thesis are as follows:

- How is inter-disciplinary teamworking implemented in Saudi healthcare settings, what are the connections between teamworking and HRM systems and HR practices, and what contradictions and tensions result?

- What are the motives for teamworking in primary healthcare centres, how do inter-disciplinary team members perceive and understand teamworking and what are the effects?

- How does gender segregation impact upon teamworking and HRM in Saudi Arabia, and what is the role played by the female supervisor in this context?

1.3 Key findings and contribution

There are five key findings of this thesis. First, effective inter-disciplinary teamworking cannot be assumed, or simply read off from a set of good practice guidelines or steps to follow. Rather, the workplace, sectoral, institutional, and country-level context in which it is implemented all matter. Whilst this finding has been emphasized in critical, workplace-based studies of teamworking in HRM and the sociology of work, there continues to be a neglect of these contingencies in much of the prescriptive literature on inter-disciplinary teams, including those conducted within healthcare. The thesis shows how bringing people together does not ensure that they will work together efficiently and make appropriate decisions. The thesis reveals how some healthcare teams may exist as teams in name only, showing little actual evidence of collaborative working. Such teamwork difficulties have been attributed to professional barriers and divides, inequitable payment and reward systems, and on-going perceived hierarchical differences between team members (Millward, Jeffries 2001).

Teamwork also requires significant development efforts and integration to establish a group into an effective team, with team members being required to overcome barriers and traditional adversarial attitudes (Baiden, Price 2011). The thesis explores in detail exactly how HRM practices might help to foster collaboration within teams in order to improve the quality of patient care as well as employee satisfaction (Harris et al. 2007), identifying how in those cases where it does work effectively, teamworking can act as a 'glue'

between other – often already strong, and underpinned by a clear strategy - HR practices, improving communication, motivation, and providing a means through which training, development and progression of staff can also be encouraged. As will be noted below, the role of the line manager is central in those cases where inter-disciplinary teamworking operates effectively. However, the thesis also shows that when other HR practices are already weak, with the operation and implementation of HRM being open to different, individual interpretations, teamworking structures can reinforce or extend organisational inequalities, poor management and supervision, leading to demotivation, confusion and poor individual and organisational performance Bacon and Blyton (2000) caution that when the aims of management are inconsistent with the type of teams initiated in the organisation, any positive effects of teams on outcomes will be hindered (Bacon and Blyton 2000, Wall and Wood 2005).

The second key finding of the thesis is that the purpose and motives of inter-disciplinary teamworking are complex and varied, and these purposes and motives have significant effects upon the operation of teamworking, and its ultimate success. Previous studies have highlighted the importance of progressive human resource management within the healthcare sector, with teamwork development policies being a key part of this, and also being able to flourish more effectively in such an environment (Leggat 2007). However, the research shows how specific HRM practices are implemented in various alternative ways by managers, for a range of purposes. These can be used to increase control, to exercise managerial prerogative, to retain and

reinforce traditional male-dominated hierarchies, to develop communication, collaboration, or to motivate and reward staff. These varied motives also impact upon team members' perceptions and understanding of teams. The thesis explores these contested views and different motives and looks at the effects they have when teamworking is implemented in these different contexts, looking at the contradictions and tensions that can be created within the team.

To understand this the thesis explores and emphasizes the traditional nature of management and HRM within the Saudi Arabian public sector. HRM practices have historically been concerned with tight managerial control through close direction. Control in this perspective is mostly focused on performance systems, performance management and tight control over individual activities. The objective of tight control, historically, has been to reduce direct labour costs and improve efficiency, through requiring employee compliance with specified procedures and rules and basing rewards on some measurable output criteria (Budhwar and Debrah 2001). Thus, managerialism in the Saudi context remains highly influenced by Taylorist scientific management concepts, in which standardization and efficiency by the separation of execution and conception of tasks are emphasised. Maximum control over employees has been achieved through narrowly specified jobs supported by task focused training, payment systems and selection.

It has been debated whether Taylorism was ever fully applicable to health care practice, given that healthcare staff do need to maintain some autonomy over working (Farr and Cressey 2015). However, there is a clear juxtaposition between old approaches, and newer approaches, including those advocated in interdisciplinary teams, which emphasise the involvement of employees by ensuring fair communications up and down the organisation, investing in training and development generally, rather than for immediate needs, and empowering employees through self-managing teams, job enrichment, and participation (Cooper and Robertson 2004). Whilst according to Friedman (1977) conditions of tight control and relative autonomy could coexist in some work settings, theories do suggest that it would be quite difficult to retain the principles of scientific management to interdisciplinary teams, since managers do not directly control the work of the workforce through control performance. How managers actually formulate and implement ideas of interdisciplinary teams within contexts such as Saudi Arabia remains then, an interesting empirical question, Is work intensified with responsibilities and workloads of team members increased, and performance management metrics increasingly quantified? Or is greater autonomy fostered and developed, with team members provided with structures and an environment in which they can communicate effectively, share knowledge, and be supported by effective line managers? The thesis finds evidence of each of these approaches, and is able to explain how, when and why such approaches occur, and with what effects.

The third main finding is the crucial role of the line manager to inter-disciplinary teamworking practice. The central role of the line manager in HRM is a familiar and well-established finding in a range of studies. This thesis highlights how, in the gender segregated Saudi working context, it is the female supervisor, as line manager to just the female members of the team, who plays a pivotal role. This is an important new insight, and the thesis sheds valuable light on how this supervisor can facilitate effective inter-disciplinary team working through informal leadership, effective communication, use of incentive structures, and by acting as a conduit between team members, medical specialists and (male) senior managers. Despite their pivotal importance to teams, the thesis highlights important status differences between female and male team leaders. The thesis also shows how these supervisors can undermine teamworking, using their power as a means of filtering communication, exerting control, and exercising managerial prerogative for their own personal agendas.

Fourth, and related to the point above, the thesis indicates how cultural and institutional factors do need to be considered closely to understand the nature and operation of teams. Here, attention focuses in particular on gender segregation in Saudi Arabia and the relatively limited participation of women in the labour market, alongside traditional, Tayloristic approaches to management and HRM that pervade working in the Saudi public sector. Together, these mean that the implementation of inter-disciplinary teamworking creates different challenges to those in Western economies. Gender segregation is a constitutive element in daily life of team members.

Men are placed as managers of primary care centres while women are placed in supportive roles. Gender is embedded in the hierarchical structure of the state. Traditional power relations between men and women are preserved through the association of masculinity with leadership and femininity with supportiveness (Acker 1988). Thus, excluding women from managing their teams of female members. Barriers to teamworking in Saudi Arabian health care centres include physical segregation of patients and workers, and teams that therefore remain divided and separate to a degree. Distinctive roles – notably the female supervisor – have been established as a result to try and facilitate teamworking, but they also create new tensions and contradictions in the operation of teamworking and HRM.

Fifth, and finally, the thesis does highlight the circumstances under which inter-disciplinary teamworking can work. In identifying the crucial importance of the female supervisor to the success or failure of teams in Saudi Arabia, the thesis is highlighting how much of the success of teams is attributable to informal leadership, and to actions which go against official organisational practice. Sophisticated HRM practices and systems, a clear senior management strategy and an organisational culture which is supportive of the goals of inter-disciplinary teamworking are all also important to understanding the success of teams. Yet, the context of Saudi Arabia also remains critical, with the role and position of women within them, and the continued prevalence of disciplinary divisions and boundaries all impacting upon the configuration and operation of teams. The thesis also reveals how the failure of teams can be understood with reference to these factors too.

Successful inter-disciplinary teamworking cannot be reduced to list of aims or good practice guidance, but needs to be sensitive to the different motives and rationales for teamworking, the traditional approach to management and HRM in Saudi Arabia and the gender segregated nature of working.

Overall, the thesis makes important theoretical, methodological and empirical insight. Theoretically, the thesis contributes to our understanding of teams, and to HRM. To teamworking debates, the thesis adds valuable new insight into how shared meanings of teams are developed within a gender segregated working environment such as Saudi Arabia and how these impact upon the operation of teams. Many studies done about teamwork have focused on team process such as decision making or communication (Opie 1997, Cook et al. 2001, Xyrichis and Lowton 2008, Deneckere et al. 2012), leadership (West et al. 2003, Salas et al. 2005, Downey et al 2011, Nancarrow et al. 2013), or team effectiveness (Barrick et al 1998, Poulton and West 1999, Leggat 2007). These studies address how teams exchange information and make patient related decisions. Yet none have considered how these operate in a segregated context. The thesis highlights in particular the crucial role of the female supervisor in this context, as a link between senior leaders and the team on the female side. In cases where teamworking works effectively, the female supervisor utilizes informal leadership as a means of ensuring communication and motivation within the team, despite barriers in the form of traditional male-constructed and male dominated hierarchies and structures. Female supervisors can also

undermine team working, using it to exert control or exercise their managerial prerogative for their own ends.

The thesis also adds to theoretical understanding of models of HRM, highlighting the synergies, tensions and contradictions between teamworking and other HRM practices, aspects which are often neglected in research into High Performance Work Systems. Structures of HRM, and supporting HR practices can help teamworking to work effectively. Similarly, the absence of HR practices, or weak HRM can undermine or constrain teamworking. The thesis shows how dominant and established approaches to HRM in use in organisations cannot simply be replaced or changed to ensure teamworking works effectively. Rather, these prevailing approaches to HRM and the culture within organisations towards people management profoundly impact upon the operations of teams.

In this context, the thesis adds valuable new insight into the nature of autonomy within teams. In the Saudi context, the thesis finds that it is better to increase employee autonomy so that teams can exercise an amount of discretion in applying their ingenuity and knowledge to the determination and distribution of work tasks, yet that this is likely to occur in Saudi Arabia as part of contemporary control mechanisms that continue to include methods that resemble formalization and standardization associated with Taylorism (Friedman 1977, Sewell 1998). The notion of autonomy is modified through individuals exercising a degree of influence over their own work formulation and also influencing the work of others in their team through exhortation,

suggestion and demonstration. In Saudi Arabia, autonomy is displayed as a collective character rather than an individual one by lengthening the degree of participation beyond the simple distribution of tasks through pursuing goals that encompass inclusion in decisions relating to the organisation of the labour process. This allows groups to formulate around interrelated or common activities, enabling multidisciplinary teams to exercise a limited form of discretion in relation to the beginning and execution of their own tasks, and thus brings about the reintegration of manual and mental labour, yet whilst considerable degrees of control continue. A noteworthy implication of this transition for critical studies of the labour process is that new means of control might have emerged to support these certain working arrangements (Friedman 1977).

The thesis also provides important methodological insight, highlighting the value of intensive workplace based studies to understand the nature of teamworking. Interviews with workers at different levels is important to provide a nuanced understanding of contested meanings of teamworking, and to understand the multiple objectives and aims of teams. The thesis also demonstrates the importance of research in non-Western contexts to broaden understanding of how teams operate and when they are successful or unsuccessful. In the Saudi context, the thesis shows that analysis of the specific composition of teams, the history of HRM and the role of the female supervisor are all crucial to understanding the nature of teams.

Empirically, the thesis sheds valuable new light on the nature of teams, the contested meaning of teams, the relationship between teamworking and HRM, the challenges of implementing inter-disciplinary teamworking, and the role of the female line manager within teams.

The structure of the thesis is as follows. In Chapter 2, the literature on teamworking is reviewed. The thesis explores the history of teamworking, examining dominant strands of thought, and different meanings of teams, before moving on to look at teamworking and HRM. This is followed by an analysis of teamworking within healthcare, and an exploration of inter-disciplinary teamworking in particular. The chapter draws out the complexities of teamworking, and highlights how the context in which teamworking is introduced is critical to understanding its effects. It also demonstrates the challenges of adopting and implementing inter-disciplinary teamworking within complex healthcare environments.

Chapter 3 provides context on Saudi Arabia, exploring the nature of the labour market, government labour market policies and HRM practice. It also sets out details of the healthcare sector, and explores policies and initiatives to develop work and employment in the sector. It shows how quality agendas and teamworking have become priorities for healthcare in recent years.

Chapter 4 sets out the methodology for the study. It describes the qualitative, case study based research, and outlines the philosophical and

methodological approach underpinning the project. It describes and analyses the strategy used, detailing the themes of the interviews, and providing details of the healthcare centres and individual participants in the study. It also considers the ethical issues associated with the project.

Chapter 5 is the first of the empirical chapters. This chapter explores the implementation of teamworking in the 6 case studies, and examines the relationship between teamworking and HRM. The chapter argues that the introduction and implementation of interdisciplinary teams cannot be considered in a vacuum, and that attention needs to be paid to the sectoral and Saudi-Arabian institutional context in which teams are introduced, and the supporting structures that are (or are not) in place. The main findings are how Incentive systems – both informal and formal - within teams, for example, need to be configured in ways that ensure individuals feel recognized for their specific contributions, whilst also providing motivation and effective reward for the team as a whole (Thompson, 1995; Fiscella and McDaniel, 2019). HRM structures can, in some cases, help facilitate change, through supporting practices. Also it uncovers the tensions and complementarities between teamworking and other HRM practices, as they related to the implementation of interdisciplinary teamworking are considered in depth.

Chapter 6 looks at perceptions towards teams. It examines how healthcare workers perceive and understand teams, and how they work together in practice. The chapter aims to provide new understanding and insight into the

nature of teamworking, the contexts in which it works effectively, as well as an understanding of barriers that impede teamworking. The focus on the chapter is on presenting the voices of those within teams in the six cases, to gain a direct understanding of perceptions of teams and their operation within the specific context in which respondents encountered teams.

Chapter 7 explores the role of the female supervisor within teams in Saudi Arabia. The female supervisor is critical to the operation of teams in the gender segregated context of healthcare centres in Saudi Arabia. It examines how the female supervisor undertakes informal leadership within teams.

The chapter finds that whilst the role, and activities of the female supervisor as team leader were, in some cases, formally defined, in many cases leadership devolved more informally as teams evolve. The authority and credibility of this supervisor derived partly from their previous experience and conduct, but also came from their evolving practice of supervising within gendered teams, and specifically from their abilities or weaknesses in bridging across disciplinary, occupational, and gender divides. In some cases female supervisors facilitated the operation of teamworking, but in other cases, these supervisors had the ability to undermine team working, or to have a negative impact upon collaborative working, creating a negative atmosphere and adversarial work relations.

Chapter 8 provides the conclusions to the thesis. This draws together the previous chapters and refines the main argument of the thesis. The

contribution to several debated about implementation and operation of interdisciplinary teamworking and its connections with human resource management (HRM) systems in Primary Healthcare Centres in Saudi Arabia. The main conclusions are how inter-disciplinary teamworking cannot be reduced to list of aims or good practice guidance, but needs to be sensitive to the different motives and rationales for teamworking, the traditional approach to management and HRM in Saudi Arabia and the gender segregated nature of working. It also reveals the idiosyncratic implementation by individual managers and how it ensured continued control over the labour process in some cases, but had the effect of intensifying work, creating stress and tensions within teams, and undermined the effective operation of teams.

Chapter 2: LITERATURE REVIEW

THE NATURE OF TEAMWORKING, AND INTER-DISCIPLINARY TEAMWORKING IN HEALTHCARE

2.1 Introduction

Organisations are always seeking a prescription for change to become more flexible in order to adapt to an increasingly competitive marketplace. Several scholars have noted that enhanced customer satisfaction and organisational performance have become vital motivators for managers when introducing team working. Teamworking was introduced as a strategy that can improve productivity and quality as well as reduce staffing (Bacon and Blyton 2003).

There are many different types of team, such as shop-floor teams, interdisciplinary teams, top management , and temporary project teams. Given this research focus on primary care employees' perception, the interest here is in interdisciplinary healthcare teams in primary care.

This chapter reviews literature on teams. It begins in section 2.2 by exploring the history of teamworking, examining dominant strands of thought, including the socio-technical systems approaches, and research within critical sociology. and different meanings of teams, before moving on in 2.3 to look at teamworking and HRM. This is followed by an analysis of teamworking

within healthcare (section 2.4) and an exploration of inter-disciplinary teamworking in particular in Section 2.5, before finishing by considering HRM in inter-disciplinary teams in healthcare. The chapter draws out the complexities of teamworking, and highlights how the context in which teamworking is introduced is critical to understanding its effects. It also demonstrates the challenges of adopting and implementing inter-disciplinary teamworking within complex healthcare environments.

2.2 Teamworking: concepts, history and contemporary debates

2.2.1 Definitions of teams

Teams and teamworking have been a central point of interest for academics and practitioners alike for more than half a century (Hootegem et al 2005). Whilst definitions vary, one commonly used is that provided by Mohrman, Cohen, and Mohrman (1995) who see it as:

"a group of individuals who work together to produce products or deliver services for which they are mutually accountable. Team members share goals and are mutually held accountable for meeting them, they are interdependent in their accomplishment, and they affect the results through their interactions with one another. Because the team is held collectively accountable, the work of integrating with one another is included among the responsibilities of each member".

The main features of teamworking, according to this view are individuals working together, towards a common purpose, with their actions being interdependent, and with joint responsibility for the outcome. Other elements, not included in this definition, but common in others (see for example Procter and Mueller, 2000; Benders et al, 1995) is that workers are multi-skilled, and learn and use various skills and rotate between the jobs, increasing functional flexibility, and reducing boredom and repetitive work. This fosters collective responsibility for work and enables members to develop the necessary mix of skills for effective work teams who share both mutual beliefs and identification with a common task. Teams are also said to assist staff participation in organisational goal setting, which is said to enhance motivation for team members (Bacon and Blyton 2003).

Whilst the origins of teamworking are contested, with antecedents and important influences being found in a number of management schools of thought and ideologies, there is widespread acceptance that limitations of the dominant scientific management approach of Taylor in the 1950s spurred interest in alternatives. Critiques of the Taylor's scientific management helped in legitimizing the shift in the unit of production from individual to the group level (Batt and Doellgast 2006), with team based work appear to outperform individually based Taylorised systems. Moreover, Taylorism included an expensive set of supervisors and it lacked a sense of flexibility, which resulted in economic problems (Pruijt 2003). This is to say, there is minimum connection between the organisation and the individual in terms of training, skill, and involvement (Littler 1978). Growing interest in

teams from the 1950s onwards came from a range of interests, and intellectual perspectives. These are reviewed in more detail below, to provide a detailed understanding of the development of teams, common areas of interest, and to highlight aspects of teamworking development that are of contemporary interest for this thesis. Two common characterisations emerge from the review below, both of which remain important in contemporary debates over the nature of teamworking:

- Teamworking as a technique readily adapted by academic commentators and management consultants as an organisational solution for a diverse of performance-related and attitudinal problems.

- Teamworking as a naturally occurring phenomenon, spontaneously and intuitively appropriated by individuals working in what they recognise to be adverse working settings (Mueller et al. 2000).

2.2.2 Sociotechnical systems and teams

As an organisational 'system' for arranging work, the notion of a team can be dated back to the early 19th century socialist movements. The concept began with autonomous groups working in mining, with teams being used as a response to dangerous underground conditions (Mueller et al 2000). Work groups were shown to experience better job satisfaction, better social health as well as being more productive. Improvement in job quality lies in the development of high-involvement models of working, which heighten the

influence that workers have over the work process (Winterton 1994, Boxall and Winterton 2018).

It provided greater power to a team worker who then have greater control over their part of production process, as in autonomous or semi-autonomous work groups. Also known as self-directed teams or self managing teams. This is underlined in the theory of Socio-technical systems (STS), which developed from British scholarships of coalmining in the 1950s (Trist and Bamforth 1951, Trist et al 1963, Boxall et al 2019).

As an organisational construct though, it became more prominent in the 1950s, driven by the work of consultants at the London based Tavistock Institute of Human Relations, founded in 1946, and which is regarded as the birthplace of Socio-technical systems design (STSD). Whilst Tavistock consultants did not create autonomous group working, their contribution was to identify, document, assess and publicise an approach that resulted in increased productivity and a decrease in absenteeism (Mueller et al 2000, Benders 2005). A socio-technical team can be defined as:

" A group of employees, generally between 4 and 20 persons, responsible for a round-off part of the production process, and entitled to take certain decisions autonomously" (Benders and Van Hootegem 1999:615)

Tavistock studies established two unique novelties in the debate on the relationship between social structure and technology. The first was in challenging the classical view that task specialisation was necessary for industrial efficiency, two decades before Braverman (1974) offered Marxist critique of Taylorist work organisation. The second was in signifying the

choice of alternative forms of work organisation of social and technical systems (Winterton 1994).

The notion of managers and engineers have an extent of choice in designing technology and work organisation was at the heart of STS design and is a central element of "anthropocentric work" in the sense of designing work suitable for humans. Such work organisation, as opposed to Taylorism, which is conducive to greater skill utilization and work autonomy (Boxall et al 2019).

In this approach, the basic building block of work design is the work group rather than the individual, and technology, which at that time covered both machines and the associated work organisation. Equally, STSD attempted to pay attention on providing a satisfying and high-quality work environment for employees (Cummings 1986, Mumford 2006). Team working was not suited to all work settings but was deemed necessary when the technology was such that interdependence among workers was crucial, in other words in production systems where staff must share time, equipment and material to achieve an outcome. Such examples included oil refineries, where workers were accountable for supplies flowing through the plant, coal mines, where staff are sequentially reliant on the output of the former worker, and hospitals, where a mixture of techniques were implemented concurrently to the same material (Cummings 1968).

After their start in the UK, socio-technical ideas were picked up by various countries, most notably in Scandinavia and in the Netherlands. The Work Research Institute in Oslo, led by Einar Thorsrud, who worked with Trist and

Emery from the Tavistock Institute promoted forms of work organisation that stimulate the collective ability to learn, adapt and cooperate, and thus design a better working environment (Boxall and Winterton 2018, Boxall et al 2019). The Norwegian Industrial Democracy movement was thriving in the 1960s and from there the ideas passed to Sweden, where the employers' federation saw it as a solution to problems related to routinised work (Benders 2005, Mumford 2006). In the mid-1970s the Centre for Working Life at Stockholm University led by Bertil Gardell, developed a similar philosophy debating that individual and collective control over the work process was significant for social democracy. In the Netherlands, STS drive placed importance on the design of "whole-task groups" in which considerable control over the production process was handed to teams of employees(Boxall and Winterton 2018, Boxall et al 2019) .

The STSD approaches to teams continued to be important throughout the 1970s to the 1990s, and remain influential to this today. They have a core focus on the characteristics of jobs, and individual task characteristics (how much autonomy and discretion do individuals have, what feedback mechanisms are in place) although performance is typically analysed at the group level (see Clegg, 2000; Wall et al, 1986). The focus of STSD has been largely on establishing quantitative relationships between individual task design and inputs to outputs or performance. Ironically, given the initial focus of STSD research on group performance within specific contexts, a limitation of the STSD research is a relative lack of attention paid to context (such as the organisational context, social or cultural context in which teams operate) to understand why and how teamworking is effective (Batt and Doellgast, 2006).

2.2.3 The Humanisation of Work Movement

Building out of the STWS approach, the Quality of Working Life (QWL) in the 1960s and 1970s embraced teamwork in the form of autonomous group working. By 1972, a Council for the Quality of Working Life was established, comprising mostly academics who spread the quality of work message globally through training sessions, meetings, books and articles. Members of the council worked with diverse companies, initially helping them to introduce STSD projects onto their shop floors and later into offices (Mumford 2006). Socio-technical teams began to influence shop floor manufacturing operations in the 1970s, particularly through 'Humanisation of Work' (HoW) initiatives. It was presented to manufacturing factories in Sweden as a means of alleviating retention difficulties and improving recruitment. Most famously, the Volvo experiment in the Swedish Kalmar and Uddevalla automotive manufacturing plants sought to use teamwork to redesign jobs, and replace short cycle, conveyer driven production with a new work system focusing upon job enrichment and semi autonomous team working. Socio-technical traditions were instigated to enhance employee sovereignty in decision making ability and involvement in organisational design which was hoped to decrease the strains of employees (Mueller et al 2000, Benders 2005).

In Germany, Fröhlich established a specific spontaneous adoption of humanisation concepts in several of their workplaces in German manufacturing industry. New forms of participation were designed which –

importantly - did not question Germany's existing institutions of employee participation. The Humanisation of Work programme, in contrast to some of the STWS approaches, did therefore, pay some attention to the context in which teamworking was being introduced, with accommodations and changes made to ensure it fitting with prevailing organisational and institutional arrangements. For example, within the automotive sector, Volkswagen was more of an active participant in 'Humanisation of Work' programme than were Ford and Opel. Management at VW initiated the process of teamworking to involve unskilled workers in active participation over assembling a whole engine, reducing job stress, enhancing work conditions, and developing scope for semi-autonomous work groups to undertake personnel planning decisions. However, this trend did not initiate a widespread trend due to the fact that semi-autonomous groups were seen as a threat in other companies, in other countries, to existing workplace institutions (Mueller et al 2000).

2.2.4 Employee involvement in design

Over the years a range STSD also developed in the direction of employee involvement in organisation design. As teams were formed and teamwork was discovered again under new labels such as employee involvement in problem solving in the 1980s (Pasmore and Friedlander 1982), special project teams, interface teams which deal with issues that cut across work groups, and teams that collect input across departments and shifts (Banas 1988). These teams provided input into organisation design, which enabled employees to influence their own working environment. A key factor in its

acceptance and dissemination was the argument that employees are more likely to accept and utilise working conditions that they were involved in creating (Benders 2005). Yet, the nature of employee involvement and participation initiatives varied across sectors, countries and contexts. Crucially, the motives for introducing these initiatives varied markedly, with it being used in some contexts to intensify work, secure worker consent, and enable the exercise of the managerial prerogative (Vidal, 2007; Brown and Cregan, 2008, Blyton and Turnbull, 1998). Whilst in some cases, involvement and participation entailed substantial changes to work design and genuine worker involvement (Marchington et al, 1993) such approaches typically occurred in contexts where there was institutional and organisational supporting mechanisms and practices in place. Such debates over the rhetoric and reality of participation and involvement continue today (Wilkinson et al, 2013; Ackers, 2019).

2.2.5 Lean production

By the 1980s, STSD systems were seen as being increasingly expensive, whilst interest in participation and involvement, which had grown in the 1970s had begun to wane (McGovern et al, 1997; Legge, 1995) Lean production emerged in the 1980s (Mumford 2006), introduced in Japanese manufacturing sector, and seen by many as a key means through Japanese firms established and maintained a competitive advantage (see Stewart, 1998, Stewart et al, 2009 for critical reviews). A key part of lean production was teamwork, although this was perceived by many as a means through which work could be intensified and control increased (Oliver et al, 1998). It

did rekindle interest in teamworking amongst politicians, academics, trade unionists and management. At that stage interest in teamwork was driven by company productivity and profitability objectives (Mueller et al 2000).

Of particular interest were the Japanese manufacturing methods developed at Toyota, than the methods of the Scandinavian exemplars Volvo. It developed a model that included the ideas of interdependence, collaboration, and knowledge sharing however in a more constrained -often assembly line - structure. Unlike socio-technical a team, autonomy was not the driven force behind the notion of lean team, but they did present a degree of participation This is exemplified in quality circles (QC) a practice where employees' knowledge extracted into improvements in products, process, operational efficiency, safety, and ergonomic themes, yet where the motives for introduction were management led (Mueller et al 2000, Benders 2005). Over time, whilst this distinction may be a little exaggerated, lean teams became particularly associated with short cycle times, work intensification, strong management control, and constrained job autonomy (Stewart et al, 2009; Martinez Lucio et al, 2000; Knights and McCabe, 2000), whereas socio-technical systems consisted of long job cycles, reduced worker hierarchy, autonomy and functional flexibility (Greenwood and Randle 2007). Lean production also grown into the public sector, involving the public health and public services, bringing into play the same concerns around workload and autonomy as are raised in manufacturing (Boxall et al 2019).

The fundamental differences between STSD and lean team design were the methods for coordinating and controlling work. Work was not made more flexible and interesting under lean. Instead, it became more streamlined, faster and more stressful. Lean design focused on the standardisation of work processes. In contrast, STSD created decentralisation of coordination and control by the user group (Mumford 2006).

2.2.6 High-performance work systems

Nowadays, lean principles applications have reached well beyond the manufacturing industry to service sector delivery, and to the subject of this thesis, healthcare. In order to compete with the global market new practices developed in the manufacturing industry. The introduction of high performance work systems (HPWSs) was seen by many to have a significant impact on organisational performance. HPWS, seen as an integrated set of people management and production practices designed to be implemented together to improve performance, included teamworking, in which frontline workers formed a team and participate in solving work problems or quality improvement teams (Appelbaum et al 2000, Boxall and Macky 2009). Teams, as in STWS, were characterised as self-managing teams or autonomous work groups. Teams in HPWS were – in theory – said to experience high autonomy over their work tasks and methods, and had higher work related communication with other workers, managers and experts (Van de Voorde and Beijer, 2015; Shin and Conrad, 2017). Teams were characterised as being supported by Human Resource policies such as selective staffing, performance-contingent compensation, self-managed

teams, decentralized decision-making, open communication, extensive training, and flexible job assignments. Factories offered workers incentives, training, and the opportunity to participate in decisions that can improve organisational performance (Evans and Davis 2005). Teams were encouraged to learn a variety of tasks and use different skills and rotate among jobs to reduce repetitive work and boredom. This allows staff to share a collective responsibility in their workplace.

Whilst the rhetoric of HPWS suggests that teamworking can have a range of positive effects, research studies present very mixed results. Data drawn from manufacturing or from a large-scale cross- sectoral surveys indicates that most performance effects came from work intensification rather than empowerment, autonomy and improved communication. Very few teams within HPWS provided workers with genuine autonomy, in terms of them having control over how they conducted their work, and having the ability to determine their own team leader (Appelbaum et al. 2000, Ramsay et al. 2000).

This research suggests that in understanding the effects of teamwork, managerial aims must be considered. In order to reach these positive aims of teamwork, managerial aims must be considered. If management rationales for the introduction of teams solely reflect economic aims such as increasing productivity and reducing employment, then it seems likely that such effects may occur through work intensification and greater control. In contrast, if the goals of teamworking incorporate social aims such as

providing an opportunity to gain more skills, and cultural aims such as increasing organisational commitment and motivation, this may mean that positive performance effects come from these mechanisms (Bacon and Blyton 2003).

Indeed, much of the scholarly debate about HPWS counterposes two broad approaches of the phenomenon. The first, which is viewed as the mainstream approach, suggests that HPWS practices are affiliated with positive outcomes for workers. It contributes to commitment, satisfaction and autonomy, which can result in superior organisational performance. Under this view, teams as a source of liberation from Taylorism, management theorists as a source of flexibility and performance (Batt and Doellgast, 2006). Team based work under this view represents real change at the work place.

The second approach is more critical in nature, incorporating labour process theories and industrial relations research, to look at the dark side of teams, and making the argument that HPWS practices, and teams within them, only happen through work intensification and shifting responsibility to workers that leads to an increase in workload and stress without an increase in rank or pay (Ramsay et al. 2000, Harley 2001, Harley et al 2007).   In this more critical view, there is an interest in the reality of teams at the workplace level, and attention paid to the reasons why teams are introduced, the organisational, institutional and cultural contexts, and a sensitivity to the varied effects of teams of different groups.

Within critical sociology and labour process studies, a healthy cynicism to the generally optimistic assessment of teams and teamwork found in the HPWS and psychology literatures can be found. they share a mutual concern with coercion, dynamics of conflict, and consent within the workplace. They also generally use intensive field-based studies to explore their theoretical assumptions and approach teamwork as part of management's strategies to control employees effort and output, rather than as possibly emancipatory forms of work organisation (Batt and Doellgast 2006). Labour process researchers are mainly concerned with explaining how management effectively controls employee effort and appropriates the surplus value of labour. In Braverman's (1974) classic depiction of deskilling the clerical work under Taylorism, management controls the labour processs through the 'separation of conception from execution'. The restoration of tasks and delegation of management functions to workers associated with post-Fordist team based production systems exemplifies a challenge to this deskilling argument. A range of new interpretations of teamwork have followed, pursuing to place it within the context of evolving management schemes to extend control over worker output and effort (Batt and Doellgast 2006).

One interpretation holds that new management practices should be understood as a specific moment in a progression of cycles or stages in which diverse methods of control dominate during different historical eras. In Edwards's influential theory of historical stages of management control (1979), organisations moved from simple or coercive control in the late

nineteenth century to technological control in the Fordist assembly line, and then to bureaucratic control in the hierarchical organisation of the mid-twentieth century. At each stage, the method of appropriation changed. Under Fordism management control over the labour process occurred through the parting of conception from the execution and the detailed division of labour. In post-Fordist regimes, the use of teams to reintegrate conception and execution of tasks exemplifies an alternative method of control (Batt and Doellgast 2006).

These theories highlight the importance of considering the context in which teams are introduced, the multiple, often contradictory motives for teams, the challenges of implementation of teamworking, and the different impacts that teams have on different groups, all of which merit closer attention.

2.3 HRM practices and teamworking

Teamworking is also played a central part in debates about HRM from the 1990s (Legge, 1995; Boxall and Purcell, 2011; Storey, 2007; Wall and Wood , 2005, Guest et al, 2012). In most models of HRM, both hard and soft, teams feature prominently, as a practice that can be used to impact upon employee behaviour and which can have a positive effect on performance (see Pauwwe and Boselie, 2005; Boxall et al, 2007; Guest, 2011). The processes and mechanisms through which this occurs are varied. A useful synthesis of approaches is provided by Purcell et al. (2003) who argue that teamworking impacts upon the 'M' and the 'O' in their Abilities-Motivation-Opportunity model, increasing motivation by giving

workers autonomy over how they work, and increasing opportunities to participate, decide how their work is done, and learn from one another.

Whilst much of the HRM-teamworking literature has been criticized for being overly prescriptive or simplistic in nature, studies have highlighted how bringing people together does not ensure that they will work together efficiently and make appropriate decisions. Teamworking difficulties have been attributed to professional barriers, different payment system, and perceived hierarchical differences (Millward, Jeffries 2001). Teamwork requires significant development efforts and integration to establish a group into an effective team. When supporting HR practices are weak, HR practices will produce messages that are vague and subject to individual interpretation leading to incompatibility of practice that can affect staff performance (Bartram et al. 2007). Bacon and Blyton (2000) caution that when the aims of management are inconsistent with the type of teams initiated in the organisation, any positive effects of teams on outcomes will be hindered (Bacon and Blyton 2000, Wall and Wood 2005).

This suggests, again, that context is important to realizing any positive effects of teamworking, with teamworking needing to 'fit' with other HR practices in places, and with the system of HR being operated within a particular firm. These practices and systems are likely to vary markedly from one organisation, sector and country to another. Nancarrow et al (2013), for example, point to the importance of effective incentive systems, strong communication, and clear and supportive line management to the success of

interdisciplinary teams (see also Xyrichis and Ream, 2007; Xyrichis and Lowton, 2008; Molyneux, 2001). Incentive systems – both informal and formal - within teams, for example, need to be configured in ways that ensure individuals feel recognized for their specific contributions, whilst also providing motivation and effective reward for the team as a whole (Thompson, 1995; Fiscella and McDaniel, 2018).

HRM structures can, then, in some cases, help support teamworking practices. For example, training and development in how to work in teams and collaborate may help to ensure that those operating within teams understand how such structures are expected to work, whilst the provision of time and capacity to communicate within teams (through regular meetings) may also help team members to work effectively in an interdisciplinary environment. For some, these supporting HRM practices provide essential 'glue' to ensure that individual practices, such as teamworking, work effectively (Whitfield, 2000; Purcell and Hutchinson, 2007; Brown et al, 2008).

However, by the same token, HRM systems and practices may also undermine teamworking. There may be tensions or contradictions between the goals of teamworking HRM practices. Payment systems may undermine the goals of interdisciplinary working by over-emphasising individual contributions, or may be confusing or overly complex in their design (Fiscella and McDaniel, 2019; Some et al, 2020). A reward system should recognize individual task interdependence and encourage team members'

collaborative work (West and Lyubovnikova 2013). A number of workplace based studies have explored these tensions and contradictions in detail, showing that the success of teamworking cannot be assumed in advance, and rather, that it depends of the realities of how it is formulated and implemented (Ogbonna and Whipp, 1999; Procter and Radner, 2014; Cook et al, 2016; Carter et al, 2017). A long-standing literature in the sociology of work and critical HRM has explored these tensions and contradictions, often as a counterpoint to normative studies on HRM and performance.

Fit between teamworking and other HRM practices is important to consider, then, as well as understanding how teamworking is implemented. A key aspect of both of these, according to much research, is the line manager. Line managers are identified in the Purcell et al (2008) AMO model of HRM as being crucial to crucial to the effectiveness of teamworking, and other HRM practices (Purcell et al., 2008; Bos Nehles et al, 2013). Line managers may help to communicate teamworking messages from the top of the organisation, rationalise and gain buy in for working together towards a common goal, identifying good performance and rewarding it, and ensuring that team members are trained and developed, and rewarded effectively (Renwick, 2003; Purcell and Hutchinson, 2007). In the Purcell et al (2008) AMO Model find, through workplace- based studies that teams can improve performance where line managers are able to work effectively. However, they may not have the skills, or the resources to act as the 'crucial causal agents' mediating HRM practices and performance (Purcell and Hutchinson, 2007).

2.4 Teamworking in healthcare

As the review above has shown, the belief that teamwork can be an effective element in delivering services and products has gained ascendancy among diverse organisational settings. This belief has pervaded healthcare, particularly since the beginning of the 21st century, where teams have been increasingly seen as an integral feature of delivering care in long term, acute, and primary care settings (Lemieux-Charles and McGuire 2006). The incremental movement of private sector management practices to the public sector has stimulated further interest in adopting teamwork in healthcare, with the introduction of the patient as a 'consumer', with rights to be ensured, and with patient-led care seen as something that can be facilitated through teamworking.

The concept of teamwork has become increasingly spotlighted in healthcare policy nationally in the UK (Darzi 2008) and internationally (Joint Commission on Healthcare 2009). Mirroring debates in the wider teamworking literature, it has been argued by some that teamwork can generate greater productivity improvements, individual creativity, and organisational adaptability than any one individual can offer. Teamworking in healthcare has been identified in studies as a key driver of improved quality, efficiency, and expenditures (Wilkinson and Witcher, 1993, Sommers, Colleagues 2000, Suganthi and Samuel, 2004, Salas et al. 2012).

Variants of teamworking in primary care can be seen in the UK as early as in the 1960s, brought to the fore by the Charter for General Practice (British Medical Association 1965), in conjunction with the movement of attaching community nursing staff to particular practices (Wiles and Robinson 1994). From the 1980s and onwards, the progress of teamworking in primary health care teamwork was driven by a desire to encourage interprofessional collaborations within healthcare settings. This stance of collaborative work was reinforced by the Cumberlege Report on community nursing in the UK, with the suggestion that nurses were most effective when they collaborated with general practitioners in a primary healthcare team (Leathard 1994).

The ideas associated with lean teams, covered in section 2.2 above, have been taken up in healthcare, and have played a pivotal role in alleviating financial pressures on public sector organisations during times of austerity and cutbacks in the last decade (Brandao de Souza 2009, Burgess and Radnor 2011). Lean teams in healthcare are typically implemented with a focus on standardization of processes, reducing waste, down-time and errors, and improving flow, with teams configured to try and enhance quality so that non-value adding activity such as waste is removed or reduced (Burgess and Radnor 2011, Al-Balushi et al 2014). Young and McClean (2008) define value from a patient pathway view, and look at how teams can ensure a smooth path for patients from entry into a hospital until a they are discharged from care.

Fillingham (2007)'s research into lean teams in healthcare in one hospital in the UK is insightful here. The hospital had financial deficit, and problems with long waits for diagnostics and many treatments. After nine months the outcome in the trauma team resulted in a reduction in the time taken to get patients into theatre, better multidisciplinary team working, reduced length of stay by 33 per cent, 42 per cent reduction in paperwork and 36 per cent reduction in mortality rate (Fillingham 2007). In her review of lean in healthcare, Mazzocato et al (2010) some of the identified positive results of the concept included improved teamwork, staff engagement and willingness to collaborate, and reduced time to resolve error alerts (Mazzocato et al 2010). There is a growing number of implementation and reports in the literature that suggest that lean teams can improve performance in healthcare (Kelly et al 2007, D'Angelo and Zarbo 2007, Mazzocato et al 2010, Brandao de Souza 2009).

Whilst in some respects, the dynamics and nature of teams in healthcare share features with other settings, there are a number of distinctive features, which merit attention. In comparison with other teams from different industries, medical teams, especially in the dynamic domains of healthcare such as intensive care, operating room, trauma and resuscitation teams work under unpredictable settings which maybe be assembled ad hoc, have a dynamically varying team membership, and often work together for a short period of time. Such teams consist of professionals workers from a range of different disciplinary backgrounds and specialisms, and importantly, they have very different professional cultures (Manser 2009).

In healthcare settings, specifically in hospitals, members contribute to various groups or teams. For example, there are profession- based groups (nurses, physicians, or pharmacists), and different units which are running by diverse professional groups (intensive care unit, neonatal care unit). Other contributors to healthcare teams are individuals who work solely night shifts and may rarely interact with those who work morning only shifts. Interactions are often virtual by leaving paper trails for others to follow in order to maintain the health and well-being of the service users (Johnson, 2009). Another team type is a transient or action teams, which is composed of health professionals who may be assembled ad hoc, and have a dynamically changing membership depending on a particular project or initiative. Such teams work together for a short time and disperse immediately after the problem is solved (e.g., a pregnant patient with high anxiety, multiple medical allergies, and high-risk for blood clotting would entail the intervention of a team of physicians that include obstetrician, psychologists, neonatologist, hematologist, and anesthesiologist) (Manser 2009, Johnson, 2009, Deneckere et al. 2012).

This leads us on to a closer inspection of the type of teams under consideration in this thesis, the inter-disciplinary team. Lemieux-Charles and McGuire (2006) provide a typology of team types based on the team's primary contribution or purpose to healthcare organisation. The four team types encompass the most commonly found care teams in healthcare:

- Project teams such as quality improvement teams (QI) that are committed to improving healthcare process and outcomes.

- Management teams that are accountable for administrative functioning.

- Interprofessional care delivery teams such as actions teams.

- Care delivery teams which are teams responsible for the delivery of healthcare.

In this thesis the focus is on care delivery teams, which are defined based on patient population (e.g. mental health patients), or disease type (e.g. stroke), and care delivery settings (e.g. acute, primary, or chronic) (Lemieux-Charles and McGuire 2006, Johnson, 2009). These teams involve a group of clinicians and staff who have a collective clinical purpose and direct care accountabilities for a well-defined group of patients (Deneckere et al. 2012).

According to Xyrichis and Lowton (2008) many diverse terms are used to describe collaborative working arrangements between professionals. Terms such as: interdisciplinary, interprofessional, multiprofessional, multidisciplinary, are commonly used interchangeably in the literature to refer to both different types of teams and the process within them (Payne 2000, Xyrichis and Lowton 2008). However, there are some consistent distinctions. Words with a 'multi' prefix refer to various diverse professional

groups working together. However, this does not indicate that they adjust aspects of their professional role, their knowledge base, skill or their agency responsibilities to fit in with the roles, responsibilities, skills, or knowledge of other groups. Rather, the focus is to collaborate within their roles, not to cross boundaries with others. On the other hand the prefix 'inter' does entail the adjustment of knowledge, skills, roles and responsibilities to adapt to those of other professional groups or agencies (Payne 2000). Moreover, the prefixes, Trans, Inter, Multi, and Cross refer to the degree of integration in the working environment with Trans (professional) being the most integrated and Multi(professional) being the least (Thlefors et al. 2005).

'Disciplinary' refers to the skills and knowledge underlying specific professional roles. 'Professional' refers to diverse professional groups and activities and functions that are associated with those groups (Payne 2000)..
According to Nancarrow et al. (2012) the term interdisciplinary is broader which includes a range of healthcare workers, both professionals and non-professionals who have a collective clinical purpose. This term is commonly used when the focus of the literature is on sharing of specialist knowledge in working collaboration (Nancarrow et al. 2012). On the other hand, the term interprofessional is commonly used when the focus of the literature is on roles, professional boundaries, and the perceived unique contribution of the individual professional (Smith 2012). Within this thesis, the term used is interdisciplinary team working as a generic term of reference to cover all these terms. The reasoning for this is twofold. Firstly, as noted above, there is some conceptual stability with these terms and they appear to be used

interchangeably in practice. Secondly, the research interventions, and data gathering activities supporting the study include all members of healthcare teams both professional, and nonprofessional.

For these reasons the term interdisciplinary appears to be most appropriate, as it includes all members of the teams being researched, focuses solely on how teams collaborate together. This said, during the literature review, where authors have used the terms inter/multi/trans- professional or inter/multi-disciplinary the authors' original terms will be used.

2.5 Inter-disciplinary teamworking in healthcare

2.5.1 The development of inter-disciplinary teamworking in healthcare

The discourse of inter-disciplinary teamwork has become a key concept for health reform in the 21st century. Inter-disciplinary teams have been hailed as the cornerstone of medical care, enabling healthcare organisation to produce safe and effective care (Firth-Cozens 2001, Propp et al. 2010). In the UK collaborative practice across disciplines is consistently advocated by the Department of Health. For example, in the UK the NHS ritualistically stress on the importance of delivering healthcare by teams in their publications including in the 'Darzi Report' (Department of Health, 2008). In

the US, the Institute of Medicine correspondingly argues that inter-disciplinary teams today are needed to deliver effective care to the public (Finn et al. 2010). In Saudi Arabia, the focus of this thesis, the global Alma-Ata declaration on primary care that supports collaboration between health and social care professionals and agencies into working together with local communities to improve service delivery, in order to promote public health and wellbeing (WHO 1978) has been taken up (Al-Ahmadi, 2005). Teamwork is acknowledged as a set in the values and principles that govern the work in all health facilities in the Kingdom (MOH 2012). The Ninth Development Plan is to improve the quality and standard of healthcare, ensuring easy access to healthcare, and widening the geographic distribution of health services in the Kingdom (Ministry of Development and Planning 9th Plan).

The complex structures of hospitals mean that inter-disciplinary teamworking is often seen as a means to improve facilities, process, and patient information and support, micro-organisational structures (multi-disciplinary teams and regional groups), macro-organisation structures (collaborative network), improve inter-organisational co-ordination (patient pathway), medical practice (booking and pooling patients, relocating surgical procedures), and goals (waiting times). However, such change also requires the consensus of powerful occupational groups (Buchanan 2007). Professionals are inherently challenging to change due to the professional resistance, complexity and lack of incentives. According to a research by Buchanan (2007) clinical staff consensus over change of goals and substance was accompanied by tension regarding their need to protect their

roles, responsibilities, priorities and manoeuvring for position in evolving structures (Buchanan 2007). Other scholarship on teamwork focus on the professional struggle between reciprocity and equality where employees are encouraged to be team players, while equally creating disciplinary effect, and encouraging self-surveillance (Finn et al. 2010).

As a result, teams in healthcare has traditionally relied upon socio-technical methods, and single specialism teams for constructing quality systems in health care organisations. This is demonstrated in the work of Stoelwinder and Clayton (1978), where they observed patient care teams consisting of all personnel delivering direct services to patients in specific areas. Each team functioned as a self-regulating work group and formed the basic organisational units for managing the delivery of healthcare services. This resulted in reduced statistics for average length of patient stay, improved problem solving of patient care teams, and improved employee morale (Stoelwinder and Clayton 1978, Chisholm and Ziegenfuss 1986, Harteloh 2003), yet no inter-disciplinary teamworking could be observed.

The challenge of inter-disciplinary teams can be seen in the example above. Healthcare professionals consist of a historically developed, institutionalised set of hierarchical relations between them that supports different professional interests (Van Der Vegt, Bunderson 2005, Finn et al 2010). Professionals who are characterised by a specialised, fragmented, division of labour, where each profession has a diverse role and delivers the strong basis for socialised membership and identity (Finn et al. 2 010, Nancarrow

and Borthwick 2005). Coordination, communication, and control over care process are complex because these teams involve different professionals that operate in different context and are temporary interactive (Deneckere et al. 2012). Consequently, Finn et al. (2010) suggests the great tendency towards rivalry, conflict, and the detriment of team integration. Nevertheless, common patient-centred interests still makes collaboration vital to attaining outcomes; ultimately this tension must be negotiated in some way for collective action to progress (Finn et al. 2010).

2.5.2 The benefits and challenges of inter-disciplinary teamworking in healthcare

Advocates of interdisciplinary teams argue that they can improve the quality of care by re-engineering or redesigning services to ensure effective care for all patents (Cameron 2011). They enabled healthcare organisation to better streamline medical services, integrate care providers roles, and implement quality improvement measures (Propp et al. 2010). In a seminal study, Grant and Finnocchio (1995) reported on the benefits of interprofessional teams for patients, health care professionals, educators and students and health care delivery system (see Table 2.1).

Table 2. 1 Advantages of Interprofessional Teams

For Patients:	For health care professionals:
• Improves care by increasing coordination of services, especially for complex problems • Integrates health care for a wide range	• Increases professional satisfaction • Facilitates shift in emphasis from acute, episodic care to long-term preventive care

of problems and needs • Empowers patients as active partners in care • Can serve patients of diverse cultural backgrounds • Uses time more efficiently	• Enables the practitioner to learn new skills and approaches • Encourages innovation • Allows providers to focus on individual areas of expertise
For educators and students: • Offers multiple health care approaches to study • Fosters appreciation and understanding of other disciplines • Models strategies for future practice • Promotes student participation • Challenges norms and values of each discipline **(Grant and Finnocchio, 1995)**	**For the health care delivery system:** • Holds potential for more efficient delivery of care • Maximizes resources and facilities • Decreases burden on acute care facilities as a result of increased preventive care • Facilitates continuous quality improvement efforts

For patients, interprofessional provides more patient centred approaches and to greater recognition of personal needs and preferences (Deneckere et al. 2012), whilst for workers, inter-disciplinary teams can encourage skill development and innovation and lead to greater satisfaction. Organisational benefits and benefits for the healthcare system can also be anticipated in the table above.

Yet, many of these benefits may not be realized in practice. Effective communication and coordination is essential for the delivery of high quality, safe patient care (Leonard et al. 2004, Manser 2009, Deneckere et al. 2012).

In patient safety literature it has been widely recognized that team performance is essential to providing safe patient care. However, there are some challenges such as poor communication and coordination among providers at various level of the organisation seems to affect the quality and safety of patient care (Firth-Cozens 2001, Leonard 2004, Manser 2009, Deneckere et al. 2012).

Professional boundaries arise in different views of the patient and the nature of teamwork differences that must be negotiated (Finn et al. 2010). Collaboration among team members is vital in achieving outcomes; ultimately any tension must be negotiated in some way for collective action to proceed. Then again such negotiation process within teams are likely to be ideological and contested with the context of strong professional boundaries (Finn et al. 2010). Working through professional boundaries can raise insecurity, rivalry, fears about losing areas of activity that bring job satisfaction, fears of loss of power and status, fears that skills are lost and services are inferior. On the other hand, flexibility around boundaries can advantage patients by promoting continuity of care, effective teamwork, and benefit highly trained staff to take on new skills and activities (Pollard et al. 2010, Nancarrow and Borthwick 2005). However, the overlap of roles and apparent intrusion of traditional territory can lead to professionals enquiring their place within the interprofessional system.

2.5.3 Perception of interdisciplinary teams

A further challenge to inter-disciplinary teamworking in healthcare comes from the different interpretations and perceptions that members have towards teams. Whilst this presents a challenge in all team contexts, it may be particularly acute in healthcare, given the range of professionals that are expected to work together under such teams. Teams even if perceived to exist by members, while conceptually in some organsations it is regarded as unnecessary and potentially cumbersome.

An early study conducted by Temkin-Greener (1983) examined health professional's understanding of teams and teamwork. The study challenged the assumption that the notion of team and teamwork were well understood by doctors and nurses. Conducting 12 interviews of department heads in medicine and nursing located in a medical centre in the US, Temkin-Greener found that nurse managers viewed interdisciplinary team working as achieving greater status for professional recognition and autonomy. Consequently, nurses viewed teamwork as a something that could provide them with equality and decentralised authority. In contrast, medical heads used teams to reinforce the traditional hierarchical view of interdisciplinary relations that placed authority and power to the doctor. Although the study was based on a small sample, it offered a clear indication of differences between the ideology expressed by policymakers and the reality in practice as comprehended by nurses and doctors. Temkin-Greener (1983) explored the differences in perceptions among disciplines, however further research might compare the perceptions of a wider range of team members to

establish the generalisability of these results. This research will provide perceptions of a wider group of primary care staff in Chapter Five.

In larger-scale research conducted by Miller et al (1999), a study of multiprofessional teams investigated the preparation of health and social care team members, and how well they worked in teams, through documentary analysis, non-participant observation, and interviews of six teams in hospital and community settings in the UK. Students, it was found, were insufficiently prepared for future multiprofessional implementation. Miller et al. (1999) argued that professionals might have to overcome various obstacles to guarantee that teams function efficiently as there was clear evidence of mismatch between policy makers' and health and social professionals goals. Team working was only one of a number of pressures and imperatives on managers, who were faced with obstacles such as economic constraints, poor workforce planning, varying commitment to role expansion and conflicting professional perspectives on service redesign and multiprofessional working. Moreover, there was a limited number of improving team working, despite the overall support for the principle.

Stark et al (2000) also found differences between the rhetoric and reality of teamworking in healthcare. Team working was often imposed by organisations without attention to team building. The research underlined that teamwork was inflicted on some team members without proper preparation, which in turn led to conflict, fragmentation and dissatisfaction. Moreover, the research drew attention to the need to understand and

recognise the impact of authority, power, status and competition between members if efforts to establish successful collaborative practice.

Similarly, in a study of medical social workers' perceptions related to interprofessional teamwork at hospitals in Saudi Arabia, Albrithen and Yalli (2015) found challenges to a successful interprofessional teamwork some included the hierarchal nature of professionals that situated authority with doctors. As a result, social workers find it difficult to voice out their opinion in the team. Cultural diversity was also a barrier due to medical care professionals (doctors and nurses) who have come from Arabic and Asian countries where their awareness of participation of non-medical professionals is limited. Other challenges to successful interprofessional teamwork were lack of organisational support for effective linkages between various professional groups (Albrithen and Yalli 2015).

If team member's perception of team working as reducing individual responsibility, teamwork will be ineffective hence causing disastrous results (Finn et al. 2010, Baxter and Burmfitt 2008). On other hand, teamwork can expand responsibilities and enrich roles. This is illustrated in a research by Carmel (2006) in an intensive care unit (ICU). Doctors and nurses worked jointly to establish ICU outreach teams in which nurses took on more responsibility of medical work, thus gaining increased autonomy. This did not constitute a threat to consultants' authority; on the contrary, ICU consultants had more freedom to pursue other sphere of interests in the hospital (Carmel 2006 page119 in Pollard).

Freeman, Miller, and Ross (2000) conducted case studies of 6 teams working in a range of specialist healthcare services (primary care, neuro-rehabilitation unit, medical ward, community mental health, diabetes, and child development assessment). They concluded that the diverse meaning professionals attached to teamwork shaped how they communicated and what they communicated about. When there was a lack of compatibility regarding aspects of teamwork, communication, and the ultimate effects of teamworking, were compromised. Members' perceptions determined how much they valued other contributors in the team, as well as the understanding of their role within the team. Differences in understanding the former concepts undermined professional esteem, creating resentments and generating conflict. Moreover, members perceptions influenced communication about tasks, and sharing professional ideas and knowledge (Freeman et al 2000).

A number of studies of inter-disciplinary teamworking in healthcare have sought to identify good practice principles for effective teamworking. Grumbach and Bodenheimer (2004) identified five factors that enhance cohesiveness among interdisciplinary teams: clear roles and responsibilities, effective communication, ongoing development and training for all staff members, firm goals and outcomes, and effective administrative systems. In addition, Borrill et al. (2000) reported that clear goals and objectives improved team effectiveness, similarly Cashman et al. (2004) stated that common goals and clear direction are one of the essential factors

for improving team functioning. However, blurring and misunderstanding of roles and responsibilities are common issues in obstructing effective teamwork. Consequently, evolving into intractable differences and conflict among team members (Cashman et al. 2004, Xyrichis, Lowton 2008).

In research by Buljac-Samardzic et al. (2010) communication and cooperation were also identified as the most important characteristics which resulted in effective interdisciplinary teamworking among members. Clarity of roles and responsibilities was also needed in order to avoid confusion regarding their roles and provide the right care (Buljac-Samardzic et al. 2010).

Finn et al (2010) also state that it is necessary for professionals to find space to negotiate what team working means in practice. They argue that the meaning of teamwork resonates with professional identity and can leave members working in silos rather than connecting with other professionals in their team. Moreover, in a research by Cafferkey et al (2020), found that HRM practices are perceived and experienced differently across diverse occupational groups. It suggests that applying a uniform HRM system to all occupational groups in healthcare can result in very different and sometimes unintended outcomes.Their research highlights the critical importance of differentiated HRM practices for different employee groups and that HRM is not a "one size fits all" concept (Cafferkey et al (2020).

These studies illustrated that despite some positive perceptions about teamwork, still there were barriers integrated team working. These include traditional hierarchical relationships with medicine, different professional ideology and meaning to teamwork, and concerns regarding professional role and territory.

2.6 Human Resource Management and inter-disciplinary teams in healthcare

In section 2.3 above, the fit between teamworking and other HRM practices, and the potential for tensions and contradictions to arise during the implementation of teamworking were emphasized. In healthcare, HRM is seen a means to influence patient care quality, mortality rate, reduce costs and medical error (West et al 2006). HRM systems are developed at the organisational level, but experienced at both the individual and group or team levels (e.g. multidisciplinary team working, individual appraisal) (West et al 2006, Leggat et al. 2011).

 In a survey by West et al. (2002), that examined the relationship between the percentage of staff working in teams, sophistication of appraisal, and sophistication of training and patient mortality in hospitals in England, it was found that the percentage of staff working in teams and sophistication of training had a strong negative relationship with patient mortality. Furthermore, the sophistication of appraisal had a significant relationship with patient mortality. Further research by West et al. (2006) revealed that people management systems that highlight a high involvement HRM polices were more successful in providing high quality healthcare. When HR

systems are perceived as supporting staff in their daily tasks, staff will be more confident in their ability to perform these tasks (Baluch et al 2013).

Similarly, in research by Moher et al. (2011) on job satisfaction of primary care members and quality of care, team-level job satisfaction was positively associated with quality of care. It was argued in this study that good patient care required practitioners not just to perform their own specific jobs well but also to integrate and work cooperatively with other practitioners who were involved in providing care of the same patient. Thus, when practitioners were satisfied with their jobs, they were more motivated to collaborate with other practitioners of their team for the purpose of delivering and managing care of patient (Mohr et al. 2011). These findings resonate with Chuang et al (2012) who identified that supervisory support, performance based incentives, and team-based work practices were necessary for high job satisfaction and high quality of care (see also Baluch et al. 2013).

Within the context of teams, individual HR practices, such as effective reward systems, training and development and appraisal all have the potential to impact upon performance. Regular appraisals offer team members a chance to improve team functioning by discussing problems and consider appropriate solution. They allow individuals to be praised for their contribution and provide support for members where needed. It directs attention to specific objectives, tasks, and assignments. It also recognizes skill acquisition and identifies further needed training (Scott and Einstein 2001, Xyrichis and Lowton 2008). Further studies highlight the importance of

performance feedback provided by supervisors, which enables team members to view themselves as capable of achieving designated levels of performance. Equally, members with higher role clarity have been shown to report higher self-efficacy. In the highly demanding hospital context, self-efficacious staff displayed their capability of dealing with work stress. Thus, staff with a strong sense of efficacy, face difficult tasks as challenges to be conquered, and are intrinsically motivated (Baluch et al 2013).

Studies have found that investment in sophisticated HR systems can increase the likelihood that staff will be able to engage in behaviours that lead to the provision of high-quality health care, thus explaining some of the results above (West et al. 2006). As noted above, individual HR practices, such as performance appraisal, team working, training and involvement in decision making can all have a positive effect on hospital performance and lower mortality rate (Hyde et al. 2005, Bartram et al. 2007, Harris et al. 2007, Chuang et al. 2012, Baluch et al 2013). However, these studies also show that HR practices, when implemented effectively together as part of a work system, can exert a greater impact upon performance. Borrill and West (2004) revealed that healthcare organisations with a well-structured Human Resource Management (HRM) systems performed better than organisations that had a less well developed HRM function. Moreover, the link between performance and human resource development were stronger when the director of HR was a voting member of the executive board (Borrill and West 2004).

A final aspect in any organisation team leadership is vital for it to succeed. Effective teams need a clear leader, and the leader should be determined by the needs of the team and not by traditional hierarchy. The primary role of a team leader is to support their team's integration as it focuses on the client, the patient, the carer or the family (Leathard 1994). Healthcare today is undeniably a team effort that entails professionals to work together successfully to take care of their patients in a holistic approach. Kennedy (2006) stated the need for strong leadership in healthcare in order to avoid medical error and failures of care such as outlined in the Bristol Inquiry Report (Bristol Royal Infirmary 2001). Pethybridge (2004) in an investigation of discharge procedures, also established that good leadership was essential to service delivery. In a report by the Institute of Medicine (IOM) stated that establishing and sustaining a healthy work environment that supports patient safety needed effective leadership, which must be exercised at all levels in the healthcare system from the ward, in the community and the boardroom. Leadership may occur in formal (appointed) and informal (unauthorized) positions and setting (IOM 2011, Boamah 2018). Moreover, Cummings et al. (2010) observed that leaders who practice transformational and relational styles had superior quality outcomes in healthcare than those who demonstrated autocracy. Hence, leadership is an important denominator that links joint working with improved service delivery or improved care.

But placing individuals together and calling them a team is not enough to ensure that work occurs effectively in a collaborative manner. Rather,

ongoing leadership is necessary to ensure groups of doctors, nurses, and allied professionals interact effectively. In many cases, this leadership emerges and evolves, with leaders volunteering for a leadership role with little previous experience or being elected to the role by their peers. Leaders in this context can use their informal power either in a positive or a negative way. Negatively, they may seek to enhance their self-serving interests rather than the interests of the group, creating an adversarial atmosphere, or manipulate information (Van Wart 2011).

On the other hand informal leaders can use their power for mentoring, teaching, and coaching within their teams (Pielstick 2000). This is described by Neubert and Pescosolido as a leadership function but with no formal management authority over the members (Neubert 1999, Pescosolido 2001, Peters and O'Connor 2001). The success of informal leaders in this context is achieved through a combination of the organisation's culture, individual competence and the specific requirements of the situation (Stincelli and Baghurst 2014). The skill of team leadership includes motivating other, structuring the task and mission analysis. Mission analysis and structuring the task are both interdepended in that they both help to provide clear direction to the team. When teams have a clear direction it gives them awareness of what is expected and how to reach the overall goal. Leadership skills also involve motivating members by providing them with a positive supportive atmosphere (Leathard 1994, Salas et al. 2000). To attain optimal levels of performance, teams are required to be skilled in the task at

hand as well as the interpersonal processes that permit team members to work together as a collective unit (Firth-Cozen 2001, Morgeson et al. 2010).

Informal leadership depends mainly on one's experience, knowledge, credibility and personal skills (Sullivan and Garland 2010). Informal leaders have credentials that may not be easily communicated or documented, much less evaluated (Downey et al 2011). However, they can be essential to processes of influence and motivation that contribute towards team effectiveness. Unlike formal leaders, they may not have access to formal organisational rewards and punishments, which can shape the behaviour of team members (Pescosolido 2002). Empirical and theoretical studies have shown that leadership is key in driving force for organisational change, ensuring optimal healthcare performance outcomes, the provision of quality care, and creating a culture of safety in the work environment (Wong and Cummings 2007, Stanley 2008, Cummings et al. 2010, Boamah 2018).

Effective interdisciplinary teams do require a clear leadership with clear direction and management, with leaders being essential to providing supervision and support over personal development, facilitating goal setting, and evaluating achievements (Nancarrow et al 2013).

Leadership in heavily state regulated organisations such as the public sector has some distinct context to leadership in commercial organisations (Alimo-Metcalfe and Alban Metcalfe 2001). In the public sector there objectives are not to profit from their consumers. Thus, impacting how an organisation operates, as they generally considering maintaining costs within an envelope rather than maximizing revenues and creating profit. Moreover, strategic

direction is largely set by civil servants or political figures rather than by organisational leaders reviewing the atmosphere for opportunities aligned with the organisations' vision, mission, values and stakeholder needs (Williams 2005). Thus, in nowadays, many regional and national health systems manage to undergo structural redesign and changes in the priorities and functions in order to face modern economic, societal, and health challenges and needs (Sfantou et al. 2017).

2.7 Conclusion

This chapter first presented the early literature of teamwork development, examining dominant strands of thought, including the socio-technical systems approaches, research within critical sociology, and different meanings of teams (Mueller et al 2000, Benders 2005, Mumford 2006). Then it moves to different meanings of teamworking and HRM and how teamworking is also played a central part in debates about HRM from the 1990s (Legge, 1995; Boxall and Purcell, 2011; Storey, 2007; Wall and Wood , 2005, Guest et al, 2012). In most models of HRM, both hard and soft, teams feature prominently, as a practice that can be used to impact upon employee behaviour and which can have a positive effect on performance (see Pauwwe and Boselie, 2005; Boxall et al, 2007; Guest, 2011). Teamwork requires significant development efforts and integration to establish a group into an effective team. When supporting HR practices are weak, HR practices will produce messages that are vague and subject to individual interpretation leading to incompatibility of practice that can affect staff performance (Bartram et al. 2007).

The chapter draws out the complexities of teamworking and outlines how the context in which teamworking is introduced is vital to comprehend its effects. It proposes that context is important to realizing any positive effects of teamworking, with teamworking needing to 'fit' with other HR practices in places, and with the system of HR being operated within a particular firm. These practices and systems are likely to vary markedly from one organisation, sector and country to another. It also demonstrates the challenges of adopting and implementing inter-disciplinary teamworking within complex healthcare environments, and how tensions must be negotiated in some way for collective joint working. Such tensions rise from professionals who are characterised by a specialised, fragmented, division of labour, where each profession has a diverse role and delivers the strong basis for socialised membership and identity (Finn et al. 2 010, Nancarrow and Borthwick 2005). Coordination, communication, and control over care process are complex because these teams involve different professionals that operate in different context and are temporary interactive (Deneckere et al. 2012). Consequently, Finn et al. (2010) suggests the great tendency towards rivalry, conflict, and the detriment of team integration.

It discusses how HRM is seen in healthcare as means to influence patient care quality, mortality rate, reduce costs and medical error (West et al 2006). HRM systems are developed at the organisational level, but experienced at both the individual and group or team levels (e.g. multidisciplinary team working, individual appraisal) (West et al 2006, Leggat et al. 2011). Based on this review of the literature, the following specific questions will be addressed in this thesis:

- How is inter-disciplinary teamworking implemented in Saudi healthcare settings, what are the connections between teamworking and HRM systems and HR practices, and what contradictions and tensions result?

- What are the motives for teamworking in primary healthcare centres, how do inter-disciplinary team members perceive and understand teamworking and what are the effects?

- How does gender segregation impact upon teamworking and HRM in Saudi Arabia, and what is the role played by the female supervisor in this context?

The next chapter considers in detail the context on Saudi Arabia, exploring the nature of the labour market, government labour market policies and HRM practice. It also sets out details of the healthcare sector, and explores policies and initiatives to develop work and employment in the sector. It shows how quality agendas and teamworking have become priorities for healthcare in recent years.

CHAPTER 3: WORK AND EMPLOYMENT AND THE SYSTEM OF HEALTHCARE IN SAUDI ARABIA

3.1 Introduction

This chapter sets out some of key contextual background for the research. It begins in section 3.2 by providing information about the Saudi Arabia economy, and work and employment in the Kingdom, noting in particular the dependence upon oil, the traditional reliance on expatriate workers in the private sector, the religious and socio-cultural context shaping employment, the relatively limited female participation in the labour market, and gender segregation in society and in employment. This is followed in section 3.3 by a description and discussion of the health care system in Saudi Arabia, where the strongly centralised governmental system is outlined. Section 3.4 focuses on the development of Primary Care Centres in Saudi Arabia. The chapter finishes by looking at the hierarchical system of employment in the public sector (3.4) and its influence on the way the healthcare sector operates.

3.2 The economic and socio-cultural context of Saudi Arabia

Saudi Arabia is a Middle Eastern country, bordered by the Persian Gulf and the Red Sea, located north of Yemen. The kingdom of Saudi Arabia (KSA) covers 2,149,690 square kilometres of the Arabian Peninsula and has a population of over 30 million (Al-Hanawi et al., 2017). The United Nations predicts that the kingdoms population will reach 35.4m by 2025, It is also

one of the largest countries in the Middle East, covered mostly by desert and huge subterranean reserves of oil (Walston et al 2008).

As a mineral rich state in the Gulf region, the economy highly dependent on oil (Walston et al 2008). Indeed, Saudi Arabia has the most extensive reserves of oil in the world, and GDP growth is closely linked to oil extraction and exporting. Oil reserves generated approximately 75% of the budget revenues, 90% of the exports earnings and 40% of Gross Domestic Product (GDP). The Saudi economy experienced high economic growth throughout the 1960s and 1970s, but experienced a downturn in the 1980s, linked to deep recessions in other countries, and a decline in export revenue from oils. Remaining heavily dependent upon oil revenues, the fortunes of the Saudi economy since this time have mirrored those of the global economy, with downturns during the Great Recession of 2008-2010 hitting the Saudi economy too. Nonetheless, average growth rates of the Saudi economy averaged 2 per cent per annum in the 1990s (Mellahi and Wood, 2001) and, with the exception of the Great Recession years, have averaged nearly 4% per annum over the 2000s (World Bank, 2020). The private sector contributes the majority of GDP (about 63.6% in 2015), with activities covering manufacturing, oil refining, finance, retail, hospitality and administration. Much capacity has moved from the public to private sector, through a privatization strategy, although the state maintains a strong role in many areas, including healthcare and education, and retains key roles in private sector firms (Meteb, 2017).

The state plays an important role in the economy, monopolized through a ruling monarchy. All political authority is centralized and vested in the capital Riyadh. The concentration of political power is within the ruling family, which monopolizes the state and controls state bureaucracy, primarily through the distribution of royal family members within government (Common 2008, Metcalfe, and Mimouni 2011). Policies are formulated and implemented by the government, with no representatives for the people or independent interest groups to represent concerns to the government around areas such as health. (Mobarabki, and Soderfeldt 2010).

Whilst nearly three-quarters of GDP is generated by oil, the structure of employment, like in many other countries, is dominated by services, with 7 in 10 people employed in the service sector (World Bank, 2020; Meteb, 2017). The majority of employment is in the private sector, around 10 million jobs out of a total of 11 million. In the private sector, most of these jobs are undertaken by expatriate workers, with employed in the private sector (8.5 million) with around 1.5 million taken by Saudi nationals. In the public sector, where just over 1 million workers are employed, nearly all of these (1 million) are Saudi nationals (Meteb, 2017).

Overall, then, expatriate workers dominate the workforce in Saudi Arabia making up around 70% of total employees. Saudi nationals are over-represented in the public sector, and expatriate (non-Saudi workers) in the private sector. This is a situation that has existed since the 1960s, with dependence on expatriate labour in the private sector growing sharply in the

1990s and 2000s. In the private sector, the majority of all workers are employed in the construction industry (36%), wholesale and retail trade (26%), community and personal services (12%) and 11% in transport (Meteb, 2017; World Bank, 2020).   In the public sector, the most important areas are education, health and working directly within government in public administration.

Labour market participation rates in Saudi Arabia have increased over the last 20 years, to stand at 60% in 2020, but this masks sharp differences in participation between men and women (Sadani, 2005; Syed et al, 2018). Participation rates for men stand at 75%, whilst for women, the rate is 1 in 5. This figure for women's participation has increased from 1 in 10 at the start of the 2000s, but remains low, compared to female participation in Western economies (Basahal et al, 2021). The socio-cultural context of Saudi Arabia is vitally important to consider here, to understand participation. Socially conservative traditions and religious law and interpretations have limited women's participation in in paid work, female employment remains heavily concentrated in the public sector. (Syed et al., 2018).

Unemployment rates have increased over recent years, to stand at 10 per cent in 2019, with some of this increase due to increases in female participation in the labour market, and some reflecting a growing population of working age. Youth unemployment is relatively high. As Mehali and Wood (2001) note, much of the oil revenues generated have been ploughed into the development of the public sector, which has been able to offer attractive

pay and conditions to locals. In contrast, wages in the private sector are relatively low. Saudi workers have a strong preference to work in the public sector as a result (Melahi and Wood, 2001). As in other Middle East and Gulf nations, 'localisation' initiatives led by the state have sought to increase participation in the labour market of Saudis, and have looked to reduce the reliance on expatriate workers (Basahal et al, 2021); Much of the focus has sought to ensure own nationals take key roles in the public and private sectors (Alshanbri et al., 2015; Sadi & Henderson, 2010).

Female participation in the labour market can only be understood with reference to the socio-cultural context of Saudi Arabia (Sidani, 2005; Syed et al, 2018). Saudi Arabia is a Muslim country, with social cultural values and attributes deeply rooted in Middle Eastern Islamic and tribal history. It is ruled in accordance with Shari'a law and a consultative council of one hundred and fifty members of the Shura council (Alfaqeeh 2015). Shari'a law governs all aspects of civil society including health care system, health and moral behavior, medical ethics and gender dynamics. This includes laws which prohibit mixing with unrelated opposite genders (Alfaqeeh 2015; Melahi and Wood, 2001).

Furthermore, Islamic laws and values influence the participation of women in the labour market. Investment in education and training of women is strong, but, as noted above, participation rates of women remain low, due to moral and religious beliefs and rules. Women's participation in the labour market is heavily concentrated in the public sector. Where women do work, there

remains extensive physical gender segregation, with women generally not permitted to work alongside men, either as co-workers or customers (Al Asfour, 2017; Syed et al, 2018; Sidani, 2005). This fundamentally shapes HRM and management practice, impacting materially upon practices such as teamworking, supervision and training (Melahi and Wood, 2001). Managerial attitudes are also shaped by Islamic values, with the authority of the leader or manager accepted as right and with subordinates expected to show respect and obedience to superiors (Mellahi and Wood, 2001).

As Syed et al (2018), adopting a relational perspective, Islamic laws and values impact upon gender equality, and the experience of women in the workplace in a number of ways. Participation of women is relatively, limited, but there are also relatively limited family friendly policies, which may serve to push women away from the labour market (Al Asfour et al., 2017). Religious and cultural norms, have until recently, prevented women to travel alone or drive a car by themselves, making commuting difficult. Physical segregation in workplaces, means that Saudi women are generally not allowed to work in the same room as men and also need separate female entrances, which may constrain women's employment (Syed et al, 2018).

3.3 The Healthcare sector in Saudi Arabia.

Oil wealth has caused a significant impact on public finances and the public sector in Saudi Arabia, with the government devoting considerable resources to the development of the public sector. The healthcare sector in particular has developed and improved as GDP growth has increased (Al-

dossary et al 2008). The healthcare system consumes 7% of the governmental budget (Al-Hanawi, 2017; Al-Hanawi et al., 2017). A long-term shift of the population into urban areas has also impacted upon the healthcare system. In the 1950s, with the population concentrated in rural areas, the model consisted of a mixed public and private provision (Mufti, 2000). The Ministry of Health established a healthcare system, which offered free healthcare for everyone from the early 1950s (Walston et al 2008), with initially 11 non-specialist hospitals, 25 health care clinics, 36 physicians, 179 general nurses, 96 special nurses, and 8 pharmacists (Mufti, 2002). There was a gradual development of the healthcare system and the Ministry of Health, with more rapid development in the 1970s when the economy flourished (Alghamidi 2007). At that time curative services were provided through hospitals, health posts, and dispensaries (Alghamdi 2007), whilst preventive measures such as immunization, hygienic skills, and breast-feeding education were provided in health posts, which later were changed to mother and child health centres. Moreover, the kingdom used a range of vertical programmes for the prevention and control of communicable diseases (Alghamdi 2007). As will be seen in section 3.4 below, there has been an increasing emphasis on the development of Primary Healthcare Centres since the 1980s.

Rapid development of the healthcare sector was needed to cope with demand for essential health services as the economy expanded. At the same time, the state saw the development of the healthcare sector as a means of creating economic opportunities, developing secure jobs for Saudi

nationals, and improving well-being of Saudi citizens. (Almalki 2011, United Nations 2013. Health planning and restructuring strategies were developed as a means of coordinating the rapid expansion of healthcare, with 5 Year Plans being put in place since 1970. The first Five-year Development Plan that was a collaboration between the Ministry of Health (MOH) and the Ministry of Economy and Planning (MOEP). A series of further Development Plans (Table3.1) have followed up to the present date, with the programmes' objectives of development plans strictly expedited. Any programs not completed in one plan are trailed in the following plan (Mufti 2000).

Early plans focused on the development of health infrastructure, buildings and basic care, as well as skills development, training and recruitment of health professionals. Later plans (from the Fourth Plan) sought to increase the role of primary health care centres and to improve management practice, strategic planning and human resource activities. The author gathered the objectives of the Five-year Development plans related to Primary Care Centres and presented them in a table. Improving efficiency and providing integrated healthcare services have become particularly important in the Ninth and Tenth plan (see below).

Table 3.1: Five-year Development Plans

#	Year	Goal / objectives	Challenges	Solutions
First	1970 – 75	• Improve standard of sanitation, diet, services and expand preventive health services; • Increase the number of health professionals and use them in a more effective manner; and • Undertake studies of policies required for scientifically based plans for future development of health services that would improve the standard of health and reduce morbidity and mortality caused by infectious diseases and nutritional deficiencies.	Shortage in fanatical resources.	Set a modest goals
Second	1975 –	• Emphasis the important of accorded planning. • Stress the importance of create a clear	Shortage of manpower in health care	Establishment of The Inter-Ministerial Health

			sector.	Manpower Planning Council.
	80	• responsibility and communication matrix for initiation, coordination, evaluation, and implementation of health care policy. • Build solid health care infrastructure including e.g. preventative and curative facilities.		
Third	1980 – 85	• Expending health care facilities. • Increase medical manpower by encouraging more Saudis to go into medicine and related careers; • Improving the quality of medical care and efficiency in the administrative aspect of health science; and • Continuing emphasis on preventative medicine and environmental health.		
Fourth	1985 – 90	• To strengthening, maintenance and coordination. • Engaging the Saudi private sector into health care. • Priority to primary centers. • Development of medical services for the *Hajj* season.	Reduction of available financial resources	
Fifth	1990 – 95	The objective of this plan aimed to address the challenges that emerged from the previous health care plans such as: • The emergence of new health problems, such as chronic health conditions and industrial and urban-related health conditions; • The increasing pressure on government budget outlays by infrastructure expenditures on health; • Problem of an insufficient health data and information base; and • Coordination and utilization of health services.		
Sixth	1995– 2000	• To continue upgrading the health standards of citizens and providing preventive and curative health care efficiently. • To focus more attention on the control of communicable diseases and to eradicate or reduce incidence of such diseases to the lowest possible level. • To emphasize primary health care programs particularly mother and child programs. • To support the referral system aimed at integrating health services.	-Financing the health services. Saudization in health services. -Balance in distribution of Primary healthcare centers.	A system of health insurance will be expanded for non-Saudis and their families which will broaden the funding.
Seventh	2000- 2005	• To continue providing preventive and curative primary health care services and facilitate their accessibility through primary health care centers along with ensuring continuous support of specialist curative services. • To continue to upgrade health standards and to reduce morbidity and mortality rates. • To prepare and develop health manpower in order to meet quantitative and qualitative needs. • To develop health management, improve information systems and conduct health research. • To ensure coordination and integration between all health activities and services provided through health care agencies, as well as the optimal use of available resources. • To enhance the role of the private sector in the provision of health services as well as in financing the construction and		

		management of health facilities.		
Eighth	2005-2010	• Providing and developing primary healthcare programs. • Developing maternity and child healthcare services. • Controlling communicable diseases and reducing their incidence. • Providing and upgrading efficiency of curative care. • Increasing the scope of health service decentralization to ensuring that powers are commensurate with responsibilities. • Developing adequate regulations for operating hospitals on commercial principles.		
Ninth	2010-2015	• Supporting and developing the primary healthcare services provided by MOH and other health sectors as the cornerstone of the health system, in such a way, as to raise efficiency and apply the integrated, comprehensive healthcare approach for the entire population.		
Tenth	2015-2019	• Establishing more primary health care centers and specialized curative services, and making them accessible to all. • Providing comprehensive, integrated, high-quality healthcare to all people of the Kingdom. • Improving the efficiency of emergency medical services and bringing the response time to international standards. • Improving the performance efficiency of management and operation systems and deepening the culture of institutional work. • Enhancing the standards of licensing medical cadres and encouraging health establishments to obtain international accreditation.		

At the present time, the state retains responsibility for providing all Saudi citizens, and expatriates working within the public sector, with full and free public healthcare services (Almalki 2011). The rising cost of health services resulting from the rapid development of medical technologies in hardware, equipment tools, and advanced and expensive medical technologies, as well as the constant discoveries of new expensive drugs has created pressures on the state (MOH 2014). Some privatization of the public health sector has resulted, along with the development of new sources of funding the health sector (7th Development plan, Kronfol 2012), including a Cooperative Health

Insurance (CHI) Scheme, civil charities and the Waqf (The 9th Development Plan 2010-2014). These schemes have eased the financial burden of healthcare on the state (Ramady 2005, Almalki 2011, Parker et al., 2010). Additionally, other sources of funding such as "Waqf" encouraged voluntary contributions to health care (9th Plan). However, healthcare remains largely free and full service for all Saudi Citizens.

The current structure of the healthcare sector can be seen below. The Ministry of Health provides and finances health care services in Saudi Arabia (Figure 1). It includes 244 hospitals and 2037 primary health care centres (PHC) that cover the Kingdom. Other governmental bodies provide health care through referral hospitals such as security forces medical services, King Faisal Specialist Hospital and Research Centre, National Guard, army forces medical services, Ministry of Higher Education hospitals (teaching hospitals), Royal commission for Jubail and Yanbu health services, ARAMCO hospitals, Red Crescent Society and the school health units of Ministry of Education (Almalki et al 2011).

There are also other governmental agencies, which are funded outside the budget of the MOH. These agencies include military and security agencies, who offer health services to their staff, as well as to other segments of eligible members of the population (Ministry of development and planning 9th plan). Such agencies are operated by National Guard Medical health affairs, Ministry of Defense and Aviation Medical Services, Ministry of Interior Medical services, Ministry of Higher Education, which cover University

hospitals, and King Faisal Specialist hospital and Research Centre (Qutub et al. 2009). Health services are provided for their staff and other segments of the general public. These agencies provide better quality and highly valued health facilities in their hospitals in comparison to other health care providers in Saudi Arabia (Walston et al. 2008). Additionally, these governmental agencies only provide 40% of health services, while 60% is provided by the Ministry of Health (Al-dossary et al. 2008).

Figure 1: Health Care system in Saudi Arabia
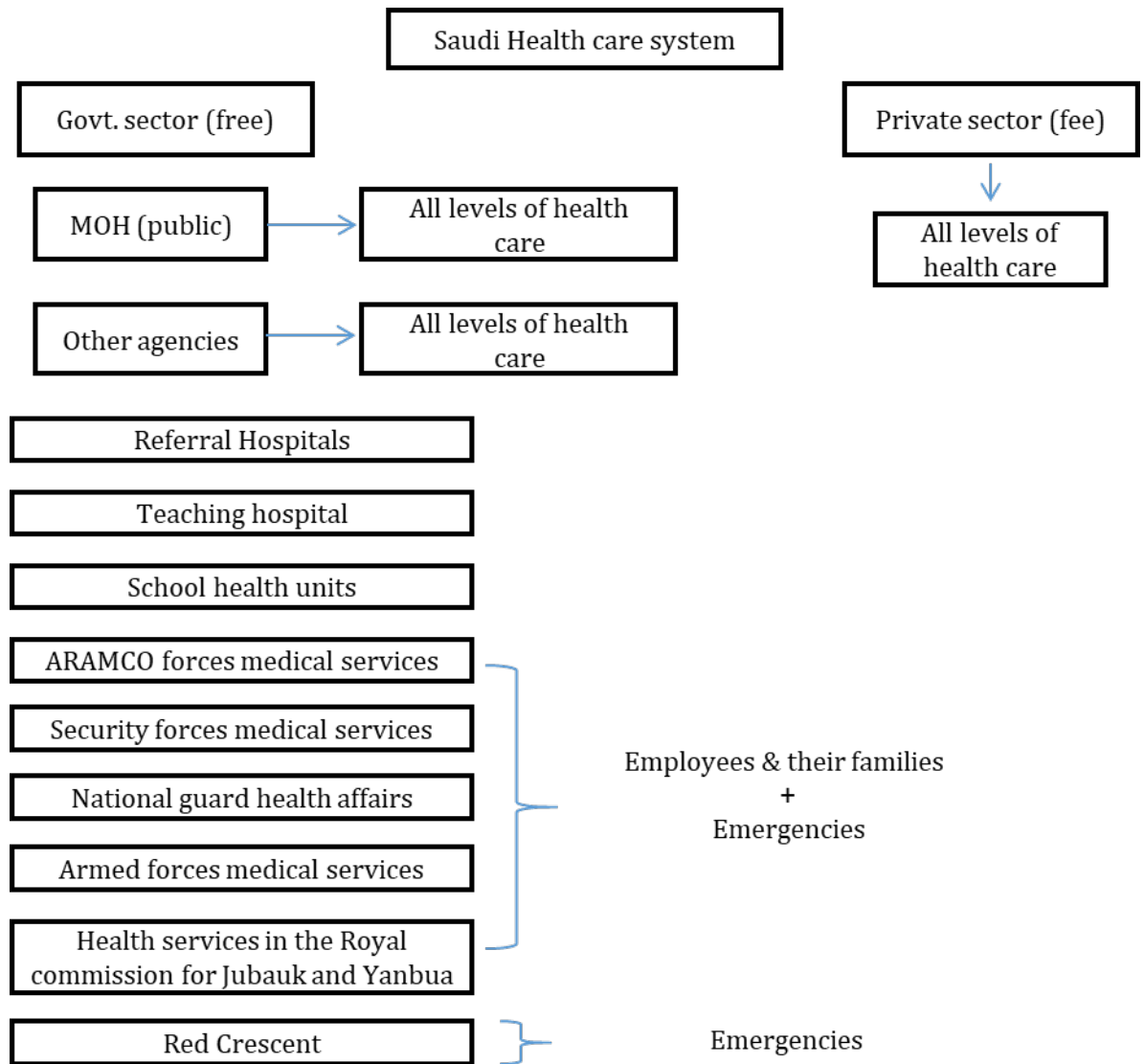
There is a degree of decentralization, with each healthcare directorate enjoying a sum of autonomy in managing and maintaining their health affairs. Nevertheless, these directorates follow guidelines, which are set by the MOH (Walston et al 2008). Overall, the organisation of work in the healthcare sector is highly hierarchical. It focuses on internal control and stability, over discretion and flexibility, with high levels of bureaucracy rules and hierarchical management (Al-Otaibi, 2014). As a result, there are often procedural delays in passing information and polices. Public management is operated with high power distance and a high uncertainty avoidance culture. Managers choose to maintain a high level of power distance with their employees and there is a culture in which managers seek to foster their personal interests (Al-Otaibi 2014). Al-Otaibi (2014) believes that the prevalence of hierarchy culture might be endorsed by the political system in Saudi Arabia, which is strongly centralized, and results in a strong organisational culture engrained within the community, and religious values, supported by social culture. The organisational structure of the healthcare system can be seen in the diagram below.

Central Ministry of health

Regional Director
Health Affairs

Deputy
Hospital

Deputy Primary
health Care

Sectoral
Coordinator

Primary Health
Care Supervisor

Health Center
Manager

Health Center
Manager

Health
Friends

Patients
Friends

Catchment
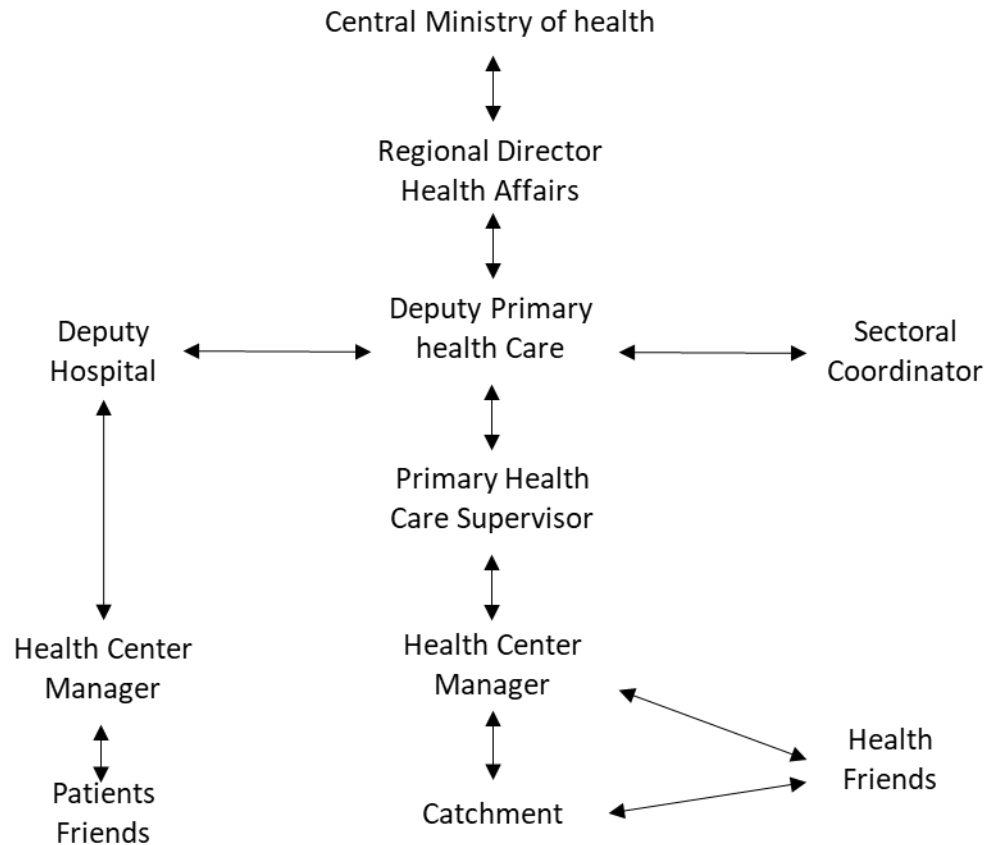
Health
Friends

Organisational structure of the Ministry of Health (Public) Healthcare system (Almalki et al. 2002).

Five year plans have included initiatives to improve management, for example, in 1995, a management development program was initiated to prepare supervisors and team leaders to be dynamic players in improving quality measures in primary care such as treatment protocols and new techniques of training staff (Al-Ahamadi, 2005). However, available evidence points to deficiencies in management, leadership and supervision within healthcare settings. A large survey-based study found that the majority of supervisors had no training in managerial skills. Most had a sound understanding of supervision as a method that involves enhancing the professional skills of personnel, coordinating activities and team

development. Nevertheless, few thought supervision was linked to quality of care or motivating staff (Al-Ahmadi, 2005). A further survey of mid-level managers level uncovered numerous managerial defects for preventing the optimal delivery of primary health care including: poor information, vague lines of responsibility, lack of qualified supervision, and poor managerial knowledge (Qutub et al., 2009) Gaps and challenges in human resource management are particularly apparent with high staff turnover, and insufficient career development being highlighted, along with stressful working conditions (Qutub et al, 2009; Al-Ahmadi, 2005).

Interest in teamworking and integrated teams has been stimulated by interest from the Saudi government in healthcare quality and improving standards under the 8th 9th and 10th plans, due in part to the increasing requirements through law to provide adequate healthcare to every citizen in every region. Under the Eight Development Plan, healthcare services progressed by expanding their infrastructure and raising performance. Curative healthcare was improved by developing and equipping more general and specialist hospitals as well as primary healthcare centers to offer family medicine services to members of the community (The Ninth Plan, 2012).

The Ministry of Health has also looked to restructure and develop its own role, concentrating on planning, monitoring, evaluation and controlling, while continuing to provide preventive and primary healthcare. This has included the establishment of a Central Council for accreditation of health facilities

and formation of sub-councils in the regions to oversee quality standards. The key tasks of the Central Council include: developing consolidated standards for health facilities and monitoring and evaluating their activities; developing medical practice standards; preparing studies and field researches to develop standards and methods of their application; establishing rules of professional practice; and cooperating with medical associations in each medical discipline to develop clinical guidelines for practice and disseminating these guidelines in hospitals. There has also been an increased emphasis on networking among various health facilities as a step towards developing an integrated health information system that meets all planning needs and helps improve the efficiency and quality of health services (The Ninth Plan 2012). An integrated system of healthcare is recognized to have implications for the organisation of employment and teamworking. The Ninth and Tenth Plans see quality as not simply something to do with training and qualification, but extending into many other areas, including: developing education and vocational skills for the healthcare workforce, improving administrative levels and skills in the sector, streamlining regulations and procedures governing the sector, developing professional work manuals for medical and healthcare practice, developing an effective accreditation system of health service institutions, and providing mechanisms to protect patients and safeguard their rights (Ninth Plan, 2012).

At the time that this research was conducted, in 2013/14, the focus of the 5 Year Plan was on addressing the expansion and increase in efficiency of

curative and primary health services by raising the number of hospital beds, physicians, and nursing staff. This required increasing health employment rates to the rates of prevalent to developed countries to facilitate the service in meeting requirements of development of the health system, as illustrated in Table 3.2, Table 3.3, and Table 3.4.

Table 3.2

Target Number of Hospital beds by the end of 2014

2008   2014

Description	Number	Average per One Thousand of Population	Number	Average per One Thousand of Population	Increase by End of Ninth Plan 2014
MOH	31720	1.3	56379	2	24659
Other Government Agencies	10828	0.45	20296	0.72	9468
Private Sector	11271	0.47	20860	0.74	9589
Total	53819	2.2	97535	3.5	43716

Table 3.3

The Number of Physicians in Hospitals by the End of 2014

2008   2014

Description	Number	Average per Bed	Number	Average per Bed	Increase by End of Ninth Plan 2014
MOH	16116	0.52	32657	0.7	16544
Other Government Agencies	10057	0.93	18875	0.93	8818
Private Sector					

	5870	0.52	14602	0.7	8732
Total	32040	0.6	66135	0.75	34095

Table 3.4

The Number of Nursing Staff in Hospitals by the End of 2014

| | 2008 | | | 2014 | | |

Description	Number	Average per One Thousand of Population	Number	Average per One Thousand of Population	Increase by End of Ninth Plan 2014
MOH	37652	1.2	65314	1.4	27662
Other Government Agencies	19511	1.80	36533	1.8	17022
Private Sector	13304	1.18	29204	1.4	15900
Total	70467	1.3	131051	1.5	60584

These targets create challenges however, with turnover rates of medical staff high. The average tenure among non-Saudi physicians and nurses is 2.3 years, with the high turnover creates problems in extra expenses for recruiting foreign cadre. Moreover, some physicians and nurses are none Arabic speakers, which can impact upon the quality of the delivered service and communication with patients (Walston et al. 2008). Therefore, the Ninth Plan sought to provide comprehensive, integrated, high-quality healthcare services, with a more balanced distribution among regions, covering all individuals and social groups, administered and supervised by competent, efficient health sector, in order to improve the health of citizens and their quality of life (The Ninth Plan 2012). The Ninth Plan sought to improve the

quality, performance management and operating systems in health facilities, enhancing the role of MOH in supervising and monitoring performance, setting health policies, and ensuring provision of health services to all population groups (Ninth Plan 2012).

3.4 Primary healthcare centres in Saudi Arabia

In recent years, international healthcare policy makers have recognized the role of *primary* healthcare as a strategic policy approach to alter the healthcare systems from orientation from disease focused systems to person, family and population-oriented systems (WHO 2008, WHO, 2020). Effective primary care is characterized as a sustained partnership between healthcare institutions and patients, healthcare practicing in the context of family and community, and the provision of integrated accessible healthcare services by clinicians who are accountable for addressing a great majority of personal healthcare needs (Institute of Medicine 1996, WHO, 2020, Stanfield et al, 2005.

There has been mounting evidence linking primary care to reduced healthcare costs (Kringos et al 2010, Starfield et al., 2005), improved health outcomes (Lee et al. 2007), and reduced health disparities (Shi et al., 2001). Primary care can improve outcomes through its role in providing preventive care, reducing the need and use of costly acute care service (e.g. lower hospital admissions rates), and promoting more appropriate use of health service (Starfield et al 2005). The World Health Organisation has sought to develop a global scheme for action to achieve universal access to an

effective and functional primary care system, particularly over the last 15 years WHO 2008; WHO, 2020).

Primary care in Saudi Arabia

As the healthcare system developed in Saudi Arabia, there was rising interest in primary care from the late 1970s, prompted by the Alma-Ata declaration at the WHO General Assembly in 1978. The Saudi MOH began to activate and develop preventive health services by establishing Primary Healthcare Centres (PHC) from 1980, in which a ministerial decree was issued to establish PHC centres and by 1985, and PHCs were identified as one of its most important strategies in the fifth development plan. Existing facilities located in nearby areas were joined into single units. These included health offices, maternal and child health centres and dispensaries (Jarallah and Khoja 1998, Almalki et al. 2011). In small and rural areas, health posts were upgraded to PHC centres. PHC centres aimed to endorse eight elements of the PHC approach, which were:

- Providing comprehensive maternal and child health care.

- Immunization of children against major communicable diseases.

- Prevention and control of locally endemic and communicable diseases.

- Appropriate treatment of common diseases and injuries.

- Delivery of essential drugs.

- Educating the population concerning prevailing health problems and methods of preventing and controlling them.

- Provision of adequate supply of safe water and basic sanitation.

- Promotion of food supply and proper nutrition (Al-Yousef et al. 2002;

The 9th Development Plan 2010-2014, Almalki et al. 2011).

Primary care services have been delivered through a national network of Community-based Primary Care (CPC) centres managed and operated by the Ministry of Health (MOH). CPC centres serve as the first portal of contact for health services utilization, providing curative and preventive health services, and coordinating care with other levels of the healthcare system (Alahmary 2014). PHC centres treat family members of all ages through a referral system, which is linked to general and specialist hospitals (Ministry of development and planning 9th plan). Citizens can only access the health centres which are located in their residential areas (Walston, 2008). While expatriates may only get specialist treatments in public sector hospitals, except in rural areas where private facilities are unreachable (Alfaqeeh 2015). Today there are 2,295 PHC centres that serve the population across 13 regions in the country. There are a total of 8,390 physicians (including dentists), 16,317 nurses, 137 pharmacists and 10,113 allied health professionals in PHC centres (WHO 2012, 2020). The Ministry of Health emphasizes mostly primary and preventive medicine and sponsors through these health centres (Walston 2008), providing guidelines on child health care, referral, immunization, chronic disease management, prescribing, health education, community participation, environmental health, management of communicable diseases, and maternal health (Al-Ahmadi, Roland 2005).

In Saudi Arabia the utilization of primary care has increased considerably. There was an 8.3% increase in in health centres visits from 50.7 million visits in 2006 to 54.95 million visits in 2010 (Ministry of Health 2010). The rise in the use of primary care services is considered an indicator of success for the governmental efforts. Such rise in utilization of primary care services is due to expanded access of primary care centres as well as public awareness about preventive health services. However, higher demands and increased workload on the primary care system might present a challenge to its organisational capacity, which can reflect on its ability to provide high quality of services (Al-Ahmadi et al 2005).

Quality Accreditation and Teamworking in Primary Care

In 2005 the state formed the Central Board for Accreditation of Healthcare Institutions (CBAHI) in Saudi Arabia. By 2010 the CBAHI accreditation began it process across the country covering hospitals and primary care centres. The state sought to use the CBAHI to help implement a programme of organisation development (OD) in healthcare settings. The CBAHI accreditation initiatives served as an impetus to the development of teamwork among staff in all centres. The CBAHI became the official agency authorised to grant accreditation certificates to all governmental and private healthcare facilities operating today in Saudi Arabia. The principal function of CBAHI is to set the healthcare quality and patient safety standards against which all healthcare facilities are evaluated for evidence of compliance. In Saudi Arabia it is mandatory for all public and private healthcare delivery facilities (hospitals, polyclinics, blood banks and medical laboratories) to

comply with national standards set by CBAHI and obtain its accreditation (CBAHI 2015).

Healthcare quality standards included quality management concepts including teamwork. The MOH strategy and values also endorse teamworking. Part of their current strategic plan is a health system completely devoted to patients in other words, a patient-centred health care system that meets patients health needs (MOH 2021). Delivering better quality for patient care is thought to be able to occur through patient focused teams, and documentation of this must exist for an audit. Good practice suggests that the implementation of integrated, patient-focused teams needs to: communicate and educate employees to help them understand the logic of change; involve participants in decision process of design and implementation of the change processes; provide support and assistance through the change process to remove any barriers of resistance to change; offer incentives to ensure that change is accepted and not blocked by individuals; and negotiate clearly with individuals to avoid resistance (Pathak 2011).

However, in Saudi Arabia the introduction of integrated teams in primary care was done in a piecemeal manner and did not result from a clear vision of a leader from within healthcare or political initiatives. Instead, it was a result of bureaucratic political change imposed without the support of stakeholders in primary care (Tovey 2000). Early team system initiatives reflected a passive compliance with the accreditation and diverse

perceptions of the meaning of teamwork within stakeholders, resulting in resistance, a lack of belief in the ideas of teams, misunderstanding of the concept, and personal dissatisfactions, risks and discomfort, with many people view teams as an extra burden that can overshadow their performance (Katzenbach and Smith 2002).

Gender segregation in Primary Healthcare Centres

As noted earlier in the chapter, Saudi Arabia has an institutional structure organized around gender. The law, politics, religion, the academy, the state, and the economy are institutions historically developed by men and currently dominated by men. In Primary Healthcare Centres, there is a highly traditional workplace hierarchy and a segregated traditional division of labour in the PHC. Power and authority are integral components of hierarchical positions, and are highly gendered. Teams ordered hierarchically in Saudi Arabia healthcare settings are unlikely to collaborate in their decision-making and practice. In traditional healthcare settings it is generally accepted that medical specialists have positional power and exercise this through decisions regarding treatment of patients (Griffiths 1997, Annandale 1998, Opie 2000). However, in PHC hierarchical structures, management (Directors of PHCs) solely consist of male nurse technicians who carry a diploma in nursing and dominate the hierarchy. Moreover, the unevenness, concentration, and isolation of female teams shaped the structural configurations of masculine dominance that are reinforced by the organisation's culture. Gender segregation in PHCs permits male management to direct work to male team members. However, female supervisors have no authority and can only complete the core tasks of the

organisation at a lower level. This female supervisor role, considered in more detail in the empirical chapters of this thesis, was created for auditing, scheduling and regulating female daily clinical activities. It carries unequal levels of responsibility and authority over female team members, compared to male supervisory roles, but they act as a key linking role to male management, thus providing the female supervisor with some power over female team members.

3.5 Conclusion

This chapter has discussed the context of the health care system in Saudi Arabia. It has shown how the health care system is influenced by a centralised governmental system, religion and culture. It illustrated the growth and development system of the health care system in Saudi Arabia and its shifts toward establishing a primary care system as first patient contact. Over the years the MOH has been rapidly expanding by building and operating more primary care centres over the years. The MOH has also addressed the quality problems through the national accreditation system (CBAHI) which has been put in place to enforce and formulate quality standards in healthcare organisation specially primary care centers. The MOH looked to restructure and develop its own role, concentrating on planning, monitoring, evaluation and controlling, while continuing to provide preventive and primary healthcare. This has included the establishment of a Central Council for accreditation of health facilities and formation of sub-councils in the regions to oversee quality standards (10th development plan).

Chapter 4: METHODOLOGY

4.1 Introduction

Following on from the review of the literature on the implementation and operation of interdisciplinary teamworking and its connections with human resource management (HRM) systems in healthcare, the perception of teamwork in healthcare and informal leadership role in supporting teamwork, this chapter sets out the methodology of the thesis. The main aim of the research is to develop a better understanding of the nature of inter-disciplinary teams in healthcare and how they function within the gender-segregated setting of Saudi Arabia, examining the tensions and contradictions between goals of teamworking and HRM practices. This chapter opens with a re-assertion of the key research questions and the approach adopted in the thesis to address these questions. It then sets out the epistemological assumptions of the thesis, presents the methodological issues, and considers the philosophical grounding of the research. It rationalises the selection of a multiple embedded case study design. Issues of generalisation and representativeness are considered in relation to the case location. The selection of the location for the research (the healthcare sector in Saudi Arabia) is then justified and the virtues of a programme of semi-structured interviews are put forward in relation to the research and numerous sources of data, which make up the case.

The aim of this thesis is not to test hypotheses or establish correlations, such as between HRM systems and organisational performance, or whether a hypothesis can be accepted or rejected. There is the need to understand the perceptions, experiences and subjective realities of HRM amongst interdisciplinary healthcare workers. In order to achieve this, an intensive case study in the Saudi Arabia healthcare sector was undertaken, through case studies in six Primary Healthcare Centres (PHCs), which were clustered into three groups, according to Ministry of Health administrative standards evaluations, as High, Medium or Low performers.   Semi structured interviews were conducted with diverse background of healthcare workers from managers, doctors, nurses, technical and reception staff. An analytical process of induction was undertaken because it was consistent with these aims. The details and justification for this methodological approach are now discussed.

The aim of this research is to investigate in depth the nature of interdisciplinary teamworking in healthcare, exploring the rhetoric and reality of how HRM contribute to such teams, in a context in which gender segregation is a defining feature of society. Through intensive qualitative research, employing multiple methods of context rich data retrieval and analysis. The study sought to add new understanding to the social processes associated with the implementation of HRM systems and progress knowledge on the channels through which they may impact healthcare workers.

- How is inter-disciplinary teamworking implemented in Saudi healthcare settings, what are the connections between teamworking and HRM systems and HR practices, and what contradictions and tensions result?

- What are the motives for teamworking in primary healthcare centres, how do inter-disciplinary team members perceive and understand teamworking and what are the effects?

- How does gender segregation impact upon teamworking and HRM in Saudi Arabia, and what is the role played by the female supervisor in this context?

4.2 Philosophical background

In every research, the adopted paradigm plays a significant role in investigating the phenomena. A paradigm provides guidance to the researcher throughout the project. It is the way a researcher understands and views the social world and becomes engrossed into theoretical and research literature. A paradigm shape questions of the research as well as identifies the theoretical positions against the investigated findings. Therefore, before conducting any empirical research, it is first necessary to consider the epistemological and ontological perspectives in relation to the specifics of the research enquiry (Silverman 2013).

Covering these ontological positions to organisational research leads to the recognition of epistemological concerns, in a matter of how that which exists can be shown to exist in a reliable ways. Kuhn (1970) proposes several paradigms which dictate how social reality and entities should be interpreted and researched. Epistemology is about how one might understand reality, and how it is interpreted to fellow human beings. On the other hand ontology entails the philosophy of reality (Krauss 2005, Burrell and Morgan 1979). While epistemology tries to understand what it means to know, ontology reflects the way the researcher think the world is (Gray 2013). Under the ontological perspective a distinction can be made of the nature of social reality. Some adopt the ontological assumption of objectivism, which suggests reality exist and is external from the social actors perceiving them. By observing interdisciplinary teams through pre-defined, objective categories, any contextual understanding about them can possibly be lost because it limits any further exploratory probing into the concepts in question (Saunders et al 2003). On the other side subjectivism suggests that social reality is only knowledgeable through constructing meanings by social actors and there are multiple meanings constructed by social actors who experience a phenomenon of interest (Krauss 2005). However this limits the explanatory capabilities of this research.

Turning to epistemology, with objectivism the researcher is independent from the investigated phenomena and the knowledge gained is real and objective (Glynn and Woodside 2009). It treats reality as hard, objective and external to the individual. It searches for a universal law, which governs the

researched and observed reality (Burrell and Morgan, 2005). Thus, the findings are expressed in mathematical precision, which are separated from the universe of objects and their social world (Giddens, 1986). An objectivist epistemology brings the social world into a constricted, tight, codified structure. It attempts to explain knowledge similarly to the methods and standards of natural science (Thorpe, and Holt 2008). This is endeavoured by comprehending the principles regulating the behaviour of a real world, based on formulating theories from data and testing them against it 'deduction' (Thorpe, and Holt 2008). It has been criticized for displaying a phenomenon as isolated, while missing the contextual features that impact upon it (Sayer, 2000). In addition, the social researcher is detached from the subject and neither affects nor is affected by the researched subject (Saunders et al., 2007). In the context of this thesis, it would provide the researcher with a limited understanding of the perception and meaning of interdisciplinary teamwork among primary healthcare employees within a specific context. Meanings are related to practical contexts and material circumstances in which communication occurs and which reference is made. Therefore, meaning has to be understood, it cannot be counted or measured (Sayer, 2000). Additionally, It would limit the explanation on how the phenomenon is experienced by interdisciplinary healthcare team members, in this case of the implementation of teams in primary care.

In contrast, epistemological subjectivism views organisations as socially reactive entities, dependent on, and shaped by researchers' observations and interpretation of participants' personal perception and recollection of

their experience. It is formed through their interactions and the context and experience in which they are situated (Creswell 2007). These subjectivist and objectivist epistemologies and ontologies thus present two opposite views on a continuum; both positions have drawbacks for this research. Hammersley (1992) suggests a position that falls between the two continuum, i.e. that of critical realism, which what this research adopts (Hammersley 1992). Critical realism holds that an objective world exists independently of people's language, imagination and perceptions. Moreover, it acknowledges that part of that work entails of subjective interpretations which influence the ways in which it is experienced and perceived. This double acknowledgment is crucial and relatively novel in social science research. Research textbooks for instinct, employ a simple dichotomy, between objectivist (deductive, positivist, and empiricist) methods, which are usually aligned with quantitative methods, and subjectivist (inductive, social constructionist, and interpretive) methods, which are usually aligned with qualitative methods (Edwards et al 2014).

The aims of this thesis is to explore questions around how interdisciplinary teamworking are implemented and their connections to HRM systems and HR practices. This entails a deep understanding of the interactions and relationships between team members, policies and institutional structures, within a specific context. Thus, it requires a process that is capable of interpreting what is happening at the organisational level and why it is happening. So it must be able to extract meaning and knowledge from the research participants. A positivist philosophy and a deductive research

approach would be weak in addressing the key aims of this thesis, since such questions could not be effectively answered by attempting to quantify the phenomena of interest into variable measure (Fleetwood and Hesketh, 2006).

4.3 The case study approach

Case studies are used to develop the empirical evidence in this researched project. It is used to enhance the understanding of a theory or concepts through illustration or examples. Case study research is particularly effective when addressing a phenomenon that is either chaotic, or ambiguous. It facilitates the understanding of the complex relationships between a large number of variables, which are difficult to predict and overview. According to Keen and Packwood (2000) case studies are valuable where policy change is occurring in a complex real world settings, as is the case in this these, which is exploring changes to working practice for professionals working in Saudi Arabia primary healthcare centres. Saudi Arabia consists of a highly individual and specific context. Although there are studies of teamwork in healthcare, none have addressed the uniqueness of teamwork practice under conditions where gender segregation in work and society is a norm. This is an important contextual feature, and thus offers a new lens through which the rhetoric and reality of interdisciplinary teamworking can be explored. Therefore, a case study approach is suitable in allowing the researcher to explore the context in depth (Yin 2009).

In a classic text on case study research, Yin (2009) suggests that case studies can employ either quantitative or qualitative research. Stake (2008) similarly, argues that a case study does not represent a specific research method but rather a choice of object to be studied. The traditional qualitative methods applied in this case study are in-depth semi-structured interviews. These methods are used to generate data for the exploration of concepts and theories. Exploratory studies stress on finding new insights and understanding what is happening. Therefore, such studies are adaptable and flexible to change according to the new data obtain by the researcher. The current research is categorized as an exploratory case study. The other forms of study are descriptive and explanatory, that are not suitable for the current research context since the former describes and event in its real-life context, while the latter is commonly used to establish a cause and effect relationships, which is challenging to control the variables that are being scrutinized under this research.

Case studies have been used widely as a tool to investigate services, polices, individuals, and teams in healthcare (Bucher and Schatzman 1964, Yin1999, Allen et al. 2002, Costantini et al. 2003, Baxter and Brumfitt 2008). Freeman, Miller and Ross (2000) reported on a serious of case studies of 6 teams working in a variety of specialist healthcare services (primary care, diabetes, medical ward, neuro-rehabilitation unit, child development assessment, community mental health) to identify individual perceptions and how it affected team working. Similarly, Temkin-Greener (1983) investigated interdisciplinary views on team working in healthcare through the use of

case studies. Edwards (2005) provides an example of the critical realist approach to case studies on teamwork, where teamwork can be comprehended in regards to the ontology of generative mechanism. Critical realism prompts the understanding that each individual case study examines the likely similar mechanism or mechanisms and its operation in different context and so the case studies can be brought together synthesized and thus generalised in terms of their findings concerning the nature of the generative mechanism and its operation in different contexts. In particular Edwards (2005) debates that cumulative lesson of the several case studies on teamwork is to show how context really matter in determining whether teamwork mechanisms attain their goals (Edwards and Paul 2005).

 Moreover, case studies were employed in an exploratory study by Baxter and Brumfitt (2008), which examined team-working perceptions of staff in the field of stroke care. The benefits of case study for the present thesis is that it allows an intense focus on a single phenomenon within its real-life context under a changing environment. As this investigation sought to examine team working practices across PHCs.

Case studies have been categorized in different ways. Stake (2008) states that a case study can be simple, focusing on single individual, or complex including multiple individuals within a certain context. He describes three different purposes for studying cases, an "intrinsic case study", which focuses on the case itself, and provides better understanding of an individual case, an "instrumental case study" gives insight into a particular

phenomenon with the intention of generating theory. The "collective case study" more than one case study is conducted and in sum these cases provide insight to the picture of a subject in general (Stake 2008).
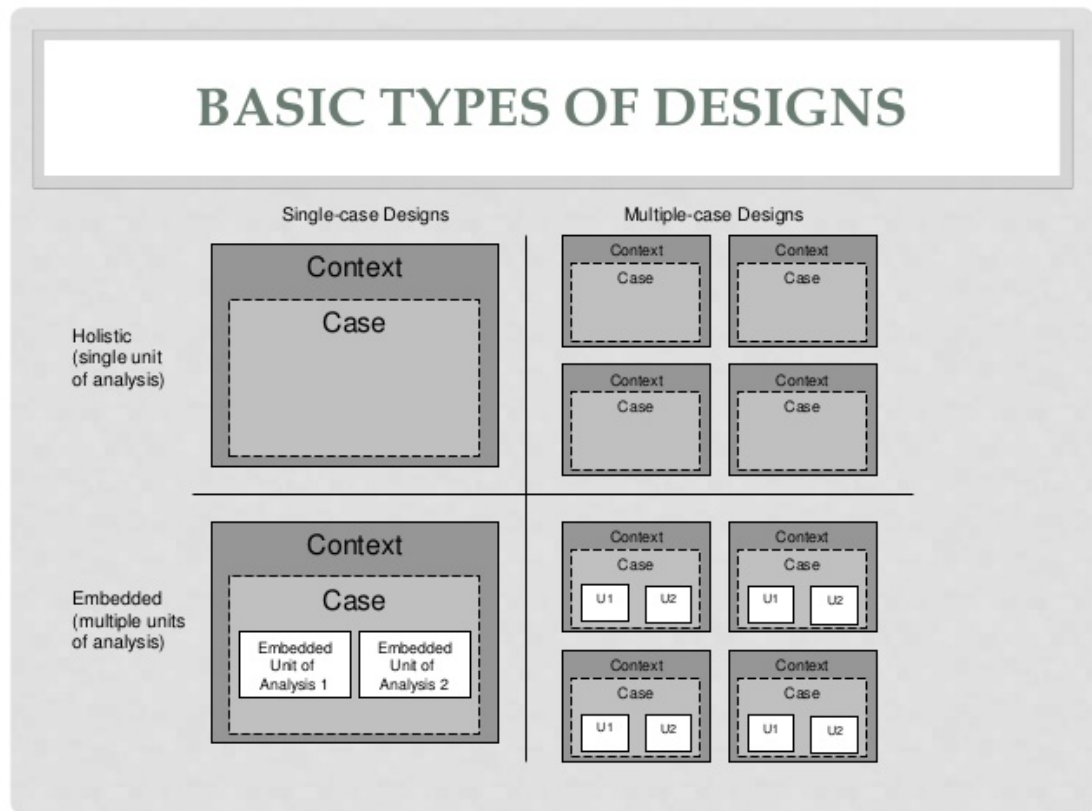
Figure 3 (Yin 2009, p.46)

According to Yin (2009) there are four types of case study design: single holistic case studies, that focus on a single case taken within its natural context, single embedded case study, which numerous occurrences of a case are chosen in the given context, multiple holistic case studies, which combines several cases, and each is set within its individual context, and multiple embedded case studies, which different context are examined by

focusing on several cases in each context (Figure 1). The present study takes a collective approach and implemented a multiple embedded case study to investigate different healthcare employee subgroups (physicians, nurses, allied sciences, and receptionists). As this investigation sought to examine the perception and structure of team working across primary care centres within the context of Saudi Arabia, six cases were selected consisting of diverse healthcare teams. The embedded units for analysis are interdisciplinary primary healthcare teams. The evidence from a multiple case design is regarded as more compelling, and the over all research is seen as more robust. Although, it requires more time and resources, multiple case studies offer replication of the experiments. The replication of procedures provides the researcher with a rich theoretical framework, which should state under what conditions the specific phenomenon was found (Yin 2003). Schofield states that conducting a qualitative multi-site study will increase the generalisability of this research. Hence, selecting multiple cases that to a degree match in populations, procedures, and settings but in different healthcare organisations would enhance generalisability (Schofield 1990).

The amount of appropriate number of case studies for a particular study has been widely debated. However, Eisenhardt (1989) recommends the use of between four to ten cases for theory building. In the present study I considered six to provide a balance between the depth of the study and the external validity of the approach. Moreover, due to the time constraints and my location in the UK, I was able to undertake that amount of cases. The

decision for the use of multiple case design consisting of six cases will be discussed later in relation to sampling.

4.4 Research design

4.4.1 Qualitative research methods

This research utilised a qualitative approach to research design and methodology. Qualitative methods include various approaches and techniques, such as interviews and observations, with the aim of gaining information and understanding regarding the subject of the investigation (Denzin and Lincoln 2008). On the contrary, quantitative methods only provides minimal explanatory value due to their statistical descriptions of the subject (Sayer, 2000). Qualitative paradigms often rely upon the actual spoken words of the subject. It is viewed by social scientists as inductive, subjective and process-oriented (Cook, 1979). It is often used when a scholar seeks "to describe and analyse the culture and behaviour of humans and their groups from the points of view of those being studies" (Bryman 1989, p.46).

Qualitative methods do not aspire for theories that offer a level of universal law-like coverage. Instead it aspires to grasp what is it like to be the individual who is investigated, and try to go through the experience as they went through it (Thorpe and Holt 2008). Through phenomenological investigation, social scientists put aside what is already known and describe how it came to a meaning, and trace the processes of how they give meaning to the world (Benton and Craib, 2011). Qualitative methods seek to

bring out the contextual information, as well as the tensions, complexities, controversies, and realities of the social process. Also they seek to answer what is happening and why (Denzin and Lincoln, 2000; Lincoln and Guba, 1985; Miles and Huberman, 1994).

Quantitative methods apply statistical methods and quantifications to enforce fixity on social life, which it does not in reality have (Giddens, 1986). Quantitative methods is seen as unsuitable for this case study, since the objective of this research is to explore a phenomenon rather than test it. Moreover, the details about this phenomenon – interdisciplinary teamworking in PHCs - are not fully known (Lee et al 1999).Therefore, qualitative methods are most appropriate for inductive and exploratory research with complex context that would not be captured by quantitative methods (Ghauri et al. 1995). This relates to what has been uncovered in the literature review chapter. Specifically, the research intends to explore how the operation of interdisciplinary teams in healthcare settings in Saudi Arabia, progressing theoretical, methodological and empirical understanding of the nature of teamworking through case studies.

While qualitative methods have value in a range of inquiries, this method has its own limitations. Firstly, the research results cannot be declared to be statistically generalisable. Still, generalisability should not be viewed as an unsolvable matter, as generalisability holds different meanings for qualitative research, which will be discussed further in this chapter. Moreover, it can be very time consuming in data collection and analysis and labour intensive.

Specifically in healthcare organisational settings where workers are consumed with appointments and patients and being able to conduct the research on the terms originally agreed (Bryman, 1989; Bryman and Bell, 2003).

4.4.2 Qualitative Methods and research into teamworking in healthcare

In the healthcare literature, both quantitative and qualitative methods have illuminated aspects of teamworking. Quantitative methods have been used widely for measuring, developing and assessing team performance and effectiveness. In primary care in the UK has been investigated by Poulton and West (1999), and Borrill et al. (2000) to explore determinants of effectiveness in primary health care teams. Quantitative measures are used in health services to measure for instance performance indicators or waiting time for patients. However it does not provide an understanding of the experience of waiting for care and the reasons behind it. The quantitative nature of such studies is used to identify a statistically representative set of respondents or to produce numerical predictions (Pope et al. 2002). This is conducted in teamwork studies by applying either intervention studies or correlational studies. Intervention studies, which use training sessions in improving situations such as interventions, can be a training session on conflict resolution. While correlational studies that provide an understanding of the relationships between team effectiveness and other variables. It investigates the correlation between team characteristics, process, and outcomes. However, these studies focus on teamwork effectiveness rather than teamwork meaning and structure. While, qualitative research offers a

richer context description than intervention studies, and they allow the researcher to investigate particular dimensions of both the culture and the structure of the organisations (Johnson 2009).

Qualitative data can also provide evidence of patterns across an enclosed grouping of organisations. This has been used widely in healthcare studies (Wiles and Robinson 1994, Field and West 1995, Cook et al. 2001). In a study by Propp et al. (2010) interviews were used to uncover healthcare team-nurse communication practices that were perceived by team members to enhance patient outcomes. Seneviratne et al. (2009) investigated nurses in acute stroke unit and employed interviews to understand their perceptions of space, time and interprofessional practice. Qualitative methods were also employed by Field and West (1995) in primary care to explore attitude to team working, team building, and change among PHCT in six practices.

The above discussion does not seek to render quantitative approaches useless for research into investigating teamwork perception and structure in healthcare, rather it is to argue that it is unsuited to answering the questions posed by this thesis in the level of depth required. Morse and Richards (2002) suggest that qualitative methods should be employed to understand an area where little is known, this is the case for the complex field of joint working in Primary care. Also if the purpose is to learn from the members the way they experience a gendered segregated environment, which this study sought to gain an understanding of the staff perceptions. Consequently, a qualitative approach was utilized in this case study to gain an understanding

of the complex working environment in healthcare. Furthermore, interdisciplinary team members consists of diverse professional groups that may hold different definitions of reality and meaning systems, thus a multiple stakeholder approach to research is needed to extract these numerous accounts (McNulty and Ferlie 2002).

4.5 Access

At the stage of data collection, the researcher contacted the Ministry of Health in Riyadh in August 2014. Contact was made initially by a telephone call by the researcher to arrange access. The researcher was directed to meet with the Assistant Director of Health Centres and programs. A preliminary meeting was set up to discuss the nature of the research, the format of the interviews and the research requirements. Once access was granted the researcher was then directed to meet with the Chairman of Supervisory Division of Public Health. After discussing access with the Chairman, the researcher requested access to centres that varied in their evaluation by the Ministry of Health. Access was granted to six centres in the northeast district of Riyadh city. The Chairman sent a memo to each centre I was vesting for data collection, which included my identity and research purpose. In every visit to a Primary Care Centre, I would meet with the director on the male section and then proceed to the female section for data collection.

The northeast district was chosen due to their similarities in services and contrast in their MOH evolution. Also, it provided their medical services to the same culturally sensitive population. Moreover, the literature review

highlighted the importance of the organisational context of team working practices. Within this frame, sampling was based on the requirement to have different contexts represented, where primary care was provided. Therefore, the choice of cases in multiple-case studies is made on conceptual grounds, adding confidence to the findings by looking at similar and contrasting cases (Miles and Huberman 1994).

A purposive approach was used in sampling, which enhances the understanding of the selected individuals or groups experiences for developing theories and concepts. By selecting information rich cases, where the processes proposed to study are more likely to be occurring (Devers et al. 2000, Silverman 2007). Being in a position as a female researcher provided an access to female interdisciplinary team members as well as unlocking the gender issues concerning teamwork in healthcare.

Documentary evidence was requested at every chance, so where a participant would mention a specific policy or document, they were asked if they could show a copy or if one was available to take away. This was met with a degree of success, varying on the perceived level of authority the participant had to distribute documents, and the sensitivity of the document. Nevertheless, over the course of interviews, almost every document that may be of use to the research was regained. These were all documents, which were of relevance to HRM systems and practices, teamwork initiatives and assessment forms of PHC. Some of the less sensitive documents were available in designated areas such as in corridors and entrance lobbies,

therefore collection of these was straight forward once permission was granted.

According to Bryman and Bell (2007) documents that can be read and seen offer possibly a valuable source of data, and as they have been produced for reasons other than that of the research they do not present the danger of reactivity, unlike human subjects, making them reliable and valid source of information. Moreover, they enable the opportunity to triangulate with other sources of data (Seale 2004). Triangulation is a strategy applied to increase the confidence in the data using multiple resources of data or employing more than one method for data collection (Denzin and Lincoln 2000). Denzin and Lincoln (2000) classified four types of methodological triangulation and triangulation: theoretical triangulation, data triangulation and investigator triangulation. This research design adapted a data triangulation strategy. The data for this research came from semi-structured interviews (which represent the main source), and document review (such as HRM systems and practices forms, teamwork initiatives and assessment forms of PHC). Furthermore, care was taking during the analysis of these documents to assess their quality in terms of representativeness, credibility, meaning and authenticity (Scott 1990).

4.6 The six PHC case studies

PHCs in Saudi Arabia treat family members of all ages through a referral system, which is linked to general and specialist hospitals in the country (Ministry of development and planning 9th plan). Saudi nationals can only

access health centres that are located in residential areas (Walston, 2008). PHC services are free of charge, however with the expense of extended waiting times (Qutub et al. 2009). There are currently 2,295 PHCs that serve the population across 13 regions in the country with a total of 53.57 million patient visits recorded during the time the primary research was conducted (MOH 2012).

All 6 PHCs in this thesis were located in the northern urban area in the capital city of Riyadh. Health care services are provided to serve the population surrounding the district. In Riyadh where gender segregation is stricter than other parts of Saudi Arabia, facilities are segregated by reason of patient's preference. The informal structure may vary greatly from the formal organisational structure located in western and eastern cities (Le Renard 2008). Saudi law does not restrict women from working alongside male doctors and other male health workers as well as see male patients (Vidyasagar, Rea 2004) and the structure of the centres in Riyadh was configured to accommodate such preference. A different line of management was provided to female team members in the PHCs in Riyadh. Reflecting the longstanding inequality between women and men at the work setting, the director role and medical manager role were all occupied by male workers on the male section. Consequently, a role was created to connect the gender-segregated facilities to their male management in each of the 6 cases. A female supervisor was allocated by female team members to serve as a communication point between male and female team members. The structure of PHC will be touched on in the next chapter.

The centres were selected based on the Ministry of Health (MOH) administrative standards evaluation and CBAHI accreditation (Appendix A). The 6 centres are listed in Table 4.1 below, and have been given pseudonyms, rather than their real names. Robinson and Richmond had high scores in the MOH evaluation and passed the Central Board for Accreditation of Healthcare Institutions (CBAHI). Williams and Harington had moderate scores, while Mayfield and Langford had the lowest scores in the MOH evaluation. Key features of the centres are outlined in Table4.1.

Table 4.1: The Primary Healthcare Centres

Primary Care Centre	Female Supervisor Background	Ministry of Health administrative standards evaluation.	Accreditation award
Robinson	Family Medicine	High	CBAHI
RIchmond	Family Medicine	High	CBAHI
Williams	Pharmacist	Medium	None
Harington	Pharmacist	Medium	None
Mayfield	Social worker	Low	None
Langford	Nurse	Low	None

This section provides some background material on each PHC. More information is presented in the context of the discussions set out in chapters five to seven.

Robinson Primary Care Centre*:*

Robinson was located in the northern urban area in the city of Riyadh and was one of the largest centres in the northern district, widely considered to be an archetype in regards of the facilities and standards. On the female side the centre consisted of maternity and child health clinics, a well baby clinic, a chronic disease clinic, a dental clinic, a laboratory, an accident and emergency clinic, and a pharmacy. At Robinson, the female healthcare team consisted of 30 members including doctors, nurses, dentists, dental assistant, dental hygienist, X-ray specialist, receptionists, and pharmaceutical technician that served the population of 35,000 patients.

Richmond Primary Care Centre:

On the female side the centre consisted of maternity and child health clinics, a well baby clinic, a chronic disease clinic, a dental clinic, a laboratory, and a pharmacy. At Robinson, the female healthcare team consisted of 21 members including doctors, nurses, dentists, dental assistant, dental hygienist, receptionists, and pharmaceutical technician.

Mayfield Primary Care Centre:

On the female side the centre consisted of maternity and child health clinics, a well baby clinic, a chronic disease clinic, a dental clinic, a laboratory, and a pharmacy. At Robinson, the female healthcare team consisted of 27 members including doctors, nurses, social worker, dental hygienist, Dietician, receptionists, and pharmaceutical technician.

Langford Primary Care Centre:

On the female side the centre consisted of maternity and child health clinics, a well baby clinic, a chronic disease clinic, a dental clinic, a laboratory, and an optometric clinic. At Robinson, the female healthcare team consisted of 18 members including doctors, nurses, dentists, an optometric technician, and receptionists.

Harington Primary Care Centre:

On the female side the centre consisted of maternity and child health clinics, a well baby clinic, a chronic disease clinic, a dental clinic, a laboratory, and a pharmacy. At Robinson, the female healthcare team consisted of 25 members including doctors, nurses, dentists, dental hygienist, receptionists, and pharmaceutical technician

Williams Primary Care Centre:

 On the female side the centre consisted of maternity and child health clinics, a well baby clinic, a chronic disease clinic, a dental clinic, a laboratory, an accident and emergency clinic, and a pharmacy. At Robinson, the female healthcare team consisted of 20 members including doctors, nurses, receptionists, and pharmaceutical technician.

In all centres the director on the male side dictated how the practice worked from an administrative aspect, while the medical manager organised the

clinical work in the healthcare teams. The female team consisted of doctors, nurses, technicians, and receptions. Doctors were responsible for the treatment of visiting patients with the assigned nurse. The pharmacist responsibility was to dispense medication and provide information to the prescription holder. Technicians such as lab tech, X-ray tech managed their labs and technical work. Receptionists maintained and retrieve manual patients' clinical files, made patient appointments, recorded patient clinical details and managed the reception for patient attendance.

Individual semi-structured interviews were used to gain an in-depth understanding of the PHC team members' perceptions. The interviews were conducted on the 24th of August 2014, with topics being developed from team-working literature reviewing (see Appendix B for interview Topic Guide). A Semi-structured interview technique was the favored interview method because it enabled the interviewer to guide the topics of the interview towards the aims of the study around HRM systems, whilst allowing the prospect for exploration around the concepts leading to data on unforeseen aspects of HRM interaction and effects of the HRM systems (McCracken, 1988). As the Topic Guide reveals, the interviews covered information relating to HRM systems, organisational conditions, team process, and their perception on teamwork. Respondents were asked to describe which team they belonged too, and the team they worked with. They were asked how they perceived working in their team, and the advantages and disadvantages of being in a team. Interviews were presented as flowing conversation rather than structured set of questions.

Providing a closed set of questions on a questionnaire would not have enabled this freedom to explore the conceptual aim of the research in such detail or depth and would not allowed the same level of data retrieval.

All respondents had previous experience of working in other healthcare facilities as internship experience or member of staff, and they were asked to reflect on any differences and similarities in the way that they worked together in different locations (Roberts, Bradley 2002, Easterby-Smith et al., 2008). Moreover, all interviews were conducted face to face and lasted 35 to 60 minutes and were Audio-recorded and later transcribed. Audio-recordings enabled the researcher to focus on the discussions verbal and non-verbal cues. Furthermore, it can be used as recorded evidence, which can be played back for further analysis (Bryman, Bell 2007). The respondents were told that the interview could be in Arabic or English, however they preferred to speak in Arabic and mixed both languages during the conversation. Interviews were translated and transcribed by the researcher. The rationale for not employing a professional transcriber was because participants used a mix of Arabic and English medical terminology, which raised difficulty in identifying a suitable experienced translator. Consequently, the researcher decided that translation and transcribing would be best achieved by the researcher in order to develop intimacy with the transcript.

Table 4.2 provides details of the interviewees in the study. 47 interviews were conducted in total, across the 6 case studies. This included interviews with the 6 female team supervisors, identified in Table 4.1 above, who came

from family medicine, pharmacist, social work and nursing backgrounds, and who play a critical role in teamworking in the gender segregated context of Saudi Arabia. The number of interviews conducted for each case study varied from centre to centre depending on the individual availability and willingness to participate. Prior to each interview consent (Appendix C) was secured and reconfirmed prior to commencement of the interview. The interviews were audio recorded and participants were asked to provide verbal consent for the possible uses of their data at the outset of the research. In some case written consent was established but in most verbal informed consent was requested due to the location of the research (Saudi Arabia). In such Middle Eastern societies cultural issues are raised in signing any kind of document, which will deter respondents from participating. Moreover, the study was conducted in their clinics where it was technically difficult to obtain written consent due to their busy schedule with their patients.

Data is stored securely with an anonymous code. Also typed transcripts and field notes from the study were stored anonymously. Data is uploaded to a secure server with a password and only the researcher will have access to the stored data.

A total of 110 hours of fieldwork was completed, during which periods of data collection were conducted around a working week when more than one team member was present at the practice. Field notes were recorded during the interviews of participants (Thorpe and Holt, 2008). Moreover, each case was visited for an intensive period of one week, which resulted of 30 days of

fieldwork. Sampling of staff was based on reaching diverse background of professionals to avoid any bias results.

Table 4.2: Participant details

Doctors:	Nurses:	Receptionists:	Pharmacists:
Robinson x2	Robinson x2	Robinson x2	Williams x1
Richmond x2	Richmond x2	Richmond x1	Harington x1
Williams x2	Williams x3	Williams x1	
Harington x1	Harington x2	Harington x2	
Mayfield x2	Mayfield x1	Mayfield x2	
Langford x2	Langford x2	Langford x2	
Medical Male Managers:	Lab Technician:	Dental Hygienists:	Optometrists:
Robinson x1	Harington x1	Robinson x1	Langford x1
Richmond x1	Mayfield x1		
Williams x1			
Harington x1			

Mayfield x1			
Langford x1			
Social Worker	Nutritionists	No of Interviews	
Mayfield x1	Mayfield x1	x 47	

4.7 Data Analysis

A thematic analysis was used to analyse the data. The thematic analysis approach serves as a flexible tool for capturing the themes and the patterns in the study. As it is a useful method for organizing and analysing the data through examining its rich details (Braun and Clarke 2013). The role of thematic analysis in qualitative research is to combine analysis of the frequency of codes with the analysis of their meaning in context. A theme refers to a recurrent pattern found in the data in which one is interested in exploring (David and Yardley 2004). It is the search for themes that appear as being of importance to the description of the phenomenon (Fereday and Muir-Cochrane 2006). In order to interpret the underlying meaning of the text, coding can be used to note the patterns in the data. This process begins by categorizing the data by coding the quotes that have relevance to the research question. A "good code" is the one that holds the qualitative richness of the phenomenon (Fereday and Muir-Cochrane 2006). After labelling the patterns with codes, data can then be organized into distinguished categories. This allows the research to count how often in a

single case the code occurred and analyse the relationship of this code to other codes in terms of sequence or occurrence (David and Yardley 2004). After the grouping the codes by their similarities and differences, themes can be constructed and extracted from the data that can be relevant to the literature review (Braun and Clarke 2013). The codes are combined and charted, then reorganized within the theme into an interpretative chain that moves among description and analytic abstraction (Tuckett 2005). Themes can be identified as bottom-up "Inductive" where the data coding and analysis is driven by what the data interprets. In other words, codes and themes are developed from the content of the data during the analysis. In contrast, a "deductive" method is identified as top-down, because the researcher brings to the data ideas, concepts, and topics to code and interpret their data (Braun and Clarke 2013).

In terms of analysing the data, I began with a read through of the whole interview transcript without coding in order to become familiarized with the data prior to thematic analysis.

Initial ideas were noted that have relevance to the researched phenomenon. Then I started by analysing each individual case as a stand-alone entity. This process allowed the unique patterns of each case to develop before generalising patterns (Miles and Huberman, 1994). By reviewing data without coding it helped in identifying the emergent themes without missing the connection between concepts and their context (Bradley et al. 2006). The transcripts were read whilst the electronic recording were repeated in order to be fully aware of the experiences and perceptions recalled by each

participant (Patton 1987). Yin (1984) supports the "replication strategy" where one single case is examined in depth and then other cases are investigated for similar patterns. Therefore, I started investigating the first case and linking elements to my research question. Once I reviewed my data and I established a general understanding of the scope and contexts of the key experiences under study, coding was developed to organize the data and develop a connection between experiences and teamworking concepts described in the data (Bradley et al. 2006).

Coded interviews in the transcript were highlighted to help in the understanding of participant's perceptions of PHC team members. At this stage, an inductive approach of data coding was developed from the relatively unstructured interviews. Descriptive coding was applied to document information about the data such as healthcare profession, age, and gender. While participant perspective coding was employed to identify a participant positive, negative, or indifference experience of teamwork (Bradley et al. 2006). A short phrase was attached to label each code as well as comments representing what was of interest in the highlighted data. Then successive cases were investigated to look for similarities and difference between cases and to understand the implications of teamwork perception. A cross-case comparison was used by grouping cases according to their MOH administrative standards evaluation. Cases were analysed in a set due to their sharing of certain configuration (Miles and Huberman, 1994). After completing each case at a time, descriptive codes were revisited and similar codes were grouped based on the common meaning they share and

Interpretative codes developed. It summarized the comprehensive meaning of the combined descriptive codes. The clustering of the codes aided in generating the themes and subthemes in the data.

Themes were then extracted in relation to the three research question, by developing an overarching theme from the data set and the research theoretical framework. Themes were identified within the transcripts, and documents based on the experiences recalled by participant. Each of these themes were built up by copying and annotating text from the transcripts. Major themes such as individual HRM practices were recognised, which had limited links between each other, so these became the themes of highest generality. By using an analytical inductive method, related themes were recognised with linkages between them, which formed the lower level themes such as dissatisfaction with particular HRM systems, or tensions, which were categorised within the overarching themes such as work intensification or problems of female line managers associated with HRM practices. All of the raw data was contrasted with other data that may have displayed a similar meaning, and was clustered within a theme, or if there was no other data with similar meaning, it served to acquire a new theme. The emergence of themes from general propositions from detailed and diverse experience of participants provided a unifying and recurrent idea regarding the subject of inquiry. Themes were reviewed in relation to the entire data set by a reread of all the data to determine if the themes extracted the meaningful aspect of the data. The intense process of thematic analysis was continued to develop a higher level and lower level of themes.

This allowed the data to be logically organized to assist with its development and presentation of the empirical chapters (Strauss and Corbin 1998). The data themes were thoroughly reviewed and checked in order to ensure they carried similar meaning with their higher level themes. Furthermore, the coding and sorting into sub-themes was discussed with my supervisor and adjustments were made based on our agreement (see example in Figure 4).

Interview	Code	Sub-theme	Theme
'It improves my performance for example when we work on an awareness day of a specific disease we all work together and this gives us a better result then working alone because you get different ideas from her and her and there is participation between members' (Interview 13 nurse in Robinson).	Teamwork through open dialogue	Communication	Positive perceptions of teamworking

Figure 4. Example of thematic analysis coding

After developing a systematic reasoning for the experiences and phenomena of inquiry, theory was connected to predict, interpret and provide an explanation for the studied phenomena. The fieldwork was driven

to a conclusion at the point at which data became theoretically saturated and no new themes were emerging (Glasser and Strauss 1967). Theory guided the research into understanding the context within which the phenomenon occurred and provided a potential framework for the research. The final stage of the analysis, notes were written on the organized thematic documents to signal the minor level themes that can assist in the process of writing the empirical chapters. Finally, this was transformed into a narrative consisting of three empirical chapters, which are to follow.

4.8 Ethical considerations

Ethical principles are an essential component to any research project. As Saunders et al. (2009, p186) states "the avoidance of harm can be seen as the cornerstone of the ethical issues that confront those who undertake research". Therefore, participants, anonymity and confidentiality are kept during the whole research process as well as after the end of the study. Participants were informed that all data was confidential and will not be shared with other participants in the study, or anyone else apart from the researcher. In order to ensure the anonymity of the organisations is not breached by the readers of this research, the Primary Healthcare Centres were given fictional names to protect the identity of the team members.

Prior to each interview, the nature of the study was explained to each and every candidate. Information sheets included the scope of the study and its objectives and an invitation to participate (Appendix D). During this process participants were invited to ask any questions or had any reservation

regarding being part of a research. Failure to establish trust can result in interviewees plainly telling the interviewer what they thought the researcher wanted to hear (Bryman and Bell 2007). In such Middle Eastern societies cultural issues are raised in signing any kind of document, which will deter respondents from participating. Moreover, the study was conducted in their clinics where it was technically difficult to obtain written consent due to their busy schedule with their patients. Therefore, consent forms were presented prior to each interview to ensure that the respondents agree to take part in the research. Having been informed that their participation would be confidential and anonymous, they gave their consent to be recorded.

Regarding data protection, all transcripts were stored temporarily on the audio recorder and on a personal laptop computer, which only can be accessed by the researcher with a password. The entire research project was reviewed and granted by the University of Leeds AREA Ethics Committee with an ethics reference: Area 19-134.

4.9 Quality of the research

The issue of quality is an essential component of any research methodology (Bryman and Bell, 2003, Saunders et al. 2009). Many have argued about the quality of qualitative inquirers and their criteria in demonstrating rigour (Lincoln and Guba 1983, Creswell and Miller 2000, Cohen and Crabtree 2008). Within qualitative scholarly researchers have suggested different criteria that can be used in the assessment but most identify reliability and validity (Bryman and Bell 2003). Reliability is the extent of which the findings

of the study in a given context can be replicated (Yin, 2009). While validity is the extent of which the claimed findings are credible, accurate and trusted (Lincoln and Guba, 1985)

In quantitative methods in order to produce systematic knowledge concerning the social world, the findings are expressed in mathematical precision, which are separated from the universe of objects and their social world. This ensures that the association between the scientific knowledge and the studied object remain technological to promote validity as well as reliability (Giddens, 1986). Reliability provides a particular strength to quantitative research, however it cannot be always judged easily in a qualitative study. The groups and settings studied within qualitative research might be of a unique or a particular context or time period and it is unlikely that a research can be replicated in the way that a controlled experiment can (Pope et al 2002).

Moreover, a single case study of one primary care centre is unlikely to represent the primary care sector or services and the findings cannot be statistically generalised to that sector. On the other hand, qualitative methods enhance the understanding of what is unique and particular to the individual rather than providing a generalised and universal law (Burrell, and Morgan, 2005). Therefore, the intention of this research was not to generalise statistically but to generalise analytically from the intensive research (Yin 2009). The empirical aim was to develop an enlightening and explanatory insight into the traditional nature of management and HRM

within the Saudi Arabian public sector. It was not to generate results that could be replicated by researcher in a similar situation.

The qualities of qualitative research are often seen as scoring high in terms of internal validity. By capturing and documenting how people behave naturally in everyday situations and examining in detail what people mean when they describe their attitudes, experiences, behavior and experiences. This method is viewed as providing an accurate representation of the phenomena studied (Pope et al 2002). While the case study might not be representative in terms of population and external validity, the single case has representative value. An intensive case study approach provides much more detailed and explanatory sight of operational systems and processes while extensive quantitative methodologies simply do not have the ability to uncover (Hamel et al 1993). The findings of the research can be of value for future researchers by providing novel understanding of processes which may be of potential application to a broader population in the Saudi healthcare sector or perhaps beyond. Yin (2009) suggest that analytic generalisability of the case study method can shed a new light upon processes which may be relevant beyond their location to the wider social world.

4.10 Conclusion

This chapter has set out the logic to the methodological approach and the logic to the research design adopted. Ontology and epistemology of objectivism and subjectivism approaches and their nature broad division was

discussed. The research aim of the thesis is to develop a better understanding of the nature of inter-disciplinary teams in healthcare and how they function within the gender-segregated setting of Saudi Arabia. This is addressed by an exploratory aspect which makers the qualitative method suitable in this research. The selected research design was that of multiple embedded case studies rather than a survey. There is the need to understand the perceptions, experiences and subjective realities of HRM amongst interdisciplinary healthcare workers. In order to achieve this, an intensive case study in the Saudi Arabia healthcare sector was undertaken, through case studies in six Primary Healthcare Centres (PHCs).

Issues of generalisation and representativeness are considered in relation to the case location. The selection of the location for the research (the healthcare sector in Saudi Arabia) is then justified. Semi structured interviews are debated to be the most appropriate format for the collection of primary data. Followed by a discussion of the analysis process and presentation of data. Finally, a discussion of ethical consideration during the research process. The following three chapters now present detailed discussions of the data generated by this methodology.

CHAPTER 5: TENSIONS AND CONTRADICTIONS IN THE IMPLEMENTATION OF INTERDISCIPLINARY TEAMWORKING IN HEALTHCARE

5.1 Introduction

This chapter considers the implementation and operation of interdisciplinary teamworking and its connections with human resource management (HRM) systems at Primary Healthcare Centres (PHC) in Saudi Arabia. It draws on evidence from managers, doctors, nurses, technical and reception staff in the six PHCs, which, as noted in the Chapter 4, are clustered into three groups, according to Ministry of Health administrative standards evaluations, as High, Medium or Low performers.

The chapter argues that the introduction and implementation of interdisciplinary teams cannot be considered in a vacuum, and that attention needs to be paid to the sectoral and Saudi-Arabian institutional context in which teams are introduced, and the supporting structures that are (or are not) in place. A range of studies have highlighted the importance of how supporting HRM structures and practices can facilitate the implementation of interdisciplinary teams and help to ensure their success. Nancorrow et al (2013) point to the importance of effective incentive systems, strong communication, and clear and supportive line management to the success of interdisciplinary teams in healthcare (see also Xyrichis and Ream, 2007; Xyrichis and Lowton, 2008; Molyneux, 2001). Incentive systems – both

informal and formal - within teams, for example, need to be configured in ways that ensure individuals feel recognized for their specific contributions, whilst also providing motivation and effective reward for the team as a whole (Thompson, 1995; Fiscella and McDaniel, 2019). HRM structures can, in some cases, help facilitate change, through supporting practices. For example, training and development in how to work in teams and collaborate may help to ensure that those operating within teams understand how such structures are expected to work, whilst the provision of time and capacity to communicate within teams (through regular meetings) may also help team members to work effectively in an interdisciplinary environment. For some, these supporting HRM practices provide essential 'glue' to ensure that individual practices, such as teamworking, work effectively (Whitfield, 2000; Purcell and Hutchinson, 2007; Brown et al, 2008).

However, by the same token, HRM systems and practices may also undermine interdisciplinary teamworking. There may be tensions or contradictions between the goals of teamworking HRM practices. Payment systems may undermine the goals of interdisciplinary working by over-emphasising individual contributions, or may be confusing or overly complex in their design (Fiscella and McDaniel, 2019; Some et al, 2020). Line managers, identified as crucial to the effectiveness of many HRM practices (Bos Nehles et al, 2013) may not have the skills, or the resources to act as the 'crucial causal agents' mediating HRM practices and performance (Purcell and Hutchinson, 2007). A long-standing literature in the sociology of work and critical HRM has explored these tensions and contradictions, often

as a counterpoint to normative studies on HRM and performance (see Obbonna and Whipp, 1999; Ramsay et al, 2000; Carter et al, 2017).

In this chapter, these tensions and complementarities between teamworking and other HRM practices, as they relate to the implementation of inter-disciplinary teamworking are considered in detail. The chapter focuses on three key aspects of these tensions and complementarities. First, it highlights the importance of considering how existing structures, hierarchies and working arrangements in place within particular settings and environments may impact upon attempts to implement change, in this case, interdisciplinary teams. This has been neglected in much research, although does feature in a number of case studies which have examined the realities and implementation of teamworking (Ogbonna and Whipp, 1999; Procter and Radner, 2014; Cook et al, 2016; Carter et al, 2017).

In Saudi Arabia, as outlined in Chapter 3, the state proposed changes across healthcare facilities, moving them toward the implementation of inter-disciplinary teamwork principles with little consideration of how these would interact with existing, long-established organisational structures, management practices, performance management and incentive systems in PHCs. Some PHCs were better prepared for change than others, and HRM practices and systems within these PHCs varied markedly.

Specifically, within Saudi Arabia, public sector HRM practices have been traditionally concerned with tight managerial control through close direction.

Control is has typically been implemented through close performance management and tight control over individual activities, with the objective of reducing direct labour costs and improving efficiency, requiring employee compliance with specified procedures and rules and basing rewards on some measurable output criteria (Mellahi and Wood, 2001). Thus, managerial approaches to work in the Saudi public sector remain heavily influenced by Taylorist scientific management concepts, which look to increase standardization and efficiency through the separation of execution and conception of tasks. This traditionally emphasis on maximizing control over employees through narrow specified jobs, supported by task focused training, standardized payment systems, close performance management is quite different to the approaches typically encouraged through inter-disciplinary teamworking. In this chapter we highlight the considerable challenges faced by PHCs in implementing inter-disciplinary teamworking due to existing, dominant HRM structures, which in many cases did not support the implementation of new approaches. Attempts by management to retain close control over the labour process within interdisciplinary teams created tensions and contradictions, undermining key collaborative goals associated with teamworking. This chapter uncovers negative impacts on team members and shows that when managers seek to retain control of teams through actions which contradict the goals of interdisciplinary teams, this can result in trust being fundamentally undermined.

Secondly, and relatedly, the chapter highlights the disconnect between the rhetoric of teamworking, as espoused by government documents and

agendas, versus the realities of its operation within specific PHCs in Saudi Arabia. The chapter reveals that in contrast to the prescriptive claims that interdisciplinary teams in healthcare can promote effective collaboration and improve efficiency (see Nancarrow et al., 2013) merely bringing people together in these teams does not ensure that they will work together efficiently and make appropriate decisions. The chapter reveals how some healthcare teams in PHCs in Saudi Arabia existed as teams in name only, with little actual evidence of collaborative working at all, indeed, in some cases with attempts to undermine by team members to undermine its operation. These difficulties can be attributed to professional and occupational barriers, poor incentive systems and perceived hierarchical differences between team members and leaders (Millward and Jeffries 2001; West and Lyubovnikova,2013). In the Saudi context it also reflected the unique sociocultural context, and segregated norms of working. Teamwork required significant efforts and integration to establish the group into an effective team, with team members expected to overcome traditional barriers and adversarial attitudes to collaborative working (Baiden and Price 2011). However, this does happen automatically, and the factors above mean that the reality of teamworking varied markedly from state expectations. In some cases, there were positive individual and organisational outcomes from the implementation of inter-disciplinary teamworking, but in other cases there were not.

Thirdly, the chapter highlights the importance of individual HRM practices, particularly incentive systems, in supporting or undermining interdisciplinary teamworking. Whilst, as noted above, studies have highlighted how HRM systems or 'bundles' of practices may support teamworking, the chapter reveals the particularly prominent role played by incentive systems. The use of both formal and informal incentive systems, and their idiosyncratic implementation by individual managers ensured continued control over the labour process in some cases, but had the effect of intensifying work, creating stress and tensions within teams, and undermined the effective operation of teams. There is strong evidence that specific HR practices can impact positively upon organisational outcomes in healthcare (West et al. 2002), however, the ability of poorly implemented practices to undermine efforts has been considered much less. The chapter argues that when the implementation of HR practices such as teamworking is weak, or neglects dominant pre-existing approaches to work, it can be subject to individual interpretation, leading to incompatibility of practice that can affect staff performance (Bartram et al. 2007). Bacon and Blyton (2000) also caution that when the aims of management are inconsistent with the type of teams initiated in the organisation, and point out that in such circumstances, positive effects of teams on outcomes will be hindered (Wall and Wood 2005).

The remainder of the chapter is structured as follows. In section 5.2, the traditional approach to HRM in the 6 PHCs is set out, highlighting the dominance of tight control and Tayloristic approaches. The remaining

sections look at the implementation of teams in each group of cases, in section 5,.3 the 2 'high performing PHCs are considered, with the focus on how quality imperatives and team based incentives and motivations are used as a means of driving through inter-disciplinary team agendas. Whilst some positive effects are observed in these cases, there is also evidence of work intensification, higher stress for staff, and undermining of trust relations through management actions. The section highlights the female supervisor role in teams as critically important to success and failure. In section 5.4, concertive control through inter-disciplinary teamworking is highlighted in these two cases. In section 5.5, the two 'medium' performing cases are examined in more detail, highlighting inequalities in the allocation and provision of incentives and, again, the crucial role of the female supervisor role in teams to success or failure. In section 5.6 the basic nature of HRM and of inter-disciplinary teamworking in the final two cases is considered, with relatively few supporting HRM structures, and with HRM practices and management retaining much with the traditional approach, and with team members experiencing considerable demotivation. Section 5.7 concludes.

5.2 Control through HRM in healthcare in Saudi Arabia

A number of studies have noted the traditional emphasis of public sector HRM in Saudi Arabia on maintaining maximum control over employees through narrowly defined job roles, supported by task focused training, standardized payment and incentive systems and strong, direct approaches to performance management (Alsaharni, 2005; Achoui, 2009; Mellahi and Wood, 2001). 'Tayloristic' approaches are known to characterize the labour

process within healthcare settings too within Saudi Arabia (Alhazemi, 2017; Alkabba et al, 2012). However, it has been argued that Taylorism is incompatible with modern health care practice, given that healthcare staff typically maintain considerable autonomy (Farr and Cressey, 2015) and are increasingly expected to work in collaborative environments, often spanning roles. This autonomy and collaboration requires the active involvement and engagement of employees, with open communication rather than limiting of information provision, investments in training and development generally, rather than for immediate needs, and empowerment employees through self managing teams, job enrichment, and participation (Cooper and Robertson 2004).

The PHCs in this study operated in an environment where activities were traditionally controlled through strong state and management direction. The healthcare sector is managed by a hierarchy model, which represents a centralized bureaucracy with a high rationalized and standardized workflow and formal procedures. As one medical manager in Harington explains:

"PHC aren't based on teamwork work here. It is either by mutual understanding between staff like here in this centre or based on a bureaucratic system of being afraid from Riyadh Health Affairs (RHA) and their unexpected inspections. If you want to change the system here you should start from the roots… it's a hierarchal chain structure not team based it will continue that way until someone realizes that teams are needed and starts building teams" Interview 33 (M/Medical Manager in Harington).

However, the Ministry of Health has developed modern methods in providing a patient-centered healthcare system with the aim of reaching patients through collaborative interdisciplinary work. In some practices in this research that were passing the Central Board for Accreditation of Healthcare Institutions (CBAHI) quality initiatives enhanced gender mixing, communication and team integration as a nurse in Robinson describes:

"When the CBAHI came to our centre we started to feel as one team (male and Female) and we started to work with each other, it gave us the opportunity to exchange experiences with each other" Interview 13 (F/Nurse in Robinson).

The principles of scientific management, many hospital staff argued, were simply not compatible with interdisciplinary teams, since managers did not directly control the work of the workforce through controlling their performance.

Managers did seek to change and accommodate the context within which teams carried out their work and exercised their professional autonomy. Thus, in the PHCs it was expected that individuals would exercise a degree of influence over their own work formulation and by influencing the work of others in their team through exhortation, suggestion and demonstration. Autonomy would often be displayed as a more collective character rather than an individual one by lengthening the degree of participation beyond the simple distribution of tasks through pursuing goals that encompass inclusion in decisions relating to the organisation of the labour process. This allows groups to formulate around interrelated or common activities, enabling

multidisciplinary teams to exercise a limited form of discretion in relation to the beginning and execution of their own tasks, and thus brings about the reintegration of manual and mental labour. This presents post-bureaucratic work organisation through its collective, rather than individual focus. A noteworthy implication of this transition for critical studies of the labour process is that new means of control might have emerged to support these certain working arrangements (Friedman 1977).

However, managers also sought to retain control and intensify work by adding to the responsibilities of staff and by using increasingly strict quantitative measures of performance. According to a medical manager in Richmond staff conducted meetings to discuss number of patients that are needed to be seen as instructed by the MOH performance measures

"Every year we prepare a plan with goals and we follow up on how far our plan is moving and how much did we accomplish for example this year in chronic disease clinic our plan is to have 72 new patients in our PHC. That means we need to see 9 to 10 new patients in a month" Interview 63 (M/ Medical Manager in Richmond).

According to Friedman (1977) such conditions of tight control, alongside relative autonomy, can coexist in some work settings. Direct control of the labour process is increasingly not seen as an effective method to reach organisational goals and secure commitment and discretionary effort from employees. It is widely recognized that increasing employee autonomy so that teams can exercise an amount of discretion in applying their ingenuity and knowledge to the determination and distribution of work tasks may be

better for securing such discretionary effort. Yet, contemporary control mechanisms within more autonomous structures might still incorporate methods that resemble the formalization and standardization associated with Taylorism (Friedman 1977, Sewell 1998). This was certainly observed in the cases here.

A second aspect of control in the healthcare (and other contexts) in Saudi Arabia relates to the scientific management of space, where control is over the built environment is heavily removed from the hands of workers, and delineated by gender, function and hierarchy. Buildings are not technical systems, rather they are configurations of spaces, designed to achieve particular ways of operating, and reflecting priorities of a social system (Baldry et al 1998). This is clearly the case in public hospitals in Saudi Arabia, reflecting the specific socio-cultural dynamics of work in the country. All six PHCs were divided into two sections, with one entrance for male patients and another for female patients, mirrored by similar segregated entrances for workers. As highlighted in detail in chapter 3, this structure was in place to ensure required physical segregation of genders, due to religious and cultural requirements, and community demands. Hierarchy and segregation are fundamental mechanisms of control over work (Leathard 1994), but the gender subtext of this control in Saudi PHCs has been considered very little in studies. Long-established gender distinctions in social practices were reproduced through organisational and individual arrangements in PHCs. The hierarchical organisational structure, as exemplified in Taylorism influenced considerably working culture and

interactions between members of teams, privileging the masculinity of authoritarianism. The masculine dominance did not allow staff to walk up to the director for enquires or communication unlike the male health workers who had the freedom of direct communication with their superiors. As a Family Medicine expat in Richmond explains:

"We are not allowed to walk to the director or administration if we have a problem we have to phone call again and again the times passes they might be busy and they don't answer. For administrative work their should not be any restrictions between male and female" Interview 57 (F/Family Medicine in Richmond).

A female line manager also emphasized the masculine dominance they are faced with in the Central Region:

"If you go around and see the male section in all the primary clinics in Riyadh, all of them have male directors who only care for their male worker" Interview 28 (F/line manager in Harington).

The construct of masculine dominance created hierarchical segmentation of jobs by allocating men in managerial positions while women performed daily tasks in their interdisciplinary team. Furthermore, the Tayloristic hierarchy in PHC produced a strong relation of authority between managers and the workers (Benschop and Doorewaard 1998). These issues are explored now in more detail through examinations of pairs of cases, which have been grouped according to performance against state benchmarks and quality inspections as 'high', 'medium' and 'low'.

5.3 Quality imperatives, incentives and Work intensification under inter-disciplinary teamworking

A key agenda driving the move towards inter-disciplinary teams in PHCs in Saudi Arabia was quality management imperatives, particularly those associated with formal accreditation. All of the PHCs studied were impacted by these quality agendas, which were written into Ministry of Health Administration Evaluation Standards which all PHCs had to meet. The extent to which PHCs met quality requirements was a key determinant of whether they were classified as 'high', 'medium' or 'low' performers by the Saudi government. In addition to this, however, two of the case study PHCs, Robinson and Richmond, were actively going through the process of seeking accreditation for quality of services and standards, through the Central Board for Accreditation of Healthcare Institutions (CBAHI), which they both ultimately secured. This accreditation program pushed PHCs towards implementing integrated teams in healthcare to a high level, and the state envisaged that all PHCs would ultimately secure this accreditation to enhance the quality of services. Implementing quality has been acknowledged by many governments as a prime objective of public service provision (Pollitt and Bouckaert, 2004), and it is seen as an essential demand for any organisations to be successful. In two of the cases, Richmond and Robinson, management had been given the task of changing the PHC culture, under the auspices of creating 'quality conscious' health care workers.

In the case of Robinson, this quality agenda, linked to accreditation, pushed team members to take on an extra work to provide better quality of services. Whilst it was commonly recognized that PHCs needed harness the efforts of its workers, a clear desire amongst senior PHC leaders to pass the accreditation program meant that this was operationalised through tighter control the labour process of team members. Management used the rhetoric of 'quality' as a common aim with which to bind together the diverse occupational team members within the PHC. This view was shared by doctors in Robinson and Richmond:

'…Because of the CBAHI we worked for five weeks continuously and even came on Saturdays, so the director agreed on awarding us with days off but he said he needs to speak to Riyadh Health Affairs first' [F/Line manager in Robinson].

'…you know now the trend is changing now the general practice is changed to family practice and family physician means you have a holistic approach to the patient we are dealing with the patient, family, community and we must approach the patient as a team to enhance quality of care' [F/ expat/ DR in Richmond].

At Robinson, workers were compelled to work more closely in teams to raise the standards of their work. The male director of Robinson PHC required members to work for six days a week – beyond the normal working week for Saudi workers - for five weeks in order to progress interdisciplinary team working, increase quality, and organize the Centre's accreditation application. Interestingly, whilst the Ministry of Health had set broad targets and guidelines about how PHCs might achieve successful accreditation,

day-to-day organisation, working arrangements and incentives were determined locally, and were not institutionalized adequately by the Ministry of Health. At Robinson, female members of the inter-disciplinary team were asked to work at weekends (something that that was atypical for female workers in Saudi Arabia) in order to help passing the accreditation. Incentives offered to staff for this additional work came in the form of days off in lieu, rather than through increased pay or bonuses.

This did encourage and motivate staff into working extra shifts, with staff highlighting the team-based nature of the effort to secure accreditation. Yet the extent to which there was, in reality, any choice over taking on these additional hours is questionable. On the front line, the female line manager was charged with implementing these additional hours and was central to securing team member commitment to the process. She supervised and evaluated how much over time was put in by female members, and sought to motivate staff, using the collective team goal of successful accreditation as a device to try and secure discretionary effort as a nurse in Robinson explains:

'…Our female supervisor evaluated how much overtime we have worked and gave us additional days off and then comes the director and tells us no you will not be rewarded anything for your overtime..' [F/Nurse in Robinson].

However, after passing the accreditation, the director of the PHC retracted his agreement to pay additional hours and refused to compensate female members blaming the decision on the Riyadh Health Affairs Department.

Field and West (1995) and Cashman et al. (2004) have highlighted how when teams do not perceive that they are receiving support to implement changes, team members are left feeling discouraged, and this can undermine efforts to improve outcomes through teamworking. This was certainly the case within Robinson PHC. As one nurse, expressing her resentment at the lack of support from the director commented:

'…Now why did he approve on rewarding us, which motivated the staff to work harder. True if we pass the CBAHI this is good for the centre, but me.. me as a person, as a mother who left her kids and home what did I gain? I mean if there is going to be any financial incentives only the director will benefit right?' [F/Nurse in Robinson].

This perception, that the 'we are all in this together' rhetoric of teamworking was not backed up by tangible, material, benefits, and, indeed, that due to the non-payment of days in lieu, work had been intensified, had the effect of demotivating staff significantly:

'…I feel everyone is not enthusiastic like when we first started. When we started we felt like one team integrated and working together but now honestly I feel demotivated…' [F/Nurse in Robinson].

With days off in lieu being advertised and promoted to staff as incentives for working collaboratively to meet accreditation, the removal of these by management after accreditation was seen as a breach of trust, and highly misleading. HR polices within the PHC were not in place to enrich the teamwork of interdisciplinary teams and do not improve long-term

motivation, commitment or individual performance, since workers felt coerced into working overtime, and then saw their work unrewarded. There is ample evidence that suggest that work at Robinson was intensified thereby increasing stress and job strain:

' The CBAHI only increased our load of work' [F/ Receptionist in Robinson]

Despite this, the female line manager in Robinson PHC herself did link teamwork to a common goal, seeing higher standards of services as an important aspiration, and recognizing the need to use incentives to motivate staff. Workers were motivated by an intrinsic desire to provide quality care, and this led to high levels of discretionary effort in the labour process overcoming much of the potential resistance to change due to common objectives of passing the CBAHI. However, the introduction of quality initiatives, and the accompanying rhetoric of a common goal to work for remained, even after accreditation. New working practices were retained, and appeared to support tighter management control.

'…but now after we were visited by the CBAHI it is a must that we work as a team even with our male co-workers and meet up to discuss our progress'
[F/ line manager in Robinson].

More profoundly, quality accreditation required enhanced gender mixing through educational meetings and mixed gender committees. PHCs had segregated spaces for women and men in accordance to Saudi cultural norms that prohibit social mixing between unrelated men and women. In the

case of Robinson this move to mixed-gender working, even though this was in selected, rather than all areas of work, thus represented a major shift in working arrangements. There were important practical aspects to consider, to ensure socio-cultural and religious norms and regulations were adhered to. For example, mixed-gender staff meetings and committees needed to be organized behind closed doors in order to not offend any visiting patients.

Alongside changes to the physical space, this move to mixed-gender aspects of working reinforced and reproduced traditional structural configurations of masculine dominance in the organisational culture. The female line manager in PHC in Riyadh acted as agents in delivering HR practices to the interdisciplinary female team. Under interdisciplinary teamworking, this was an added responsibility added on to their existing role. Whilst these female team leaders had no disciplinary powers, their pivotal role was to watch over the interdisciplinary team members. This acted as a motivational force in some cases, but contributed to tacit pressure and surveillance of work performance in more cases. In Robinson, the female line manager reported to the technical manager, a role held by a male doctor, whilst a male nurse acted as a director of the PHC in the male department. Thus the gendered division of labour, and the use of the female line manager role served the purpose of helping PHC senior managers achieve quality goals, but reinforced existing inequalities, with segregation of roles presenting a barrier between management and team members. However, team members did integrate in quality committees, accident and emergency services, and a number of specific campaigns, such as school

and health promotion campaigns. Moreover, during the accreditation process management encouraged integration with male members.

The primary interest of PHC management throughout was the achievement of the various targets set by the Ministry of Health to pass the accreditation, at whatever costs they were achieved at. On the ground, this meant that inter-disciplinary teams were left with some capacity to organize their overtime and work with some autonomy. Most projects and activities undertaken were monitored by the state, with senior management typically being rewarded financially when goals were achieved. Therefore, interdisciplinary team members felt that management involvement became much more visible and hands-on when there were tangible projects and deadlines to reach. Sometimes, this management involved close scrutiny and control, and at other times, it largely consisted of overseeing and inspecting the process of the interdisciplinary team - during the CBAHI for example. The crucial issue was for the team to be seen to be operating effectively, by external accreditation standards:

'Our team here works well, however the most important thing for our director is just keep on working even if there is shortage in staff or resources' [F/ Hygienist in Robinson].

Despite these negative views, workers viewed quality initiatives as having some positive aspects, moving towards working as 'one team'. At Robinson, commitment to quality outcomes did have some impact on team integration,

however this came at the cost of higher workload and increased responsibility. This suggests that management has translated its responsibility for achieving higher standards of quality into de facto greater control of the intensity of teamwork. The director operated teams as a mechanism of administrative control, seeking to maintaining productivity output at an acceptable level and meet accreditation requirements, rather than improve discretionary effort and collaborative working.

Managers failed to provide adequate supervision feedback to team members regarding their performance, and did not offer support for their staff in continuing education and training programs. According to Jarallah and Khoja (1998) the challenges of implementing interdisciplinary teams were compounded by a lack of training, which hindered teamwork development. Line managers had to rely upon their knowledge and experience in healthcare, rather than knowledge and skills needed for operating and implementing interdisciplinary teams. In a survey of technical managers conducted at one of the case studies the majority of supervisors (65%) had received no managerial training. The survey conducted also revealed that a tiny minority of managers thought that motivation of staff (5.9%) and improving quality of care (4.4%) was an important component of their supervision. In fact, many supervisors appeared still view supervision as a form of inspection focusing mainly on looking for defects, problem solving and discovering mistakes (see also Alahmadi and Roland 2005, Jarallah and Khoja 1998).

Accreditation at Richmond and Robinson did push management to apply basic quality management concepts such as team working through training, and there was some basic training in quality management processes. However, it did not provide a clear process of how the progress in achieving these concepts could be established through defined activates or reports on a regular basis. For many managers in the case studies, the accreditation provided a 'tick in the box' and a means of securing compliance with state goals and aspirations. There were few other measurable or evaluated outcomes, beyond measures of quality of care and safety and risk reduction. Problematically, the accreditation did not involve patients or stakeholders input in any of the standards (Alkenizan and Shaw 2010, Central Board of Accreditation for Healthcare Institutions 2011 p.20.). For front line staff, there were quite cynical views about the rationales behind accreditation and the way that it had been implemented through integrated teamworking.

A wide range of research has highlighted how training needs to be offered consistently to support the interpersonal team processes of communication, cohesion, and coordination and to minimize the different views of teamwork maintained by different professional models of practice (Mickan and Rodger 2000, Weaver et al. 2014; Whitfield 2000). In Saudi Arabia, The Ministry of Health (MOH) did provide basic training for PHC workforce in communication skills that focused on effective interaction with patients and families, rather than on communication and collaboration skills across professions and team members. PHCs relied on internal training offered by management or staff. Education sessions were organized by some female

line manager to provide information and skill development opportunities for staff as well as for patients, yet overall, training did not, in the case studies, act as a glue to help connect HRM practices and teamworking.

5.4 Concertive control under interdisciplinary teamworking

As highlighted in Chapter 2, concertive forms of control seek to promote a strong feeling of empowerment and ownership amongst team members, whilst ultimately extending management control over the labour process (Barker, 1993). Such concertive control could be seen in the 'high performing cases', particularly Richmond, implemented through a range of tasks.

Incentives were used by management to expedite programmes that were monitored by the Ministry of Health such as quality initiatives and health promotion programmes. These incentives were typically symbolic rather than material in nature, but had a strong effect of ensuring compliance and gaining buy in for initiatives. Letters of appreciation were used extensively by managers to enlist participation and celebrate results for interdisciplinary teams. Letters encouraged members to participate in health promotion campaigns and health programmes. These promotional campaigns included cancer awareness days, requiring the PHC to reach out to the community in their district and invite them for awareness lectures. Health programmes covered local districts surrounding the PHC, and included regular, often annual, programmes such as vaccination programmes.

In Richmond, such activities were not presented as voluntary, and instead demanded the involvement of all staff in the PHC, and crucially, the integration of male and female workers to collaborate on health programmes. Staff would meet with the PHC director in a meeting room to organize these activities. The gender barrier was removed as an issue for carrying out the needed tasks in this context, yet, the integration of male and female staff was behind patients' presence in order to not offend traditional and cultural values. The director was quite closely involved in overseeing the initiative, but only conducted meetings with the female interdisciplinary teams to arrange health promotional programmes. Management did seek to motivate staff to work together specifically in health promotion programmes.

 'We do have meetings regularly with the female staff but the director is not on a regular basis. We only meet the director if there is work ahead. We meet upstairs in his office as a team of doctors, nurses, and receptionists to discuss our roles in vaccination campaigns for example this is the role of the doctor or this is the role of the nurse and cooperate together for this campaign…' [F /DR/ Manager in Richmond].

The director encouraged the female members of the interdisciplinary team to work 'as a family' and to collaborate on their programs. This created a perception of collective endeavour and value of working together in teams, particularly around health programmes. Management created a "familial rhetoric" that the staff did attach and value in their interdisciplinary interaction:

'Here we are a family we don't call ourselves a team we call ourselves a family…' [F/ Nurse in Richmond]

The collective team identity that bridged them with other healthcare members did give management greater control over the labour process. There was a shared sense of team identification, with individuals being committed to the team and its goals, rather than their own individual goals or the goals of their specific specialty. As opposed to operating under a united interdisciplinary team, members operated on a level of simplified relationships of 'familial rhetoric' with this identity established over personal and social relationships- as opposed to a relationship built around teams.

According to Baker (1993) concertive control can emerge when teams establish their own norms of task performance evaluation, direction, and internal discipline. This could be seen in a number of the cases. In Richmond, interdisciplinary teams supplanted informal norms with their own local rationalization of work behaviour. Concertive control offered a means through which the intended action of teams to accomplish organisational goals was secured by management while overcoming the stultifying and constraining effects of bureaucratic hierarchy (Sewell 1998). In the case of Richmond, a strong 'familial rhetoric' represented an important shift in the locus of control from management to team members, who increasingly went about establishing norms for their team activity and collaborated to develop the means of their own control. Members saw other team members as sisters and their centre as their second home:

'This centre is like our home we all get along like a family here' [F/Receptionist in Richmond].

Beyond offering their labour to participate in these initiatives, interdisciplinary team members also demonstrated additional commitment to programmes. At Richmond, team members *paid* for hospital resources that helped patients in educational programs and donating to refurbish PHCs. Members who were reluctant to participate in educational programs felt pressured to donate money by some of their peers. Members took ownership of their success and took responsibility for passing the accreditation programe as well as being a distinguished centre. Moreover, team members were able to make their own decisions within guidelines set by management. They set their own work schedules, buying missing materials they needed for health promotional programes, and coordinating with other members of the interdisciplinary team. Yet, using these values as their starting point, female members modified behaviour further towards collaborating and achieving organisational goals, demonstrating the power of management concertive control in this context.

Value-laden premises manifested as rules, ideas, and norms became, in a number of the cases, the supervisory force that directed activity in a system of concertive control A consensus over team values and a 'we are in this together' approach was used to make sense of and guide their everyday interactions. The consensus about values influenced and informed members' outlook on and processes of work activity such as decision-making. Members saw collaborating as a family and helping each other was a form of kindness that needs to be passed from member to member. In doing this, members placed a psychological premium on themselves to act

in ethical means in terms of their values. These values were morally set to the team members because it represents the will of the team to participate rather than being forced by management. Thus, team member could turn their value consensus into social norms and rules. Management created the meanings that structure the system of control in the PHC, with rule generation moving from the traditional supervisor-subordinate relationship to the actors' negotiated consensus about values (Barker 1993).

Due to segregation management was able to exert tight control over female interdisciplinary team. By giving up some of its authority to the team members (particularly the female line manager), this had the effect of increasing the effectiveness of control in PHCs, whilst members were unaware of how the system actually controls their actions. Concertive control was more elusive than a supervisor telling team members what to do, and members of teams appeared to willingly submit to their own control system because it seems natural, resulting in a system of control that guides their value-based rational rules in their team.

In terms of direct observation, the director of the PHC at Richmond would visit the female receptionists in the medical records department to see if they had participated in health awareness campaigns, and informally encouraging them to participate as being part of one family. This acted as a strong compelling force for made the medical record receptionist to actively participate in the team. PHC activities such as school vaccination programs or awareness days also encouraged integration through a focus on the

organisation as a whole rather than on daily clinical activates. Incentives were presented to encourage team members. Whilst rewards on PHC activities and health programs were not officially rewarded by the organisation, recognition was used as a form for conception and execution of their teamwork:

'Sometimes we get a few days off work added to our annual leave and sometimes we get letters of appreciation the letters don't do much but morally I feel they help a little' [F/receptionist Richmond].

In a number of the PHCs, managers would take over the responsibility for the conception of work, while non-managers were simply left to execute programmes or projects. In Richmond recognition was commonly used as part of team-based reward, yet staff did not feel it served much purpose, beyond celebrating the achievement of the team internally. The reward system was designed to reinforce team effort into expediting promotional programs. Interdisciplinary team members took ownership of their work and were committed to the success of their PHC. They even had the letters of appreciation hanged in their clinics, yet there was recognition that these incentives were local in nature:

'The director encourages us as much as he can especially when we work district vaccination programs but nothing official from any governing body' [F/DR in Richmond].

Effort at work within teams should be matched with appropriate rewards to promote feelings of self-esteem and self-efficacy among staff and to prevent distress (Siegrist 1996). Interdisciplinary team members in the cases in this

study did not feel that recognition would serve them because it was not from a governing body. While most healthcare institutions stress the value of high-quality care in their mission, few in the cases under study here offered the supportive environment to achieve this goal.

5.5 Inequalities and perceived unfairness in interdisciplinary teams

Other PHCs, particularly the 'medium' performers Mayfield and Langford, used alternative means to incentivize teams, with a number of them focusing on offering non-traditional, flexible, working arrangements to allow interdisciplinary team members to work in shifts. PHCs generally operated for eight hours a day and covered their local district. The shifts were arranged between morning and evening. Teams would be divided, with one team serving the morning shift and the other covering the evening. Such arrangements were organised by the female line manager who supervised their work. The director and the technical manager did not mind how female teams were configured as long as their team was covering the requirements of female patients in the centre. However, the Ministry of Health did not set these arrangements.

In Mayfield and Langford control of the labour process was embedded in the social organisation that constitute a structural form of control. Line managers combined incentives and sanctions in quite an unsystematic and idiosyncratic mix. Across these two cases, there appeared to be less structure over how power was exercised, and team members tended to be treated more arbitrarily. Yet, the opportunity for workers to participate and

access non-traditional working arrangements provided line managers with some power over team members. Institutionalization of hierarchical power enhanced bureaucratic control in these cases. Control appeared more impersonal in this case, and somewhat disconnected to the team since its authority rested ultimately with the system, leaving organisation member, in many cases with what Weber (1958:182) called "specialists without spirit, sensualists without heart". Workers expected and required supervisory approval because that was the norm in these contexts. Thus, the appearance of control becomes hidden in the bureaucracy's seemingly natural rules of hierarchy (Edwards 1979, Barker 1993, Sewell 1998).

Mayfield operated under conditions of teamwork, where formalization and standardization of tasks were imposed at an individual rather than a collective, team level. The female line manager used incentives such as non-traditional arrangements, days off, and extra breaks to compel individual staff into completing tasks, rather than encouraging them to integrate and work as a team. Traditionally in healthcare, both power and authority resided with medical specialists. However, with responsibility delegated to female line mangers their control over individuals within teams was legitimised. As a result, tension and stress was evident among team members. The director offered incentives to female team members based on the input of their line manager. Direct incentives were rarely used in Mayfield, and staff were actively discouraged from participating in any promotional campaigns:

'…from time to time we prepare programs and no one cares if it is implemented or not. We could offer to help let's say for example immunization awareness program I might participate if I want, it is not an

obligation and if I did I would do something quick and simple like a basic broacher…' [F/Nurse in Mayfield].

In the case of Mayfield, incentives were not linked to goals or performance, instead the line manger used her position to control staff and reward them based on her personal relationship with members of the female team.

'Rewards such as days off or sometimes I let them have an extra hour on their break, or I grade them with higher scores on their appraisal if she was good and worked well with me… that is what a PHC offers of course with the approval of our director' [F/line manager in Mayfield].

In the case of Mayfield, the role of the line manager transformed from the active supervisor and overseer of work activities to that of evaluator and monitor of the teams performance. The line manager did not interact with any patients and only served as a supervisor over interdisciplinary teams. In Mayfield, there was significant divisions amongst team members, with fragmentation and conflict among members commonplace. Staff worked in line with contracts and duties, in order to avoid any negative feedback, but discretionary effort was minimal and members were not interested in participating in any activities for the centre.

'If you excel in something else or organize lectures for staff or patients it goes unnoticed. Not even a letter of appreciation we get nothing. I think eventually we will be discouraged to do anything extra for this centre' [F/Lab-specialist in Mayfield].

Consequently, members were only concerned with executing daily tasks with minimal interaction with other members to avoid conflicts and delays that could reflect on their productivity:

'Staff here are treated differently because of our female supervisor which has caused a lot of problems among staff. There is conflict and hate between us. Most of us work to get things done…' [F/Receptionist in Mayfield].

One of the important outcomes of this was there was a perception of unfairness, with a good or bad relationship with a line manager influencing perceptions of workers towards management:

'They are always critical never encouraging us in any way. We don't get any incentives or rewards I don't even feel like making any effort towards my work I just sign in work and sign out' [F/Receptionist in Mayfield]'

A recurring theme throughout the cases, then, is the crucial role played by the line manager and their interpretation of how to implement inter-disciplinary team working. This resonates with a long-established literature in HRM over the importance of the line manager (Purcell, 2004; Purcell and Hutchison, 2007; Kinnie et al, 2010), as well as specific literature within healthcare on the implementation of interdisciplinary teams (REFS here). Line manager actions in the cases here were shaped by quality imperatives and demands, supporting (or non-supporting) HRM practices, existing hierarchical and employment structures, and socio-cultural norms around gender segregation in Saudi Arabia. In the case of Mayfield, the control of team members based on favourable relationships between line manager and staff reflected negatively on the morale of the workforce.

'…To her I feel it is about controlling staff more than organizing work around here' [F/ Dietitian in Mayfield].

'Their isn't any appreciation basically they are concerned with patients statistics their should be appreciation and encouragement so we can work with our heart and give one hundred percent when they worry about statistics then that's all they will get' [F/ DR in Mayfield].

The female line manager significant role in Mayfield was a permanent, direct, presence ensuring that members were not distracted from application to their task. She did not use incentives to motivate members into working together on tasks or projects; rather it was used based on personal relationships with members on the team. Therefore, team members felt less eager to go 'beyond contract' than in the 'High' performing PHCs, whilst some team members actively sought to resign. The director in Mayfield rarely used incentives to motivate staff, and relied on the female supervisors' judgment when it came to rewarding staff. Team members were much more task oriented and overall, were less concerned and interested in the collective aspects of working in a team.

Similarly in Langford, the female line manager used incentives sparingly, and only for specific members in the team, something that was perceived to be inequitable:

'What I have noticed from our supervisor is that people who work in here are treated equally with people who are most of the time sleeping at home [mostly on annual leave or sick leave]. It is very frustrating and it makes me think everyday of quitting my job' [F/ Nurse in Langford].

Line managers can look to minimize role conflict through their actions, by, for example, recognizing the value of work-life balance, and working outside of formal rules to permit some flexibility in a work schedule to take care of non-work burdens such as a sick parent or child. Employees whose line mangers permits for schedule flexibility to meet home related demands indicated that they have lower levels of psychological strain (Cooper and Robertson 2004). In the case of Langford, however, the use of such flexibility, and the attempt to incentivize staff by offering non-standard work schedules was used strategically – some would say cynically – just before a visit from the Ministry of Health or the quality committee (CBAHI). After these visits the director rarely encouraged staff with incentives and work went back as it was before:

'…there are letters of appreciation and I don't feel that they make any difference. We don't get any bonuses in our salaries or promotions just a letter that is all' [F/ Optometrist in Langford].

'„,we have here our female supervisor she can either make the members integrate and work together or she can split them apart by favouring some staff over others or giving them priorities such selecting them in attending seminars or sometimes allowing them to leave work early and while others don't. This is done here by our female supervisor and in a very obvious way' [F/Optometrist in Langford.

Where such flexibility was offered outside of accreditation or quality inspections, this was reserved for just selected staff members, and seemingly offered on the basis of favouritism:

'…The system is not organized and it does not support incentives or punishments. This system has affected staff that came in enthusiastically to work, it made them feel frustrated and discouraged to work because when they looked around them whether you work or not they are all treated alike' [F/ DR in Langford].

Overall, then, in Mayfield and Langford team-based rewards were used largely in health projects and activities. Incentives and rewards motivated staff to integrate in health promotion activities, although without wider managerial support staff felt discouraged to do any extra task for their organisation.

5.6 Non-existent incentives and impoverished HRM

In PHCs that had scored low in the Ministry of Health administrative standards evaluation and had no accreditation awards, incentives were not typically used. Interdisciplinary team's were interdisciplinary and collaborative in name only. In both Williams and Harrington, members largely worked in silos and did not integrate in any activities. HRM in many respects retained the feel of traditional practices, and looked like the 'impoverished' HRM described by Dundon and Rafferty (2018).

The line manager role was important here, but served largely to reinforce silos and established patterns of working. At Williams, for example, the line manager did not engage with team members and saw any administrative direction regarding teamwork as unnecessary and cumbersome. As a result,

the team structure was ineffective, and far from interdisciplinary and collaborative:

'There are teams here but they are not organized. I noticed it when I started working here 3 months ago, its different here the system, the structure is different then where I used to work. The structure should be director, medical director, quality coordinator, and a nurse supervisor. Here everything is floating on its own [mayhem]' [F/DR in Williams].

For staff working within team's, there was little evidence of teamworking in practice, and supporting HRM structures and activities appeared to be largely absent. This extended to training, team meetings, and communication upwards:

'I do not have any communication with the male management in this primary clinic' [F/Nurse in Williams].

Similar to some of the high performing cases, there were some days off in lieu promised, but not delivered by management, following staff involvement in initiatives. However, the widespread perception was that there were few direct or indirect incentives to engage in interdisciplinary team processes:

'Monetary rewards are not allowed in our systems however from time to time we do get days off when we work on projects together and sometimes we do not get any days off' [F/Nurse in Williams].

There is high control, lack of concern for employee welfare and limited commitment to training where teamwork is unlikely to thrive. Despite

continuous healthcare reforms the MOH did not implement a system to support interdisciplinary teamwork development and building in Primary Healthcare Centres. Therefore, Continues support from management is key to the success or failure of teamwork.

'There isn't any encouragement, no training courses, and no incentives for teamwork' [F/Receptionist in Harington].

Lack of knowledge about the process of team development and lack of organisational rewards have left healthcare team members unaware of the benefits of teamworking. Team members in Williams and Harington preferred working in and identifying with their own professional group. They did not identify with other peers from different backgrounds and did not see the importance of joint working. The director and line manager echoed the same voices and managed the primary clinics by isolating themselves from their staff.

'Honestly we rarely get rewarded here with days off and we rarely are in contact with our director' [F/Lab technician in Harington].

The importance of incentives seems to have been overlooked by the MOH and left for directors and line managers to implement for group activities. Thus, staff did not recognize the importance of interdisciplinary teamwork and how it reflected on the quality of service and patient care. Incentives systems need to be reviewed and adjusted so that rewards for individuals, teams, and organisations encourage desired outcomes for patients (Xyrichis and Lowton 2008).

5.7 Conclusion

This section has shown how transformation in organisations' work systems and the human resource policies supporting them, are rarely synchronized.

Teamworking difficulties have been attributed to professional barriers, different payment system, and perceived hierarchical differences (Millward, Jeffries 2001). Teamwork requires significant development efforts and integration to establish a group into an effective team. When supporting HR practices are weak, HR practices will produce messages that are vague and subject to individual interpretation leading to incompatibility of practice that can affect staff performance (Bartram et al. 2007).

 The implications of a predominantly ad hoc stance on incentives in relation to altering working arrangements is that work systems will become primarily non-aligned with the incentive systems in the organisation. Such developments will lead to the build up of substantial pressure within organisation which may result in poor morale, higher labour turnover or higher absence (Thompson and Bevan 1995). A long-standing literature in the sociology of work and critical HRM has explored these tensions and contradictions, often as a counterpoint to normative studies on HRM and performance. Fit between teamworking and other HRM practices is important to consider, then, as well as understanding how teamworking is implemented.

Organisations need teams to set and then reach objectives that enable the organisation to achieve its own goals and targets. Hence, incentives make it

possible to reward people on the basis of the results they achieve and the extent to which their work promotes quality, innovation, continual improvement and teamworking. By rewarding team outcomes, perceived interdependence can be heightened, consequently enhancing cooperation. While recognition is used here as a reward for group work, tangible rewards might be more effective in motivating team members and achieving the purposed of the team based system (McClurg 2001). The reward systems were used as some kind of negotiated outcome, tending to signify the language of teamwork itself as the medium through which these negotiations take place. The reward systems are problematically implemented in various ways by management to draw more value from the labour force.

High levels of interdependency and information sharing characterize teams in healthcare; hence they are more suited for team-based rewards (Thompson and Buchan1992). Nevertheless, PHC only evaluated individual work not team members, and emphasis was on improving individual output. Organisational reward systems failed to align with the structure of work in teams (Cooper and Robertson 2004). At the organisational level, team based working must be supported and embedded in the context. A reward system should recognize individual task interdependence and encourage team members' collaborative work (West and Lyubovnikova 2013). Moreover, incentives demonstrate the organisation's commitment to those values. Incentives should include individual team member, the team, and the organisation (West 2004).

CHAPTER 6: PERCEPTIONS OF TEAMS, THE EFFECTS OF TEAMS AND BARRIERS TO SUCCESS

6.1 Introduction

The first key empirical chapter considered the implementation and operation of interdisciplinary teamworking and its connections with HRM systems at Primary Healthcare Centres in Saudi Arabia. Significant problems were found regarding the interpretation of policy and practice often resulting in tension and contradictions between goals of teamworking and HRM practices. As identified in chapter five it was possible to cluster the six separate case studies into three rough groups. This chapter discusses the perception of teamwork in the six primary Healthcare cases.

The quality and perception of teamwork are known to affect patient outcomes. In the health care settings, practitioners from diverse disciplines come together to care for patients. On account of a number of factors, such as an ageing population and the burden of illness from acute to chronic care, these require a number of different health and social care professionals to be involved in the delivery of care (Reeves et al. 2009). Healthcare today is undeniably a team effort that requires professionals to work together effectively to take care of their patients holistically. But placing individuals together and calling them a team is not enough. Failures in communication and coordination among hospital workers have been associated with longer length of hospital stay, higher mortality rate as well as nursing staff turnover,

and greater postoperative pain with lower functioning levels for patients (Carney et al 2010).

Working effectively in a team entails members to acquire attitudes, knowledge, and skills that allow workers to engage, support and build on the work of other team members, get along with people generally and manage conflict (West, Slater 1996). In order to establish and maintain good working relationships, team members must acknowledge and understand each other's roles and skills. Moreover, team members need an agreed process for resolving conflict, which might escalate periodically from time to time (Borrill et al., 2000, West and Slater, 1996). Finn et al (2010) states that it is necessary for professionals to find space to negotiate what team working means in practice. They argue that the meaning of teamwork resonates with professional identity and can leave members working in silos rather than connecting with other professionals in their team.

This chapter explores how workers perceive and understand teams, and how they work together in practice. The chapter aims to provide new understanding and insight into the nature of teamworking, the contexts in which it works effectively, as well as an understanding of barriers that impede teamworking. The focus on the chapter is on presenting the voices of those within teams in the six cases, to gain a direct understanding of perceptions of teams and their operation within the specific context in which respondents encountered teams. There has been long-standing and on-going debate within the academic literature around the composition and

meaning of teams (see Knights and McCabe, 2000; Mueller et al, 2000; Sangaleti et al., 2017).

The first part of the chapter looks at the composition of teams in the six cases, providing insight into a number of important aspects. The size of the primary health care centres varied markedly, as did the services that they offered. Some had been driven towards more active engagement with inter-disciplinary teamworking as a result of attempts to secure quality accreditations. A factor specific to Saudi Arabia, and a feature of working in all six cases was gender segregation, which impacted profoundly on the nature of teams and their operation. This section of the chapter reveals how inter-disciplinary teamworking was configured formally only in a few of the cases, and in practice, the extent to which groups worked in cross-disciplinary teams, or even engaged in basic team activities such as regular meetings, varied considerably. Sizes of teams also varied. A female supervisor role was a feature of all six cases, and this role-holder was seen as vital to knowledge sharing and collaboration across male and female sections of the hospital, and to the success of any mixed-gender elements to teamworking.

In section 5.3 attention turns towards the perceptions of respondents to teams. In the two cases where quality accreditation efforts and applications were well-progressed, there was more evidence of some organisational infrastructure to support teamworking, but nonetheless, much activity was quite informal and organic. In these cases there was buy-in and

self-expression of the importance and value of teams, but alongside this there was expression of support for a more loosely defined 'family', and strong identification with individual discipline-specific units, and an allegiance for these groups over inter-disciplinary teams. In other cases, these disciplinary boundaries were even stronger and individuals tended to identify with their unit or specialism more than the inter-disciplinary team. Attempts by some groups to define teams and their value in terms of their own particular specialism also undermined attempts to foster a genuine organisation wide view of teams.

In section 5.4 positive and negative aspects of teams, as expressed by respondents, are considered in more detail. The main benefits and enablers of teams are explored under three areas: effective communication, an emphasis on patient-focused care, and benefits for education and skill development. Evidence from the cases is presented to give examples of all of these benefits, and the analysis explores why these benefits are seen in some cases, but not in others. Looking at the negative aspects of teams, and barriers to teamworking, the second part of this section of the chapter examines working in silos, and a lack of belief in the team concept in some of the cases. Section 5.5. offers some conclusions, returning to the theme of the rhetoric of inter-disciplinary healthcare teamworking, and the reality.

6.2. The composition of teams

All 6 hospitals operated teamworking structures, although these were configured in quite different ways at the 6 hospitals. At two, Richmond and Robinson, the hospitals were seeking accreditation from the CBAHI for quality of services and standards. The accreditation program pushed towards implanting teamwork in all centres in the Kingdom to enhance the quality of services. Of the six cases, inter-disciplinary teamworking was the most advanced, at both of these centres, structures facilitated and enabled some working across functions, and across male and female parts of the hospital. In the other four, teamworking structures were in place, but silos of single function or specialism remained.

Robinson was located in the northern urban area in the city of Riyadh and was one of the largest hospital centres in the northern district, widely considered to be an archetype in regards of the facilities and standards. On the female side the centre consisted of maternity and child health clinics, a well baby clinic, a chronic disease clinic, a dental clinic, a laboratory, an accident and emergency clinic, and a pharmacy. Facilities were segregated for patient care, which was culturally and spiritually sensitive to the populations served. Therefore, separate facilities in some centres were provided for women where appropriate (CBAHI 2011). In addition, there was segregation in the management of employees, with separate lines of management provided to serve female employees. However, some facilities in Robinson were shared and mixed-gender, specifically the reception desk, pharmacy and laboratory. At Robinson, the female healthcare team

consisted of 30 members including doctors, nurses, dentists, dental assistant, dental hygienist, X-ray specialist, receptionists, and pharmaceutical technician that served the population of 35,000 patients.

In Robinson the female healthcare team interacted mainly with each other and the supervisory female doctor, who played a crucial role spanning male and female teams. Members of the team (apart from the female supervisor) had little contact with the director and medical manager due to strict gender segregation. The female team had monthly meetings to discuss issues including current problems, cases, staff absenteeism and patient statistics, as well as weekly educational meetings to discuss current needs and training requirements.

The Richmond practice was smaller than Robinson and did not have an accident and emergency clinic. Most of the other services available at Robinson were available at Richmond. Similar to Robinson, segregation could be seen between male and female patients, and between staff. The female healthcare team consisted of 25 members of female employees that worked in similar areas as Robinson.

Mayfield centre consisted of different clinics such as maternity and child health clinic, well baby clinic, chronic disease clinic, dental clinic, a laboratory, and a pharmacy. The team had 28 members of doctors, nurses, lab technicians, dentist, dental assistance, pharmacists and receptionists. Langford centre consisted of more clinics such as maternity and child health

clinic, well baby clinic, chronic disease clinic, dental clinic, a laboratory, and accident and emergency clinic. The team had 21 members of doctors, nurses, lab technicians, dentist, and receptionists. The centre covered 12,517 of the population located in the district.

Williams and Harington were small centres without accident and emergency departments. The services provided at both were similar, consisting of maternity and child health clinics, well baby clinic, chronic disease clinic, a laboratory, and a pharmacy. Harington had a dental clinic on the female side whilst Williams did not provide any dental service. As with the other cases, there was gender segregation, with the female primary team comprising 16 members that including doctors, nurses, pharmacists, and receptionists. In contrast the Harington team was larger, and included 24 staff members that consisted of doctors, nurses, lab technicians, dentist, dental assistance, pharmacists and receptionists. The female supervisors in both centres were pharmacists. In their operational roles, each of these pharmacists worked alone in an isolated dispensary. Formal team meetings were rarely conducted at either centre and any new tasks, policies or initiatives were communicated informally with members in person. Formal meetings tended to be held only to organize and implement health promotion projects.

6.3. The meaning of teams

At Richmond and Robinson, inter-disciplinary teamworking occurred and developed quite informally and organically, alongside a drive for higher quality standards. Members did not receive any training on team building and development but received support from their line managers on the importance of joint working for patient care. When staff interviewed referred to the 'team' they were generally referring to those staff who helped them get the work done and envisioned this usually in the context of work tasks and sharing of knowledge and information, with notions of a single team often coinciding with, but also overriding functional roles:

'I work mostly with other receptionists and we are here one team' [F/ Receptionist in Richmond].

Team members did not typically view themselves as part of the delivery of primary healthcare, but doctors, nurses and specialists were included in definitions of teams, if they helped them to get their work done in the clinic:

'I'm in the maternity and well baby team because these are the clinics that I'm responsible for with the nurse, lab tech, pharmacists and receptions' [F/ DR in Robinson].

At both Richmond and Robinson, members believed in the importance of teamwork, with many buying into the notion that it provided a means for achieving higher standards of service, and with team members engaging in significant amounts of knowledge sharing across functions and roles to facilitate team goals. Strak et al (2000) and Borrill et al (2003) have argued that team working is often imposed by organisations, with little consideration

for the process of building teams. Gulliver et al (2002) and Hudson (2002) highlight the problems caused by this approach in primary health care, and show how this imposition of teams can undermine attempts to collaborate, with the result that teamwork is rendered simply as a label, with issues of power and control, competing professional ideologies, and traditional hierarchical structures remaining in place. However, in Robinson and Richmond there was evidence that teams were genuinely being built, rather than being formally imposed on staff by management (even though they were formally required as part of the CBAHI accreditation). Iterative processes of learning and working together helped to build this sense of teams, with team members gradually acknowledging the nature of teams over time. Data analysis illustrated that notions of power, hierarchy and competing ideology were not foregrounded by team members, who instead reported on processes of sharing information and helping each other in tasks. Potential barriers to effective team working may have been reduced as a result:

'Definitely it improves our work, when one has an idea and wants to implement it, members of the team can share their knowledge and say 'no this idea is correct so it is a way for us to exchange opinions and it is better than working alone' [F/ DR in Robinson].

This sharing of information had become a central component of day-to-day working, with team members seeing the broader benefits of this exchange, beyond the gains that they personally benefitted from:

'I prefer to work in a team because everyone has knowledge that they can offer to other member some members have more experience than others and everyone can benefit from that' [F/ Nurse in Robinson].

This knowledge exchange also helped team members to improve their skills and competence, something that was seen to be important in centres where a wide range of services were offered. Working in an environment in which colleagues felt comfortable being given advice, and being able to seek assistance from others was seen as a positive aspect of teamworking:

'We exchange our knowledge and information which improves our experience for example if I receive a patient with a case of unclear veins to prick, a team member can come over and help me through the case while explaining the procedure' [F/ Nurse in Richmond].

Even in these cases, however, the concept and notion of a team was interpreted in quite different ways. At Richmond, for example, the team was characterized by some groups more in terms of a 'family'. Whilst this might be dismissed as simply a semantic difference, it is interesting that this identification of a 'family' unit was expressed, often, alongside comments about the strong culture and set of working practices that existed within a particular discipline or area in a hospital. Some of these were distant from primary care (receptionist services), whereas others were teams of nurses, who had long-established norms of working practices. Inter-disciplinary team working enabled this familial rhetoric to be extended beyond disciplinary boundaries to a wider group:

'This centre is like our home we all get along like a family here'[F/ Receptionist in Richmond].

'Here we are a family we don't call ourselves a team we call ourselves a family…' [F/ Nurse in Richmond].

This familial rhetoric that the staff attached to their interdisciplinary interaction gave them a collective team identity that bridged them with other healthcare members. This notion of a family was used by staff to convey the value of working together in teams, and could be seen in Richmond specifically when teams across disciplines were asked and expected to participate in community health programmes. With this shared sense of team identification, individuals appeared more committed to the team and its goals, rather than their own individual goals or the goals of their specific specialty – although often the achievement of the wider team goal also ensured that specialism specific goals were also realised.

Invariably, when staff in Richmond defined their team, it included staff across disciplines that helped them get the task done on a daily basis. Rather than operating under a united interdisciplinary team, members operated on a level of simplified relationships based around the familial rhetoric above. This was an identity built around personal and long-standing social relationships- as opposed to a relationship built primarily around the notion of a team. In both Richmond and Robinson, the size of units and complexity of services meant that respondent were generally in agreement over the importance of working together because no single individual could provide

full patient care. However, with formally configured interdisciplinary teamwork only really occurring when programmes or projects were organized by the director, operationalizing these 'teams' in those circumstances built upon already established notions of working together, often expressed in terms of a family.

At the other four centres, however, this shared vision and view of the meaning and goals of teamworking was somewhat less clear. In Mayfield, Langford, Harington, and Williams team membership did occur across departments or disciplines, yet team members retained a primary attachment and subjective interpretation of teams that was departmentally or discipline focused, rather than institutional or goal oriented. Team members, when asked to describe the nature and process of teamworking talked about their disciplinary allegiance, in terms of doctors' teams or nurses' teams. In all four cases, this disciplinary allegiance remained much stronger in day-to-day working than any notion of or allegiance to the Primary Health Care Trust as a whole. This is not unusual in healthcare setting, with professional practice typically seen as a historically developed, institutionalised set of hierarchical relations between groups that supports a wide range of different professional interests (Van Der Vegt, Bunderson 2005, Finn et a.l 2010). Coordination, communication, and control over care processes are known to be complex because these teams involve different professionals, who operate in very different contexts. Furthermore, these teams are 'temporary interactive', with many team members moving roles, departments and

centres on a much more frequent basis than teamworking in other settings (Deneckere et al. 2012).

Thus, team members in the other four cases continued to define themselves by their institutional background rather than being members of the PHCT. Studies demonstrate that team membership and loyalty to the team can be highly problematic, if it is misaligned. When members identify closely with a group, they tend to embrace the group's central problems as their own and can collaborate effectively in the resolution of problems, regardless of their feelings toward other members in the group. Such strong team identity also encourages members to engage in behaviours that benefit the group rather than there own individual interests (Scott 1997). Interdisciplinary work requires people to engage and understand each other. However, with the absence of a system and structure that support interdisciplinary collaborative practice, professionals may revert to their default backdrop of traditional modalities of practice, with the system's tendency to encourage professionalization and working along disciplinary lines, rather than collaborative inter-disciplinary practice (Cashman et al 2004)

This siloed form of teamworking can be seen in a number of the cases. At Harington, for example, doctors in the centre appeared to buy into the concept of teamworking, but when this was unpacked, this belief stemmed from the idea that teams existed to suit doctors' needs, and that the role of teams was to assist doctors specifically in their needs and requirements:

'Doctors need all the help they can get to improve their attitude and performance when they get a load of patients…I mean we cannot do it all on our own' [F/DR in Harington].

In Saudi Arabia traditionally nurses have acted on doctors' orders, with the hierarchical structure and lines of management dominated and determined by medical seniority profession. Similar to Harington, doctors in Williams saw the need for teams because they provided a clearer structure and set of rules through which doctors could impose their authority and prerogative on nurses, to ensure that they helped out with accessing and processing patients' medical records and ordering and conducting tests. To establish a collaborative practice, team working assumes a status-equal basis between different team members. Such a structure challenges the process of sharing knowledge, decision-making, requiring new definitions of goals and joint responsibility towards the patient (Hall 2005). However, doctors saw teamwork as a means to strengthen their management prerogative over others.

Shared notions of quality and a single team concept were also absent amongst other team members in these four cases. At Williams, nurses saw teamwork as a way to provide cover for each other, amidst quite strict working practices and a close monitoring regime from management:

'…as you know we are all here women and sometimes one is away on maternity leave and another is sick we need to cover for each other… and

that's the essence of teamwork when someone is away the group does not get effected by there absence' [F/Nurse in Williams].

Similarly for staff in Harington teams were used to cover each other spaces when another member of similar disciplinary background was absent or on leave. It was not seen as a means of improving quality or productivity. In both Harington and Williams, staff in the centres did not see the need for interdisciplinary teams, and largely carried on their work independently, even though there was an expectation they would work in teams, and formal systems and processes to try to ensure that this happened. The ideology of teamwork was even viewed as unnecessary by some. As one nurse commented:

 'We have very simple cases and we do not need teamwork for that'
[F/Nurse in Harington].

Some recognized that teams existed in their hospitals, but could not see how it would benefit them, how it would affect their work, or how it would lead to any improvements in the way that things were done:

 'I'm sure teamwork is important but I don't understand how…I mean we need each other for help" [F/Receptionist in Harington31].

For this receptionist, teamworking was understood in quite simple, operational terms, as a system through which she interacted with other peers in the reception areas to ensure that they finished their daily task. Their was little shared understanding beyond this functional team about any

wider interaction or teamworking. Other members such as receptionists did not understand the ideological return of teams or the economic returns.

Overall, then, there were quite diverse views across the centres on the meaning of teams and their nature. Indeed, even within individual centres, particularly where disciplinary boundaries and a culture of working within a single function and role remained strong, there were different views held by different team members on the meaning and purpose of teams. For some, particularly where quality accreditation was being pursued, here was quite widespread buy-in for the concept of the team, working towards a shared goal. However, even in these instances, there were instances where individuals perceived the 'team' more in terms of their own discipline or function, rather than a wider notion of inter-disciplinary teams. Furthermore, the teamworking idea was sometimes perceived in these cases in terms of a looser notion of 'family', with the familial rhetoric masking often quite different elements of actual teamworking in practice.

Taking the cases as a whole, it is reasonable to say that engagement and understanding of the team concept varied. Some groups, particularly those most distant from primary care, such as receptionists, were less likely to perceive that there were benefits to inter-disciplinary teams, although these groups often did have a particularly strong sense of a team identity in their own unit. For nurses, as noted above, there was some recognition of the need for teamworking to do their daily tasks, however the main value of teamworking was that it enabled them to collectively share responsibility and coverage for scheduling and accommodate unexpected absence

satisfactorily within the teams. Workers' participation in team system here reflected more than passive compliance with managerial initiatives, it also signalled workers' determination to use the new team system to their advantage such as coverage. For doctors, there was some recognition of the value of teams, but this was understood in terms of benefits for doctors, with other members in a team reducing to a supporting and subservient role. Nonetheless, there was recognition from doctors that such team-based practices could lead to significant productivity improvements.

6.4 Perceptions towards teams and their purposes

The interview data and analysis above have already pointed to some of the views of team members in the six cases towards teams, highlighting that in some instances it facilitated knowledge sharing, but in other cases, it was seen of little value. In this section, perceptions of team members across the six cases, both positive and negative, are outlined. In the first part below the analysis focus on some of the positive elements of teamworking, observed mostly in the Robinson and Richmond cases, but also observed in aspects of the other four cases. In particular, the role of team working in extending communication, improving patient focused care, and as mechanism for education and skill development are considered. In some of the cases, these roles of teamwork were seen as crucial to enabling team members to 'get the task done' and increase productivity. The potential for teams to have a positive impact upon productivity is recognized in many survey-based studies (see Delarue et al, 2008 for a review). However, the mechanisms

through which such positive effects occur remain underexplored, hence the qualitative analysis presented sheds important new light on these processes.

In the second part, more negative aspects of teamworking are considered, notably, the ways in which it is perceived as a means of control, and also that it conflicts with established (often effective) established ways of working.

6.4.1 Positive perceptions of teamworking

Communication

In most of the cases, there was some recognition that teamworking was a means through which more open forms of communication could be fostered and developed. Indeed, team members in Robinson thought that teamwork open communication with other workers was essential to effective teamworking. Regular communication ensured everyone understood how members envisioned patient care, that they were clear about their role in the system, and that through open dialogue, performance in the hospital could be improved:

'It improves my performance for example when we work on an awareness day of a specific disease we all work together and this gives us a better result then working alone because you get different ideas from her and her and there is participation between members' [F/Nurse in Robinson].

This did require a different mind-set, and approach to working than that used traditionally in Saudi healthcare work, in which hierarchies were broken down, and team members were open to guidance, advice and

communication from colleagues at different levels, from different specialisms, and from different units.

'I prefer working in a team because you always learn from another person, from my experience don't think even that you know everything about medicine there is always something to learn from another person and in the team you will get more ideas from everyone around you in your team' [F/Dr in Robinson].

Regular interaction and continuous patient discussion of patient needs and problems provided opportunities to develop team members' understanding of updated medical information and built on their existing disciplinary knowledge. This cut across the usual occupational and role boundaries, extending, developing and embedding knowledge in hospitals. A nurse in Richmond noted how regular access to other team members facilitated dialogue:

'Its beneficial to work in teams for example if I sit with a doctor who has up dated medical information it gives me a chance to learn and improve my experience another example is when I talk to the girls at the files, they have new information concerning patients records it gives me an idea even if I get asked by a patient I could guide them and provide her with needed information instead of saying I don't know or go there and ask them the patient might tell me why don't you know? Don't you work here? So it's a positive thing to share with other staff information and knowledge' [F/ Nurse in Richmond].

Through communication with other members, staff were able to share knowledge and information. It was described as being of benefit for staff and patient care. The perception of the benefit of sharing information is

reinforced by the Nelson and Cooprider (1996) and Hoopes and Postrel (1999) who argue the notion of creating a shared (team) knowledge. The authors conclude that a shared knowledge base is linked with superior team performance. It is also linked to gaining a better holistic view of a patient, which as staff described as beneficial for providing better care. This is described by a nurse in Mayfield:

'Communicating with each other helps us in exchanging information for better care lets say while working with a doctor she might share new information from the WHO about diabetes, or hypertension this can be shared through collaborative working and communication' [F/Nurse in Mayfield].

Communication and sharing of information was a prominent feature in cementing the team relationships in Primary Healthcare Clinics. It facilitated sharing new procedures and policies regarding care of patients and also enhanced joint working. Others viewed it as a way of gaining knowledge from older peers or other professions in their interdisciplinary teams as a nurse in Williams explains:

'Working in a team improves my performance especially when you are a new graduate and you share a clinic with someone with five years of experience or even ten! You get a chance to share information and benefit from her experience even from members with different backgrounds' [F/Nurse in Williams].

Regular patterns of communication where all members shared information and ideas with each other quickly and easily were identified as important aspects of teamworking. It also improved interpersonal relations that helped

in achieving and encouraging a work environment where team members felt trust in sharing information and exchanging knowledge.

Patient focused care

In both Richmond and Robinson practices team members identified their collaborative work as having a strong patient focus. Significantly, teamworking was not primarily identified or interpreted in terms of competition for control of resources, recognition, financial reward or increased status, arenas in which professional struggles for occupational control often play out at either local level and sometimes at a national level (Adams 2004, Timmons and Tanner 2004). In Robinson and Richmond patient focused collaboration seemed to be a key driver for knowledge sharing and cross-team communication. This was not the case in some of the other cases presented in 5.4,2 below, where conflict within teams, and management imperatives to increase control drove team members to continue to largely work in silos.

At Robinson, this patient focused goal of teamworking was most apparent, where the most important purpose of the team was clearly to impact upon the patient. This was a galvanizing target and outcome, which respondents felt could be shared across the entire team practice:

'We are here one team and our goal is to treat the patient' [F/Nurse in Robinson].

Teamworking was seen very much as a 'glue', and the engine enabling other activities to occur effectively. The size, scale, and complexity of activities and services at Robinson (one of the larger cases studied, offering the largest number of services, including an accident and emergency service and laboratories) meant that patient focused care was complex and challenging, with teamworking seen as an important structure to enable staff to work together towards a common goal:

'Without teamwork our work will stop, we cover here a huge number of patients and we need to collaborate as a team to get the job done' [F/ Nurse in Robinson].

This view, that teamworking could provide more effective patient-focused care was shared by doctors, as well as nurses, and hinged on the notions that teams could help the centres be more efficient and treat patients more rapidly. Beyond this, however, was the important belief, highlighted above also, that teamworking allowed for sharing of knowledge across different team members, facilitating the embedding of good practice across units and different healthcare professionals:

'When we work as a team we can provide for the patient the best service and when we collaborate the patient will be seen quickly and most importantly is our patients and serving them with best practice' [F/ DR in Robinson].

There was also a strong sense at Robinson that teamworking enabled the most effective possible use of resources, focused towards a common goal, patient care, and in which duplication could be avoided, and the highest

possible concentration of resource could be targeted towards providing effective care:

'The main objective of the primary healthcare is to give a good care to the patient, I mean the maximum care that we can give to the patient (is) the excellent care, and that is the essence of teamwork' [F/ DR in Robinson].

On the other hand, in Langford patient care was seen as a group effort and a single member in the team could not manage it. Their view was not as in Robinson and Richmond for providing patient-focused care. There overall team vision was collaborative work is needed because no single person can see a patient. This is illustrated by a doctor in Langford:

'We work here as a team because we share here the care of the patient' [F/Expat Dr in Langford].

Teams that are collaborative and participative are more likely to achieve a patient-focused service and be more efficient. Patient-focused care was not a shared objective among members in Langford. Clarity and commitment of team objectives are crucial factors influencing effectiveness in primary care.

Education and skill development

An underexplored aspect of teamworking, in terms of how these structured might enhance individual, team and organisational performance is the role of education and training. Teamworking may force or compel organisations and team members to invest in education and training, in order that teams can function effectively. Team objectives and outcomes may include some that

focus on education and training. It is also possible that education and skill development occur relatively informally, on an ongoing basis within teams (see Feitosa and Fonseca, 2020). Such practices, and the role they play in motivating workers in teams, and ensuring that teams can function effectively are often 'hidden' in accounts of the impact of teams on performance.

In a number of the case studies, educational sessions were set up to offer specialist information and skill development opportunities. These were useful in themselves, providing individuals with new knowledge and opportunities for further development, but these had an even more significant and enduring contribution to the achievement of teamwork. Bringing all professional groups together to learn new needs skills in their units conveyed a powerful message, this was essentially that team members could learn from each other and needed to work together to address the complicated issues in primary healthcare. This message was particularly evident in the cases that were going through quality accreditation processes through the CBAHI. At Richmond, for example, entire teams were required to attend a regular set of continuous learning sessions, alongside regular team meetings. This included some mixed-gender elements to teams so that learning was consistent across female and male areas. The continuous learning meetings were seen as an integral part of interdisciplinary team working, so that staff across units and specialisms were able to understand and disseminate good practice, and present a consistent approach to

patients around regularly occurring (but changing) health programmes such as influenza vaccinations:

'yes, we have regular meetings about work, new guidelines, but mostly we meet to attend our continuous learning lectures. These lectures are helpful in increasing our knowledge regarding seasonal diseases or epidemics. It is also helpful to update our information regarding any illness especially when patient asks, you need to be prepared. Other meetings that include the entire centre are for vaccination campaigns for the district. The females meet with the male staff and we do field work in covering specific areas for vaccination' [F/Nurse in Richmond]

This shared learning contributed to the development of a work climate where different team members did, ultimately, feel *motivated*, and confident to come together and discuss plans and goals for running the practices. On the female side of the healthcare practice at Richmond, for example, the team had developed a supportive approach through which knowledge could be shared, which broke down hierarchies, and allowed members of the team to offer their insights and contribute to discussions. The female supervisor acted as a bridge to the wider team (attending meetings with male staff), with regular meetings ensuring that knowledge could be shared rapidly. Training and development was offered not just by those in supervisory positions, but other team members too, providing a valuable means through which workers have the *opportunity* to participate in teams:

'Our female supervisor organizes weekly meetings, every Monday we discuss our plans for the centre what has been done and what is missing

from our goals. Today we had a meeting and one of the staff presented an educational lecture and it was very useful' [F/Receptionist in Richmond].

Professional development meetings were also a means through which cutting edge knowledge on current illnesses and medical practice could be shared. In this respect, meetings were beneficial for raising knowledge and *abilities* and sharing information. The teamworking literature has highlighted how shared learning sessions can sometimes result in interdisciplinary conflict with professional groups seeking to reinforce and protect their status, privileged knowledge, or to dispute authority and control of others in respect of aspects of specific knowledge and skills (Farrell, et al 2001, Hudson 2002). However, members in Richmond felt that it provided them with a positive environment to collaborate as a team. In terms of Wenger (1998) proposal that collaborative interdisciplinary teams could be regarded as learning communities, working and learning together in Richmond did allow members to perceive themselves as a team jointly working for the patient. Purcell (2004) suggests that HRM practices can contribute to workers' abilities, motivation or opportunity to participate in organisations, with the evidence above suggesting that the training and education aspect of teams can impact upon all three of these areas.

On the other hand, in Langford, Harington and Williams education and skill development was not implemented or enforced from management. Skill development and continuous learning need to be provided to enable healthcare professionals to gain the skills and knowledge required for effective teamworking. Therefore, joint working is not naturally bountiful and generally need to be developed. Providing a learning community with

shared goals, and opportunities for training, development and learning among member. An important mechanism for creating opportunities for team members to join for a clear purpose. This develops member skills and builds commitment to the team. However, in Langford training was provided to members who were favored by the line manager which created conflict and resentment among staff as a nurse explains:

'We hear about training courses but there are specific people who get chosen by management' [F/Nurse in Langford]'

In Williams the lack of skill development left team members demotivated and willing to leave for skill development. Organisations need to focus on creating effective education and skill development that support the workforce continuity and maximize benefits of interdisciplinary working. According to Cashman et al. (2004) time set aside for regular teamwork training and development resulted in members expressing values of a high functioning team. The Ministry failed to provide the necessary educational skills and relied on management for arranging educational trainings. Lack of skill development has been a predictor of high turnover. Professional advancement and skill development within the organisation can influence turnover intentions as noted by a nurse in Williams:

'The problem is from the Ministry their isn't any development or training since I graduate it is the same routine work, I did not get any courses and every day I keep thinking of leaving to pursue further educational development' [F/Nurse in Williams].

HRM structures can, then, in some cases, help support teamworking practices. For example, training and development in how to work in teams and collaborate may help to ensure that those operating within teams understand how such structures are expected to work, whilst the provision of time and capacity to communicate within teams (through regular meetings) may also help team members to work effectively in an interdisciplinary environment. For some, these supporting HRM practices provide essential 'glue' to ensure that individual practices, such as teamworking, work effectively (Whitfield, 2000; Purcell and Hutchinson, 2007; Brown et al, 2008).

6.4.2 Negative perceptions and barriers to teamworking

Some negative perceptions towards teams have already been considered in section 5.3 above, where respondents didn't recognize any value or benefit to teams, or saw that those benefits came from working practices other than formally configured teams. In the section below, negative aspects of teamworking, and barriers to the effective operation of teams in the six cases are explored in more detail, with a focus on continued working in silos, and a lack of belief in the team concept.

Working in Silos

In a number of the cases, including those where there was widespread acceptance of teams, challenges of working across long-established disciplinary boundaries could still be observed. At Robinson, nurses' views were that teamwork enabled more effective sharing of knowledge with other

primary health care members in the practice. Yet, in the centre receptionists worked physically separately from other team members. They attended meetings on a regular basis with other team members, although they did not typically contribute in any decision-making. Their level of contact with other team members was low. As a result, receptionist felt more of a team with other receptionists rather than the team in the practice.

'We are all one team here and that is the team of receptionists' [F/Receptionist in Robinson].

This sense, of the importance of the team within a particular unit or discipline was reinforced by the fact that inter-disciplinary teams tended only to come together formally for specific initiatives, such as health programmes. Receptionists at Richmond felt that teamworking was largely project based, with inter-disciplinary teams only really being formally configured when the director assigned them in health programmes or awareness days for the centre. This limited the building of a genuine inter-disciplinary team culture and tended to strengthen notions of the team within a particular discipline, unit or occupational area.

Furthermore, despite a relatively strong team rhetoric in the centre, linked with their attempt to secure quality accreditation, there remained important perceived differences amongst team members of their role and status within the team. Receptionists felt that they were seen as 'lower status professionals', and that their contribution was sometimes not recognized, with this profoundly impacting upon their sense of belonging and

contribution. Receptionists were not well integrated with other members outside their own area but viewed themselves as a strong reception team – albeit one that was isolated from organisational wide notions of a team. Receptionists felt alienated from teamwork by the team structure that limited their participation.

Finn et al (2010) also state that it is necessary for professionals to find space to negotiate what team working means in practice. They argue that the meaning of teamwork resonates with professional identity and can leave members working in silos rather than connecting with other professionals in their team. Despite some positive perceptions about teamwork, still there were barriers integrated team working. These include traditional hierarchical relationships with medicine, different professional ideology and meaning to teamwork, and concerns regarding professional role and territory.

This alienation may stem partly from their low level of contact with other team members. Receptionists had little day-to-day involvement in decision-making and patient care. As a result, they felt alienated from some of the patient-centred goals and aspirations of the team and did not share the same view of other team members. Despite this, there was recognition amongst all members of the team that individuals within a team did play different roles, some more involved in direct primary care, and others in supporting roles. All members agreed that teams were necessary because no single individual can provide full patient care. Members believed in the importance of teams for productivity and best patient practice.

In Langford members were fragmented and preferred to work with their division of labour, this is due to conflict, rivalry, and the detriment of team integration that was created by management. The line manager caused conflict and stress, which caused members to retreat into their professional silos as noted by a nurse in Langford:

'I feel that I am all alone'[F/Nurse in Langford].

Similarly a receptionist expressed the same:

'Honestly we don't have team spirit here everyone is working on their own' [F/Receptionist in Langford].

In Langford staff preferred working independently and avoided direct confrontation with their line manager. Thus, lack of managerial support caused team members to revert to working in silos in order to finish their tasks independently. The line manager used her position to control the flow of information, constrain activities, and as a mechanism for exercising managerial prerogative this will be discussed in depth in section 7.4.

Lack of Belief in the Team Concept:

The success of teamworking is often attributed to team members recognizing a greater value to collective over individual goals, and a willingness to accommodate changes in working practices to ensure team goals can be achieved. However, there is significant evidence from other studies that workers have quite different working styles and varying preferences for working in teams (Micken and Rodger, 2000; Kiffin-Peterson

and Cordery, 2003; Khawan et al, 2017). At Mayfield, for example, many team members expressed a preference for working alone. For some, this reflected underlying concerns about conflict that was generated through the introduction of inter-disciplinary teamworking, whilst in others it reflected long-standing norms and established working practices within a particular discipline area, which were difficult to change.

'for teamwork here its different because I'm the only one who works as a dietician…' [F/Dietician in Mayfield].

Staff from allied sciences backgrounds, along with some others, simply did not see themselves as part of the primary health care trust, instead they identified and interacted with other peers who came from similar disciplinary background. The view that working in teams was a source of conflict was observed in a number of the cases. Receptionists at Mayfield saw teamwork as a complicated concept that increased the potential for tensions across groups. Here, in contrast to the notion expressed earlier that teams helped to 'get the task done', teams were instead seen as a barrier to the completion of work:

'It causes a lot of problems when you work with other peers, I like to work alone your more at peace when you work alone' [F/Receptionist in Mayfield]

This conflict and stress may cause members to retreat into their professional silos, where there are perceived to be clearer limits, safety, recognized professional value and a license to work autonomously (Hall 2005). Low proximity to wider team members, and deliberate avoidance of others limited receptionists' interaction at Mayfield with others. Indeed, even in areas

where collaboration was required, such as sharing of medical information, there was, in practice little teamworking. Receptionists who perceived that their status in teams was relatively low, had limited physical and professional proximity with medical staff, and did not see themselves as directly contributing to patient care, a situation reinforced by active avoidance of interdisciplinary teams in Mayfield by this group of workers. In contrast, medical professionals team members' relationships – within their own disciplines - were underpinned by a shared notion around the care of the patients. As a result, receptionist were poorly integrated with the rest of the primary health care trust.

At other centres, attempts had been made to try and improve collaborative working across units, to actively encourage inclusion of groups such as receptionists. The Langford centre was preparing for the CBAHI accreditation programme, which required staff members to work in inter-disciplinary teams. The receptionist joined a team with a laboratory technician and a dental assistant to reorganize the patients' records in accordance with the accreditation, giving a shared sense of working and collaborating across units:

 ' …Its nice to work in teams with others especially with people who like to give their input…' [F/Receptionist in Langford].

Teamwork was not prominent in the centre, however, and was only really seen as a system used to organize work for the purposes of the accreditation, rather than a longer-term quality initiative that would filter

through all work processes in the centre. As a result, individual staff members sometimes expressed a resistance to teams:

'For myself I don't like to work with others, its better to work alone' [F/Optometrist in Langford].

Teamwork does have the ability to enhance the contribution of members to provide holistic care to their patients. But when members lack the knowledge about others roles, skills and agencies, a situation that can occur when members are sceptical about sharing information or actively collaborating in teams, it can result in distrust of other members (Cook 2001). Members of the centre at Langford may have resisted the concept of teams due to the failure of the organisation to convey a clear understanding of the ideological and economical returns that teams could bring to the organisation as a result of accreditation. It was also due to long-established norms of working within individual units, that were hard to break down. Furthermore, different people attributed very different meanings to the concept of 'teams'. As a result, staff resisted working together and did not see the gained benefits from interdisciplinary teams.

Teamwork at Langford was described as 'non-existent' as a result of all these factors, with no team goal setting or evaluation. There were some meetings held, but staff reported that the quality of meeting varied markedly with some meetings achieving nothing. Staff pointed to the crude, numerical targets that they were expected to meet in teams, which were focused on the number of patients seen, and neglected the quality of care, and the

progress made by patients, issues which had been important prior to the teamworking agenda. Others described meetings as useless because there were no clear objectives, or the appropriate or desired outcome had not been secured.

6.5 Conclusion

Based on the fieldwork conducted in the primary healthcare centres, which varied markedly by size and clinical services, the findings illustrate the gap between policy and practice in healthcare, and specifically between the rhetoric and reality of teamworking. The Ministry of Health strategy has been to promote patient-centred-care, which means interactions between healthcare team members is determined by the needs of the patients care. This strategy also recognizes the need of members to integrate and participate in planning and delivering care. However, across many of the cases, team members' perceptions of teamwork was ambivalent, or contradictory, while others actively resisted the concept. The strong sense that comes across from the data, even where notions of teams were relatively well-established and shared, was that interdisciplinary teamwork was an administrative construct rather than a practice. Interdisciplinary teams served a purpose for pushing and promoting quality agendas, and in some instances had led to improvements in specific practices, more active collaboration, and achievement of patient-centred approaches to care. Yet, diverse management structures, strong disciplinary and professional boundaries and long-established norms of working created barriers to the effective operation of teams.

Reflection, collaboration and shared knowledge remains at the margins of working cultures in primary care clinics in Saudi Arabia. Moreover, diverse management structures, which are often focused and moving towards different rather than common goals, along with the autonomous status of particular groups, such as GPs, who do not share the same status and reward systems are a major threat to interdisciplinary collaboration and teamwork.

It was relatively rare in the cases for respondents to refer to teams as identifiable, bounded units with set goals and objectives. "Teaming" in this study setting does not, for the most part, reflect a programmatic or administrative decision, but rather a moving, ad hoc structure which, once disbanded, may or may not rejoin again. This ad hoc structure is open to quite different interpretations from individuals within teams, and across centres, these differences are even more pronounced. In some of the cases, individuals are generally not designated formally as team members, but informally may be expected to perform in a team-like fashion. There is also considerable conflict over decision-making structures and the position of leadership within teams. While, conceptually, teamwork is perceived as desirable and positive by some respondents, structurally inter-disciplinary teamworking, even in those cases that have been forced to put in place some structures, to accompany accreditation, it is rarely evident.

Crucially, even in those cases where teams were perceived to exist by respondents, they were often not evaluated for their performance as teams, nor were the centres evaluated in the context of their presumed team membership. The general absence of structural characteristics of an interdisciplinary team in this setting may in part be attributed to the structure of many medical centers and professional schools, which encourage and reinforce disciplinary norms and conventions, often through occupational closure. One should expect that when loyalties are disciplinary, and goals are discrepant, and where there is no organisational payoff for interdependent behaviour, teams as structural units conceived in the literature are not likely to be present (Temkin-Greener 1983).

CHAPTER 7: THE ROLE OF THE FEMALE SUPERVISOR IN INTER-DISCIPLINARY TEAMS IN HEALTHCARE IN SAUDI ARABIA

7.1 Introduction

This chapter examines the influence of female supervisors' informal leadership role in supporting teamwork in Primary Healthcare Centres (PHC) in Saudi Arabia, under conditions of gender segregation. It is an element of teamworking that has rarely been explored in research, being particular to the Saudi context, due to socio-cultural norms of gender-segregated working in most workplaces in the country. The chapter highlights the crucial role of the female supervisor to the success or failure of teamworking initiatives, identifying a number of key features and characteristics of this role.

The chapter examines how the female supervisor undertakes informal leadership within teams. Whilst most leadership research focuses on the characteristics of an individual and their activities in relation to the organisation as a whole, typically focusing on leadership style, personality types and personal attributes (Nawaz and Khan, 2016; Caraso-Saul et al, 2015; Mishra and Panday, 2019), studies of leaders within teams are less common (although see Day et al., 2004; Morgensen et al., 2010; Burke et al., 2006). Where studies have looked at leaders within teams, they have tended to focus on the authority formally given to team leaders. A key insight from this chapter is that whilst the role, and activities of the female supervisor as team leader were, in some cases, formally defined, in many

cases leadership devolved more informally as teams evolve. The authority and credibility of this supervisor derived partly from their previous experience and conduct, but also came from their evolving practice of supervising within gendered teams, and specifically from their abilities or weaknesses in bridging across disciplinary, occupational, and gender divides. In some cases female supervisors facilitated the operation of teamworking, but in other cases, these supervisors had the ability to undermine team working, or to have a negative impact upon collaborative working, creating a negative atmosphere and adversarial work relations.

The chapter begins by outlining the context and nature of the female supervisor role, its origins, and its implementation at each of the six cases, in section 7.2. This is followed by a more detailed discussion of the nature of the female supervisor role in the three groups of cases. In Section 7.3, the female supervisor role at Robinson and Richmond is analysed. The female supervisor is characterised as an Active Enabler, with power and informal leadership success derived from expertise in their role, alongside a belief in teamworking. In Section 7.4, informal leadership at Langford and Mayfield is outlined. Here, the female supervisor is characterised as a Controller, with these informal leaders using their position to control the flow of information, constrain activities, and as a mechanism for exercising managerial prerogative. In Section 7.5, informal leadership at Harington and Williams is outlined. Here, the female supervisor is characterised as a Reluctant Coordinator, with their main focus being on maintaining their autonomy and established patterns of working, whilst accommodating inter-disciplinary team requirements only where necessary. Section 7.6 concludes.

7.2 Leadership in gender-segregated Saudi healthcare teams and the female supervisor role

In the health care setting, as the previous two empirical chapters have demonstrated, practitioners from diverse disciplines come together to care for patients. On account of a number of factors, such as an ageing population and the burden of illness from acute to chronic care, these require a number of different health and social care professions to be involved in the delivery of care (Reeves et al. 2009). Healthcare today is undeniably a team effort that requires professionals to work together effectively to take care of their patients holistically. But, as chapters 5 and 6 have shown, placing individuals together and calling them a team is not enough to ensure that work occurs effectively in a collaborative manner. Rather, on-going leadership is necessary to ensure groups of doctors, nurses, and allied professionals interact effectively. In many cases, this leadership emerges and evolves, with leaders volunteering for a leadership role with little previous experience or being elected to the role by their peers. Leaders in this context can use their informal power either in a positive or a negative way. Negatively, they may seek to enhance their self-serving interests rather than the interests of the group, creating an adversarial atmosphere, or manipulate information (Van Wart 2011).

On the other hand informal leaders can use their power for mentoring, teaching, and coaching within their teams (Pielstick 2000). This is described by Neubert and Pescosolido as a leadership function but with no formal

management authority over the members (Neubert 1999, Pescosolido 2001, Peters and O'Connor 2001). The success of informal leaders in this context is achieved through a combination of the organisation's culture, individual competence and the specific requirements of the situation (Stincelli and Baghurst 2014). Informal leadership depends mainly on one's experience, knowledge, credibility and personal skills (Sullivan and Garland 2010). Informal leaders have credentials that may not be easily communicated or documented, much less evaluated (Downey et al 2011). However, they can be essential to processes of influence and motivation that contribute towards team effectiveness. Unlike formal leaders, they may not have access to formal organisational rewards and punishments, which can shape the behaviour of team members (Pescosolido 2002). Empirical and theoretical studies have shown that leadership is key in driving force for organisational change, ensuring optimal healthcare performance outcomes, the provision of quality care, and creating a culture of safety in the work environment (Wong and Cummings 2007, Stanley 2008, Cummings et al. 2010, Boamah 2018)

This thesis has already set out key features of work and employment in Saudi Arabia, including the convention, for socio cultural and religious reasons, for gender segregation in the workplace (see chapter 4). In healthcare settings, as in many other workplace contexts, this involves segregated patient areas, and segregated working arrangements between men and women. As noted in chapter 5, the development of inter-disciplinary teams in Saudi primary healthcare centres can only be understood by playing close attention to this very specific context, which fundamentally shapes the way that teamworking is configured and operates in practice.

Interdisciplinary teams in the six primary healthcare centres studied in this thesis spanned male and female segments of the organisations, with the female teams varying from between 10-25 in size (see chapter 5). In each of the cases, a female line manager had emerged to serve as an informal supervisor to her interdisciplinary team. This supervisor was vital in organizing teams, and to facilitating team processes and outcomes. In some cases, this worked effectively, but in others, a lack of leadership clarity as well as conflicts over team leadership and direction had a negative impact on levels of engagement and participation in teams, and on employee commitment to quality, support for innovation and clarity of objectives (see also West et al 2003).

Effective interdisciplinary teams do require a clear leadership with clear direction and management, with leaders being essential to providing supervision and support over personal development, facilitating goal setting, and evaluating achievements (Nancarrow et al 2013). In the six cases here, it is important to stress again that the female practitioner emerged as an informal leader within prevailing organisational cultures and structures. All of the PHC Health care services were based in Riyadh where gender segregation is stricter than other parts of Saudi Arabia. The structures of teams, and the female supervisor role described and analysed here may vary greatly from the formal structures of teams and supervisory roles located in western and eastern cities (Le Renard 2008). Saudi law does not forbid women from working alongside male doctors and other male health

workers as well as see male patients (Vidyasagar, Rea 2004), and there has been attempts to implement mixed gender working practices in healthcare across a number of years. The structure of teams in primary healthcare centres in Riyadh was configured to accommodate preferences of patients (for gender segregation) along with demands and pushes for more mixed-gender working, which had accompanied labour market participation, Saudisation and quality improvement initiatives from the state over the last decade (Basahal et al, 2021).

Management within the six female teams in the cases were also distinctive to other commonly understood notions of teams. A different line of management was provided for female team members. Female leaders acted as informal supervisors in the female teams and reported to a male manager on the male side. A female line manager was appointed by female team members with the purposes of serving as a communication point between male and female team members, yet as will be demonstrated below, the role extended beyond this into many other areas of HRM. This female supervisory role was an additional task with no remuneration. Because of their linking position in the team, the female line managers were recognised to be key to determining how the teams function on a daily basis.

Male directors and medical managers in each primary healthcare centres (formally recognised as team leaders) communicated their opinions, ideas and new policies to female team members through the female line supervisor. As a result, the female supervisory leader emerged as a role with

a potentially high level of power and influence in the primary healthcare centre teams. However, these female supervisors did not command any additional salary, and the role was temporary, with leaders being self-appointed through consensus and agreement of the team, or through someone volunteering for the position. In the cases studies there was a description of activities associated with the role, which retained the traditional hierarchical dominance of males in health care leadership roles, prescribing the role as having minimal formal authority and decision-making power within established hospital working structures.

This list of activities below, which comprise the female supervisor role, has been translated from a document presented by Robinson's informal leader. This list of responsibilities was created for staff to understand the informal role in the primary clinics, however management did not formalize the role in terms of job title or formal payment. (which is produced in original form in the Appendix E of this thesis).

Female Supervisor Job Responsibilities:

1. Supervision of female division administrative work.

2. Participate in the preparation of annual plan for the female division.

3. Auditing female attendance and work uniform

4. Reviewing female appraisals and providing input if needed.

5. Reviewing patients statistical reports issued from the female division before submitting it to the medical director.

6. Coordinating regularly with the primary centre director to assure that the centre is consisting and working as an effective unit in serving the population.

7. Participating and following up on training courses, and quality programs

8. Participating in the optimal distribution of the female workforce.

9. Reviewing reports on medical and technical activities and presenting their results to the medical director.

10. Participation in the preparation of annual reports for medical services.

11. Assessing in the Primary centre committees.

12. Observation of medical and technical conditions in the female division (Appendix E).

What is interesting from this list of duties is that the female supervisor role is severely constrained and limited in their authority, and decision-making powers, with emphasis on participation, assessment, auditing and 'coordination with…' activities. There was no authority for female supervisors to direct the work of team members. In contrast, on the male side, gender segregation permitted male management to direct the work of male team members and actively manage. Female supervisors had no authority and undertook core tasks of the organisation at a lower level. The role was created for auditing, scheduling and regulating female daily clinical activities. Compared to male supervisory and team leader roles, it carried unequal levels of responsibility and bestowed less authority on female supervisors over female team members. Nonetheless, the female supervisor role did permit and establish means of communication between male management and female staff. Thus, the linking position of

the female supervisor gave her some control and power over female team members, albeit, typically this was less than for male leaders.

7.3 The female supervisor as 'Active Enabler'

At Robinson, the primary health care centre was located – as were the other five cases - in the northern urban area in the city of Riyadh and was one of the largest centres in the northern district. As noted in previous chapters, and common to the other five cases, facilities were segregated by gender for patient care and for working arrangements, being culturally and spiritually sensitive to the populations served. Therefore, separate facilities in some centres were provided for women where appropriate, but with some facilities shared such as the reception desk, and pharmacy. In terms of the hierarchical structure of the health care centre, the director of Robinson dictated how the practice worked from an administrative aspect, while the medical manager organized the clinical work in the healthcare teams. Both of these roles were occupied by males.

In Robinson the female healthcare team interacted mainly with each other and with the female supervisor, who was a doctor. This female healthcare team had very little contact with the director and medical manager due to cultural influences of gender segregation. The female team consisted of doctors, nurses, technicians, and receptions. They had monthly meetings to discuss the practice current problems, absenteeism and analyse patients' statistics, as well as weekly educational meetings to discuss current

educational needs. These meetings were coordinated by the female supervisor.

The female supervisor in Robinson believed in the values and ideology of inter-disciplinary teamwork, and the idea that it was an integral part of providing high standards of services to achieve patient satisfaction. Her role is characterised in this thesis as an 'active enabler' to convey the idea that she believed in the potential for teamworking to have a positive impact, and sought through her actions to create an environment in which teamworking could flourish. With this in mind, she sought to provide a safe, comfortable environment for interdisciplinary members, in which they could contribute, engage and participate in the running of the hospital. The style of leadership adopted by this informal leader in Robinson focused on relationship building, adopting a friendly and open tone, in which peers felt able to share and confide information:

'When we work together as a team on the same tone, we can serve the patient as soon as possible that way the patient is satisfied and that's what matters to us. It will also raise the standards of the services that we provide for our patients' [F/Dr/supervisor in Robinson].

This important focus on maintaining an even and equal tone (even where hierarchically, workers operated at different levels) was valued by fellow team members, and a widely held view was that the supervisor was approachable, and cultivated a positive working environment within the inter-disciplinary team:

'The supervisor treats us well, I mean we are all here one team kind and tolerant with each other, we work with sincerity and good team spirit and no conflict or distraction during our work' [F/ Receptionist in Robinson].

The female supervisor in Robinson was committed to the importance of teamwork and extolled the need to adopt a patient focused approach to care, something which teamworking was thought to facilitate. This commitment to shared goals and values of the organisations contributed to team member willingness to collaborate with others in the practice, something which has been found also in other studies of informal leaders (Stincelli and Baghurst 2014).

A similar attitude towards teamworking could be found from the female supervisor at Richmond, who similarly could be characterized as an active enabler, holding and openly promoting the view that without teamworking, it was impossible to deliver patient-focused care. The value of teamworking came from the capacity for groups of workers to be able to more effectively overcome challenges collectively than individually. It also provided a system through which problems could be identified and overcome more effectively, with team members undertaking self-checks and checks on each other (in a collaborative spirit) to achieve team goals:

'In PHC we are obligated to work in teams because without it we can't offer a good service to our patients. If there is any misunderstanding between staff it needs to be sorted quickly or it will reflect on our teamwork'[F/DR/supervisor in Richmond].

The female supervisors at both centres had the same background in family medicine, with this background providing an important background in collaborative working. Both explained that team working was one of the first basic concepts taught to them in family medicine. Their view of their managerial function was that they had a role in regulating the female team members (but not actively managing) as well as auditing and facilitating dialogue within the team, and liaising with the male side. Teamwork was essential in providing better services for their patients. The female supervisors saw it as part of their role to instill a belief in teamworking amongst all team members, something that they felt they had been able to achieve. In turn, this shared understanding of the importance of teams providing the grounding for achieving higher standards of services.

Notions of unequal power and hierarchical differences, and their impact upon teamworking, were not formally acknowledged by team members interviewed at either of these centres. Data illustrates that these aspects were not absent at Robinson and Richmond. The description of activities to be undertaken by the female supervisor above, along with the commentary provided on what the role entails indicates a strong focus on auditing, measurement, regulation and encouraging dialogue, but relatively little on direct line management. Long standing status differentials between men and women, in terms of those in senior roles in the practice were also apparent. However, any potential barriers that these generated had been largely overcome through a positive, open approach adopted by the female supervisor towards their role:

'The supervisors role is to organise the girls from their attendance to their coverage of daily clinical work other responsibilities for example if there is a technical problem in the lab she will be responsible for sending out letters to the director as well as receiving circulars that she delivers to the girls, also in my case there is the covering of the chronic disease clinic' [F/DR/Supervisor in Richmond].

In many areas in Robinson and Richmond, the female supervisor did extend their role – informally – to providing ongoing verbal feedback to her staff, which encouraged them to integrate together towards a common goal. This suggests the boundaries between this informal supervisory role and formal line management may be somewhat blurred. However, the female supervisor did not see these activities as formal line management, but rather interpreted them as being primarily focused on creating an environment in which the team could function effectively, and in which there was a supportive and enabling culture. This was a view shared by team members:

'She is very supportive and always appreciate our hard work even if it was verbal it makes a difference, it gives a push to work together towards our main goal which is serving the patient' [F/Nurse in Richmond].

It is important to recognize that this had not always been the case with incumbents of the female supervisory role (each of whom obtained their position through consensus within the team rather than being externally appointed). An earlier holder of the female supervisor role at Richmond had not been successful in creating a supportive, collaborative environment, and had used her position as a means of enforcing control and publicly

highlighting poor performance. This had been seen as highly demotivating, and discouraged active team collaboration, and hence the current supervisor's approach was seen as a very positive change:

'Recently we feel more of a team because of our supervisor, she is more involved with staff. Our pervious supervisor was not cooperative and if any staff member did something wrong she would put us down in front of patients, which is very embarrassing. However our new supervisor calls us to her office explains what went wrong and shows me how it should be done. The way we are treated now made me keener on providing a good service for our patients. Unlike before I only felt obligated to work and get things done so I can go home' [F/Nurse in Richmond].

Hierarchies and power distance do frequently inhibit people form speaking up and contributing within teams. However, effective leaders can flatten the hierarchy, create familiarity and make it feel safe to speak up and participate (Leonard 2004). Informal leaders who provide feedback can also enhance the bond among team members and their commitment to the team. The female supervisor at Richmond was an active enabler in this respect, involved in providing feedback to her staff regarding their clinical tasks and encouraged teamwork because she believed that teamwork was necessary in providing a good service and enhances performance. Moreover, the female supervisors at both Richmond and Robinson possessed a strong interpersonal aptitude as well as building trust by engaging positively with team members. Formal leadership often exerts influence through the use of authority while informal leadership influences team members through building a relationship and gaining respect (Stincelli and Baghurst 2014).

7.4 The female supervisor as 'controller'

Analysis of the interview data indicated that in the Mayfield and Langford centres, teams were highly fragmented. Teams received little support and encouragement from management, or from the female supervisor. Female staff within teams at both these centres remained closely attached to their own area, and largely preferred to work alone. This severely constrained the opportunities for any collaborative interdisciplinary teamworking, but this situation was made worse by the actions of the female supervisor in both cases.

In Mayfield the director and medical manager were completely isolated from the female team members. The female supervisor was a social worker rather than a medical professional and was therefore already at a distance from many members of her team. Female supervisors at Mayfield and Langford interpreted their role narrowly and focused mostly on passing information up the male-dominated hierarchy, and implementing decisions that were passed down from the top of the organisational hierarchy to the team. This did give the supervisor at Mayfield considerable power over staff, which was, unlike at Robinson and Richmond, exercised and used. Through her role, the female supervisor exerted control to serve her own self-interest, disciplining team members and judge individual performance. Team members had no decision-making capabilities within the team, and largely followed the direction of the female supervisor.

> 'Primarily I am a supervisor here in this PHC. I don't feel my role here is as a social worker…' [F/social worker/Supervisor in Mayfield].

In Mayfield, then, the female supervisor role was largely indistinguishable to a line manager. The description of this supervisory function as a 'controller' reflects the notion that the purpose of supervision was seen to be to implement commends from management, which in turn helped the supervisor meet her obligations, whilst managing through the creation of a climate of fear. Team members felt that their supervisor was one of the main barriers to teamwork integration. Despite being a key bridge of communication between management and team members, the exercising of power by the female supervisor, as a means of ensuring control over the team had a very negative effect on team members, being a demotivating force, and with team members perceiving that the position was being used to actively control, restrict and manipulate the flow of information between management and staff towards their personal advantage. This was described by a lab specialist:

> 'The system here in this PHC is steered by divide to conquer and it all depends on the female supervisor that is why we don't have teamwork…' [F/lab technician in Mayfield].

In contrast to Richmond and Robinson, the female supervisor at Mayfield sought to ensure that direction was the top was implemented within the team, with no scope for discussion, engagement or autonomous team based decision making. As one team member noted:

'… I have noticed that teamwork is not part of her agenda because she controls staff by the saying divide and conquer. She doesn't have a clinic and she only oversees our work. Unlike hospitals where most supervisors have clinics and see patients while managing their staff. To her I feel it is about controlling staff more than organizing work around here'[F/Dietitian in Mayfield].

However, the ability of team members to express this view and generate change was limited. Communication with the centre director was restricted and if female staff contacted the director regarding any problem, the director would direct them back to the female supervisor to raise issues:

'Staff here are treated differently because of our female supervisor which has caused a lot of problems among staff. There is conflict and hate between us. Most of us work to get things done and avoid her tongue lashing at us' [F/Receptionist in Mayfield].

This 'supervision by fear' approach may have ensured that staff 'got the task done' but also resulted in a loss of morale and motivation, and widespread disquiet with the interdisciplinary teamworking agenda. Most staff agreed that the background and inexperience of the supervisor was the cause of many of the problems that resulted, particularly fragmentation and division between team members. The preference of the female supervisor for working alone, within her own discipline area was another important constraining factor. Other members explained that the hierarchical nature of the employment system, and the way that the female supervisor role had been implemented was not well suited to inter-disciplinary teamwork:

'In order to have teamwork you need to look at management first if they deal with staff clearly and equally not differently from person to person. I mean it is like one member of staff gets permission to leave early while others are punished for little things. Other times when you work hard on something and the only one who gets credited for our work is the female supervisor and this is not fair' [F/receptionist in Mayfield].

Using gender segregation as the reasoning, the director at Mayfield continued to request that female team members contacted their team supervisor and not involve him in any issues. Consequently, female members felt very isolated from management, and perceived a lack of support, which resulted in them retreating towards working independently rather than collaboratively. Members in the team felt that managerial support and input was essential in ensuring collaboration among health professionals. However, in Mayfield members were more focused on meeting quantitative targets around the number of patients seen per day, something that had been demanded by management, and implemented as a key target by the female supervisor:

'That approach will never help us work together or even help each other in here, eventually we will never give more to this centre' [F/Receptionist in Mayfield].

Unlike the cases at Robinson and Richmond, gender segregation at Mayfield, and the creation of the female supervisor role, alienated the female team members from management and gave considerable unrestricted power to their female supervisor. Therefore, team members retreated to work individually on their tasks and were not interested in working together as a

team. Poor leadership resulted in low levels of participation among team members.

In Langford the female supervisor's background was in nursing, and she created division between staff by actively excluding staff from meetings and limiting training opportunities. Some members were excluded because of their background, on the basis that they weren't directly part of the primary care structure:

'In any team there is a leader, we have here our female supervisor she can either make the members integrate and work together or she can split them apart by favouring some staff over others or giving them priorities such selecting them in attending seminars or sometimes allowing them to leave work early and while others don't. This is done here by our female supervisor and in a very obvious way' [F/Optometrist in Langford].

The female supervisor sought to regulate and limit interaction between the team and senior management, instead seeing herself as the only means of bridging between the female team and directors. This was viewed as highly problematic, divisive and demotivating by team members at Langford and ran completely counter to commonly held views about the purposes of teams:

'No there isn't any (teamworking), in this centre everyone is on their own and that is due to management. I have never met our director he never even asked to meet us. Our female supervisor communicates with him about staff here. You could be an honest loyal staff member, however she can manipulate your image inadequately to the director… All of this can reflect on your appraisal, which is done by our female supervisor…' [F/Nurse in Langford].

Of particular note is the range of activities undertaken by the female supervisor at Langford, which like at Mayfield, looked identical to that undertaken by a line manager, and covering appraisal, allocation of training and development, monitoring of staff. In addition, active manipulation of messages and reporting were used to divide and rule. Senior management distanced themselves from the female team, leaving staff under the control of their female supervisor. As a result, both the Langford and Mayfield cases highlight how the female supervisor can actively hinder teamwork by favouring staff over others.

*A l*ack of support had caused team members to revert to working in silos in order to finish their tasks independently, which was seen as a means of avoiding direct confrontation with the female supervisor. This retreat from teamworking towards ensuring they were focused on their individual tasks had resulted in some staff at Langford questioning whether the current supervisor was not relevant and whether she was there or not it did not affect their job:

'Honestly, I don't see any teamwork in here everyone is doing their job on their own. There should be a leader to unite us but if the female supervisor is one of us and sometimes they change randomly it will affect our work. It should be someone with experience and a voice to guide us as a team but if it is one of us, I feel that she is irrelevant and she is not proactive as leader not even the previous supervisor' [F/Receptionist in Langford].

There were no opportunities for open dialogue with management and the female supervisor consequently leading to internal conflicts among staff. Moreover, managerial neglect did lower staff morale – staff within teams felt isolated and detached from senior management:

> 'It is one of the major obstacles because our management is on the male side the director and the medical manager. Both they only hear about us, we don't see them and they don't either' [F/ DR in Langford].

Due to these factors, female staff at Langford were demoralized and were willing to leave the centre for better circumstances, a finding that resonates with other studies exploring the link between job satisfaction and teamwork, and the mediating role played by supervisory support. The study found that teamwork can have a negative impact on job satisfaction because of the lower levels of supervisory support. Therefore, leader behaviors have an impact on supporting teamwork in an organisation (Griffin et al. 2001).

From the perspective of senior managers, any problems associated with teamworking were attributed to gender segregation rather than the female supervisory role. The male medical manager stated that there was effective teamwork in the male side, however because of gender segregation he was not even sure if it was evident in the female side.

> '… I am responsible for inspecting and appraising clinical staff and their clinics through observation and following up on their work. And this is impossible if you are not allowed inside the female division…' (M/Medical Manager in Langford]

The medical manager in Langford argued that he could not carry on his full responsibilities due to gender segregation and can only visit the female side once a month. Gender segregation prohibited the medical manager in Langford from carrying on his responsibilities of inspecting facilities and appraising staff in the female side and he therefore relied solely on the female supervisor judgment. Thus, the organizational culture reinforced masculine dominance through the structural configuration of the centre.

7.5 The female supervisor as 'Reluctant Co-ordinator'

In both centres of Williams and Harington the female supervisors were pharmacists who worked alone in an isolated dispensary. The female teams in Williams and Harington had no supervisory capacity over each other and proceeded with their tasks autonomously and independently. Other than dispensing medication these supervisors were merely responsible for regulating the female team. They saw their role in a sense of passing information up the gendered hierarchy and carrying out decisions that were passed down. In this sense activities conducted by the female supervisor could be described as being similar to Mayfield and Langford. However, the active manipulation and exercise of managerial prerogative was not prominent in Williams and Harington. Most of the tasks undertaken by the female supervisor were carried out in compliance with the Ministry of Health administrative standards, notably having monthly meetings. In this sense the female supervisors were best characterised as 'reluctant coordinators'.

In contrast to Richmond and Robinson, female supervisors did not see the benefits of teamworking, and had not bought into the rhetoric of teamworking as necessary for effective patient focused care. In Williams the female supervisor mentioned that staff did routine work and centres do not need teamwork for such tasks. Any new tasks and policies that were required by directors were communicated informally with members in person. Beyond minimal compliance with Ministry of Health standards, team meetings were only held to organize health promotion projects. Interestingly, given their role as female supervisors, the incumbents of these roles at Williams and Harington saw themselves as somewhat detached from active supervision and focused mainly on their tasks in pharmacy, which was reflected in their orientation to their work and teamwork. As one of the supervisors commented:

'PHC generally don't have a lot of workload, work here is mostly routine and I don't see the need for teams in here…I usually like to work alone and finish my work quickly without asking anyone for help over and over. I love my job, which I work hard for and I want to be credited for it. I don't want to do all the work in a team and someone else gets credit for it while I end up being called lazy' [F/Pharmacist/supervisor in Williams].

The supervisor did not recognize the notion of teamwork as a fundamental component at all for working in PHC, she did the required tasks that were delegated by the director. This attitude towards teams was seen by team members to stem from the top of the organisation, something that could be observed at Williams through a change in approach that had accompanied a change in the senior management team:

' In the past we had a director who came over to this side and encouraged us to work in teams we were more excited to work but the new director has no relationship with us. He mostly deals with the male section but not us' [F/nurse in Williams].

According to Ross, Rink and Furne (2000) team readiness to integrate in teams can be severely constrained by the absence of common set of values about the benefits of teamwork. They highlight the need for clear leadership, objectives, commitment and wide organizational ownership as precursors for working in teams. Female members' managerial support could enhance their productivity, however this support was largely absent at Williams.

In Harington the female supervisor only communicated with staff when there was a defect in their task or a complaint from a patient. This supervision at a distance was used to regulate work in her own self-interest, and to ensure that her time could largely be spent on running her pharmacy clinic and managing female employees there.

At Harington, whilst this focus on her pharmacy role limited the time she was willing to spend on being the female supervisor, there was also a strong desire to retain the role, to prevent anyone else from taking it on, with the supervisor feeling that others would not be able to undertake the role effectively.   The female supervisor role was either elected by female employees or volunteers for the position:

'A female supervisor its something you volunteer for with no financial returns or any incentives. I mean if a female supervisor was fed up and quit, anyone can be a supervisor just to keep work going. And it doesn't matter to them if it causes problems among the girls as long as work is moving on…I talked to Riyadh Health Affairs and they told me that I'm not obligated but I told them I can't do it by myself with my load of work as a pharmacist and I'm only tolerating the extra load of supervision because I can't handle another staff member with this position who comes in and messes everything I did. And I end up leaving to another primary centre far away from my home" [F/Pharmacist/supervisor in Harington]

At Harington, then, the female supervisor interests were individualistic and very focused on her tasks. The lack of support and engagement with female team members was reflected in the way they talked about teamwork. For the most part, they did not talk about how teamwork improved the quality of the work done, only how it was not essential in helping them complete their work, In this sense the team members had internalized the view that was coming from the female supervisor, and saw teamworking as an unnecessary inconvenience:

'We have very simple cases and we do not need teamwork for that' [F/Nurse in Harington].

Leaders frequently try to recognize deficiencies in the team's abilities, either in the case of individual team members not being equipped to accomplish their assigned tasks or the team as a whole not capable of working together effectively. Such deficiencies in team performance abilities provide the impetus for leaders to develop and train their team skills (Salas et al. 2008).

Leadership actions aimed at mentoring, coaching, and developing the team have been shown to improve team effectiveness and processes within a wide range of formal and informal leadership sources. To attain optimal levels of performance, teams are required to be skilled in the task at hand as well as the interpersonal processes that permit team members to work together as a collective unit (Firth-Cozen 2001, Morgeson et al. 2010).

'The majority of us not integrating in a team is related to personal issues between employees but the female supervisor tries to keep us in order' [F/Nurse in Harington].

A lack of support from management made the female staff – including the female supervisor - at Harington feel they are in a separate centre and that male management only took care of their male staff on their side. Segregation allowed management to focus on male staff interests by overlooking their attendance to work. This resulted in shortage of staff in the pharmacy, with the female supervisor having to take on extra workload to cover absent male colleagues:

 '…He rarely comes in, always on sick leaves or presents a crazy amount of excuses just to leave work. I would get a call from the director telling me that he isn't coming today, tomorrow, and after tomorrow, while I continue to cover for him. After a while I found out that the director is easy-going with him and at my expense because I didn't know that I'm not obligated to cover the male pharmacy. I didn't see the employee for 6 months and I really got tired of covering his work so I asked the director where is he?...' [F/pharmacist/ supervisor in Harington].

Segregation permitted the director to exploit the female pharmacist by increasing her workload in covering the male pharmacy on the male side.

Examples such as this highlight communication difficulties in the segregated work structures of Saudi healthcare centres. In Harington the male medical manager explained that he is not obligated to interact with the female side and communication with the female supervisor was being done once a month through the phone.

'I'm not required to visit the other side that's what I was told, what was requested from me is to call them once a month to check on female staff and to sign any necessary paper work sent from them I feel this is what staff and patients are asking for. It is like a venting spot for people who want to segregate genders so they come here instead of hospitals' [M/Medical Manager in Harington].

Sophisticated HRM practices and systems, a clear senior management strategy and an organisational culture which is supportive of the goals of inter-disciplinary teamworking are all important to understanding the success of teams. However, segregation allowed management to abandon the female members and not provide them with any managerial support. Therefore, inter-disciplinary teamworking cannot be reduced to list of aims or good practice guidance, but needs to be sensitive to the different motives and rationales for teamworking, the traditional approach to management and HRM in Saudi Arabia and the gender segregated nature of working.

7.6 Conclusion

The previous chapter showed how workers perceive and understand teams, and how they work together in practice. It provided new understanding and insight into the nature of teamworking, the contexts in which it works effectively, as well as an understanding of barriers that impede teamworking. This chapter has shown how the female supervisor undertakes informal leadership within teams across six cases. The role, and activities of the female supervisor as team leader were, in some cases, formally defined, in many cases leadership devolved more informally as teams evolve. The authority and credibility of this supervisor derived partly from their previous experience and conduct, but also came from their evolving practice of supervising within gendered teams, and specifically from their abilities or weaknesses in bridging across disciplinary, occupational, and gender divides. In some cases, such as Richmond and Robinson the female supervisor facilitated the operation of teamworking, but in other cases, these supervisors had the ability to undermine team working, or to have a negative impact upon collaborative working, creating a negative atmosphere and adversarial work relations.

In Robinson the informal role impacted team members positively and provided a supportive environment. Her role was a key driver in having team members work and commit to a common goal, which was patient-focused care. Informal leaders can use their power to shape strategies, establish teams' basic vales and norms, and coordinate group efforts. Similarly, in Richmond the female supervisor was characterised as an active enabler, holding and openly promoting the view that without teamworking, it was

impossible to deliver patient-focused care. Moreover, the informal leaders in Robinson and Richmond extended their role by providing ongoing verbal feedback to staff, which encouraged them to integrate together towards a common goal. This suggests the boundaries between this informal supervisory role and formal line management may be somewhat blurred. However, the female supervisor did not see these activities as formal line management, but rather interpreted them as being primarily focused on creating an environment in which the team could function effectively, and in which there was a supportive and enabling culture. This is due to the background of the female supervisors at both centres had the same background in family medicine, and teamwork was one of the first basic concepts being taught in family medicine. With this background providing an important backdrop in collaborative working.

Other centres such as Mayfield and Langford had highly fragmented teams that preferred to work alone. This is due to the actions of their informal female supervisor who acted as a controller role narrowly and focused mostly on passing information up the male-dominated hierarchy, and implementing decisions that were passed down from the top of the organizational hierarchy to the team. This did give the supervisor at Mayfield and Langford considerable power over staff, which was, unlike at Robinson and Richmond, exercised and used. Through their role, the female supervisor exerted control to serve her own self-interest, disciplining team members and judge individual performance. Team members had no decision-making capabilities within the team, and largely followed the direction of the female supervisor. Team leader need to steer their team members rather than drive and control them like hierarchical leader. As a

result, team members retreated to work individually on their tasks and were not interested in working together as a team. Poor leadership resulted in low levels of participation among team members.

Other cases, the female supervisor did not manipulation and exercise of managerial prerogative such as in Williams and Harington. The informal leader were characterised as 'reluctant coordinators'. They did not see the benefits of teamworking and had not bought into the rhetoric of teamworking as necessary for effective patient focused care. In this sense the team members had internalized the view that was coming from the female supervisor, and saw teamworking as an unnecessary inconvenience.

Leadership is necessary to ensure groups of doctors, nurses, and allied professionals interact effectively. In many cases, this leadership emerges and evolves, with leaders volunteering for a leadership role with little previous experience or being elected to the role by their peers. Leaders in this context can use their informal power either in a positive or a negative way. Negatively, they may seek to enhance their self-serving interests rather than the interests of the group, creating an adversarial atmosphere, or manipulate information (Van Wart 2011). On the other hand informal leaders can use their power for mentoring, teaching, and coaching within their teams (Pielstick 2000).

In summary this chapter adds to the argument that informal leadership is an important denominator that links joint working with patient-focused care. Informal leadership depends mainly on one's experience, knowledge,

credibility and personal skills (Sullivan and Garland 2010). Informal leaders have credentials that may not be easily communicated or documented, much less evaluated (Downey et al 2011). However, they can be essential to processes of influence and motivation that contribute towards team effectiveness. The success of informal leaders in this context is achieved through a combination of the organisation's culture, individual competence and the specific requirements of the situation (Stincelli and Baghurst 2014).

CHAPTER 8: CONCLUSION

8.1 Introduction

This chapter summarises the thesis, setting out how the research questions have been addressed, and looking at the contribution of the thesis to our understanding of teamworking. This thesis has examined the nature of inter-disciplinary teamworking in healthcare in Saudi Arabia. It has explored the relationship between teamworking and HRM, and the rhetoric and reality of inter-disciplinary teamworking within a context where gender segregation remains a defining feature of society and workplaces. Drawing on intensive qualitative research, comprising interviews with senior managers, medical specialists, nurses, female team supervisors, and other team members, the thesis has examined inter-disciplinary teamworking in six primary care centres in Riyadh City, the capital of Saudi Arabia. It has unpacked the synergies, tensions and contradictions between teamworking and HRM, examines different perceptions and meanings of teams amongst team members, and highlights the crucial role of the female supervisor to teams in the Saudi Arabia context, an aspect of teams that has been unexplored in research to date.

The overall aim of the thesis was to develop a better understanding of the nature of inter-disciplinary teams in healthcare and how they function within the gender-segregated setting of Saudi Arabia. In this concluding chapter, the main findings are summarized in the 8 following sections. In section 8.2,

answers to research question are provided, focusing on the implementation of teamworking and its connections with HRM. In section 8.3 attention turns to research question 2 which looks at different and contested meaning and interpretations of teams by team members, and those designing and implementing interdisciplinary teamworking. Then, in section 8.4, the third research question is explored, focusing on the female supervisor role, a unique feature of teamworking in the gender segregated context of teams in PHCs in Saudi Arabia.

In section 8.5 the main theoretical contributions of the thesis are outlined, followed in 8.6 by key methodological innovations. Section 8.7 looks at areas for future research and section 8.8 highlights implications for practice. Finally, section 8.9 concludes the thesis.

8.2 Research question 1: The implementation of teamworking and its connections with HRM

The first research aim was to explore the implementation of teamworking and its connections to HRM systems and HR practices. As outlined in Chapter 3, the Saudi Arabian state, over the last decade, has sought to introduce change across healthcare facilities, to implement inter-disciplinary teamwork principles, as part of the development of an integrated patient-focused care system. However, very little consideration was given by policy makers about how a new system of interdisciplinary teamworking would interact with existing, long-established organizational structures, management practices, performance management and incentive systems in

PHCs. Some PHCs were better prepared for change than others, and HRM practices and systems within these PHCs varied markedly.

Chapter 5 revealed how, within Saudi Arabia, public sector HRM practices have been largely concerned with tight managerial control through close direction. Control was, in many PHCs, typically implemented through close performance management and very tight control over individual activities, with the objective of reducing direct labour costs and improving efficiency. Employee compliance with specified procedures and rules was emphasized, and rewards largely fixed, or where they did vary, were based on measurable output criteria (Mellahi and Wood, 2001). Thus, managerial approaches to work in the Saudi public sector remained, at the time of the research, heavily influenced by Taylorist scientific management concepts. In terms of HRM, jobs in PHCs were narrowly specified, supported by task focused training, standardized payment systems, and close performance management. These were very different to the approaches typically encouraged through inter-disciplinary teamworking.

Chapter five revealed the challenges faced by PHCs in implementing inter-disciplinary teamworking due to these existing, dominant HRM structures. The key argument put forward in the chapter is that the existing approaches to HRM did not in many cases support the effective implementation of interdisciplinary teamworking. Attempts by management to retain close control over the labour process within interdisciplinary teams created many tensions and contradictions, undermining a number of the key collaborative

goals associated with teamworking. Specifically, the chapter uncovered negative impacts of the move to interdisciplinary teams in cases where managers and supervisors sought to retain control of teams through their actions, which contradict the goals of interdisciplinary teams. In many of the cases, this resulted in trust being fundamentally undermined. Management sought to operate teams as an additional mechanism of administrative control, seeking to maintain productivity output at an acceptable level and meet accreditation requirements, rather than improve discretionary effort and engender collaborative working.

The chapter also highlights the disconnect between the rhetoric of teamworking, as espoused in the more prescriptive literature, and in government documents and agendas about its implementation in healthcare in Saudi Arabia, versus the realities of its operation within specific PHCs. Merely bringing people together in these teams does not ensure that they will work together efficiently and make appropriate decisions. The chapter reveals how some healthcare teams in PHCs in Saudi Arabia existed as teams in name only, with little actual evidence of collaborative working at all, indeed, in some cases with attempts to undermine by team members to undermine its operation. An important finding of the thesis, extending knowledge of the realities of teamworking, is its explanation of why these difficulties occur. The evidence from the six PHCs points to the following challenges and barriers to effective teamworking in PHCs: professional and occupational boundaries, which may be difficult to break down; poor incentive systems, with uneven and inequitable rewards, or the removal of

anticipated rewards for operating in teams; and established hierarchical differences between team members and leaders, which are amplified under interdisciplinary teamworking (Millward and Jeffries 2001; West and Lyubovnikova, 2013).

In the Saudi context, some of the challenges of interdisciplinary teamworking also resulted from the unique sociocultural context, and gender segregated working. Due to the complex fringed environment, management sought, in many of the cases was successful, in exerting tight control over female interdisciplinary team members through concertive control. As highlighted in Chapter 2, concertive forms of control seek to promote a strong feeling of empowerment and ownership amongst team members, whilst ultimately extending management control over the labour process (Barker, 1993). According to Baker (1993) concertive control can emerge when teams establish their own norms of task performance evaluation, direction, and internal discipline. This could be seen in a number of the cases. In some cases, interdisciplinary teams supplanted informal norms with their own local rationalization of work behaviour, overseen and managed by the female team supervisor. Concertive control, in many cases, offered a means through which the intended action of teams to accomplish organizational goals was secured by management while overcoming the stultifying and constraining effects of bureaucratic hierarchy (Sewell 1998). It was elusive than a supervisor telling team members what to do, and members of teams appeared to willingly submit to their own control system because it seems

natural, resulting in a system of control that guides their value-based rational rules in their team.

Teamwork required significant efforts and integration to establish the group into an effective team, with team members expected to overcome traditional barriers and adversarial attitudes to collaborative working (Baiden and Price 2011). The thesis revealed that this does not happen automatically, with the reality of teamworking varied markedly from state expectations. In some cases, there were positive individual and organizational outcomes from the implementation of inter-disciplinary teamworking, largely where the female supervisor had a clear vision and approach, and managed her team in an equitable and collaborative manner, but in other cases there were not.

Finally, in terms of HRM practices, the thesis has pointed to the particularly prominent role played by incentive systems in the success or failure of interdisciplinary teams. The use of both formal and informal incentive systems, and their idiosyncratic implementation by individual managers ensured tight control over the labour process in some cases, but had the effect of intensifying work, creating stress and tensions within teams, and undermined the effective operation of teams. The evidence in Chapter 5 showed that when inadequate attention is paid to the implementation of HR practices under teamworking, or when dominant pre-existing approaches to management and supervision are allowed to continue, processes of reward can be subject to individual interpretation, leading to incompatibility of practice that can affect staff performance (Bartram et al. 2007). The findings

here resonate with Bacon and Blyton (2000), who caution that any positive potential effects of teamworking can be hindered if the aims of management are inconsistent other practices, notably reward systems (Wall and Wood 2005).

The thesis highlights an important point about the formulation and implementation of HRM practices: HRM systems are developed at the organizational level, but experienced at both the individual and group or team levels (e.g. multidisciplinary team working, individual appraisal) (West et al 2006, Leggat et al. 2011). Teamwork does require significant training and development efforts and integration to establish a group into an effective team. When supporting HR practices are weak, HR practices are likely to produce messages that are vague and subject to individual interpretation (Bartram et al. 2007). In this thesis, attention has been directed towards the critical role of the female supervisor in the implementation of teams in PHCs in Saudi Arabia, an aspect that it considered in more detail in sections 8.3 and 8.4 below.

The thesis also highlights the important role of understanding and considering context when looking at any positive or negative effects of teamworking – teamworking does need to 'fit' with other HR practices in place, and with the prevailing system of HR being operated within a particular firm. The implementation of HRM is not context-free, and practices and systems are likely to vary markedly from one organization, sector and country to another. Nancorrow et al (2013), for example, point to the

importance of effective incentive systems, strong communication, and clear and supportive line management to the success of interdisciplinary teams (see also Xyrichis and Ream, 2007; Xyrichis and Lowton, 2008; Molyneux, 2001). Yet, as the empirical evidence in this thesis demonstrates, these practices operated quite differently in PHCs in Saudi Arabia to other countries, and indeed varied from one case to another. Incentive systems – both informal and formal - within teams, for example, need to be configured in ways that ensure individuals feel recognized for their specific contributions, whilst also providing motivation and effective reward for the team as a whole (Thompson, 1995; Fiscella and McDaniel, 2019).

The 'glueing' nature of particular HRM practices has been emphasized in the literature on HRM, particularly in 'best practice' approaches. Particular configurations of HRM structures, it is argued, may help to support teamworking practices in some contexts. Training and development in how to work in teams and collaborate, for example, may help to ensure that those operating within teams understand how such structures are expected to work, whilst the provision of time and capacity to communicate within teams (through regular meetings) may also help team members to work effectively in an interdisciplinary environment. For some, these supporting HRM practices enable practices such as teamworking, to work effectively (Whitfield, 2000; Purcell and Hutchinson, 2007; Brown et al, 2008).

However, this thesis has highlighted how HRM systems and practices may also undermine teamworking. It has revealed the tensions and contradictions

between the goals of teamworking HRM practices. Payment and incentive systems in PHCs undermined some of the goals of interdisciplinary working by over-emphasising individual contributions, or by removing rewards that were expected. Female supervisory roles were not attached or connected to progression and promotion,and had lower levels of authority for female supervisors than male counterparts. A reward system should recognize individual task interdependence and encourage team members' collaborative work (West and Lyubovnikova 2013), yet in the cases in this thesis, they were often demotivating and constraining at the individual level. The realities of how HRM practices and systems are formulated and implemented (Ogbonna and Whipp, 1999; Procter and Radner, 2014; Cook et al, 2016; Carter et al, 2017) are, this thesis has found, of central importance in understanding the effective of interdisciplinary teamworking in a specific context, such as PHCs in Saudi Arabia.

8.3 Research question 2: Perceptions of Teams, The Effects of Teams and Barriers to Success

The second key research question asked: what are the motives for teamworking in PHCs, how do inter-disciplinary team members perceive and understand teamworking and what are the effects? Chapter six looked in detail at the perceptions towards teams and examined the voices of those within teams in the six cases, to gain a direct understanding of perceptions of teams and their operation within the specific context in which respondents encountered teams. It explored how workers perceive and understand teams, and how they work together in practice.

The thesis revealed how the range of meanings and interpretations of teams amongst those working in PHCs impacted upon teamworking, and how quality agendas, used as a mechanism for progressing interdisciplinary teamworking, were quite varied in terms of how they shaped teamworking in practice. The thesis found that in cases where quality accreditation efforts and applications were well-progressed, there was more organizational infrastructure to help support and sustain teamworking, but nonetheless, much activity was quite informal and organic. In cases where teams were working relatively effectively, there was buy-in and self-expression of the importance and value of teams, and some shared understanding and interpretation of what a team was. Alongside this, notions of looser terms such as 'family', and strong identification with individual discipline-specific units, and an allegiance for these groups over inter-disciplinary teams could also be seen. The result is quite complex set of affiliations and motivations that cannot be neatly ascribed to a well-formulated notion of a team.

 In other cases, disciplinary boundaries were particularly strong and individuals tended to identify with their unit or specialism more than the inter-disciplinary team. Attempts by some groups to define teams and their value in terms of their own particular specialism also undermined attempts to foster a genuine organization wide view of teams. These disciplinary and professional boundaries did run deep within individual PHCs, and cannot be neglected in terms of how they shape and constrain the day to day operation of teams.

In the cases where interdisciplinary teams did work effectively, there was good sharing of knowledge, with iterative processes of learning and working together helped to build this sense of teams, and with team members gradually acknowledging the nature of teams over time. Data analysis illustrated that notions of power, hierarchy and competing ideology were not foregrounded by team members in these teams (which were in a minority of the cases) who instead reported on processes of sharing information and helping each other in tasks. This knowledge exchange also helped team members to improve their skills and competence, something that was seen to be important in centres where a wide range of services were offered. Working in an environment in which colleagues felt comfortable being given advice, and being able to seek assistance from others was seen as a positive aspect of teamworking. Overall, then, it seems that an externally defined notion of a team cannot simply be imposed within a particular setting, rather, such they are shaped and moulded within particular (already existing) team units.

The findings also reported the diverse views across the centres on the meaning of teams and their nature. Indeed, even within individual centres, particularly where disciplinary boundaries and a culture of working within a single function and role remained strong, there were different views held by different team members on the meaning and purpose of teams. For some, particularly where quality accreditation was being pursued, here was quite widespread buy-in for the concept of the team, working towards a shared

goal. However, even in these instances, there were instances where individuals perceived the 'team' more in terms of their own discipline or function, rather than a wider notion of inter-disciplinary teams. Furthermore, the teamworking idea was sometimes perceived in these cases in terms of a looser notion of 'family', with the familial rhetoric masking often quite different elements of actual teamworking in practice.

Taking the cases as a whole, it is reasonable to say that engagement and understanding of the team concept varied. This seems like a straightforward finding, but it is neglected or ignored in many studies of teams, yet it does profoundly shape how teams operate. Some groups, particularly those most distant from primary care, such as receptionists, were much less likely to perceive that there were benefits to inter-disciplinary teams, although these groups often did have a particularly strong sense of a team identity in their own unit. For nurses, as noted above, there was some recognition of the need for teamworking to do their daily tasks, however the main value of teamworking was that it enabled them to collectively share responsibility and coverage for scheduling and accommodate unexpected absence satisfactorily within the teams. Workers' participation in team system here reflected more than passive compliance with managerial initiatives, it also signalled workers' determination to use the new team system to their advantage such as coverage. For doctors, there was some recognition of the value of teams, but this was understood in terms of benefits for doctors, with other members in a team reducing to a supporting and subservient role.

Nonetheless, there was recognition from doctors that such team-based practices could lead to significant productivity improvements.

The Ministry of Health strategy has sought to promote patient-centred-care, which means interactions between healthcare team members is determined by the needs of the patients care. This strategy also recognizes the need of members to integrate and participate in planning and delivering care. However, across many of the cases, team members' perceptions of teamwork was ambivalent, or contradictory, while others actively resisted the concept. The strong sense that comes across in the thesis, even where notions of teams were relatively well-established and shared, was that interdisciplinary teamwork was an administrative construct rather than a practice. Interdisciplinary teams served a purpose for pushing and promoting quality agendas, and in some instances had led to improvements in specific practices, more active collaboration, and achievement of patient-centred approaches to care. Yet, diverse management structures, strong disciplinary and professional boundaries and long-established norms of working created barriers to the effective operation of teams. This finding highlights the importance of breaking down these professional boundaries and encouraging more active collaboration, if interdisciplinary teams in a complex setting like primary healthcare is to succeed.

It was relatively rare in the cases for respondents to refer to teams as identifiable, bounded units with set goals and objectives. "Teaming" in this study setting does not, for the most part, reflect a programmatic or

administrative decision, but rather a moving, ad hoc structure which, once disbanded, may or may not rejoin again. This ad hoc structure is open to quite different interpretations from individuals within teams, and across centres, these differences are even more pronounced. In some of the cases, individuals are generally not designated formally as team members, but informally may be expected to perform in a team-like fashion. There is also considerable conflict over decision-making structures and the position of leadership within teams. While, conceptually, teamwork may be strategised and formulated as desirable (and indeed perceived as positive by some respondents) structurally, *genuine* inter-disciplinary teamworking, even in those cases that have put in place sound accompanying structures, alongside accreditation, is rarely evident.

Crucially, even in those cases where teams were perceived to exist by respondents, they were often not evaluated for their performance as teams, nor were the centres evaluated in the context of their presumed team membership. The general absence of structural characteristics of an interdisciplinary team in this setting may in part be attributed to the structure of many medical centers and professional schools, which encourage and reinforce disciplinary norms and conventions, often through occupational closure. One should expect that when loyalties are disciplinary, and goals are discrepant, and where there is no organizational payoff for interdependent behavior, teams as structural units conceived in the literature are not likely to be present (Temkin-Greener 1983).

Interdisciplinary work requires people to engage and understand each other. However, with the absence of a system and structure that support interdisciplinary collaborative practice, professionals may revert to their default backdrop of traditional modalities of practice, with the system's tendency to encourage professionalization and working along disciplinary lines, rather than collaborative inter-disciplinary practice (Cashman et al 2004).

8.4 Research question 3: The Role of The Female Supervisor in Inter-disciplinary Teams in Healthcare In Saudi Arabia

The final research question posed by the thesis was how does gender segregation impact upon teamworking and HRM in Saudi Arabia, and what is the role played by the female supervisor in this context? The central role of the line manager in HRM is a familiar and well-established finding in a range of studies (Purcell and Hutchinson, 2007; Renwick, 2003). A key finding of this thesis is how, in the gender segregated Saudi working context, it is the female supervisor, as line manager to just the female members of the team, who plays a pivotal role in the success or failure of teams. This is an important new insight, and the empirical data sheds valuable light on how this supervisor can facilitate effective inter-disciplinary team working through informal leadership, effective communication, use of incentive structures, and by acting as a conduit between team members, medical specialists and (male) senior managers.

Status differentials between team leaders has not been considered in any detail in studies of team leaders, particularly differences by gender. Despite

their pivotal importance to teams, the thesis points to significant material and qualitative status differences between female and male team leaders, and how cultural and institutional factors do need to be considered closely to understand the nature and operation of teams. In Saudi Arabia, the limited participation of women in the labour market, and physical gender segregation, alongside traditional, Tayloristic approaches to management and HRM that pervade working in the Saudi public sector, create quite different challenges to those observed in Western economies. The data has revealed how gender segregation is a constitutive element in daily life of team members. Men are placed as managers of primary care centres while women are placed in supportive roles. Gender is embedded in the hierarchical structure of the state, and traditional power relations between men and women are preserved through the association of masculinity with leadership and femininity with supportiveness (Acker 1988). This places considerable constraints on females abilities to manage teams. Barriers to teamworking in Saudi Arabian health care centres include physical segregation of patients and workers, and teams that therefore remain divided and separate to a degree. Distinctive roles – notably the female supervisor – have been established as a result to try and facilitate teamworking, but they also create new tensions and contradictions in the operation of teamworking and HRM.

An interesting finding in the thesis is how leadership emerges and evolves quite informally in this context, with leaders volunteering for a leadership role with little previous experience, or through being elected to the role by their

peers. Leaders in this context can use their informal power either in a positive or a negative way. Negatively, they may seek to enhance their self-serving interests rather than the interests of the group, creating an adversarial atmosphere, or manipulate information (Van Wart 2011).

Another important finding is that some informal leaders did not see the benefits of teamworking, and had not bought into the rhetoric of teamworking as necessary for effective patient focused care. Primary care work was seen in some cases as routine work and centres do not need teamwork for such tasks. When leaders interests are individualistic and focused task oriented is will reflect on team members. In this sense the team members had internalized the view that was coming from the female supervisor, and saw teamworking as an unnecessary inconvenience.

Informal leadership did depend mainly on one's experience, knowledge, credibility and personal skills (Sullivan and Garland 2010), with informal leaders exhibiting credentials that may not be easily communicated or documented, much less evaluated (Downey et al 2011). However, they can be essential to processes of influence and motivation that contribute towards team effectiveness. Unlike formal leaders, they may not have access to formal organisational rewards and punishments, which can shape the behaviour of team members (Pescosolido 2002). The six cases studied in this thesis showed circumstances in which these team leaders worked effectively, and others where they did not, shedding new light on how leadership is key in driving force for organisational change, ensuring optimal

healthcare performance outcomes, the provision of quality care, and creating a culture of safety in the work environment (Wong and Cummings 2007, Stanley 2008, Cummings et al. 2010, Boamah 2018).

The thesis has identified three styles of leadership in this unique female leadership role. In some cases the informal leader was characterized as an 'active enabler' to convey the idea that she believed in the potential for teamworking to have a positive impact, and sought through her actions to create an environment in which teamworking could flourish. With this in mind, she sought to provide a safe, comfortable environment for interdisciplinary members, in which they could contribute, engage and participate in the running of the primary clinic. The style of leadership adopted by this informal leader was focused on relationship building, adopting a friendly and open tone, in which peers felt able to share and confide information. Prior studies have showed informal leaders can use their power for mentoring, teaching, coaching and developing the team, which can improve team effectiveness and processes within a wide range of formal and informal leadership sources. To attain optimal levels of performance, team supervisors are required to be skilled in the task at hand as well as the interpersonal processes that permit team members to work together as a collective unit (Firth-Cozen 2001, Morgeson et al. 2010).

The other two roles undertaken by female supervisors were categorized as Controller, and Reluctant Coordinator, both of which were associated with less effective teams. Controllers used teams as a way of reinforcing their

control and power over a team, with largely demotivating consequences, whilst Reluctant Coordinators sought to minimize the work undertaken in their role, and retreat into their previous disciplinary-focused role. The context of Saudi Arabia also is critical to understanding these supervisory roles and their operation in PHCs, with the role and position of women within them, and the continued prevalence of disciplinary divisions and boundaries all impacting upon the configuration and operation of teams. The thesis also reveals how the failure of teams can be understood with reference to these factors too. Successful inter-disciplinary teamworking cannot be reduced to list of aims or good practice guidance, but needs to be sensitive to the different motives and rationales for teamworking, the traditional approach to management and HRM in Saudi Arabia and the gender segregated nature of working.

8.5 Theoretical contribution of the thesis

Taken together, these results contribute a number of important theoretical insights. One is that prevailing models of teamworking need to play closer attention to context, and to the socio-cultural environment in which teamworking is introduced. Whilst this is something that is recognised in critical HRM and sociology of work based studies of teamworking (Procter and Mueller, 2000; Whipp, 1999; Procter and Radner, 2014; Cook et al, 2016; Carter et al, 2017), it is typically neglected in studies of inter-disciplinary teamworking in health, which often presents universal, good practice principles (see Nancarrow et al, 2013). The female supervisor, in a gender segregated working context like Saudi Arabia, is critical to the

operation and implementation of teamworking The thesis reveals not only that the Saudi context is a unique, and to date underexplored lens, but more generally, it highlights that in quite different settings and contexts, gender segregation, and gender inequality are likely to have profound impacts on teamworking. Advancing knowledge on teamworking requires that closer attention is paid to this. The female supervisor role has been designed in Saudi Arabian PHCs to try to address challenges of teamworking in this context, yet this innovation has occurred within a context in which there remain considerable gender inequalities in work, and within a quite traditional HRM system.

Thus, whilst the female supervisor, as line manager to just the female members of the team, plays a pivotal role, this role itself is embedded within the gendered hierarchical structure of work and society in Saudi Arabia. Traditional power relations between men and women are preserved in the structure of work in PHCs through the association of masculinity with leadership and femininity with supportiveness (Acker 1988). Women face constraints in managing their teams, due to status differentials, physical segregation and the dominance of males in senior decision-making positions within PHCs. The establishment of a female supervisor role – a workaround to challenges and contradictions that have occurred as a result of teamworking in Saudi Arabia – has itself created new tensions and contradictions in the operation of teamworking and HRM.

The second theoretical innovation is the unpacking of the tensions and contradictions in the implementation of interdisciplinary teamworking. Again, the critical HRM and sociology of work has considered such tensions and contradictions across a range of practices (see Legge, 2007; Cook et al, 2016), yet studies of teamworking remain rare. The challenges and contradictions highlighted in this thesis stem from highly bureaucratic and hierarchically organized workplaces, with sharp divisions between units and groups. Inter-disciplinary teamworking has been advocated over recent years as a means of developing effective patient focused care and is increasingly a part of quality improvement agendas and initiatives within health. These new approaches to teamworking are predicated on changes to traditional modes of working, yet they may be impeded by professional and disciplinary boundaries, unclear reward systems, poor supporting HR practices and poor management. A key message from the thesis is that structures and systems of HRM vary markedly across, even across seemingly similar healthcare practices, and these systems of HRM may facilitate teamworking in some circumstances, and constrain it in others. This thesis has explored these conditions in detail, highlighting a strong HR strategy, fit between HR practices, and informal leadership from female line managers, within traditionally male dominated organizational hierarchies as key elements to the success of inter-disciplinary teams.

Again, there continues to be a neglect of these contingencies in much of the prescriptive literature on inter-disciplinary teams, including those conducted within healthcare. The thesis has shown that when other HR practices are

weak, with the operation and implementation of HRM being open to different, individual interpretations, teamworking structures can reinforce or extend organizational inequalities, poor management and supervision, leading to demotivation, confusion and poor individual and organizational performance. This is something that needs to be considered more closely within the High Performance Work Systems literature in HRM, which – in many quantitative studies at least – assumes a straightforward link between the implementation of teamworking and performance.

The third theoretical innovation appears relatively straightforward but is one that has been underplayed in much of the HRM literature. That is, that the purpose and motives of inter-disciplinary teamworking are complex and varied, and these purposes and motives have significant effects upon the operation of teamworking, and its ultimate success. Previous studies have highlighted the importance of progressive human resource management within the healthcare sector, with teamwork development policies being a key part of this, and also being able to flourish more effectively in such an environment (Legge 2007). However, the research shows how specific HRM practices are interpreted and implemented in various alternative ways by managers, for a range of purposes. These can be used to increase control, to exercise managerial prerogative, to retain and reinforce traditional male-dominated hierarchies, to develop communication, collaboration, or to motivate and reward staff. These varied motives also impact upon team members' perceptions and understanding of teams, which are also shaped by disciplinary and professional norms, the socio-cultural context of work,

and organisational culture. A key focus if this thesis is to explore how, and to explain why specific groups react in different ways to a uniform HRM system. An assumption here is that universal HRM investment covering all health workers equally, may actually prove to be disadvantageous to the organisation because HRM systems should be designed to reflect the variable roles and identities that particular working groups add to the organisation (Lepak and Snell 1999, McClean and Collins 2011, Cafferkey et al 2020). A possible explanation is that HRM systems alone may be insufficient for specific groups because they have different needs that may be explicable in terms of their specific occupational identities (Lopez-Cabrales et al 2006).

The thesis is one of only a few studies to explore these contested views and different motives in detail and look at the effects they have when teamworking is implemented in these different contexts, looking at the contradictions and tensions that can be created within the team.

Fourthly, this thesis has provided a deeper insight into managerialism in the Saudi context where it remains highly influenced by Taylorist scientific management concepts, in which standardisation and efficiency by the separation of execution and conception of tasks are emphasised. Maximum control over employees has been achieved historically through narrowly specified jobs supported by task focused training, payment systems and selection. It has been debated whether Taylorism was ever fully applicable to health care practice, given that healthcare staff do need to maintain some autonomy over working (Farr and Cressey 2015). However, there is a clear

juxtaposition between old approaches, and newer approaches, including those advocated in interdisciplinary teams, which emphasise the involvement of employees by ensuring fair communications up and down the organisation, investing in training and development generally, rather than for immediate needs, and empowering employees through self managing teams, job enrichment, and participation (Cooper and Robertson 2004). Whilst according to Friedman (1977) conditions of tight control and relative autonomy could coexist in some work settings, theories do suggest that it would be quite difficult to retain the principles of scientific management to interdisciplinary teams, since managers do not directly control the work of the workforce through control performance.

8.6 Methodological contribution of the thesis

The thesis highlights the value of a detailed intensive, qualitative case study approach to explore the rhetoric and reality of teamworking. Much insight on teams has been generated from the High Performance Work Systems literature, which uses quantitative data to examine the relationship between HR practices and performance. Yet, within critical HRM and employment relations, and the sociology of work, the value of intensive qualitative case studies to understand processes and the context in which HRM practices occur has long been recognized.

Much of the qualitative evidence generated on the realities of teamworking has been gathered from studies in industrialised, Western countries. This thesis has provided evidence from the Saudi Arabia context, involving

interviews with workers – male and female - at different levels. This has allowed for a nuanced understanding of contested meanings of teamworking, the multiple objectives and aims of teams, the relationship between HRM practices, and the role of the female supervisor, to be generated. More research in non-Western contexts is needed to broaden understanding of how teams operate and when they are successful or unsuccessful. In the Saudi context, the thesis shows that analysis of the specific composition of teams, the history of HRM and the role of the female supervisor are all crucial to understanding the nature of teams.

8.7 Implications for future research

The findings in this thesis provide useful direction for future research into HRM systems in healthcare, their implementation and their vulnerabilities. The review of the literature discussed numerous studies based on extensive quantitative methodologies which address the issues of team process such as decision making or communication (Opie 1997, Cook et al. 2001, Xyrichis and Lowton 2008, Deneckere et al. 2012), leadership (West et al. 2003, Salas et al. 2005, Downey et al 2011, Nancarrow et al. 2013), or team effectiveness (Barrick et al 1998, Poulton and West 1999, Leggat 2007). These studies address how teams exchange information and make patient related decisions. Yet none have considered how these operate in a gender segregated context.

The intensive focus in this thesis on the implementation of HRM systems and the knowledge of resulting social processes at the case organisation

level can be contrasted with the dominant quantitative methods that have been used widely for measuring, developing and assessing team performance and effectiveness. Primary care in the UK has been investigated by Poulton and West (1999), and Borrill et al. (2000) to explore determinants of effectiveness in primary health care teams, and through a range of intervention or correlational studies. However, these studies focus on teamwork effectiveness rather than teamwork meaning and structure and the processes which determine any effects observed. Qualitative research can offer a richer context description than intervention studies, and they allow the researcher to investigate particular dimensions of both the culture and the structure of the organisations (Johnson 2009), and merits further research to explore teamworking in more detail.

Future research might also explore the role of the female supervisor in more detail, in contexts where gender inequality and segregation exists. In this thesis, the female supervisor provides a vital link between senior leaders and the team on the female side. In cases where teamworking works effectively, the female supervisor utilises informal leadership as a means of ensuring communication and motivation within the team, despite barriers in the form of traditional male-constructed and male dominated hierarchies and structures. And how in some cases female supervisors undermine team working, using it to exert control or exercise their managerial prerogative for their own ends. Are such supervisors found in PHCs in other countries where segregation exists, or do different approaches to HRM, different

cultures, and different styles of management and work organisation shape the implementation of teamworking?

Further research is also needed on the effects of interdisciplinary teams on workers. This thesis has revealed how teamworking intensified work and resulted in more stress for work. It has pointed to the value of learning from the members the way they experience a gendered segregated environment, through an understanding of staff perceptions, and of gathering insight from workers across a range of professions, occupations and departments in PHCs. Interdisciplinary team members consists of diverse professional groups that may hold different definitions of reality and meaning systems, thus a multiple stakeholder approach to research is needed to extract these numerous accounts (McNulty and Ferlie 2002).

It is recognised that this work has reported findings from particular groups in PHCs in healthcare, in a small number of study sites. In common with most qualitative studies, it makes no claim to generalisability. The intention of this research was not to generalise statistically but to generalise analytically from the intensive research (Yin 2009). As Yin (2009) suggests this analytic generalisability of the case study method can shed a new light upon processes which may be relevant beyond their location to the wider social world. Therefore, the empirical aim was to develop an enlightening and explanatory insight into the traditional nature of management and HRM within the Saudi Arabian public sector, rather than to generate results that could be replicated by researcher in a similar situation.

Further, work is needed to assess whether the identified barriers and losses in this study are transferable to other interdisciplinary teams in other contexts. This investigation of interdisciplinary teams has also not explored the service user perspective. This is an important area for further work, as patient views of teamworking are currently under researched. It would be interesting to compare healthcare workers and patients' perspectives on teams for future research and how it reflects on the quality of services. Additionally, further research is needed to identify and eliminate the policies, regulations, attitudes, and practices that might inhibit the continuous improvements in a segregated healthcare environment. Also, elaborate studies that detail the steps of successful team building and development in segregated healthcare sector and outline specific healthcare measures in evaluating a gendered healthcare system.

Despite some of the challenges and tensions highlighted, the results of the current study suggest that facilitated interdisciplinary joint working can provide opportunities for healthcare works to engage in structured dialogue about preferred methods for treating patients. These could provide substantial learning and development opportunities in terms of commitment to collaboration and development of skills and knowledge for interdisciplinary teamworking. Such opportunities should be deeply exploited.

Finally, one of the goals of Saudi Vision 2030 is developing and improving the healthcare delivery system by enhancing community health status. Moreover, it is predicted that the demand for nurses in Saudi Arabia will be

more than doubled by 2030 due to annual population growth. This shows that approximately 150,000 nursing positions should be filled by 2030 to meet the needs of the population. To accomplish this almost 10,000 new nurses should graduate and be employed each year in Saudi Arabia. As 80% of the nursing workforce are females. Therefore, further research is needed to uncover challenges such as socio-cultural norms, factors enhancing nursing environment in segregated communities, HRM policies and regulations, and empowering nurses in decision making and retaining nurses (Alsufyani et al 2020).

8.8 Implications for practice

Many healthcare organisations support the concept of teamworking, however, the reality is that a few have invested in developing a culture where interdisciplinary teamwork is identified as likely to improve patient outcomes. There is a growing consensus that working practices in Saudi Arabia healthcare will need to change if the objective of developing patient centred health services is to become a reality. This demands commitment to acknowledge and tackle professional organisational barriers and changes, Interdisciplinary teams demonstrated a remarkable capacity to find ways of overcoming or compensating for barriers to teamworking but the Ministry of Health in Saudi Arabia could do more to aid them in this work.

The study suggests that a supportive environment for interdisciplinary teams such as supporting HR practices can help teamworking to work effectively. Prevailing approaches to HRM and the culture within organisations towards

people management profoundly impact upon the operations of teams. When supporting HR practices are weak, HR practices will produce messages that are vague and subject to individual interpretation leading to incompatibility of practice that can affect staff performance (Bartram et al. 2007). Therefore, Teamwork requires significant development efforts and integration to establish a group into an effective team.

Another crucial insight for practice is that context needs to be closely considered to understand the likely impact of teamworking. These practices and systems are likely to vary markedly from one organisation, sector and country to another. For example Incentive systems – both informal and formal - within teams, need to be configured in ways that ensure individuals feel recognised for their specific contributions, whilst also providing motivation and effective reward for the team as a whole (Thompson, 1995, Fiscella and McDaniel, 2019). Organisational structures and strategies such as rewards systems need to be aligned to sustain team functioning.

Other supporting practices can include training and development in how to work in teams and collaborate may help to ensure that those operating within teams understand how such structures are expected to work, whilst the provision of time and capacity to communicate within teams (through regular meetings) may also help team members to work effectively in an interdisciplinary environment. Therefore, facilitating personal development through rewards, opportunities for career development, training and recognition is vital for generating effective teams.

Lack of leadership clarity is also a predictor of lower levels of team effectiveness and is associated with poor quality teamworking. Hence, leaders in healthcare teams need to be assigned and trained in collaborative joint working and decision-making while providing support and supervision to the team members by utilizing communication strategies that promote collaborative decision-making, intra-team communication and effective team processes. Minimising the bureaucracy of the team and autocratic modes of working is fundamental for achieving shared goals, beliefs and decision-making regarding the future of the team and client care. Moreover, teams need to regularly invest time in the process of team development and maintenance of team function to ensure that these skills are enacted and entrenched in their daily practice.

The findings from the study outline the challenges to meeting the requirements of the Strategic Plans for PHC in Saudi Arabia set out by the Ministry of Health. There is evidence that key elements of the 9th and 10th plans have not been achieved by 2020, particularly around integrated patient focused care. Clearer documentation and guidance on minimum standards, and the role of interdisciplinary teamworking within this, are needed to provide a benchmark against which PHC can be measured. In turn, this thesis has shown that there needs to be much closer attention paid to the Saudi PHC context, rather than seeking to implement 'off the shelf' good practice approaches to teamworking in healthcare. It is important for senior management to find ways to modernize and benefit, if possible, from

Western management philosophy, whilst recognizing the cultural and religious context of work, employment and society in Saudi Arabia. This creates many challenges, as this thesis has set out.

8.9 Limitations of the thesis

This study involved one episode of fieldwork. It did not take into account subsequent changes in the organisation after the implementation of the accreditation. Adopting a longitudinal design could have been beneficial for studying the changes in interdisciplinary team dynamics and if joint working has transformed. Whilst this was not feasible for this thesis because of the limited time scale and resources, further longitudinal work might unpack the realities of teamworking over an extended period to explore whether the tensions and contradictions observed can be addressed, or whether new problems and issues emerge over time.

This study relied on interviews as a primary data sources, some information might not be drawn out through interviews, implying the need to incorporate intensive observation which could of uncovered detailed data regarding teamwork dynamics in PHC.

Although, generalisation of findings is argued to be one of the limitations of conducting qualitative research (Murphy et al 1998). It is not the intentions of the case study to make statistical generalisations, but to be an analytical one (Yin 2009). Six primary care centres were investigated in this research, each centre with its own characteristics. Hence, the findings might not be suitable to be used as generalised outcomes for other settings.

Other limitations included the opacity of the accreditation process , the accreditation provided a 'tick in the box' and a means of securing compliance with state goals and aspirations. There were few other measurable or evaluated outcomes, beyond measures of quality of care and safety and risk reduction. Problematically, the accreditation did not involve patients or stakeholders input in any of the standards (Alkenizan and Shaw 2010, Central Board of Accreditation for Healthcare Institutions 2011 p.20.). For front line staff, there were quite cynical views about the rationales behind accreditation and the way that it had been implemented through integrated teamworking.

Finally, future research would benefit from broadening interviews with policy makers involved in policy and planning for PHC in the MOH. Such interviews would generate more in-depth information.

8.10 Conclusion

Primary healthcare has gained attention across the world as an important factor for efficient, effective, and integrated healthcare systems that can improve health and health equity while reducing healthcare costs (Kringos et al., 2010, Strafield et al. 2005). Therefore, working to deliver services based on patients' needs requires healthcare professionals who know not only why they should integrate and work in teams, but more importantly who know how they can work together to achieve integrated interdisciplinary practices. The findings of this study extend and add to the argument that our efforts as practitioners and researchers should focus on exploring ways that professionals work well as teams in distinctive settings.

This study of PHCs in Saudi Arabia has provided crucial evidence relating to the social processes, which contributed to the maintenance and development of interdisciplinary teamwork. In turn, these processes could contribute to achieving and maintaining collaborative interdisciplinary working and contribute to developing patient focused services that must be central to our healthcare service.

List of References

- Acker, J. (1998), "The future of 'gender and organizations': connections and boundaries", Gender, Work & Organization, 5(4), 195-206.

- Ackers, P., 2019. Workplace Participation in Britain, Past, Present, and Future: Academic Social Science Reflections on 40 Years of Industrial Relations Change and Continuity. In The Palgrave Handbook of Workers' Participation at Plant Level (pp. 557-574). Palgrave Macmillan, New York.

- AL-AHMADI, H. & ROLAND, M. 2005. Quality of primary health care in Saudi Arabia: a comprehensive review. International Journal for Quality in Health Care, 17, 331-346.

- Al-Asfour, A., Tlaiss, H., Khan, S. , Rajasekar, J. (2017) Saudi Women's Work Challenges and Barriers to Career Advancement, *Career Development International*, Vol. 22 (2), 184-199. doi: 10.1108/CDI-11-2016-0200

- Al-Balushi, S., Sohal, A.S., Singh, P.J., Al Hajri, A., Farsi, Y.M. and Al Abri, R. (2014), "Readiness factors for lean implementation in healthcare settings – a literature review", Journal of Heath Organization and Management, 28(2), pp. 135-153.

- Al-Hanawi, M.K., 2017. The healthcare system in Saudi Arabia: How can we best move forward with funding to protect equitable and accessible care for all?. International Journal of Healthcare, 3 (2), pp.78-95.

- Al-Otaibi, A.S., 2014. Assessment of Dominant Organisational Cultures Role in Health Care Provision in Riyadh, Saudi Arabia. Middle-East Journal of Scientific Research, 21 (10): 1898-1907

- Albrithen, A. and Yalli, N. (2015) 'Hospital Social Workers in Saudi Arabia: Characteristics and Functions', Social Work in Health Care 54(2) , 158-76.

- Alfaqeeh, G., Cook, E.J., Randhawa, G., Ali, N., 2017. Access and utilisation of primary health care services comparing urban and rural

areas of Riyadh Providence, Kingdom of Saudi Arabia. BMC Health Services Research, 17(106), pp.1-13.

- Alhazemi, A., 2017. Critical Analysis and Current Challenges Facing HRIS Adoption in Arab Countries-the Case of Saudi Arabia. International Journal of Heritage, Tourism and Hospitality, 11(2), pp.143-164.

- ALIMO-METCALFE, B. & ALBAN-METCALFE, R. J. 2001. The development of a new Transformational Leadership Questionnaire. JOURNAL OF OCCUPATIONAL AND ORGANIZATIONAL PSYCHOLOGY, 74, 1-27.

- Alimo-Metcalfe, B., & Alban-Metcalfe, R. J. (2001). Development of the TLQ. Journal of Occupational & Organizational Psychology, 74(1), 1-24.

- Alkabba, A.F., Hussein, G.M., Albar, A.A., Bahnassy, A.A. and Qadi, M., 2012. The major medical ethical challenges facing the public and healthcare providers in Saudi Arabia. Journal of Family and Community Medicine, 19(1), p.1.

- Alsarhani, Khaled (2005) Saudiization and job performance: opportunities and constraints in the management of Saudi national employees in the public sector. PhD thesis, University of Glasgow.

- Alshanbri, N., Khalfan, M., & Maqsood, T. (2015). Localization Barriers and the Case of Nitaqat Program in Saudi Arabia *Journal of Economics, Business and Management, 3*(9), 898-903. doi: 10.7763/JOEBM.2015.V3.305

- Abdulaziz M. Alsufyani, Mohammed A. Alforihidi, Khalid E. Almalki, Sayer M. Aljuaid, Ayman A. Alamri, Mussad S. Alghamdi (2020) 'Linking the Saudi Arabian 2030 vision with nursing transformation in Saudi Arabia: Roadmap for nursing policies and strategies', International Journal of Africa Nursing Sciences, Volume 13, 100256, ISSN 2214-1391

- Appelbaum, E., Bailey, T., Berg, P. and Kalleberg, A.L. (2000). Manufacturing Advantage. Why High- Performance Work Systems Pay Off. New York: Cornell University Press.

- Bacon, N. and Blyton, P. (2003). The impact of teamwork on skills: employee perceptions of who gains and who loses'. Human Resource Management Journal, 13(2), 13-29.

- Bacon, N., & Blyton, P., (2000). High Road and Low Road Teamworking: Perceptions of Management Rationales and Organizational and Human Resource Outcomes. Human Relations, 53(11), 1425-1458.

- Baiden, B.K., & Price, A. D. F., (2011). The effect of Integration on Project Delivery Team Effectiveness. International Journal of Project Management, 29(2), 129-136.

- Baluch, A. M., Salge, T. O., & Piening, E. P. (2013). Untangling the relationship between HRM and hospital performance: The mediating role of attitudinal and behavioural HR outcomes. International Journal of Human Resource Management, 24(16), 3038–3061.

- Banas, P., 1988. Employee involvement: A sustained labor/management initiative at Ford Motor Company. In J. P. Campbell & R. J. Campbell (Eds), Productivity in organizations (pp. 388-416). San Francisco: Jossey-Bass.

- Barker, J. R., 1993. Tightening the Iron Cage: Cpncertive Control in Self-Managing Teams. Administrative Science Quarterly. 38(3), 408-437.

- Barrick, M. R., Stewart, G. L., 1998. Relating member ability and personality to work-team processes and team effectiveness. Journal of Applied Psychology. 83(3), 377-391.

- Bartram, T., Stanton, P., Leggat, S., 2007. Lost in translation: exploring the link between HRM and performance in healthcare. Human Resource Management Journal, 17(1), 21-41.

- Basahal, A., Forde, C., and MacKenzie, R. (2021) 'The role of HR capabilities in external change in Saudi Arabia', Journal of HRM, Volume 9, number 2.

- Batt, R., Doellgast, V., 2006. Groups, Teams, and the Division of

Labor- Interdisciplinary Perspectives on the Organization of Work. n S. Ackroyd, R. Batt, P. ompson, & P. S. Tolbert (Eds.), *The Oxford handbook of work and organization*. New York. Oxford University Press.

- Baxter, S.K., & Brumfitt, S.M. (2008). Benefits and losses: A qualitative study exploring healthcare staff perceptions of team-working. Quality and Safety in Health Care, 17, 127–130.

- Bender, J., Hootegem, G. V., 1999. Teams and their context: Moving the team discussion beyond existing dichotomies, Journal of Management Studies. 36(5), 610-628.

- Benders, J. (1996). "Leaving Lean? Recent Changes in the Production Organization of some Japanese Car Plants." Economic and Industrial Democracy 17: 9-38.

- Benders, J. (2005), 'Team working: a tale of partial participation', in B. Harley, J. Hyman and P. Thompson (eds), Participation and Democracy at Work, Basingstoke: Palgrave Macmillan, pp. 55–74.

- Benton, T., and I. Craib. 2011. Philosophy of Social Science: The philosophical foundations of social thought. England: Macmillan Publishers Limited.

- Blyton, P. and Turnbull, P., 1998. Employee involvement and participation. In The dynamics of employee relations (pp. 217-244). Palgrave, London.

- Boamah, S., 2018. Emergence of informal clinical leadership as a catalyst for improving patient care quality and job satisfaction. Journal of Advanced Nursing, 75(5), 1000-1009.

- Bolton, S. C., 2004. A Simple Matter of Control? NHS Hospital Nurses and New Management, Journal of Management Studies, 41(2), 318-333.

- Borrill C.A., West M.A., Carletta J., Carter A.J., Dawson J.F., Garrod S., Rees A., Richards A., Shapiro D., 2000. The effectiveness of health care teams in the National Health Service. SDO Programme. DOH SDO Programme.

- BORRILL, C. A. & WEST, M. A. 2004. Effective human resource management and patient mortality: a toolkit for use by HR

professionals in the NHS. Birmingham (Aston Business School): Department of Health, NHS Leadership Centre.

- Bos-Nehles, A.C., Van Riemsdijk, M.J. and Kees Looise, J., 2013. Employee perceptions of line management performance: applying the AMO theory to explain the effectiveness of line managers' HRM implementation. Human resource management, 52(6), pp.861-877.

- Boxall, P. and Purcell, J. (2011). 'Strategy and human resource management', London: Palgrave Macmillan.

- Boxall, P., and K. Macky. 2009. "Research and Theory on High-Performance Work Systems: Progressing the High-Involvement Stream." Human Resource Management Journal, 19 (1): 3–23.

- Boxall, P., Huo, M., Macky, K. and Winterton, J. (2019) 'High-involvement work processes and systems: A review of theory, distribution, outcomes and tensions', Research in Personnel and Human Resources Management, 37: 1-52.

- Boxall, P. and Winterton, J. (2018) 'Which conditions foster high-involvement work processes? A synthesis of the literature and agenda for research', Economic and Industrial Democracy, 39(1): 27-47.

- Brandao de Souza, L. (2009), "Trends and approaches in lean healthcare", Leadership in Health Services, 22 (2), pp. 121-39.

- Braverman, H. (1974). Labor and Monopoly Capital. New York: Monthly Review Press.

- Brown, A., Forde, C., Spencer, D. and Charlwood, A., 2008. Changes in HRM and job satisfaction, 1998–2004: Evidence from the Workplace Employment Relations Survey. Human Resource Management Journal, 18(3), pp.237-256.

- Brown, A., Forde, C., Spencer, D. and Charlwood, A., 2008. Changes in HRM and job satisfaction, 1998–2004: Evidence from the Workplace Employment Relations Survey. Human Resource Management Journal, 18(3), pp.237-256.

- Brown, M. and Cregan, C., 2008. Organizational change cynicism: The role of employee involvement. Human Resource Management, 47(4), pp.667-686.

- Brown, M., & Cregan, C., 2008. Organizational change cynicism: The role of employee involvement. Human Resource Management. 14(4), 668- 686.

- Bryman, A. & Bell, E. 2003. *Business research methods*, Oxford, Oxford University Press

- Bryman, A. 1989. *Research Methods and Organisation Studies*, London, Unwin Hyman

- Bryman, A. and Bell, E., 2003. Business research methods. Oxford: Oxford University Press.

- Bryman, A., and E. Bell. 2007. Business Research Methods. New York: Oxford University Press.

- Buchanan, D. (2000) 'An Eager and Enduring Embrace: The Ongoing Rediscovery of a Manage- ment Idea'. In Procter, S. and Mueller, F. (eds) Teamworking. London: Macmillan, pp. 25–42.

- Budhwar, P. & Debrah, Y. (eds) (2004) Human Resource Management in Developing Countries. London: Routledge.

- Buljac-Samardzic, M., Dekker-van Doorn, C. M., van Wijngaarden, J. D. H., & van Wijk, K. P. (2010). Interventions to improve team effectiveness: a systematic review. Health Policy, 94, 183-195.

- Burgess, N., & Randor, Z.,2010. Evaluating lean in healthcare. International Journal of Health Care Quality Assurance, 26(3), 220-235.

- Burke, C.S., Stagl, K.C., Klein, C., Goodwin, G.F., Salas, E. and Halpin, S.M., 2006. What type of leadership behaviors are functional in teams? A meta-analysis. The leadership quarterly, 17(3), pp.288-307.

- Burrel, G., and G. Morgan. 2005. Sociological Paradigms and Organisational Analysis. England: Ashgate Publishing Limited

- BURRELL, G. and MORGAN, G., 1979. Sociological paradigms and organisational analysis: elements of the sociology of corporate life. Aldershot: Gower.

- Cafferkey, K., Dundon, T., Winterton, J. and Townsend, K. (2020) 'Different strokes for different folks: Group variation in employee

outcomes to human resource management', Journal of Organizational Effectiveness: People and Performance, 7(1): 1-19.

- Carasco-Saul, M., Kim, W. and Kim, T., 2015. Leadership and employee engagement: Proposing research agendas through a review of literature. Human Resource Development Review, 14(1), pp.38-63.

- Carmel, S. (2006) Boundaries obscured and boundaries reinforced: incorporation as a strategy of occupational enhancement for intensive care, Sociology of Health and Illness, 28, 2, 154– 77.

- Carter, B., Danford, A., Howcroft, D., Richardson, H., Smith, A. and Taylor, P., 2017. Uncomfortable truths–teamworking under lean in the UK. The international journal of human resource management, 28(3), pp.449-467.

- Cashman, S.B., Reidy, P., Cody, K., Lemay, C.A., 2004. Developing and measuring progress toward collaborative, integrated, interdisciplinary health care teams. Journal of Interprofessional Care 18 (2), 184–196.

- Chang, W.Y., Ma, J.C., Chiu, H.T., Lon, K.C. and Lee, P.H. (2009), "Job satisfaction and perceptions of quality of patient care, collaboration and teamwork in acute care hospitals", Journal of Advanced Nursing, Vol. 65, pp. 1946-55.

- Cherns, A. (1976) 'The principles of sociotechnical design'. Human Relations, 29(8): 783-792.

- Chisholm, R. F. & Ziegenfuss, J. T., 1986. A Review of Applications of the Sociotechnical Systems Approach to Health Care Organizations. The Journal of Applied Behavioral Science. 22(3), 315-327.

- Chuang, E., Dill, J., Morgan, J.D., and Konrad, T.R. (2012), 'A Configurational Approach to the Relationship Between High-Performance Work Practices and Frontline Health Care Worker Outcomes,' Health Services Research, 47, 1460–1481.

- Clegg, C.W., 2000. Sociotechnical principles for system design. Applied ergonomics, 31(5), pp.463-477.

- Cook, G., Gerrish, K., & Clarke, C. (2001). Decision-making in teams: issues arising from two UK evaluations. Journal of Interprofessional

Care, 15(2), 142- 150.

- Cook, H., MacKenzie, R. and Forde, C., 2016. HRM and performance: the vulnerability of soft HRM practices during recession and retrenchment. Human Resource Management Journal, 26(4), pp.557-571.

- Cook, T. ed.1979. Qualitative and quantitative methods in evaluation research. London: Sage Publications Ltd.

- Cott, C. 1998. Structure and meaning in multidisciplinary teamwork. Sociology of Health & Illness, 20(6), 848-873.

- Creswell, J. W. 2007. Qualitative Inquiry and Research Design: Choosing Among Five Traditions, 2nd, Thousand Oaks, Ca, Sage

- Cummings, G., MacGregor, T., Davey, M., Lee, H., Wong, C. A., Muise, M., & Stafford, E. (2010). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. International Journal of Nursing Studies, 47, 363–385.

- Cummings, G.; Midodzi, W.; Wong, C.; Estabrooks, C. The contribution of hospital nursing leadership styles to 30-day patient mortality. Nurs. Res. 2010, 59, 331–339

- Cummings, G.G., Midodzi, W.K., Wong, C.A., Estabrooks. (2010). 'The Contribution of Hospital Nursing Leadership Styles to 30-day Patient Mortality'. Nursing Research, 59(5): 331-339.

- D'Angelo R, Zarbo RJ., 2007.The Henry Ford production system: Measures of process defects and waste in surgical pathology as a basis for quality improvement initiatives. American Journal Clinocal Pathology,128(3),423-429.

- Darzi, A.W. (2008), High Quality Care for All: NHS Next Stage Review, Department of Health, London.

- Darzi, A.W. (2008), High Quality Care for All: NHS Next Stage Review, Department of Health, London.

- Day, D.V., Gronn, P. and Salas, E., 2004. Leadership capacity in teams. The Leadership Quarterly, 15(6), pp.857-880.

- Delarue, A., Van Hootegem, G., Procter, S. and Burridge, M., 2008. Teamworking and organizational performance: a review of survey-based research. International Journal of Management Reviews, 10(2), pp.127-148.

- Deneckere, S. M., Euwem, M., Van Herck, P., Lodewijckx, C., Panella, M., Sermeus, W., & Vanhaecht, K. (2012). Care pathways lead to better teamwork: Results of a systematic review. Social Science & Medicine, 75(2), 264-268.

- Denzin, N. K. & Lincoln, Y. S. 2000. Introduction: The discipline and practice of qualitative research. *In:* Denzin, N. K. & Lincoln, Y. S. (eds.) *Handbook of qualitative research.* 2nd ed. Thousand Oaks, CA: Sage.

- Denzin, N. K. & Lincoln, Y. S. 2000. Introduction: The discipline and practice of qualitative research. In: Denzin, N. K. & Lincoln, Y. S. (eds.) Handbook of qualitative research. 2nd ed. Thousand Oaks, CA: Sage.

- Downey, M., Parslow, S., & Smart, M. (2011). The hidden treasure in nursing leadership: Informal leaders. Journal of Nursing Management, 19(4), 517–521.

- Dundon, T. and Rafferty, A., 2018. The (potential) demise of HRM?. Human Resource Management Journal, 28(3), pp.377-391.

- Edwards, P. (1990). 'Understanding conflict in the labour process: the logic and autonomy of struggle'. In D. Knights and H. Willmott (eds.), *Labour Process Theory*. London: Macmillan, pp. 125–52.

- Edwards, P. 2005. 'The challenging but promising future of industrial relations: developing theory and method in context-sensitive research', Industrial Relations Journal 36(4): 264–82.

- Edwards, P., K, O'Mahoney, J., Vincent, S. (2014). Studying Organizations Using Critical Realism: A Practical Guide. Oxford. Oxford Press

- Evans, W. R., & Davis, W. D. 2005. High-performance work systems and organizational performance: The mediating role of internal social structure. Journal of Management, 31. 758-775.

- Farr, M., & Cressey, P., (2015). Understanding staff perspectives of

quality in practice in healthcare.

- Feitosa J., Fonseca A. (2020) Teamwork: Education and Training in Healthcare. In: Paige J., Sonesh S., Garbee D., Bonanno L. (eds) Comprehensive Healthcare Simulation: InterProfessional Team Training and Simulation. Comprehensive Healthcare Simulation. Springer, Cham. https://doi.org/10.1007/978-3-030-28845-7_4

- Fillingham, D. (2007), "Can lean save lives?", Leadership in Health Services, 20(4), pp. 231-241

- Finn, R., Learmonth, M., Reedy, Patrick. 2010, some unintended effects of teamwork in healthcare. Social Science & Medicine. 70, 1148-1154.

- Firth-Cozens, J. (2001), "Cultures for improving patient safety through learning: the role of teamwork", Quality in Health Care, 10(2), Supplpp.26-31.

- Firth-Cozens, J. (2001), "Cultures for improving patient safety through learning: the role of teamwork", Quality in Health Care, 10(2),26-31.

- Fiscella, K. and McDaniel, S.H., 2018. The complexity, diversity, and science of primary care teams. American Psychologist, 73(4), p.451.

- FLEETWOOD, S. and HESKETH, A., 2006. HRM-Performance research: under-theorized and lacking explanatory power. International Journal of Human Resource Management. 17(12), pp. 1977-1993.

- Forest J, Sousa M. 2006.Oil and terrorism in the New Gulf: framing US Energy and security policies for the Gulf of Guinea. Lanham: Lexington.

- Freeman, M., & Miller, C., & Ross, N. (2000). The impact of individual philosophies of teamwork on multi- professional practice and the implications for education. Journal of Interprofessional Care, 14, 237 – 247.

- Friedman, A. (1977). Industry and Labour: Class struggle at work and monopoly capitalism. London: Macmillan.

- Giddens, A. 1986. The constitution of Society. Oxford: Basil Blackwell Ltd.

- Glasser, B. and Strauss, A., 1967. The discovery of grounded theory: strategies for qualitative research. Chicago: Aldine.

- Grant, R., & Finocchio, L. (1995). Interdisciplinary collaborative teams in primary care: A model curriculum and resource guide. San Francisco, CA: Pew Health Professions Commission.

- Grumbach K, Bodenheimer T., 2004. Can health care teams improve primary care practice? JAMA. 291(10), 1246-1251.

- Gunnar, A. 1994. Criticism and the History of Science: Kuhn's, Lakatos's and Feyerabend's Criticisms of Critical Rationalism. Netherlands: EJ. Brill.

- Hamel, J., Dufour, S. and Fortin, D., 1993. Case study methods. London: Sage Publications.

- Hammersley, M. 1992. What's Wrong with Ethnography?, London, Routledge

- Harley, B. (2001). 'Team membership and the experience of work in Britain: an analysis of the WERS98 data'. *Work, Employment and Society*, 15 (4): 721–42.

- Harley, B., Belinda, C., Allen and Leisa, D Sargent. (2007). 'High performance work systems and employee experience of work in the service sector: The case of the aged care'. British Journal of Industrial Relations, 45(3): 607-633.

- Harris, C., Cortvriend, P., Hyde, P., (2007). Human resource management and performance in healthcare organisations. Journal of Health Organization and Management, 21(4/5), 448-459.

- Harteloh, P. P. M., 2003, Quality systems in health care: a sociotechnical approach. Health Policy. 64, 391-398.

- Hoopes, D. & Postrell., S. (1999). Shared knowledge, "glitches" and product development performance. Strategic Management Journal, 20, 837-865.

- Hootegem, G. V., Benders, J., Delarue, A., Procter, S., 2005. Teamworking: looking back and looking forward. Human Resource Management, 16(2), 167-173.

- Hyde, P., McBride, A., Young, R. and Walshe, K. (2005), "Role

redesign: new ways of working in the NHS", Personnel Review, 34 (6), 697-712.

- Institute of Medicine (IOM). (2011). The future of nursing: Leading change, advancing health. Washington, DC: The National Academies Press.

- Joint Commission (2009), "Patient safety goals", available at: www.jointcommission.org/ standards_information/npsgs.aspx

- Kanter, R.M. 1979. "Power Failure in Management Circuits." *Harvard Business Review* 57(4): 65–75.

- Kasi, P. M. 2009. Research: What, Why, and How?: A treatise from researchers to researchers. USA: Author House.

- Kelly AM, Bryant M, Cox L., Jolley, D. 2007. Improving emergency department efficiency by patient streaming to outcomes-based teams. Australian Health Review.31(1),16-21.

- Kennedy, Professor Sir Ian (2006). Learning from Bristol: are we? London: The Healthcare Commission.

- Khawam, A.M., DiDona, T. and Hernández, B.S., 2017. Effectiveness of teamwork in the workplace. International Journal of Sciences: Basic and Applied Research (IJSBAR), 32(3), pp.267-286.

- Kiffin-Petersen, S. and Cordery, J., 2003. Trust, individualism and job characteristics as predictors of employee preference for teamwork. International Journal of Human Resource Management, 14(1), pp.93-116.

- Knights, D. and McCabe, D., 2000. Bewitched, bothered and bewildered: The meaning and experience of teamworking for employees in an automobile company. Human Relations, 53(11), pp.1481-1517.

- KUHN, T., 1970. The structure of scientific revolutions. 2nd edn. Chicago: University of Chicago Press.

- Leathard A. (1994) Going Inter-Professional. Working Together for Health and Welfare. Routledge, London.

- Leggat, S. G., (2007). Effective healthcare teams require effective team members: defining teamwork competencies. BMC Health Service Research, 7(17).

- Legge, K., 1995. What is human resource management?. In Human resource management (pp. 62-95). Palgrave, London.

- Lemieux-Charles, L., & McGuire, W. L. (2006). What do we know about health care team effectiveness? A review of the literature. Medical Care Research & Review, 63, 263-300.

- Lemieux-Charles, L., M. Murray, G. R. Baker, J. Barnsley, K. Tasa, and A. I. Salahadin. 2002. The effects of quality improvement practices on team effectiveness: A meditational model. *Journal of Organizational Behavior* 23:533-53.

- Leonard, M., Graham, S., Bonacum, D. 2004. The human factor: the critical importance of effective teamwork and communication in providing safe care. BMJ Quality and Safety. 13(1), 185-190.

- Lepak, D.P. and Snell, S.A. (1999), "The human resource architecture: Toward a theory of human capital allocation and development", Academy of Management Review, Vol. 24 No.

- 1, pp. 31-48.

- Lincoln, Y. S. & Guba, E. G. 1985. *Naturalistic Inquiry*, Beverly Hills, SAGE Publications

- Littler, C.R. (1978). 'Understanding Taylorism'. British Journal of Sociology, 29 (2): 185-202.

- Lopez-Cabrales, A., Valle, R. and Herrero, I. (2006), "The contribution of core employees to organisational capabilities and efficiency", Human Resource Management, Vol. 45 No. 1, pp. 81-109.

- Lucio, M., Jenkins, S., Noon, M., Management strategy, union identity and oppositionalism: Teamwork in the Royal Mail. In S. Procter and F. Mueller (Eds), Teamworking. Basingstoke: Macmillan, 2000, pp. 262-79.
M., & Patelarou, E. (2017). Importance of leadership style towards quality of care measures in healthcare settings: A systematic review. 5(4),74

- Manser, T., 2009. Teamwork and patient safety in dynamic domains of healthcare: a review of the literature. Acta Anaesthesiol Scand.53, 143-151.

- Marchington, M., Wilkinson, A., Ackers, P. and Goodman, J., 1993. The influence of managerial relations on waves of employee involvement. British Journal of Industrial Relations, 31(4), pp.553-576.

- Mazzocato, P., Savage, C., Brommels, M., Aronsson, H. and Thor, J. (2010), "Lean thinking in healthcare: a realist review of the literature", Quality and Safety in Health Care, 19(5), pp. 376-382.

- McClean, E. and Collins, C.J. (2011), "High-commitment HR practices, employee effort, and firm performance: Investigating the effects of HR practices across employee groups within professional services firms", Human Resource Management, Vol. 50 No. 3, pp. 341-363.

- McCracken, G., 1988. The long interview. London: Sage.

- McGovern, P., Gratton, L., Hope-Hailey, V., Stiles, P. and Truss, C., 1997. Human resource management on the line?. Human Resource Management Journal, 7(4), pp.12-29.

- Mellahi, K. and Wood, G. (2001) 'Human resource management in Saudi Arabia', in Budhwar, P.S. and Debrah, Y.A. eds., 2001. *Human resource management in developing countries*. Routledge.

- Mellahi, K. and Wood, G.T., 2001. Human Resource Management in Saudi Arabia in Budwhar and Debrah (2001) eds, Human resource management in developing countries, 5, p.135-149.

- Meteb, A.M., 2017. Unemployment and Economic Growth in Saudi Arabia 2000-2015. *International Journal of Economics and Finance*, 9(9), pp.83-93.

- Mickan, S. and Rodger, S., 2000. The organisational context for teamwork: comparing health care and business literature. Australian Health Review, 23(1), pp.179-192.

- Miles, M. B. & Huberman, A. M. 1994. *Qualitative data analysis: An expanded source book,* 2nd, Thousand Oaks, CA, Sage

- MILLER, C., ROSS, N. & FREEMAN, M. 1999. The role of collaborative/shared learning in pre- and post-registration education in nursing, midwifery and health visiting. English National Board for Nursing, Midwifery and Health Visiting.

- Millward, L, J. & Jeffries, N. (2001). The team survey: a tool for health care team development. Methodological Issues In Nursing Research, 35(2), 276-287.

- Mishra, M. and Pandey, A., 2019. The impact of leadership styles on knowledge-sharing behavior: a review of literature. Development and Learning in Organizations: An International Journal.

- Mobaraki, A.E.H., and Soderfeldt, B., 2010. Gender inequity in Saudi Arabia and its role in public health. Eastern Mediterranean Health Journal, 16 (1), pp.113-118.

- Mohman, S.A., Cohen, S.G. & Mohrman, A.M.,1995. Designing Team-Based Organizations. San Francisco: Jossey-Bass.

- Molyneux, J. (2001). Interprofessional teamworking: what makes teams work well? Journal of Interprofessional Care, 15(1), 30 – 35.

- Morgeson, F.P., DeRue, D.S. and Karam, E.P., 2010. Leadership in teams: A functional approach to understanding leadership structures and processes. Journal of management, 36(1), pp.5-39.

- Mueller, F., Procter, S. and Buchanan, D. (2000). Teamworking in its context(s): antecedents, nature and dimensions. Human Relations, 53, 1387– 1424.

- Mueller, F., Procter, S. and Buchanan, D., 2000. Teamworking in its context (s): Antecedents, nature and dimensions. Human Relations, 53(11), pp.1387-1424.

- Mumford, E., 2006. The story of socio-technical design: reflections on its successes, failures and potential. Information System Journal. 16, 317-342.

- Mustapha M. Achoui (2009) Human resource development in Gulf countries: an analysis of the trends and challenges facing Saudi Arabia, Human Resource Development International, 12:1, 35-46

- Nancarrow S, Enderby P, Ariss S, Parker SG, Campbell M: Enhancing the effectiveness of interdisciplinary team working.

Southampton: National Institute of Health Research, Service Delivery and Organisation; 2012.

- Nancarrow, S., & Borthwick, M. (2005). Dynamic professional boundaries in the healthcare workforce. Sociology of Health and Illness, 27(7), 817–919.

- Nancarrow, S.A., Booth, A., Ariss, S. et al. Ten principles of good interdisciplinary team work. 2013. Human Resource for Health, 11, 19.

- Nawaz, Z.A.K.D.A. and Khan_ PhD, I., 2016. Leadership theories and styles: A literature review. Leadership, 16(1), pp.1-7.

- Nelson, K., & Cooprider, G. (1996). The contribution of shared knowledge to IS group performance. MIS Quarterly, December, 409-432.

- Ogbonna, E. and Whipp, R., 1999. Strategy, culture and HRM: Evidence from the UK food retailing sector. Human Resource Management Journal, 9(4), pp.75-90.

- Oliver, N., Delbridge, R. and Lowe, J. (1998) 'Japanization on the shopfloor', Employee Relations, 20(3), pp.248–260.

- Opie, A. 1997. Effective teamwork in health care: A review of issues discussed in recent research literature. Health Care Analysis, 5 (1), 62-73.

- Paauwe, J., and Boselie, P. (2005), 'Best Practices... In spite of Performance: Just a Matter of Imitation?, International Journal of Human Resource Management, 16, 6, 987–1003.
Palgrave, London.

- Pasmore, W., & Friedlander, F., 1982. An Action-Research Program for Increasing Employee Involvement in Problem Solving. Administrative Science Quarterly. 27(3), 343-362.

- Patton, M., 1987. How to use qualitative methods in evaluation. London: Sage.

- Payne, M., 2000. Teamwork in Multiprofessional Care.

- Pescosolido, A. T. 2002. Emergent leaders as managers of group emotion. Leadership Quarterly, 13: 583-599.

- Peters, L. H., O'Connor, E. J., 2001. Informal Leadership Support: An

Offten Overlooked Competitive Advantage. Physician Executive Leadership.27(3), 35-39.

- Pethybridge, J. (2004). How team working influences discharge planning from hospital: a study of four multi- disciplinary teams in an acute hospital in England. Journal of Interprofessional Care, 18(1), 29 – 41.

- Pielstick, C. D., 2000. Formal vs Informal Leading A Comparative Analysis. The Journal of Leadership Studies, 7(3).100-114.

- Poulton, B. C., West, M. A., 1999. The determinants of effectiveness in primary health care teams. Journal of Interprofessional Care. 13(1), 7-18.

- Procter, S. and Radnor, Z., 2014. Teamworking under Lean in UK public services: lean teams and team targets in Her Majesty's Revenue & Customs (HMRC). The International Journal of Human Resource Management, 25(21), pp.2978-2995.

- Procter, S., and Mueller, F. (2000). 'Teamworking: Strategy, Structure, Systems and Culture', in S. Proctor and F. Mueller (eds.), Teamworking. London: Macmillan.

- Propp, K., M., Apker, J., Ford, W. S. Z., Wallace, N., Serbenski, M. 2010. Meeting the Complex Needs of the Health Care Team :Identification of Nurse- -Team Communication practices perceived to Enhance patient outcomes. Qualitative Health Research, 20(1), 15-28.

- Pruijt, H. (2003). 'Teams between neo-Taylorism and anti-Taylorism' 24(1): 77-101.

- Purcell, J. and Hutchinson, S., 2007. Front-line managers as agents in the HRM-performance causal chain: theory, analysis and evidence. Human Resource management journal, 17(1), pp.3-20.

- Purcell, J., Kinnie, N., Hutchinson S., Rayton B., & Swart, J. (2003). Understanding the people and performance link: unlocking the black box. London.

- Ramsay, H., Scholarios, D. and Harley, B. (2000). 'Employees and high-performance work systems: testing inside the black box'. *British Journal of Industrial Relations*, 28 (4): 501–31.

- Ramsay, H., Scholarios, D. and Harley, B., 2000. Employees and

high-performance work systems: Testing inside the black box. British Journal of industrial relations, 38(4), pp.501-531.

- Reeves, S., Zwarenstein M, Goldman J, Barr H, Freeth D, Koppel I, Hammick M: The effectiveness of interprofessional education: key findings from a new systematic review. J Interprof Care 2010, 24:230–241.

- Renwick, D. (2003). HR managers, guardians of employee wellbeing?, Personnel Review, 32(3), 341-359.

- Sadi, M. A., & Henderson, J. (2010). Towards Job Localization in Saudi Arabia: Drivers and Barriers within the Services Industry. *Journal of Immigrant & Refugee Studies, 8*(2), 121-134.

- Salas, E., King, H. B., Rosen, M. A., Improving teamwork and safety: Toward a practical systems approach, a commentary on Deneckere et al. 2012. Social Science & Medicine. 75, 986-989.

- Sangaleti, C., Schveitzer, M.C., Peduzzi, M., Zoboli, E.L.C.P. and Soares, C.B., 2017. Experiences and shared meaning of teamwork and interprofessional collaboration among health care professionals in primary health care settings: a systematic review. JBI database of systematic reviews and implementation reports, 15(11), pp.2723-2788.

- SAUNDERS, M., LEWIS, P. and THORNHILL, A., 2003. Research methods for business students. 3rd edn. Harlow: Financial Times Prentice Hall.

- Saunders, M., P. Lewis, A. Thornhill. 2007. Research Methods for Business Students. England: Pearson Education Limited.

- Sayer, A. 2000. Realism and Social Science. London: SAGE publications Inc.

- Scott J, 1990. A matter of record: documentary sources in social research. Cambridge: Polity Press.

- Seale, C., ed, 2004. Researching society and culture. 2nd edn. London: Sage.

- Sewell, G., 1998. The Discipline of Teams: The Control of Team-

Based Industrial Work through Electronic and Peer Surveillance. Administrative Science Quarterly. 43(2), 397-428.

- Sfantou, D., Laliotis, A., Patelarou, A., Sifaki-Pistolla, D., Matalliotakis,

- Sidani, Y. (2005). Women, work, and Islam in Arab societies. *Women in Management Review, 20*(7), 498-512. doi: 10.1108/09649420510624738

- SILVERMAN, D. 2010. Doing qualitative research : a practical handbook. 3rd ed. ed. London: SAGE.

- Smith T, Cross E, Booth A, Ariss S, Nancarrow S, Enderby PM, Blinston A: Interdisciplinary management tool - workbook. Southampton: National Institute of Health Research Service Delivery and Organisation Program; 2012.

- Smith, M.G. 1960. Government in Zazzau: 1800-1950. New York: Oxford University Press.

- Somé, N.H., Devlin, R.A., Mehta, N., Zaric, G.S. and Sarma, S., 2020. Team-based primary care practice and physician's services: Evidence from Family Health Teams in Ontario, Canada. Social Science & Medicine, 264, p.113310.

- Sommers, L.S., Marton, K.I., Barbaccia, J.C. & Randolph, J. (2000). Physician, nurse and social worker collaboration in primary care for chronically ill seniors, Archives of Internal Medicine, 160, 1825-1833.

- Stark, S., Stronach,I., Warne,T.,Skidmore,D., Cotton,A. and Montgomery.M. (2000). Teamworking in Mental Health: Zones of Comfort and Challenge. Researching Professional Education. London, English National Board for Nursing, Midwifery and Health Visiting.

- Stewart, G.L. and Barrick, M.R. (2000). Team structure and performance: assessing the mediating role of intra-team process and the moderating role of task type. Academy of Management Journal, 43, 135 –148.

- Stincelli, E., & Baghurst, T., 2014. A Grounded Theory Exploration of Informal Leadership Qualities as Perceived by Employees and Managers in Small Organizations. International Journal of Business Management and Economic Research, 5(1), 1-8.

- Stoelwinder, J. U., & Clayton, P. S., 1978. Hospital Organization Development Changing the Focus from "Better Management' to "Better Patient Care", The Journal of Applied Behavioral Science. 14(3), 400-414.

- Storey, J. (2007). Human Resource Management: A Critical Text, 3rd edn, London: Thomson.

- Strauss, A. and Corbin, J., 1998. Basics of qualitative research. 2nd ed. Thousand Oaks, CA: Sage.

- Suganthi, L., & Samuel, A. (2004). Total quality management. New Delhi: Prentice Hall.

- Syed, J., Ali, F., & Hennekam, S. (2018). Gender equality in employment in Saudi Arabia: A relational perspective. *Career Development International, 23, 2,* Doi: 10.1108/CDI-07-2017-0126,

- Taylor, S.J., and R. Bogdan. 1998. Introduction to qualitative research methodology. Canada: John Wiley & Sons,Inc.

- Temkin-Greener, H.(1983), Interprofessional perspectives on teamwork in health care: a case study, Milbak Memorial Fund Quartarly, 61(4), 641-58.

- Thompson, P. (1995) Teamworking and Pay, Institute of Employment Studies, Research Report: https://www.employment-studies.co.uk/system/files/resources/files/281.pdf

- Thorpe, R., and R. Holt. 2008. The Sage Dictionary of Qualitative Management Research. London: SAGE publications Inc.

- Vallas, S. P., 2003. Why Teamwork Fails: Obstacles to Workplace Change in Four Manufacturing Plants. American Sociological Review, 68(2), 223-250.

- Van de Voorde, K., & Beijer, S. (2015). The role of employee HR attributions in the relationship between high performance work systems and employee outcomes. Human Resource Management Journal, 25(1), 62-78.

- Van der Vegt, G. S., & Bunderson, J. S. (2005). Learning and performance in multidisciplinary teams: The importance of collective team identifi- cation. Academy of Management Journal, 48(3), 532–

547.

- Vidal, M., 2007. Manufacturing empowerment?'Employee involvement'in the labour process after Fordism. Socio-economic review, 5(2), pp.197-232.

- Wall, T. D., & Wood, S. J., (2005). The romance of human resource management and business performance, and the case for big science. Human Relations, 58(4), 429-462.

- Wall, T.D., Kemp, N.J., Jackson, P.R. and Clegg, C.W., 1986. Outcomes of autonomous workgroups: A long-term field experiment. Academy of Management journal, 29(2), pp.280-304.

- Weerawardena, J., R., M. & Sullivan Mort, G. 2010. Sustainability of nonprofit organizations: An empirical Investigation. *Journal of World Business,* 45:4**,** 346-356.

- West, M.A. and Lyubovnikova, J., 2013. Illusions of team working in health care. Journal of health organization and management.

- West, M.A., Borrill, C., Dawson, J., Scully, J., Carter, M., Anelay, S., Patterson, M., Waring, J., 2002. The link between the management of employees and patient mortality in acute hospitals. International Journal of Human Resource Management 13 (8), 1299–1310.

- West, M.A., Borrill, C.S. & Unsworth, K. (1998). Team Effectiveness in Organisations. In C.L. Cooper & I.T. Robertson (eds) International Review of Industrial Organisational Psychology. Vol 13. Wiley & Sons: Chichester.

- West, M.A., Guthrie, J.P., Dawson, J.F., Borrill, C.S. and Carter, M. (2006), "Reducing patient mortality in hospitals: the role of human resource management", Journal of Organizational Behavior, 27, 983-1002.

- Whitfield, K., 2000. High-performance workplaces, training, and the distribution of skills. Industrial Relations: A Journal of Economy and Society, 39(1), pp.1-25.

- WHO (2020) Primary health care on the road to universal health coverage. Geneva: World Health Organization; 2019. Available from: https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf

- Wiles R., Robison J., 1994. Teamwork in primary care: the views and experiences of nurses, midwives and health visitors. Journal of Advanced Nursing, 20:324–330.

- Wilkinson, A., Townsend, K. and Burgess, J., 2013. Reassessing employee involvement and participation: Atrophy, reinvigoration and patchwork in Australian workplaces. Journal of Industrial relations, 55(4), pp.583-600.

- Wilkinson, A., Witcher, B., 2006. Holistic total quality management must take account of political processes. Total Quality Management, 4(7), 47-56.

- WILLIAMS, S. 2005. Evidence of the contribution of leadership development for professional groups makes in driving their organisations forward. London: Department of Health, Modernisation Agency.

- Winterton, J. (1994) 'Social and technological characteristics of coal-face work: A temporal and spatial analysis'. Human Relations, 47(1): 89-118.

- WOOD, S., 1999. Human resource management and performance. International Journal of Management Reviews, 1(4), pp. 367.

- World Bank (2020) Labour market Statistics on Saudi Arabia, available

- at: https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=SA

- Xyrichis A, Lowton K (2008) What fosters or prevents interprofessional teamworking in primary or community care? A literature review. Journal of Nursing Studies, 45: 140-143. 10.1016/j.ijnurstu.2007.01.015.

- Xyrichis A, Ream E (2007) Teamwork: a concept analysis. Journal of Advanced Nursing 61: 232-241. 10.1111/j.1365-2648.2007.04496.x.

- Yin, R., 2009. Case study research: design and methods. 4th edn. London: Sage.

- Young, T. and McClean, S. (2008), "A critical look at lean thinking in healthcare", Quality and Safety in Health Care, 17. 5, pp. 382-386.

Appendix A

DRAGOMAN

Infrastructure and Resources (Medical and Non-Medical Equipment)

	Completed		Incomplete		Requirement	
	Completed		Incomplete		Requirement	
	Completed		Incomplete		Requirement	
	Completed		Incomplete		Requirement	
Recommendations						

Second: Administrative Standards (Administrative Discipline)

Center Manager	Available	4	Unavailable	0	Total Grades	Statement of Attendance	Closed	4	Non-closed	0
Registration of violators	Complete	4	Incomplete	0		Distribution of tasks	Compliance	2	Non-compliance	0
Statement of employees	Attached	4	Not attached	0		Organizational structure	Compliance	2	Non-compliance	0
Permission papers	Existing	4	Non-existing	0		Submitted Violations	Monthly	2	Not monthly	0
Vacation copies	Attached	4	Not attached	0		Compliance of the existing employees	Compliance	2	Non-compliance	0
Vision and mission	Significant	4	Non-significant	0		Patient rights	Significant	2	Non-significant	0
Suggestion box	Existing	4	Non-existing	0		Patient relations	Existing	2	Non-existing	0
Employees' files	Complete	4	Incomplete	0		Job Description	For everyone	4	For some	0
Recommendations										
Excellent	52	–	47	Good	47	–	36	Average	36	–	31	Weak	31	Total	

Administrative Standards (Teamwork)

Meetings	Monthly	2	Not monthly	0	Total Grades	Work plan	Compliance	2	Non-compliance	0
Minutes of the meeting	Compliance	2	Non-compliance	0		Follow up on the plan	Existing	2	Non-existing	0
Employee participation	Notice	2	Unnoticed	0		Familiarity with the plan	Existing	2	Non-existing	0
Departments plan	Existing	2	Non-existing	0						
Excellent	14	–	13	Good	13	–	10	Average	10	–	8	Weak	8	Total	
Recommendations										

Administrative Standards (Community Participation)

Existence of the commission	Existing	2	Non-existing	0	Total Grades	Society representation	Represent	2	Non-represent	0
Meetings	Periodic	2	Non-periodic	0		Minutes of the meeting	Compliance	2	Non-compliance	0
Participation	Existing	2	Non-existing	0		Support the center	Complete	2	Incomplete	0
Recommendations										
Excellent	12	–	11	Good	11	–	8	Average	8	–	7	Weak	7	Total	

Administrative Standards (Training)

Existence of the program	Existing	2	Non-existing	0	Total Grades	Subjects	Comprehensive	2	Incomprehensive	0

DRAGOMAN

Appendix B

Interview questions for interdisciplinary team members.

---

1. What is your background?
   - Occupational background.
   - Contractual arrangement.
   - Length of service.

2. What is you position in this organization?
   - Hierarchical power
   - Status

3. How long have you worked in this organisation?
1. Tenure

4. Do your work in teams?

5. How many members are in your team?

6. To which team do you belong?
   - Team membership to which team?
   - Do you feel part of a team?
   - Do you work by yourself?

7. How well do you work with your team members?
   - Is there regular communication?
   - Do you feel integrated with your team?
   - Do you feel isolated from the team? If yes, how?

8. Are there meetings between your team members?
   - How many meetings per month do you conduct meetings?
   - Do all members of your team meet regularly?

9. What do you discuss during your team meetings?
   - Do you discuss future goals and objectives?
   - What other topics do you go through during your meetings?

10. Do you set goals during you meetings?
    - Do you revisit these goals?

- Do you evaluate team goals?

11. What are the benefits of interdisciplinary teamwork?
- Can you give an example from your personal experience?

12. What are the disadvantages of interdisciplinary teams?
- Can you give an example from your personal experience?

13. Does segregation between male and female employee effect teamwork in the centre?
- Can you explain how it hinders teamwork?

14. Do you believe that teamwork is important for your organisation?
- Why do you think it is important?

15. Does teamwork improve your performance?
- How does it improve your performance?

16. Do you prefer working in a team?
- Why do you prefer working with your team?

17. Does your organisation encourage teamwork?
- Does it provide teamwork performance feedback
- Does it provide training in teamwork?
- Does it provide incentives to encourage teamwork in your centre?
- Does the organisation support teamwork?
- How does the organisation support teamwork?

Appendix C

<u>Consent Letter</u>

UNIVERSITY OF LEEDS

LEEDS UNIVERSITY BUSINESS SCHOOL

	Add your initials next to the statements you agree with
I confirm that I have read and understand the information sheet/ letter dated on………….. explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. Contact number of lead researcher: …………………………………….	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential.	
I agree for the data collected from me to be used in relevant future research.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change.	

Name of participant	
Participant's signature	
Date	
Name of lead researcher	
Signature	
Date*	

*To be signed and dated in the presence of the participant.

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/ pre-written script/ information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.

Appendix D

Invitation Letter to Employees in Primary Care Centres

LEEDS UNIVERSITY BUSINESS SC [WORK & EMPLOYMENT RELATIONS DIVISON]

Date: ………………………………

Dear Sir/ Madam,

This letter is an invitation to consider participating in a study I am conducting as part of my PhD degree in the Department of Work and Employment Relations at Leeds University Business School under the supervision of Professor Christopher J. Ford.

I would like to provide you with more information about this research and what participant's involvement would entail if they decide to take part. Participation in this study is voluntary, it will involve an interview of approximately 45 minutes in length to take place in a mutually agreed upon location. You may decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study at any time without any negative consequences by advising the researcher. With your permission only, the interview will be audio recorded to facilitate collection of information, and later transcribed for analysis. The data will be stored securely with an anonymous code. All data will be handled, processed, stored and destroyed by the research team. All data collected from you will be anonymised and given a unique identifier. Only the research team will have access to the data. If your interview is conducted in Arabic the anonymised transcripts will be translated by the researcher. However no personal data including your name or job or work location will appear in the transcript.

The Study:

In 1978 a global need was recognized, when Alma-Ata declaration on primary care that supported the collaboration between health and social care professionals and agencies into working together with local communities to improve service delivery, in order to promote public health and wellbeing (WHO 1978). In accordance with the Alma-Ata declaration Saudi Arabia identified the need for teamwork in healthcare delivery (Al-Ahmadi, Roland 2005). Teamwork is even acknowledged as a set in the values and principles that govern the work in all MOH facilities (MOH 2012). Therefore, teams have been hailed as the cornerstone of medical care, enabling healthcare organization to produce safe and effective care (Firth-Cozens 2001, Propp et al. 2010). Considerable attention has been placed on how interdisciplinary teams can improve quality of care, professional relationships and collaboration. Consequently, improved teamwork is becoming an aspiration of health and social care practitioners, managers and organisations. This study of perception, structure of interdisciplinary primary health care teams and human resource practices was conducted to better understand teamwork in health care and how they function in a segregated organisation.

Given this context, the purpose of this study is to address Multi-professional teams capabilities in primary care centers as well as understanding the conditions that supports or hinders it. Participation in this study is voluntary; it will involve interviews with line managers and interdisplinary team members in primary care centres (i.e. doctors, nurses, allied medical staff and receptionist).

Confidentiality and Data protection

- No sensitive data will be requested, any participants may decline to answer any of the interview questions if they wish. Further, they may decide to withdraw from this study at any time without any negative consequences by advising the researcher.
- The participants name or the company name will NOT appear in any thesis or report resulting from this study. Data will be used synonymously. The information obtained will be used for research purposes only and will be treated confidentially and will not be seen by anyone except the researcher. All information you provide is considered completely confidential. Your name will not appear in any thesis or report resulting from this study, however, with your permission anonymous quotation may be used.

- Data collected during my study will be retained for three years after the data collection in my account at university local drive. Only researcher associated with this project will have access.
- Any findings displayed in the thesis will be presented in a synthesised findings and conclusions without giving any reference or indication to any company
- There are no known or anticipated risks to any participants from your company or anticipated risks to the company name in this study.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me at …………………… or by email at ………………….. . You can also contact my supervisor, at ……………………. or email ………………

Kind Regards,

……………………………………..

Lead Researcher

…………………………………….

Email:

Mobile no:

Appendix E

Kingdom of Saudi Arabia General Administration for Health Centers and Programs Affairs Northern Health Sector Prince Sultan Health Center //Logo of Ministry of Health//	Department: TQM	Page: 1 of 2
	Index Number: TQM-JD-008	Issue Date: 03/11/1434
Title: Medical Supervisor in the Women's Department		Review Date: 03/11/1437

1- **Section**: Center Administration.

2- **Job Title**: Medical Supervisor in the Women's Department.

3- **Organizational Relationship**:

3.1 Responsible before: Administratively the center's manager and medically the center's medical director.

3.2 Responsible for: All female employees in the Women's Department.

4. **Job Responsibilities**:

4.1 Administratively supervise the Women's Department at the Health Center.

4.2 Participate in preparing the annual plan to supervise the Women's Department.

4.3 Pay the attention to some administrative aspects; such as discipline in work and observance of uniform.

4.4 Review the job performance reports of the Department's employees and signing these reports as amended, if necessary.

4.5 Study and audit the statistics and periodic reports (weekly = or monthly) received from the departments, and then submit the necessary ones to the medical director.

4.6 Coordinate with the center's manager on an ongoing basis to ensure the formation of an effective unit that helps improve the standard of the center's performance of the tasks assigned to it in its field of specialization.

4.7 Participate in training programs and courses, development programs, and quality and follow up their implementation.

4.8 Participate in the optimal distribution of the manpower in the departments that the employee supervises.

4.9 Study all activity reports and technical correspondence received from the departments, present their results to the medical director, and respond with what is necessary.

4.10 Participate in preparing annual reports of medical services.

4.11 Participate in the center's committees.

4.12 Supervise the medical and technical sections in the Women's Department.