Exploring Factors Influencing Job Satisfaction and Wellbeing of Healthcare Workers in Kuwait

Anfal AlTaleb

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Declaration

I, the author, confirm that the Thesis is my own work. I am aware of the University's Guidance on Academic Integrity (https://www.sheffield.ac.uk/study-skills/assessment/academicintegrity/academic-integrity). This work has not previously been presented for an award at this, or any other, university.

Abstract

Healthcare workers play a central role in sustaining effective healthcare systems, yet their job satisfaction and mental wellbeing remain unevenly understood in many settings. Existing research in Kuwait and Gulf Cooperation Council (GCC) countries has largely relied on cross-sectional quantitative studies focused on single professional groups and negative outcomes such as burnout, limiting understanding of healthcare workers' experiences of job satisfaction and wellbeing.

This study aimed to explore factors shaping job satisfaction and mental wellbeing among healthcare workers in Kuwait and to examine variation in these experiences across professional roles, nationality, and gender. The study was conducted at Mubarak Al-Kabeer Hospital in Kuwait and involved 20 healthcare workers from diverse professional backgrounds, nationalities, and genders.

This applied qualitative study adopted an interpretivist and contextualist approach. Data were generated through purposive sampling and semi-structured interviews and analysed using reflexive thematic analysis. The analysis was conducted inductively, with the Job Demands-Resources (JD-R) model subsequently used to support interpretation.

Leadership and management practices emerged as the most influential factors shaping participants' job satisfaction and mental wellbeing. Participants described leadership instability due to frequent managerial turnover, authoritarian management styles, poor communication, and bureaucratic control driven by external pressures. Surveillance-oriented attendance systems were commonly experienced as signals of mistrust rather than support. Perceived inequities between Kuwaiti and non-Kuwaiti staff in recognition, promotion, and access to training further contributed to dissatisfaction. Gendered expectations and limited organisational flexibility intensified work-home spillover, exacerbating strain and undermining wellbeing within a highly hierarchical organisational context.

This thesis contributes by providing qualitative insight into the lived experiences of a multi-professional healthcare workforce in Kuwait and refining the JD-R model for this context. In particular, leadership is conceptualised as a multi-positional factor that can function as a demand, a resource, and a meta-moderator shaping how other workplace demands and resources are experienced.

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List of Abbreviations

Healthcare workers: HCW

Ministry of Health: MOH

Gulf Cooperation Council: GCC

Job Demands- Resources: JD-R

Reflexive Thematic Analysis: RTA

World Health Organization: WHO

Thematic Analysis: TA

Chapter 1: Introduction

Healthcare systems depend on a workforce that can deliver technically competent care while sustaining engagement, motivation, and psychological wellbeing over time. In many settings, healthcare workers' (HCWs) job satisfaction and mental wellbeing influence staff retention, quality of care, professional identity, and the overall functioning of health services. These experiences are shaped by workload and compensation, as well as by everyday organisational practices, leadership arrangements, workplace relationships, and wider institutional and cultural conditions.

Background and study context

The healthcare sector plays a central role in societies' overall wellbeing and development. Within this demanding context, healthcare workers' (HCWs') job satisfaction and mental wellbeing have received increasing attention within both academic and professional literature internationally and across different healthcare systems (Maslach and Leiter, 2016; Shanafelt et al., 2015; Al-Wotayan et al., 2019; Rostami et al., 2021). Ensuring adequate levels of job satisfaction and mental wellbeing among HCWs is therefore an important concern for healthcare systems. Both factors have been linked to HCWs' turnover intentions, with implications for workforce stability and service delivery (Labrague & de Los Santos, 2021; Poon et al., 2022). High turnover associated with low job satisfaction and poor mental wellbeing can lead to staffing shortages and, in turn, compromise the quality of patient care (Poon et al., 2022). Job satisfaction has been shown to influence the level of engagement and commitment with which healthcare services are provided (De Simone et al., 2018; Platis et al., 2015). Mental wellbeing also affects the likelihood of work-related errors, patient safety outcomes, and service satisfaction (Gray et al., 2019; Nowrouzi-Kia et al., 2021).

Healthcare roles have long been recognised as highly stressful, characterised by sustained work demands and emotionally demanding working conditions (Ruotsalainen et al., 2014). Maintaining satisfactory levels of job satisfaction and mental wellbeing under these conditions is challenging. Understanding these experiences therefore requires attention to the everyday work practices and organisational conditions within which HCWs operate. This study approaches job satisfaction and wellbeing through HCWs' own accounts of their working lives, focusing on how they experience their work and what they identify as potential areas for improvement. The study is situated in Kuwait, where high prevalence rates of job dissatisfaction and indicators of poor mental wellbeing, including burnout, depression, and anxiety, have been consistently reported across different HCW groups (Al-Wotayan et al., 2019; AlKandari et al., 2022; AlObaid et al., 2022; Aon et al., 2020).

Job satisfaction

Job satisfaction is widely recognised as an important psychological construct in workforce and organisational research, reflecting how individuals evaluate and experience their work. In broad terms, it has been defined as the degree to which people like their jobs (Spector, 1997), and has been linked to motivation, engagement, and performance among HCWs (Platis et al., 2015; Rostami et al., 2021).

Despite its frequent use, job satisfaction is not a straightforward or uniformly defined concept. Previous research has conceptualised it in different ways, including as an emotional response to work, a sense of pleasure or accomplishment, or the extent to which job realities align with individual expectations (Gyekye & Salminen, 2006; Saari & Judge, 2004; Mitchell, 1974). There is general agreement that job satisfaction is a composite construct, although considerable variation exists in its proposed dimensions and methods of measurement (Spector, 2022).

Comparative research suggests that the aspects of work contributing to job satisfaction may vary across countries and socio-cultural contexts, indicating that findings from one setting may not readily transfer to another (Andreassi et al., 2014; Andrade & Westover, 2020; Westover & Taylor, 2010). A more detailed examination of how job satisfaction is conceptualised, measured, and understood within healthcare research, including its relevance to the Gulf and Kuwaiti context, is presented in the conceptual grounding (Chapter 3). Accordingly, in this thesis, job satisfaction is approached as a context-dependent experience shaped by organisational, cultural, and relational conditions.

Mental health and mental wellbeing

Mental health is a key concept in healthcare research. The World Health Organization (WHO) defines mental health as “Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn and work well, and contribute to their community.” (World Health Organization, 2025). This definition emphasises coping, functioning, and participation in everyday life, rather than viewing mental health only as the absence of mental illness. Similarly, Galderisi et al. (2015) describe mental health as a dynamic state that enables individuals to manage daily challenges and fulfil social roles, while still experiencing a range of normal human emotions.

Reflecting this emphasis on everyday psychological functioning, this thesis retains the term mental health when referring to the existing literature, while mental wellbeing is used as an analytic lens to focus on how HCWs cope, function, and experience their working lives. This choice does not introduce a new definition of mental health, nor does it imply the absence of distress. Rather, it reflects an analytic focus on everyday psychological functioning within

demanding organisational contexts. Further conceptual discussion of mental wellbeing is provided in the conceptual grounding (Chapter 3).

Job satisfaction and mental wellbeing are frequently examined together in healthcare research, reflecting recognition that how HCWs experience their work is closely linked to their mental wellbeing (Faragher et al., 2005; Friganovic et al., 2019). Existing studies often report an association between lower job satisfaction and poorer mental health outcomes, while more positive work experiences may support aspects of mental wellbeing (Faragher et al., 2005; Friganovic et al., 2019). However, this relationship is not uniform and appears to be shaped by contextual factors such as work demands, stress, and organisational conditions (de Sousa et al., 2021; Scanlan et al., 2021). This highlights the importance of examining how job satisfaction and mental wellbeing interact within specific organisational and cultural contexts, rather than assuming a consistent relationship across settings.

Study context and healthcare system in Kuwait

Kuwait is a small country in Western Asia, located at the northern edge of the Arabian Gulf and bordered by Iraq to the north and Saudi Arabia to the south (Figure 1). Kuwait's total population is estimated at around 5.0 million in 2025, with expatriates continuing to make up approximately 70% of the population (World Population Review, 2025). This demographic structure has important implications for the organisation and delivery of healthcare services, as well as for the composition of the healthcare workforce.

Figure 1: A map of Kuwait

The public healthcare system in Kuwait is primarily funded and administered by the Ministry of Health (MOH). Healthcare services are organised into several regional healthcare areas, each

comprising primary healthcare centres, secondary general hospitals, and tertiary specialised services. Kuwaiti citizens have unrestricted access to public healthcare services free of charge, while non-Kuwaiti residents are required to pay a health insurance fee to access care (AlRuthia et al., 2025) In addition to MOH facilities, some government hospitals operate under other authorities, including the Kuwait Oil Company and the Ministry of Defence (Alsabah, 2022).

According to the Kuwait MOH Annual Health Report (2022), the MOH employs a healthcare workforce exceeding 70,000 staff across clinical and administrative roles. Nursing staff constitute the largest professional group within the public healthcare system, followed by physicians, allied health professionals, and administrative staff (Ministry of health, 2022).

Despite substantial public investment in healthcare infrastructure, the healthcare system faces increasing pressure due to population growth and rising demand for services. National reporting indicates that private healthcare provision is expected to assume a more prominent role within Kuwait's health system, supported by continued investment in hospital infrastructure by private entities (International Trade Administration, 2023). Utilisation of private services has been linked to shorter access times and greater flexibility in care delivery, despite the availability of publicly funded services (International Trade Administration, 2023). In parallel, the government continues to fund overseas treatment for selected patients when services are considered unavailable or insufficient domestically (Ministry of health, 2022).

The high proportion of expatriates within Kuwait's population is reflected in the composition of the healthcare workforce. The Kuwait Health System Review (2018) reports that HCWs in both public and private sectors are predominantly expatriates, with the exception of dentists in the public sector, where Kuwaiti nationals form the majority (Mossialos et al., 2018). More recent national statistics suggest that this workforce structure has remained largely unchanged between 2018 and 2022, with non-Kuwaiti staff continuing to constitute a substantial proportion of physicians and the majority of nurses within the Ministry of Health (Ministry of Health, 2022).

The health system review further highlights that recruitment and employment processes for expatriate HCWs are bureaucratic, contributing to delays in full-time employment and continued reliance on short-term contracts. It also reports fragmented responsibility for healthcare workforce planning and education, alongside the absence of an overarching workforce strategy (Mossialos et al., 2018). In addition, healthcare management roles are not consistently occupied by individuals with formal training in health systems or public health (Mossialos et al., 2018).

It should be noted that these data are drawn from the most recent comprehensive national health system review available at the time of writing. While some changes in workforce composition, governance arrangements, and employment practices may have occurred since publication, no more recent national documents providing comparable system-level detail were

available for this study. Together, these structural and demographic features shape the everyday working environment of HCWs in Kuwait and provide an important contextual background for understanding experiences of job satisfaction and mental wellbeing within the public healthcare system.

Rationale for the study

Against this background, existing research in Kuwait has examined job satisfaction and mental health among HCWs predominantly using cross-sectional survey designs (Al-Wotayan et al., 2019; AlKandari et al., 2022). Studies of job satisfaction have largely focused on physicians and nurses, linking satisfaction levels to working conditions and organisational factors (Al-Eisa et al., 2005) Separate survey-based studies have documented high levels of psychological distress among HCWs, including anxiety, depression, sleep disturbance, and burnout (Aon et al., 2020; Abbas et al., 2021; AlObaid et al., 2022).

However, the existing literature in Kuwait remains limited in two important respects. First, job satisfaction and mental health have typically been examined as separate outcomes, with little direct investigation of how they interact in everyday work settings. Second, there is a lack of qualitative research exploring HCWs' own accounts of how organisational conditions shape both job satisfaction and mental wellbeing. Addressing these gaps is important for developing contextually grounded evidence to inform policy and practice within Kuwait's public healthcare system.

Despite the central role of HCWs in sustaining Kuwait's public healthcare system, existing research offers limited insight into their lived experiences of job satisfaction and wellbeing. Research in Kuwait and the wider Gulf Cooperation Council (GCC) region has also tended to focus on specific professional groups, particularly physicians and nurses, with less attention to the perspectives of other HCWs.

Within the Kuwaiti healthcare system, these limitations are particularly relevant given the organisational and workforce conditions under which healthcare work is carried out. National health system reporting has highlighted features such as fragmented workforce governance, bureaucratic employment processes, and a highly diverse healthcare workforce (Mossialos et al., 2018). However, little is known about how HCWs themselves experience and make sense of job satisfaction and wellbeing within these system-level conditions.

This thesis addresses these gaps by adopting a qualitative, interpretivist approach to explore how HCWs in Kuwait understand and experience job satisfaction and wellbeing in their everyday working lives. Rather than assessing predefined levels of satisfaction or distress, the study examines how these experiences are constructed, sustained, and challenged through

daily work practices, workplace relationships, and organisational arrangements. In doing so, the research foregrounds the organisational, structural, and cultural conditions within which healthcare work takes place. Together, these considerations shape the overall purpose and contribution of the present study.

Overall, this thesis seeks to provide a contextualised qualitative account of how HCWs in Kuwait understand and experience job satisfaction and wellbeing. By centring HCWs' voices and situating their accounts within the realities of public healthcare work, the study aims to contribute to both scholarly understanding and ongoing efforts to support a more sustainable and humane healthcare system.

The development of this research was also influenced by my professional and academic background. As a psychiatrist who previously worked within Kuwait's public healthcare system, I became increasingly aware during the COVID-19 pandemic of the emotional and psychological strain experienced by many HCWs around me. Colleagues frequently described feeling exhausted, emotionally drained, and overwhelmed by ongoing workplace pressures. One particular conversation with a colleague who expressed feeling unable to continue working was an important turning point that prompted me to reflect more deeply on HCWs' wellbeing and the factors shaping it. As I explored the topic further, it became apparent that many of the organisational and emotional pressures experienced during the pandemic had already existed beforehand, but became more visible and intensified during COVID-19. My earlier public health research interests had also focused on the effects of COVID-19 on HCWs' mental health in Kuwait, which later developed into a broader interest in understanding HCWs' wellbeing and job satisfaction beyond a pandemic-specific context. Together, my clinical experience in psychiatry and academic training in public health shaped my interest in exploring wellbeing not only as an individual psychological issue, but also as an organisational and systemic experience.

Aims, objectives, and research question

This study was guided by two overarching aims:

- To explore the key factors that influence job satisfaction and mental wellbeing among HCWs in Kuwait, as constructed through their day-to-day work experiences.
- To examine how experiences of job satisfaction and mental wellbeing may vary across professional roles and demographic groups, including nationality and gender.

To address these aims, the study pursued the following research objectives:

- Examine existing literature on job satisfaction and mental wellbeing among HCWs in Kuwait and the wider GCC region.

- Explore HCWs' accounts of the organisational, relational, and contextual factors shaping their experiences of job satisfaction and mental wellbeing through semi-structured interviews.
- Identify patterns and variations in how job satisfaction and mental wellbeing are experienced across different professional and demographic groups.
- Develop a contextually grounded understanding of the conditions that support or challenge HCWs' wellbeing within Kuwait's public healthcare system.

These aims and objectives were addressed through the central research question:

> How do HCWs in Kuwait's public healthcare system interpret and experience the factors that influence their job satisfaction and wellbeing?

Thesis structure

This thesis is organised into eight chapters. Following the Introduction in Chapter 1, Chapter 2 presents a systematic literature review examining empirical studies on job satisfaction and mental health among healthcare workers in Kuwait and the wider Gulf Cooperation Council region. Chapter 3 provides the conceptual grounding for the study, situating job satisfaction and wellbeing within broader theoretical debates while attending to the institutional and cultural context of Kuwait's public healthcare system. Chapter 4 outlines the methodological approach, including the study design, setting, sampling strategy, data collection, analytic process, and researcher reflexivity. Chapter 5 presents the findings, organised into five themes capturing how leadership, workplace relationships, work environment, workplace inequities, and work-related stress shape healthcare workers' experiences. Chapter 6 introduces and critically reflects on the Job Demands-Resources model as an interpretive lens for the findings. Chapter 7 brings these elements together in the discussion, interpreting the findings in relation to organisational, cultural, and structural conditions, reflecting on my positionality, and outlining implications for practice and future research. Chapter 8 concludes the thesis and is followed by the appendices.

Chapter 2: Systematic literature review

Introduction

This systematic review was completed in 2023 and involved full screening, critical appraisal, and synthesis of studies examining job satisfaction and mental health among healthcare workers (HCWs) in Kuwait and the wider Gulf Cooperation Council (GCC) region. The GCC is a regional grouping of six countries located on the Arabian Peninsula: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates (Aldhamin and Al Saif, 2023). In addition to geographical proximity, these countries share key socio-cultural, religious, and institutional

characteristics, as well as broadly similar healthcare governance structures (Aldhamin and Al Saif, 2023). These shared features provide a meaningful regional context for examining HCWs' experiences of work, wellbeing, and organisational life.

The aim of this systematic review was to provide a comprehensive and structured assessment of existing empirical evidence on the relationship between job satisfaction and mental health among HCWs in GCC countries.

The overarching review question guiding the review was:

- What is the evidence of the relationship between job satisfaction and mental health among HCWs in GCC countries?

To address this overarching question, the review was guided by the following sub-questions:

- How are job satisfaction and mental health defined and conceptualised in the existing literature; how are job satisfaction and mental health empirically related?
- What factors influencing job satisfaction and mental health have been examined?
- What is the type and quality of knowledge generated by studies in this area?

Addressing these questions enabled a systematic synthesis of what is currently known, while also identifying areas of inconsistency, omission, and limited explanatory depth within the regional evidence base.

In this chapter, the term mental health is used to remain consistent with the terminology adopted in the reviewed literature. Most studies included in the review operationalised mental health using symptom-focused measures, commonly assessing outcomes such as depression, anxiety, stress, burnout, or psychological distress through standardised screening instruments (AlWotayan et al., 2019; AlKandari et al., 2022).

To ensure the thesis reflected more recent developments in the field, the systematic search was updated in late 2025 using the original strategy. Given the substantial volume of newly identified studies and the advanced stage of the research, the decision was taken, in consultation with my supervisors, to document the updated search and screening process, and identify the key findings without undertaking full critical appraisal or synthesis. The 2023 systematic review therefore remains the analytical foundation of this chapter and provides the principal evidence base for identifying gaps addressed by the thesis, while the 2025 update serves a confirmatory role by assessing whether subsequent evidence alters these conclusions.

Methods

The literature review followed the PRISMA 2020 framework (Page et al., 2021) to select the papers and report the study results. The framework was designed specifically for systematic reviews of medical and healthcare studies. Following the proposed framework, the approach for the current review is described below.

Eligibility Criteria

The following are inclusion and exclusion criteria determining whether the study was selected for the review:

Table 1: Eligibility criteria for study selection

Domain	Inclusion criteria	Exclusion criteria
Concept	Studies that examined the relationship, either fully or partially, between job satisfaction and mental health	Studies examining only job satisfaction or only mental health
Population	Healthcare workers, including clinical staff, administrative healthcare roles, and technicians	Non-healthcare professions
Language	Published in English	Non-English publications
Publication type	Published in peer-reviewed journals or peer-reviewed conference proceedings	Grey literature, opinion papers, and predatory journals
Setting	Conducted in Kuwait or another GCC country	Studies conducted outside the GCC, unless comparative and including a GCC country
Timeframe	Published between 2018 and 2023	Published before this period
Publication status	Fully published studies	In-press or incomplete studies

Information Sources

Table 2: Information sources used in the literature search

Source type	Details

Bibliographic databases	PubMed; Scopus; EBSCO Medline; Cochrane Library; Embase
Supplementary source	Google Scholar (searched using the same search strings to identify potentially overlooked studies)

Search Strategy

Table 3: Summary of search strategy components

Search component	Terms included
Job satisfaction terms	Job satisfaction; professional satisfaction; work satisfaction; career satisfaction
Mental health and wellbeing terms (positive)	Mental health; cognitive health; emotional health; intellectual health
Mental health and wellbeing terms (negative)	Burnout; stress; depression; anxiety; exhaustion; moral distress; moral injury; mental illness
Population terms	Healthcare workers (HCWs); physicians; doctors; nurses
Time filter	2018 onwards
Language filter	English
Publication type filter	Peer-reviewed journal articles and conference proceedings
Geographic filter	Kuwait and other GCC countries (Bahrain, Saudi Arabia, Oman, Qatar, UAE); Middle East region
Access filter	Full text available

The search strategy and applied filters are summarised in Table 3. A sample search string is provided below.

(Job Satisfaction OR Career Satisfaction OR Work Satisfaction OR Professional Satisfaction)

AND

(Mental Health OR Cognitive Health OR Emotional Health OR Intellectual Health OR Burnout OR Stress OR Depression OR Anxiety OR Exhaustion OR Moral Distress OR Moral Injury OR Mental Illness)

AND

(HCWs OR Physicians OR Nurses OR Doctors)

Additional search filters were specified in order to meet the study eligibility criteria as discussed above: time (2018-), publication type (journal, conference proceedings), language (English), text (Full Text Available), country (Bahrain, Kuwait, Saudi Arabia, Oman, Qatar, UAE), region (Middle East). A separate search using the same strategy was conducted in Arabic outside the formal review process. As there are no specialised healthcare research databases in Arabic, this search was carried out using the multidisciplinary databases e-Marefa and Dar AlMandumah. No studies meeting the inclusion criteria were identified through this process.

Selection and analysis process

The study selection process involved several sequential steps. I exported all identified records to EndNote reference management software (Clarivate, 2025) and removed duplicate records. I then reviewed the remaining titles and abstracts to exclude studies that did not align with the study aims or the inclusion and exclusion criteria. I retrieved and read the remaining papers in full to confirm their relevance, completeness, and eligibility for inclusion in the review. Studies that met the inclusion criteria were re-read and organised according to the predefined analytical categories. The results of the review are reported using tables and figures, and a synthesis of the literature was undertaken to address the research questions guiding the review. As one of the research questions focused on the quality of the existing evidence, quality criteria were not applied during the study selection process. Instead, all studies meeting the predefined topic and population criteria were included, and their quality was assessed subsequently to evaluate the overall strengths and limitations of the evidence base.

Critical appraisal was conducted using the AXIS tool developed by the University of Nottingham (Downes et al., 2016). The extracted literature was grouped in several ways for analysis and reporting. First, the studies were grouped by year and country to show the research dynamics in terms of time and location. Second, the studies were grouped by research methods to analyse the quality of the research. Third, the studies were organized per population focus to demonstrate which populations have been most researched and which require more attention. Fourth, the studies were grouped by reported outcomes. Specifically, the foci were on the

relationship between job satisfaction and mental health, the particular elements within these constructs which were studied, and any additional variables investigated in the context of the relationship.

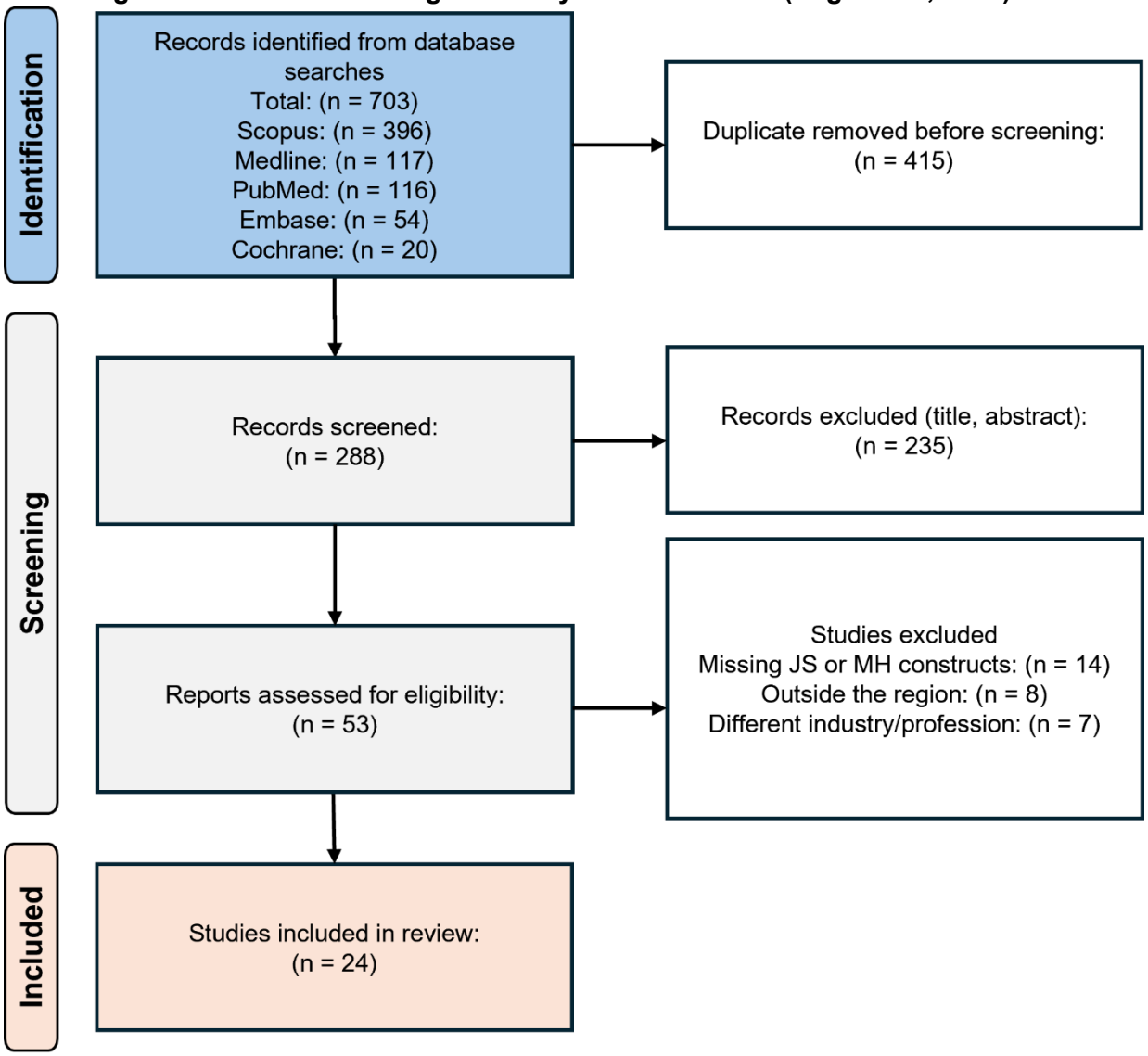
The results of the critical appraisal are presented in Appendix A. While the original AXIS tool includes 20 items, it was adapted in this review to align with the specific aims of the appraisal and the scope of the included cross-sectional studies. The goal of appraisal in this review was to determine whether the study covered the key elements of cross-sectional research to ensure sufficient clarity and robustness of the analysis to provide reliable and valid results. Accordingly, this review used an 8-item analysis that covered all major evaluation aspects: Introduction, Methods, Results, Discussion, and Other.

The original search across the selected databases returned 703 papers in total. The largest number was retrieved from Scopus (n = 396) and the lowest number was retrieved from Cochrane (n = 20).

Findings

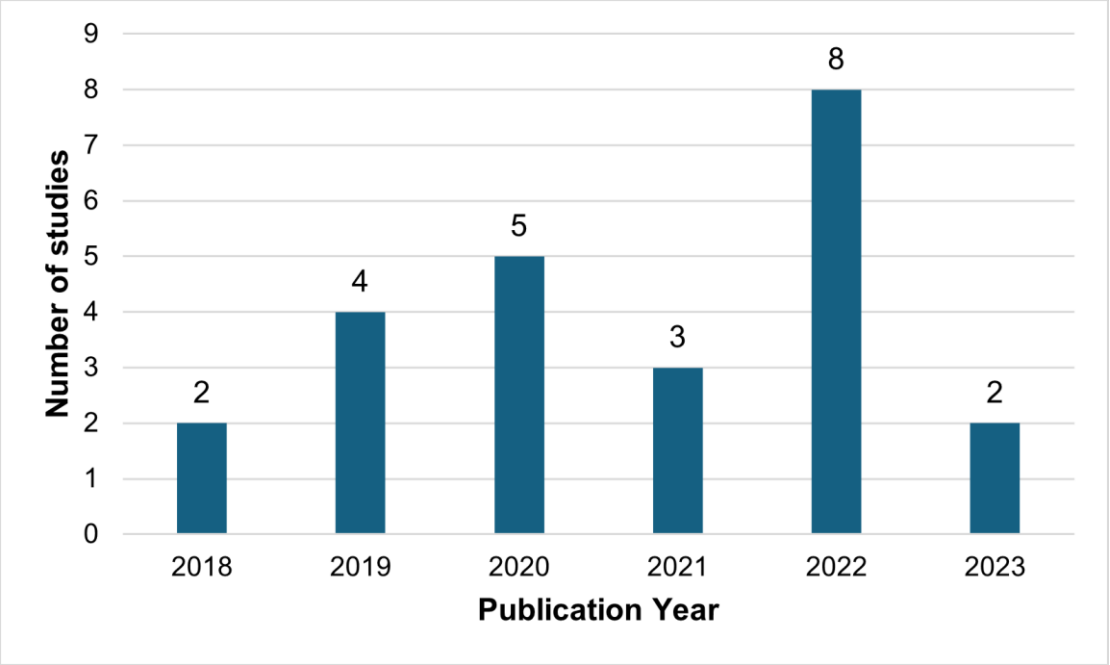
After eliminating duplicate titles, 288 papers remained. Title and abstract screening excluded a further 235 papers. In the final step, a full-text analysis of the papers eliminated 29 other papers for not fitting the study purpose or the inclusion criteria. As illustrated in the PRISMA diagram (Figure 2), studies were excluded due to missing job satisfaction or mental health constructs (n = 14), being conducted outside of the GCC region (n = 8), or focusing on a different industry or profession (n = 7). In total, 24 papers were included in the review. An additional Google Scholar search using the original parameters did not identify any further eligible studies. The process of screening the search results is illustrated in the PRISMA flow diagram (Figure 2).

Figure 2: PRISMA flow diagram for systematic review (Page et al., 2021)



With respect to time distribution, there has been a steady increase in the number of papers exploring job satisfaction and mental health among HCWs in the GCC region (Figure 3).

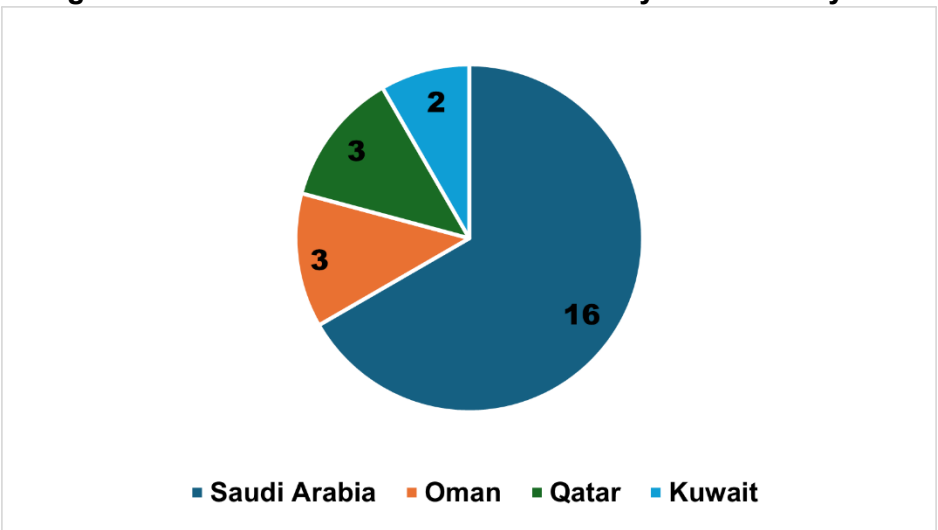
Figure 3: Distribution of included studies by year (2018-2023)



Notably, there was a slight decline in the number of studies published in 2021 (*n* = 3), which may reflect disruptions to research activity during the COVID-19 pandemic, including restrictions on data collection and pressures on frontline healthcare services, followed by a marked increase in 2022 (*n* = 8), indicating growing research interest in this area. Only two studies published in 2023 met the inclusion criteria, reflecting the timing of the search cut-off.

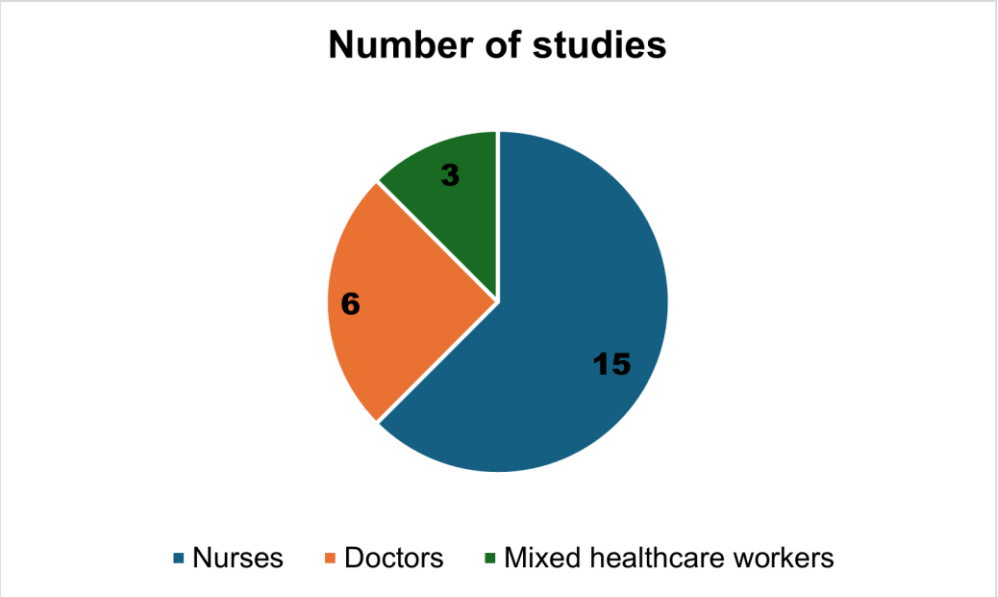
In terms of GCC country distribution (Figure 4), the majority of the studies (n = 16) were conducted in Saudi Arabia. There were three studies published in each of Qatar and Oman, and two studies published in Kuwait. The review did not identify any papers examining the relationship between job satisfaction and mental health among HCWs in the UAE or Bahrain, although a number of studies in these countries have investigated the prevalence of either construct, as well as factors associated with them and their outcomes.

Figure 4: Distribution of included studies by GCC country



In terms of the study population (Figure 5), the majority of the papers in the review focused on nurses (n = 15), including one study that examined expatriate nurses specifically. Six studies focused on doctors: three targeted physicians, one focused on psychiatrists, one on resident doctors, and one on dentists. The remaining three studies examined mixed populations, such as nurses and physicians, clinicians and administrative hospital personnel, and frontline hospital workers.

Figure 5: Distribution of included studies by population focus



Construct composition

Both job satisfaction and mental health are complex constructs, and how they were defined and operationalised varied across the included studies. As discussed in the conceptual grounding (Chapter 3), the contemporary literature tends to treat both constructs as composites with more than a single dimension of measurement. While job satisfaction was considered as such in all but one study, only five papers looked at mental health from a multi-dimensional perspective.

Most of the studies addressed this concept through the lens of the medical paradigm and measured it as presence or absence of specific disorders such as burnout, anxiety, and depression. In terms of job satisfaction, only a few papers used the scales that had been previously validated in the Middle East. In most papers, researchers used standardised and validated measures to operationalise these constructs for statistical analysis; however, there was considerable variation in the specific definitions and measurement approaches used.

For job satisfaction, the most common approach involved the use of custom or authordeveloped question sets, often informed by previously validated scales but not reported as formally revalidated, with seven studies adopting this strategy. The Professional Quality of Life Scale (ProQOL-5) was used in five studies, in which job satisfaction was operationalised through

compassion satisfaction, defined as the level of pleasure derived from being able to perform one's work well (Stamm, 2010). Three studies adopted a more simplified approach, measuring job satisfaction using a single questionnaire item.

Other validated measures used to assess job satisfaction included the Areas of Worklife Survey (AWS), Bowling Scale (BS), Job Satisfaction Scale (JSS), Generic Job Satisfaction Scale (GJSS), Job Descriptive Index (JDI), Warr-Cook-Wall Scale (WCWS), Practice Environment Scale-Nursing Work Index (PES-NWI), and the NIOSH Generic Job Stress Scale (GJSS). Each of these instruments adopts a distinct conceptual approach, incorporating multiple domains to define job satisfaction (Table 4).

Table 4: Job satisfaction construct components

Paper	**Measurement scale**	**Construct components ((dis)satisfaction with…)**
Al Sabei (2022); Alharbi et al. (2020); Jradi et al. (2020)	Single Item	Self-measured level of overall job satisfaction
Alenezi et al. (2022)	Custom	Work-life balance, decisionmaking, workload, training
AlHamdan et al. (2021)	Custom	Psychological flow: self-efficiency, control, confidence
Anzar et al. (2022)	Custom	Time availability, decisionmaking, workload, task clarity, conflict, support
Baghdadi et al. (2020)	Custom	Salary, current job, chosen specialty
Batran (2019)	Custom	Conflict, workload, uncertainty, dealing with death and dying, support and resources
Salem et al. (2018)	Custom	Workload in terms of patients, social problems
Saquib et al. (2019)	Custom	Salary, teamwork, workload

Alonazi et al. (2023); Aruta et al. (2022); Falatah and Alhalal (2022); Bahari et al. (2022); Inocian et al. (2021)	Professional Quality of Life (ProQOL)	Compassion, being able to help others
Albashayreh et al. (2019), Shdaifat et al. (2023)	Job Satisfaction Scale (JSS)	Pay, promotion, supervision, fringe benefits, contingent rewards, operating conditions, coworkers, nature of work, communication.
Al Sabei et al. (2020)	Practice Environment Scale of the Nursing Work Index (PES-NWI)	Participation in hospital affairs, management support, leadership, staffing, resources, work relationships
Alenezi et al. (2022)	Areas of Worklife Survey (AWS)	Workload, control, rewards, community, fairness, values
Alblihed and Alzghaibi (2022)	Bowling Scale (BS)	Expectations, clarity, job duties
Alboughami et al. (2020)	Generic Job Satisfaction Scale (GJSS)	Stress, boredom, isolation, danger of injury/illness
Kader et al. (2021)	Job Descriptive Index (JDI)	Stability, career development and growth, work-life balance
Al-Wotayan et al. (2019)	Warr-Cook-Wall Scale (WCWS)	Working conditions, freedom of work method, colleagues, recognition, responsibilities, income, opportunity to use abilities, relations, variety of tasks
Yehya et al. (2020)	Generic Job Stress (GJS)	Role ambiguity, work conflict, skill utilization, workload

Researchers used a variety of instruments to measure the mental health of study participants (Table 5). The Maslach Burnout Inventory (MBI) was the most commonly used tool, applied in

eight studies. As its name suggests, the MBI focuses on burnout and emotional exhaustion as key components of mental health. Burnout was, in fact, the most frequently examined mental health indicator across the included studies, with a total of 13 papers investigating this outcome, regardless of the measurement instrument used. Other commonly assessed indicators of mental health included emotional exhaustion and fatigue (five studies), general mental health status (five studies), and secondary traumatic stress (four studies). Less frequently examined indicators included depression (two studies), as well as anxiety, affective wellbeing, and depersonalisation (one study each).

Table 5: Mental health measurement scales and constructs used across included studies

Paper	Measurement Scale	Construct Components
Al Sabei et al. (2020); Al Sabei et al. (2022); Alblihed and Alzghaibi (2022); Alenezi et al. (2022a); Alharbi et al. (2020); Kader et al. (2021); Salem et al. (2018)	MBI	Burnout, emotional fatigue, emotional exhaust
Alenezi et al. (2022b)	MBI, GAD-7, PHQ-9	Emotional fatigue
Alonazi et al. (2023); Bahari et al. (2022); Falatah and Alhalal (2022); Inocian et al. (2021); Shdaifat et al. (2023)	ProQOL	Burnout, secondary traumatic syndrome
Falatah and Alhalal (2022)	ProQOL	Affective well-being
Aruta et al. (2022)	ProQOL, WEMWBS	Burnout, overall MH
Anzar et al. (2022); Baghdadi et al. (2021); Batran (2019)	Custom	Burnout
AlHamdan et al. (2021)	Custom	Overall MH
Alboughami et al. (2020)	WHOQOL-BREF	Overall MH
Albashayreh et al. (2019)	NEW	Overall MH
Yehya et al. (2018)	NIOSH	Depression
Al-Wotayan et al. (2019)	GHQ-12	Overall MH
Saquib et al. (2019)	DASS-21	Depression, anxiety

Relationship between job satisfaction and mental health

The majority of the studies in the review (n = 14) identified a link between job satisfaction and the mental health of HCWs. Because most of the studies examined factors associated with mental health outcomes, associations between dissatisfaction with specific aspects of work and poorer mental health were commonly reported. Low levels of overall job satisfaction were found to be negatively related to mental and psychological wellbeing (Al-Wotayan et al., 2019; AlHamdan et al., 2021) and positively correlated with burnout (Anzar et al., 2022). In addition, burnout was associated with specific elements of job dissatisfaction, including compassion satisfaction (Aruta et al., 2022; Bahari et al., 2022; Inocian et al., 2021), role ambiguity (Alblihed and Alzghaibi, 2022), work-life balance (Alenezi et al., 2022), and healthcare specialty (Baghdadi et al., 2020). Moreover, burnout associated with low levels of compassion satisfaction was often accompanied by secondary traumatic stress (Bahari et al., 2022; Inocian et al., 2021).

The effects of specific aspects of job dissatisfaction on general mental health and specific mental health outcomes were well examined in the reviewed literature. Dissatisfaction with salary, coworker relationships and teamwork, high workload, and role ambiguity was associated with higher levels of anxiety and depression (Saquib et al., 2019; Yehya et al., 2020). Dissatisfaction with coworkers, work opportunities, compensation, and a lack of resources or supervisory support was also associated with elevated levels of emotional exhaustion (Kader et al., 2021).

Several studies explored indirect relationships between job satisfaction and mental health among HCWs in GCC countries. For example, AlHamdan et al. (2021) examined the relationship between psychological immunity and mental health during the COVID-19 outbreak and found that job satisfaction mediated the relationship between psychological immunity, optimism, self-confidence, and psychological wellbeing. Similarly, Al Sabei et al. (2020) found that job satisfaction moderated the relationship between the work environment and burnout, as well as turnover intentions.

Some studies modelled mental health variables as predictors of job satisfaction within crosssectional analyses, although these designs do not allow conclusions about directionality (Alenezi et al., 2022b). These analyses relied on cross-sectional data and therefore reflect statistical modelling choices rather than evidence of causal direction. Similarly, Saleh et al. (2018) reported that burnout and emotional exhaustion among physicians were associated with job dissatisfaction. Albashayreh et al. (2019) found that good mental health and favourable working conditions were associated with higher levels of job satisfaction among nursing staff.

These findings suggest that the direction of the relationship between job satisfaction and mental health is not clearly established. Indeed, cross-sectional study designs are unable to offer proof of causality, only associations between variables.

Factors influencing job satisfaction and mental health

Some studies did not examine the relationship between job satisfaction and mental health directly. Instead, they incorporated job satisfaction and mental health within broader analytical models, where these constructs were statistically associated with other outcomes, treated as dependent variables, or positioned as intermediate variables within cross-sectional analyses. Two studies examined the combined effects of job satisfaction and mental health. Shdaifat et al. (2023) found that job dissatisfaction, reflected in emotional strain related to caring work and work-related burnout, was associated with secondary traumatic stress among nurses. Similarly, Alboughami et al. (2020) reported that dissatisfaction with salary and poorer mental health were associated with nurses' intention to leave.

Two independent studies conducted in Oman and Saudi Arabia examined the combined mediating role of job satisfaction and mental health related constructs. Al Sabei et al. (2022) showed that job satisfaction and burnout mediated the relationship between teamwork and nurses' intention to leave. Likewise, Alharbi et al. (2020) found that job satisfaction and emotional exhaustion mediated the relationship between nurses' participation in hospital affairs and intention to leave.

Finally, two studies examined job dissatisfaction and negative mental health outcomes as study outcomes. Batran (2019) reported that higher levels of work-related stress were associated with both lower job satisfaction and poorer mental health outcomes. Alonazi et al. (2023) found that higher levels of psychological resilience among nurses were associated with higher job satisfaction through compassion satisfaction, alongside lower levels of burnout and secondary traumatic stress.

Quality and type of knowledge

Of particular concern was the dominance of a single research approach among the reviewed studies. Specifically, in terms of research design, all studies included in the review adopted a cross-sectional questionnaire-based design. In all cases, standardised instruments relied on Likert-scale items and did not include open-ended questions. As a result, there is a notable lack of qualitative data and qualitative analysis in this area. While surveys may be an appropriate approach for examining relationships between variables and influencing factors, the value of such studies depends heavily on the quality of data collection, analysis, and reporting (Creswell

and Poth, 2017). In this regard, several concerns relating to the quality of the existing evidence were identified.

As all studies included in the review were cross-sectional, the AXIS tool, designed specifically for appraising cross-sectional studies, was used to assess study quality (Downes et al., 2016). The number of respondents in the reviewed studies ranged from 90 (AlHamdan et al., 2021) to 2113 (Al Sabei et al., 2022). In large populations, smaller sample sizes increase the margin of error, a limitation acknowledged in several studies with relatively small samples (AlHamdan et al., 2021; Baghdadi et al., 2020; Kader et al., 2021). In addition, most studies (n = 17) relied on convenience sampling, typically recruiting participants from one or a small number of healthcare centres or hospitals. Simple random sampling was reported in only four studies (Alblihed and Alzghaibi, 2022; Alenezi et al., 2022; Aruta et al., 2022; Yehya et al., 2020). Other sampling approaches included proportional stratified cluster sampling (Al Sabei et al., 2022), consecutive sampling (Anzar et al., 2022), and purposive sampling (Batran, 2019). Overall, the predominance of convenience sampling limits the generalisability of the findings, while the cross-sectional nature of the studies prevents conclusions regarding causality. Because all studies in the review relied on closed-ended questionnaires developed in Western contexts, the mechanisms underlying the relationship between job satisfaction and mental health in GCC may appear similar to those identified in other countries. However, the use of these instruments may have prevented the identification of context-specific factors relevant to the GCC region.

The quality appraisal results are presented in Appendix A. Overall, the appraisal indicated that most studies were clear in their study aims and outcome measurement, while common limitations related to sampling approaches, response rates, and the lack of explicit assessment of non-response bias. In general, the studies performed adequately in defining study populations and reporting limitations. However, in addition to small sample sizes in some studies, many papers failed to report response rates or provided limited detail regarding sampling procedures. Only eight studies reported response rates above 50 percent, four reported response rates between 15.6 percent and 47.7 percent, and 13 studies did not report response rates at all. Low or unreported response rates increase the risk of non-response bias.

Furthermore, seven studies did not report reliability analyses, and only six described validity testing. In many cases, authors relied on previously reported psychometric properties of instruments or reported Cronbach’s alpha values without accompanying validity assessments. A further limitation across the evidence base was the lack of acknowledgement or assessment of non-response bias. In addition, six studies did not clearly describe ethical considerations or approval procedures.

Overall, the existing body of evidence on job satisfaction and mental health among HCWs in the GCC region is of variable quality. Methodological limitations, inconsistencies in construct measurement, and weaknesses in sampling and reporting make it difficult to draw a comprehensive or robust picture of the relationship between these constructs. The findings of many studies are context-specific and time-bound, limiting their generalisability and their ability to demonstrate consistent patterns over time.

Another notable feature of the reviewed literature is the concentration of studies conducted during the COVID-19 pandemic. Sixteen of the 24 included studies collected data between 2020 and 2022, with the end of the pandemic declared by the World Health Organization in May 2023 (World Health Organization, 2023). This period may be considered atypical and not fully representative of routine healthcare settings. It remains unclear whether the patterns observed during and after the pandemic reflect longer-term trends or represent heightened responses to an exceptional period. The existing literature does not yet provide sufficient evidence to address this uncertainty.

Strengths and limitations

This review makes a strong contribution to understanding job satisfaction and mental health among healthcare workers within the Gulf Cooperation Council (GCC) context. To the best of my knowledge, relatively few systematic reviews have examined these issues across Middle Eastern healthcare systems, and this review helps to address this regional gap. The literature search followed a comprehensive strategy and applied well-established standards for reporting (PRISMA) and for the appraisal of cross-sectional studies (AXIS). Using a systematic approach enabled a structured understanding of the dominant methodological approaches used to study HCWs' job satisfaction and mental health, the ways in which these constructs have been measured, and the factors examined in relation to them. The findings are relevant not only to Kuwait but also to other GCC countries included in the search. Accordingly, the review enabled the identification of several important gaps that informed the development of the current study and may guide future research in this area.

At the same time, the findings of the literature review need to be interpreted with several limitations in mind. The search was subject to potential language bias, as only English-language studies were included. Another limitation relates to the exclusion of grey literature. An in-depth search of grey literature was not undertaken because the review was deliberately scoped to peer-reviewed empirical studies. Grey literature, including reports, dissertations, conference papers, and ongoing research, may offer additional insights (Paez, 2017), but accessing and systematically appraising such sources is challenging in Middle Eastern contexts, where many government and industry reports are not publicly available and, when available, are not

consistently produced to the same methodological and reporting standards as peer-reviewed research. Nevertheless, grey literature was partially explored through Google Scholar, which retrieves conference papers and dissertations alongside journal articles. On this basis, reasonable efforts were made to capture relevant evidence beyond indexed journal publications.

In reflecting on the original 2023 review from the perspective of the later stages of the doctoral process, I became more aware of several additional methodological limitations. Although the review followed a systematic and transparent process, the original search strategy may not have captured the full breadth of relevant literature. For example, some potentially important search terms relating to wellbeing and specific healthcare professions, such as laboratory technicians and allied health staff, were not included in the search string. In addition, while the AXIS tool was used to appraise study quality, I used an adapted 8-item version rather than the full 20-item checklist. Although this approach was considered appropriate at the time, use of the complete checklist may have allowed for a more detailed assessment of methodological quality and risk of bias. These limitations reflect, in part, the experience of conducting a systematic review during the early stages of doctoral training. Looking back, broader use of truncation, more profession-specific terminology, and application of the full AXIS framework may have strengthened both the comprehensiveness of the search strategy and the methodological depth of the review. As my understanding of systematic review methods developed over the course of the PhD, I became more aware of how these decisions may have influenced the scope and rigour of the review.

Update to the systematic review

Purpose and methodological consistency

To ensure that this thesis reflects developments in the literature since completion of the original systematic review, the original search strategy was re executed in October 2025. The updated search used exactly the same databases, search terms, eligibility criteria, and screening procedures as the 2023 review, with date limits adjusted only to capture studies published from January 2023 onwards. This update was undertaken to document the currency and scope of the post 2023 evidence base, rather than to conduct a second full systematic synthesis.

The decision not to undertake full critical appraisal or formal synthesis of the updated studies was made in consultation with my supervisors and reflects the advanced stage of the doctoral programme, alongside the substantial volume of newly identified literature. The 2023 systematic review therefore remains the primary analytic foundation of this chapter, while the updated search serves a confirmatory and contextual function by assessing whether subsequent evidence alters or destabilises the conclusions drawn from the original review.

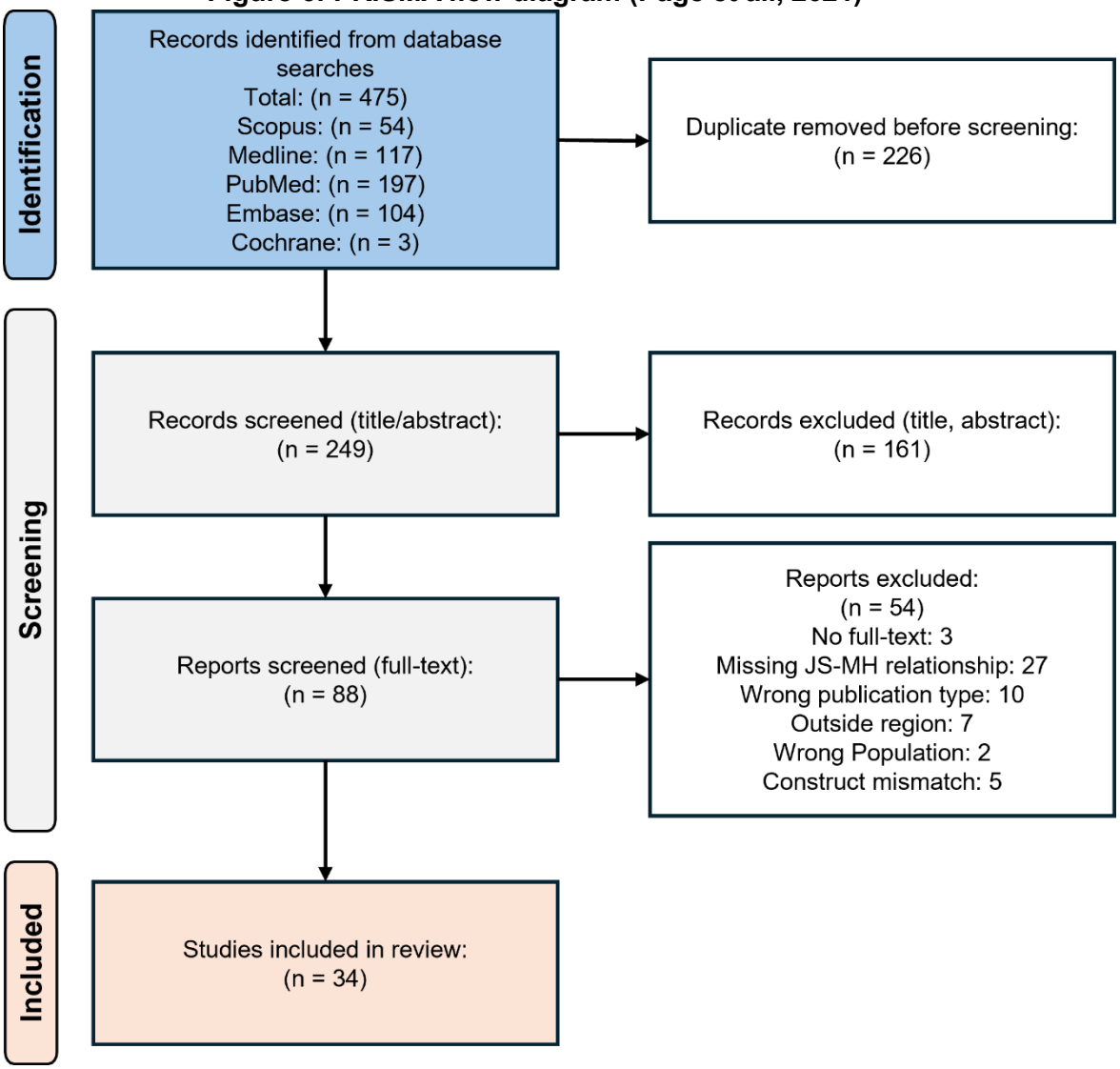
Search results and screening

The updated search yielded a total of 475 records across the five databases: Scopus (n = 54), PubMed (n = 197), EBSCO Medline (n = 117), Embase via Ovid (n = 104), and the Cochrane Library (n = 3). All records were exported to EndNote to support citation management and duplicate removal. Following initial deduplication, 288 unique records remained. These were then exported to Rayyan, a web-based screening platform designed to support transparent and reproducible title and abstract screening (Ouzzani et al., 2016). A second round of deduplication within Rayyan resulted in 249 unique records for screening.

Title and abstract screening excluded 161 records that did not meet the predefined eligibility criteria. The most common reasons for exclusion were absence of an examined relationship between job satisfaction and mental health, publication type violations, studies conducted outside the GCC region, or omission of one of the core constructs. Eighty-eight records were identified as potentially relevant and progressed to full text assessment.

Of the 88 full text articles sought, three could not be retrieved despite attempts through institutional access and interlibrary loan services. The remaining 85 full texts were assessed against the eligibility criteria, resulting in the exclusion of 51 studies. Reasons for exclusion included inadequate examination of the job satisfaction mental health relationship, publication type violations, geographic mismatch, population mismatch, or construct and measurement limitations. The updated search and screening process is summarised in the PRISMA 2020 flow diagram.

Figure 6: PRISMA flow diagram (Page et al., 2021)

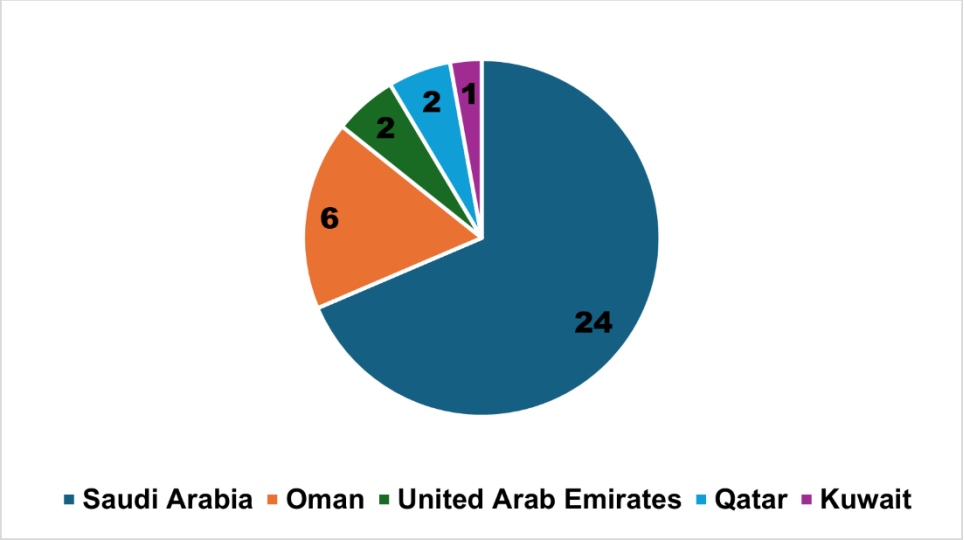


Consistent with the purpose of the update, no formal critical appraisal or synthesis was undertaken. The original 2023 systematic review therefore continues to provide the principal analytic basis for identifying gaps addressed by this thesis.

Characteristics of the updated evidence base

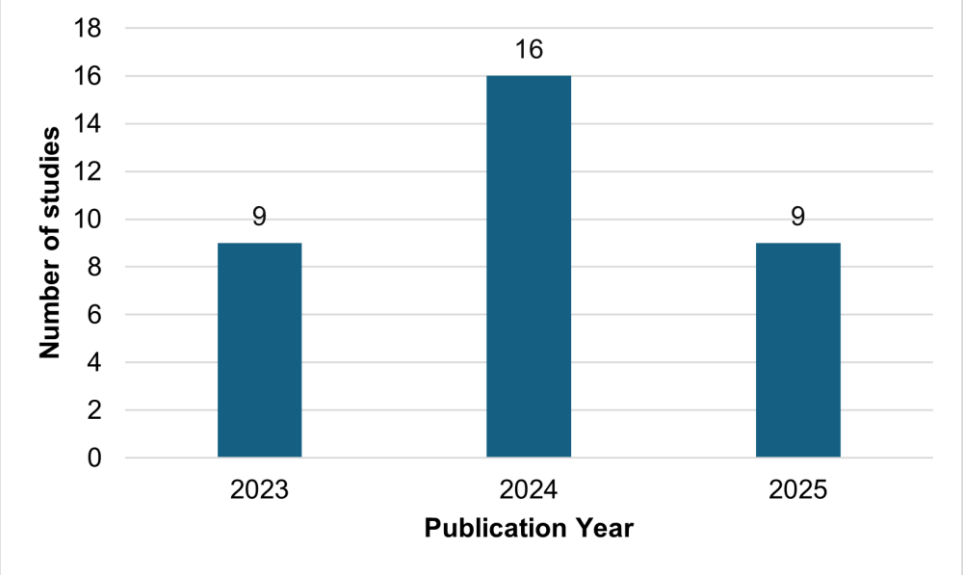
The updated search identified 34 studies published between 2023 and 2025 that met the eligibility criteria. As in the original review, the updated evidence base was dominated by studies conducted in Saudi Arabia, with substantially fewer studies originating from other GCC member states. Only one eligible study conducted in Kuwait was identified during the update period.

Figure 7: Distribution of included studies by country (2023-2025)



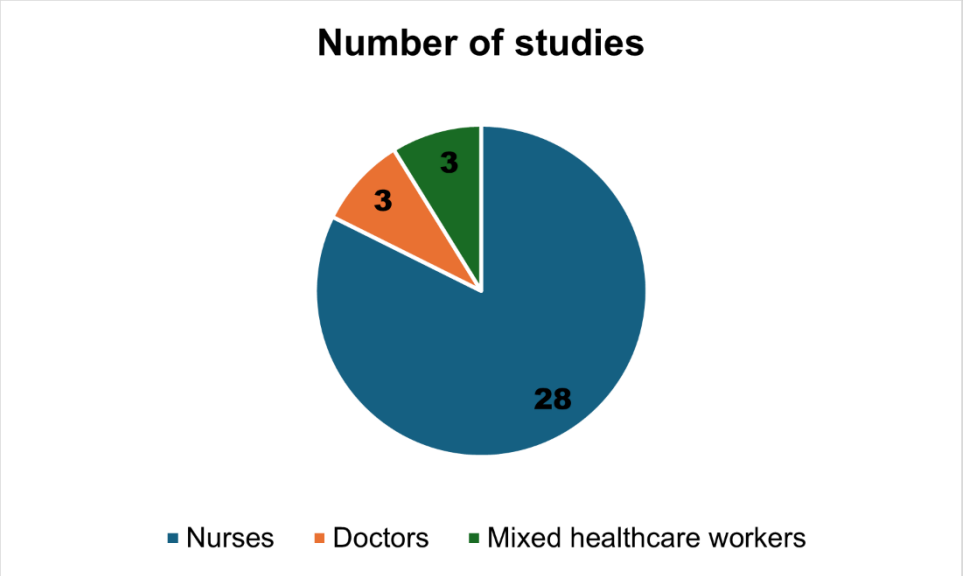
In terms of temporal distribution, publications spanned the entire update period, with a peak in 2024, indicating sustained research activity in the post pandemic phase rather than a transient surge.

Figure 8: Distribution of included studies by year of publication (2023-2025)



Methodologically, the updated literature continued to rely predominantly on cross sectional quantitative designs. Mixed methods and qualitative approaches remained rare, mirroring the methodological patterns identified in the original review and limiting the ability of the evidence base to capture temporal dynamics or lived experience. Nursing populations continued to dominate the literature, reinforcing the population imbalance previously identified, with comparatively limited representation of physicians, allied health professionals, and administrative healthcare workers.

Figure 9: Distribution of included studies by target population



With respect to measurement approaches, use of the Professional Quality of Life Scale (ProQOL) was particularly prominent in the updated literature, appearing in 14 of the 34 included studies. This represents an increase in reliance on ProQOL compared with the original review and suggests a degree of growing standardisation in how job satisfaction and mental health related constructs are operationalised, although substantial heterogeneity in measurement persists.

Table 6: Summary characteristics of studies included in the updated review (2023-2025)

Country	Saudi Arabia	24
	Oman	6
	UAE	2
	Qatar	2
	Kuwait	1
Year	2023	9
	2024	16
	2025	9
Study design	Cross-sectional quantitative	27
	Mixed methods	3
	SEM or path analysis	2
	Qualitative	1

Population	Nurses only	28
	Mixed HCWs	6
	Allied health	1

Synthesis and implications

Across the updated evidence base, findings remained highly consistent with those of the original systematic review. Studies continued to report negative associations between job satisfaction and adverse mental health outcomes such as stress and burnout, alongside positive associations with psychological wellbeing. The direction and nature of these associations did not differ meaningfully across countries, professional groups, or publication years within the update period.

Importantly, the consistency of these findings across a larger and more recent body of literature strengthens confidence in the stability of the observed relationship between job satisfaction and mental health among healthcare workers in the GCC. Despite variation in settings and measurement instruments, the alignment of post 2023 findings with those identified prior to 2023 suggests that this relationship reflects a persistent feature of healthcare work in the region rather than a time limited or pandemic specific phenomenon.

While some updated studies demonstrated increased attention to individual and organisational factors such as resilience, leadership practices, and perceived support, the continued dominance of cross-sectional designs and nursing focused samples indicates that many of the methodological and conceptual limitations identified in the original review remain unresolved. Overall, the updated evidence reinforces rather than alters the conclusions of the 2023 review and further supports the need for context sensitive qualitative research to explore how job satisfaction and wellbeing are experienced and negotiated within specific organisational and cultural settings. This rationale directly informs the design and focus of the empirical study presented in the subsequent chapters.

Knowledge gaps

Despite the growing numbers of studies examining job satisfaction and mental health among HCWs in GCC countries, the available literature remains limited in terms of what it can explain about HCWs' experiences. Based on the findings of this systematic review, several overarching evidence gaps were identified.

Methodological limitations: Research in the GCC, including Kuwait, has been dominated by cross-sectional, survey-based studies using closed-ended questionnaires, with no qualitative

data or open-ended responses included. In addition, a substantial proportion of the evidence was generated during the COVID-19 pandemic, raising questions about the extent to which findings reflect routine, non-crisis healthcare settings.

Measurement limitations: There is substantial variation in how job satisfaction and mental health are defined and measured across studies, with many instruments developed in Western contexts and variable reporting of validation within GCC settings.

Population limitations: The evidence base focuses predominantly on nurses and, to a lesser extent, doctors, with limited attention to mixed professional groups, administrative staff, or differences between expatriate HCWs and other staff groups.

Overall, these limitations indicate that the current evidence base is constrained in its ability to provide context-sensitive explanation of how job satisfaction and mental health are experienced and shaped within GCC healthcare systems. This thesis addresses these gaps through an interpretive qualitative study in Kuwait. While Chapter 2 establishes what has been studied empirically and where evidence remains limited, Chapter 3 provides conceptual grounding by examining how job satisfaction and wellbeing have been defined and theorised, and what existing frameworks may overlook when applied to Kuwait and the wider GCC context.

Chapter 3: Conceptual grounding

Introduction

This chapter provides an in-depth conceptual grounding of healthcare workers' (HCWs) job satisfaction and wellbeing, with particular attention to their relevance within the GCC and Kuwaiti healthcare context. Rather than duplicating the systematic review, this chapter engages selectively with international and regional literature to clarify key concepts, theoretical debates, and contextual issues that are essential for interpreting the qualitative findings and discussion that follow. While the systematic review focused on identifying and appraising empirical studies conducted in Kuwait and the wider Gulf Cooperation Council (GCC) region using a systematic approach, this chapter adopts a wider perspective. It situates job satisfaction and wellbeing within international theoretical debates while paying close attention to the institutional, cultural, and structural features of Kuwait's public healthcare system. Rather than attempting to review all available studies, the chapter takes a selective and analytical approach, focusing on how these concepts have been defined, understood, and examined across different contexts. Combined, these chapters establish the conceptual foundation for the study and highlight the key knowledge gaps that justify the present research.

As outlined in the Introduction (Chapter 1), HCWs' wellbeing and job satisfaction are widely recognised in the literature as central to the effective functioning of health systems, with clear implications for patient safety, quality of care, and staff retention. Despite this importance, much of the existing research in the GCC has focused primarily on quantifying levels of job satisfaction and wellbeing, most commonly through cross-sectional survey designs (e.g. Shah et al., 2004; Al-Turki et al., 2010; Al-Wotayan et al., 2019; AlKandari et al., 2022). While this work has generated valuable descriptive insights, it has tended to place less emphasis on exploring how these concepts are experienced and understood in everyday working life. Consequently, contextual factors related to organisational culture, institutional practices, and social hierarchies within GCC healthcare systems are less frequently examined in depth.

The purpose of this chapter is to synthesise existing literature to clarify how job satisfaction and wellbeing have been defined, measured, and experienced across different healthcare contexts. In doing so, the chapter identifies conceptual and contextual gaps that directly inform the study's aims and research questions. The chapter is organised into three main sections. The first examines how job satisfaction and wellbeing have been conceptualised in the literature, drawing attention to debates around definitions, cultural differences in interpretation, and the limitations of standardised measurement tools when applied in GCC settings. The second explores the relationship between job satisfaction and wellbeing, considering how this relationship may operate within Kuwait's public healthcare system. The final section synthesises the literature to

identify conceptual, methodological and population related gaps that provide a clear rationale for the present study.

Job satisfaction

Job satisfaction is commonly described in the literature as how individuals feel about their work and work experiences (Spector, 1997). However, there is no single agreed definition of job satisfaction, and different authors have defined the concept in different ways (Aziri, 2011). Some approaches emphasise emotional responses to one's job (Spector, 1997), while others focus on the alignment between workplace expectations and actual work experiences (Locke, 1976). Saari and Judge (2004) describe job satisfaction as an attitude that involves both emotional responses and cognitive evaluations of work experiences.

These differences show that job satisfaction is not treated as a single or uniform concept across studies but is understood in relation to both individual characteristics and work-related conditions (Aziri, 2011; Saari and Judge, 2004). Comparative research further suggests that perceptions of job satisfaction may vary across countries and contexts, indicating that findings from one setting may not always apply directly to another (Andrade and Westover, 2020). Research reviewed by Saari and Judge (2004) also indicates that features of the work itself, including job challenge, autonomy, and the range of tasks involved, play an important role in shaping job satisfaction.

Research suggests that individual characteristics explain only a limited proportion of job satisfaction, while features of the job itself play a more substantial role (Judge et al., 2001). This indicates that although personal differences matter, working conditions and organisational structures are often more influential in shaping how satisfied people feel in their jobs. Evidence from healthcare settings in the GCC region supports this view, showing that nationality-based differences in pay, benefits, and career opportunities are associated with variations in HCWs' job satisfaction (Almansour et al., 2021).

In Western studies, autonomy at work has consistently been linked to higher job satisfaction (Judge et al., 2001). However, in hierarchical healthcare systems such as those found in the GCC, where authority is concentrated at senior levels and respect for hierarchy is strongly emphasised, other factors may carry greater weight (Metcalfe, 2007; Almansour et al., 2021). In these contexts, fairness, respectful treatment, and job security appear particularly salient for HCWs' job satisfaction, especially among expatriate staff whose employment conditions are shaped by contractual and residency arrangements (Almansour et al., 2021).

Evidence from GCC healthcare systems further indicates that job satisfaction is closely tied to structural and relational features of work, including pay equity, promotion opportunities,

supervision quality, workload, leadership practices, and workplace relationships (Alkhateeb et al., 2025). Qualitative research with nurses in Saudi Arabia reinforces this pattern, highlighting how perceptions of fairness, stability, and respectful treatment shape job satisfaction in ways that reflect broader institutional and social arrangements (Almansour et al., 2021).

Altogether these findings underline the importance of understanding job satisfaction as contextdependent, shaped by local organisational structures and social norms rather than being universally defined across settings (Metcalfe, 2007). These conceptual differences have direct implications for how job satisfaction is measured **(**Spector, 1997). Variation in how job satisfaction is conceptualised is also reflected in measurement practices, particularly when standardised instruments developed in one context are applied in different institutional settings (Batura et al., 2016; Almansour et al., 2021). Validation research conducted outside Western contexts has shown that job satisfaction instruments may not replicate their original structure or fully capture locally relevant aspects of work, highlighting the need for contextual interpretation and adaptation (Batura et al., 2016).

Evidence from Kuwait illustrates this issue clearly. In a study of nurses working in public hospitals, the authors adapted the Mueller-McCloskey Satisfaction Scale by selecting 21 items from the original 31-item instrument and excluding ten items that were not applicable to the Kuwaiti healthcare system (Shah et al., 2004). The excluded items related to benefit packages, medical insurance, part-time work, childcare facilities, flexible scheduling, and weekends off. The authors explained that these aspects were not part of the employment benefits or administrative arrangements within the Kuwaiti Ministry of Health, where HCWs receive standardised salaries, free medical care, and fixed working conditions (Shah et al., 2004). This adaptation demonstrates how standardised job satisfaction measures may require modification to reflect local employment structures and organisational realities when used in different contexts.

Wellbeing

Wellbeing is a complex and multifaceted concept that has been conceptualised in different ways across disciplines, including psychology, public health, and organisational studies. In this thesis, wellbeing is understood in line with the World Health Organization’s framing introduced in Chapter 1, which emphasises positive functioning, the capacity to cope with everyday stresses, and meaningful participation in work and community life. Importantly, this framing positions wellbeing as more than the absence of mental disorder, foregrounding functional and positive dimensions of experience.

This study therefore prioritises the concept of ‘mental wellbeing’ over the broader term ‘mental health’. While ‘mental health’ is frequently operationalised in the literature as the absence of psychiatric pathology, ‘wellbeing’ explicitly encompasses positive dimensions of human experience, including flourishing, resilience, and optimal functioning (Keyes, 2005). This distinction is particularly relevant for studying HCWs, who may experience significant occupational strain without meeting clinical criteria for a mental health disorder. By focusing on wellbeing, this study avoids a purely deficit-based approach, allowing exploration of how workers continue to function and derive meaning from their work, even under sustained workplace pressures.

In healthcare contexts, wellbeing has also been defined in relation to work. Wellbeing at work has been described as a state in which workplace conditions enable staff to feel satisfied, function effectively, and sustain their professional roles, with benefits for both individuals and healthcare organisations (Boskma et al., 2023). This framing highlights the importance of workplace conditions in shaping HCWs’ wellbeing and reflects a normative, organisationoriented perspective that links staff wellbeing to patient care and organisational outcomes.

Hedonic and eudaimonic dimensions

To understand how these broad definitions translate into lived experience, a useful distinction in research differentiates between hedonic and eudaimonic dimensions (Ryan and Deci, 2001). Hedonic wellbeing is concerned with subjective experiences of pleasure, happiness, and the presence or absence of negative affect, while eudaimonic wellbeing focuses on meaning, purpose, self-realisation, and psychological functioning (Ryan and Deci, 2001). Rather than representing competing definitions, these perspectives capture different aspects of how wellbeing is experienced and sustained (Huta and Waterman, 2014). In the context of work, hedonic wellbeing reflects how individuals feel in response to their working conditions, whereas eudaimonic wellbeing relates more closely to how individuals understand their role, value, and sense of purpose within their work (Wright et al., 2007).

Despite the holistic definitions offered by the WHO, healthcare workforce research has largely examined wellbeing through a hedonic and deficit-oriented lens, with a strong emphasis on distress, burnout, and psychological symptoms (Maslach and Leiter, 2016). This pattern is particularly evident in studies from the GCC region, where wellbeing is frequently operationalised through burnout prevalence and severity, often using standardised instruments such as the Maslach Burnout Inventory (Chemali et al., 2019). While this literature e.g., (Chemali et al., 2019; Elbarazi et al., 2017) has been important in documenting the scale of occupational strain faced by HCWs, it has tended to equate wellbeing with the absence of

burnout. As a result, positive or meaning related dimensions of wellbeing are rarely explored, despite their theoretical relevance to healthcare work.

The limited attention paid to eudaimonic wellbeing is not simply a conceptual omission. Evidence from broader wellbeing research suggests that eudaimonic dimensions may play a particularly important role in sustaining health and resilience over time (Ryff, 2014). Longitudinal studies indicate that wellbeing grounded in meaning and purpose is more strongly associated with long-term health outcomes than hedonic indicators, which are more sensitive to short term emotional states (Garris and Weber, 2018). From this perspective, approaches that focus primarily on reducing distress may overlook the factors most likely to buffer chronic strain and support sustained engagement in demanding professions such as healthcare.

This imbalance is especially striking given the nature of healthcare work itself (Grant, 2007). Healthcare professions are commonly associated with moral purpose, social contribution, and meaningful engagement, yet the literature examining HCWs' wellbeing has largely neglected these dimensions. Conceptual work on meaning in healthcare has emphasised that feeling valued, trusted, and able to contribute meaningfully to patient care is central to professional identity and motivation (Toubassi et al., 2022). When these aspects are undermined, wellbeing may deteriorate even in the absence of acute distress, suggesting that eudaimonic wellbeing is not an optional addition but a core component of professional sustainability (Wright, et al., 2007; Steptoe et al., 2015).

Addressing this imbalance is particularly important in healthcare settings, where workers often continue to perform despite high levels of strain, sustained not by the absence of distress but by a commitment to their professional role (Toubassi et al., 2022). This perspective highlights the need for approaches that attend to both hedonic and eudaimonic dimensions when examining HCWs' wellbeing.

Sociocultural context

In Kuwait and the wider GCC, healthcare organisations are characterised by nationality-based employment structures and hierarchical systems of authority, both of which influence everyday workplace interactions and decision-making (Alkhateeb et al., 2025). Qualitative research with nurses in Saudi Arabia suggests that these structural features are not merely administrative arrangements but actively shape how HCWs understand job satisfaction, security, and wellbeing in their daily work (Almansour et al., 2021).

These organisational arrangements are closely connected to broader cultural expectations surrounding authority, hierarchy, and obedience, which have been widely discussed in relation to organisational and institutional contexts in the GCC region (Metcalfe, 2007; Hofstede

Insights, 2017). One way these expectations have been conceptualised in cross-cultural research is through the concept of power distance. Power distance, as defined by Hofstede, refers to the extent to which unequal distributions of power are accepted and expected within organisations and societies (Hofstede and Bond, 1988, cited in Rinne et al., 2011). In high power-distance contexts, authority tends to be centralised, hierarchical relationships are normalised, and opportunities for junior staff to influence decisions are limited (Matusitz and Musambira, 2013).

Kuwait is consistently classified as a high power-distance society in Hofstede's country-level comparisons (Hofstede Insights, 2017). Within healthcare settings, this has important implications for how HCWs experience and evaluate their work. Hierarchical decision-making may be viewed as legitimate or inevitable, yet it can also restrict professional voice, reduce perceived autonomy, and shape how concerns are raised or silenced (Matusitz & Musambira, 2013; Morrison, 2014). These dynamics are particularly relevant for understanding job satisfaction and wellbeing, which are not experienced solely at an individual level but are embedded within organisational power relations (Hofstede, 2001).

The effects of hierarchy are further intensified by nationality-based employment arrangements within Kuwait's public healthcare system (Al-Enezi et al., 2009). Kuwaiti nationals are employed under permanent civil service contracts, while most expatriate HCWs work on renewable contracts that are directly linked to residency status (Mossialos et al., 2018).

In Kuwait, civil service contracts are standardised public sector employment arrangements applied primarily to Kuwaiti citizens, and to a small proportion of expatriates, working in government institutions such as public hospitals. These contracts involve fixed salary scales, regulated working hours, and centrally defined promotion and appraisal systems. Employment conditions are overseen by the Civil Service Commission (CSC), the government body responsible for regulating recruitment, grading, and personnel affairs across the public sector (Civil Service Commission Kuwait, n.d.; Sakan, 2025).

By contrast, most expatriate HCWs are employed on more contingent and time limited contracts. Although expatriates have historically formed a substantial proportion of the public healthcare workforce, recent policy directions linked to 'Kuwaitization' signal restrictions on contract renewal for non-nationals, with potential implications for workforce stability in public hospitals (Kuwait Times, 2025). For expatriate staff, job satisfaction and wellbeing are therefore closely tied to job security, professional dignity, and protection from arbitrary decision making (Almansour et al., 2021). Kuwaiti nationals, by comparison, typically experience greater employment stability, which may shape how workplace stressors are perceived and managed.

As a result, the same organisational conditions can carry very different emotional and psychological meanings for different groups of HCWs.

Gender norms further shape how work-related pressures are experienced. For many female HCWs in Kuwait, wellbeing is influenced not only by hospital-based demands but also by social expectations surrounding family responsibilities, caregiving, and gendered roles (Kreedi, 2022).

These expectations can intensify work-home tensions, particularly in work contexts characterised by long hours and limited flexibility (Byron, 2005) and may in turn constrain opportunities for recovery and psychological detachment from work (Sonnentag and Fritz, 2015). Such dynamics are often inadequately captured by standardised wellbeing measures that prioritise individual symptoms over contextual pressures (Ryff, 2014).

These sociocultural and structural features raise important questions about the use of Westerndeveloped measurement scales in culturally distinct settings. Job satisfaction and wellbeing are frequently treated in the literature as stable, universally measurable constructs (Spector, 1997). However, cross-cultural research has long highlighted the limitations of this assumption, particularly when instruments are transferred across contexts without sufficient adaptation (van de Vijver and Leung, 2000; Beaton et al., 2000). In settings such as Kuwait, where work experiences are shaped by hierarchy, nationality, gender, and contract type, standard measures may fail to capture what wellbeing actually means to HCWs themselves.

Treating job satisfaction and wellbeing as fixed constructs risks oversimplifying HCWs' lived experiences and obscuring the institutional and cultural conditions that shape them, a concern widely raised within qualitative methodological scholarship (Braun and Clarke, 2020). This issue is especially salient in Kuwait's public healthcare system, which is highly stratified by profession, nationality, and gender, and where organisational policies may affect different groups in uneven and sometimes invisible ways (Almutairi and McCarthy, 2012; Kreedi, 2022). Existing studies therefore point to the need to understand HCWs' job satisfaction and wellbeing as contextdependent, socially situated experiences rather than abstract psychological states. This perspective has direct implications for research design and supports the use of qualitative approaches that centre HCWs' own interpretations of their working lives.

Relationship between job satisfaction and wellbeing

The relationship between job satisfaction and wellbeing has been widely examined in organisational and occupational health research (Spector, 1997). Across international and regional literature, a consistent positive association has been reported between how satisfied individuals feel in their jobs and their psychological wellbeing (Wright et al., 2007). Meta-analytic evidence indicates that job satisfaction is strongly linked to mental health outcomes, with lower

satisfaction associated with higher levels of stress, burnout, anxiety, and depressive symptoms (Faragher et al., 2005). This relationship has been observed across a range of occupational groups and settings, suggesting that job satisfaction is a meaningful correlate of wellbeing rather than a peripheral factor in working life.

Research from healthcare settings similarly reports links between job satisfaction and indicators of wellbeing, including emotional strain and stress-related outcomes (Al-Enezi et al., 2009).

Studies consistently show that HCWs who report lower job satisfaction also report poorer wellbeing, including higher emotional exhaustion and psychological distress (Friganović et al., 2019; Maulidina and Iswiniarti, 2025). Given the demanding nature of healthcare work, this association is particularly salient. Work in caring professions often involves sustained interpersonal engagement and moral responsibility, all of which shape how satisfaction and wellbeing interact over time (Grant, 2007).

At the same time, the relationship between job satisfaction and wellbeing is not uniform. Evidence suggests that job satisfaction and psychological wellbeing are distinct constructs and that their relationship does not operate in a simple or universal manner but varies depending on individuals' levels of wellbeing (Wright et al., 2007). Workload intensity, autonomy, quality of supervision, and access to social support all influence how job satisfaction translates into psychological wellbeing (Tatlıcıoğlu et al., 2024; Kautish et al., 2025). This complexity is especially evident in high-demand professional environments such as healthcare, where sustained exposure to chronic stressors may compromise wellbeing even among individuals who report moderate or relatively high levels of job satisfaction (Cefai et al., 2025). In such contexts, satisfaction alone may be insufficient to buffer the cumulative effects of workload pressure and organisational strain. HCWs may continue to value and feel committed to their work despite these pressures, reflecting the moral and relational dimensions of caring roles (Grant, 2007), while simultaneously experiencing deterioration in their psychological wellbeing, indicating that satisfaction does not automatically translate into positive wellbeing outcomes in demanding institutional settings (Ryff, 2014).

Within the GCC region, available evidence broadly mirrors international findings. Survey-based studies conducted in Kuwait, Saudi Arabia, and other GCC countries consistently report associations between job satisfaction and indicators of mental health, with lower satisfaction linked to higher stress, burnout, and psychological distress (Shah et al., 2004; Al-Turki et al., 2010; Elbarazi et al., 2017). These findings confirm that the relationship between job satisfaction and wellbeing is evident within GCC healthcare systems, not only Western contexts. However, the institutional characteristics of these systems appear to intensify this connection for certain groups of workers.

For expatriate healthcare staff, employment is often directly linked to residency status, creating a situation in which job dissatisfaction carries implications that extend beyond the workplace to legal, economic, and family stability (Baazeem, 2018; Yehya et al., 2020). In this context, dissatisfaction with pay, recognition, or treatment is experienced not solely as a negative work attitude but as a threat to security and professional dignity, as workplace treatment functions as a signal of status and belonging within the organisation (Lind and Tyler, 1988). The protective function that job satisfaction typically provides against occupational stress may therefore operate differently for expatriate staff, whose workplace challenges are tied to broader life circumstances (Almansour et al., 2021).

Despite these consistent statistical associations, existing research offers limited insight into how HCWs themselves understand and navigate the relationship between job satisfaction and wellbeing in their daily working lives. Survey-based studies confirm that satisfaction and wellbeing move together in predictable ways but do not capture the processes through which workers manage these tensions in practice. In particular, the literature has yet to explore how resources such as religious faith, family and community support, and the intrinsic meaning derived from patient care may allow some workers to sustain their wellbeing even under conditions of low job satisfaction or high occupational strain (Badawy et al., 2024; Ali and Shaban, 2025). Understanding these connections requires approaches that move beyond documenting the magnitude of associations to exploring how the relationship between job satisfaction and wellbeing is experienced, negotiated, and given meaning within specific healthcare settings. These limitations are addressed in the following section, which identifies key gaps in the existing evidence base.

Knowledge gaps

Building on the systematic review (Chapter 2), this chapter highlights a set of conceptual and contextual gaps that limit how existing research interprets HCWs' job satisfaction and wellbeing in Kuwait and the wider GCC. These gaps are not only about study design or coverage, but about the underlying assumptions through which job satisfaction and wellbeing are defined, measured, and understood.

A central limitation is the tendency for regional research to use narrow operational indicators that do not capture the full range of HCWs' experiences. While international research increasingly recognises that job satisfaction and wellbeing encompass both positive and negative dimensions of working life (Faragher et al., 2005; Schaufeli et al., 2009), GCC research often relies on a limited set of quantifiable factors. Job satisfaction is commonly assessed using indicators such as salary, workload, and working hours (Alkhateeb et al., 2025), while wellbeing is frequently operationalised primarily through burnout and psychological

distress, with burnout often treated as the dominant marker of wellbeing (Elbarazi et al., 2017; Chemali et al., 2019). This emphasis produces an imbalance in the literature in which sources of dissatisfaction and stress are well documented, but positive dimensions such as meaning, professional pride, fulfilment, and resilience receive comparatively less attention (Alkhateeb et al., 2025). Although some qualitative studies have begun to explore coping, resilience, and meaning among GCC-based HCWs, this body of work remains limited (Badawy et al., 2024; Ali and Shaban, 2025).

A further conceptual weakness is the tendency to treat job satisfaction and wellbeing as separate constructs. International evidence suggests an interrelationship between the two, with job satisfaction supporting psychological wellbeing and wellbeing shaping how individuals evaluate their work (Faragher et al., 2005; Schaufeli et al., 2009). In the GCC context, however, studies often report statistical associations without examining how satisfaction and wellbeing interact in everyday working life (Alkhateeb et al., 2025). This limits understanding of how HCWs make sense of these experiences as interconnected dimensions of daily work.

Limited engagement with cultural meaning and institutional interpretation

Existing studies highlight that satisfaction in Kuwait and the wider GCC is shaped by organisational and contextual conditions such as pay, supervision, working conditions, and career progression, rather than by individualised notions of autonomy alone (Shah et al., 2004). Among expatriate HCWs, quantitative evidence reports strong associations between dissatisfaction with employment conditions (including salary, workload, and teamwork) and poorer mental health outcomes (Saquib et al., 2019). However, insufficient attention is paid to how HCWs interpret and prioritise job satisfaction and wellbeing within these institutional and cultural arrangements, including how hierarchy, nationality, and contractual conditions shape what wellbeing and “good work” mean in practice.

The dominance of cross-sectional questionnaire designs constrains explanatory depth by limiting insight into how workplace experiences relate to one another and evolve over time (Wang and Cheng, 2020; Alkhateeb et al., 2025). Survey-based approaches rely on predefined categories, which can restrict exploration of how HCWs interpret and describe their experiences (Wang and Cheng, 2020). These limitations are reinforced when standardised instruments developed in Western organisational contexts are applied without sufficient adaptation or validation, as cross-cultural research has shown that assumptions embedded in measures do not always translate across settings with different social and institutional norms (van de Vijver and Leung, 2000). The relative lack of qualitative inquiry in the regional literature further limits understanding of how HCWs make sense of workplace pressures, organisational practices, and sources of support in everyday working life (Badawy et al., 2024; Ali and Shaban, 2025).

Taken together, these gaps indicate a need for approaches that move beyond documenting levels of satisfaction or distress to examine how job satisfaction and wellbeing are constructed, negotiated, and sustained within the organisational and sociocultural realities of Kuwait's public healthcare system. This provides the rationale for the interpretive qualitative approach adopted in this thesis, outlined in the following section.

Rationale for this study

Building on the empirical gaps identified through the systematic review in chapter 2, the conceptual, methodological, population, and contextual limitations identified in this literature review indicate a clear need for an alternative approach to understanding job satisfaction and wellbeing among HCWs in Kuwait. While existing research has generated valuable descriptive evidence, its predominant reliance on standardised survey designs has provided limited insight into how HCWs themselves understand and experience these aspects of working life within their specific institutional and sociocultural contexts.

Conceptually, this study approaches job satisfaction and wellbeing as experiences shaped through everyday work practices, relationships, and organisational arrangements, rather than as isolated variables captured solely through predefined measures. By focusing on how HCWs describe and interpret satisfaction and wellbeing in practice, the study responds to the limited attention given in the literature to the lived and relational dimensions of these experiences, including how meaning, professional identity, and commitment are sustained within demanding healthcare environments.

Methodologically, the study addresses the dominance of cross-sectional survey designs in the GCC literature by adopting a qualitative approach based on semi-structured interviews and reflexive thematic analysis. This approach enables a more detailed examination of how job satisfaction and wellbeing are experienced, negotiated, and connected in practice, offering insight into processes that are not readily captured through quantitative measures alone.

In terms of population scope, the study includes HCWs from multiple professional groups, including physicians, nurses, pharmacists, laboratory staff, and administrative personnel. This responds directly to the narrow professional focus identified in previous research (Chapters 2 and 3) and allows for exploration of variation in experiences across different roles and hierarchies within the hospital setting.

Contextually, the study attends to the organisational and institutional environment in which HCWs are embedded. By considering how workplace structures, nationality-based employment arrangements, and workforce stratification shape everyday experiences of job satisfaction and

wellbeing, the research addresses the limited engagement with context identified in the existing literature and situates HCWs' accounts within the realities of Kuwait's public healthcare system.

Overall, this study seeks to provide a contextualised qualitative account of how HCWs in Kuwait understand and experience the relationship between their work and their wellbeing. The following chapter outlines the methodological approach adopted to support this aim.

Conclusion

The literature reviewed in this chapter shows that job satisfaction and wellbeing among HCWs cannot be understood only as individual psychological experiences. They are also shaped by the organisational, relational, and cultural conditions within which healthcare work takes place. Although job satisfaction and wellbeing are frequently discussed together in the international literature, evidence from Kuwait and the wider GCC continues to conceptualise and measure them in relatively narrow ways, often through survey-based assessments focused on burnout, stress, and psychological distress. This limits what can be understood about how HCWs themselves experience wellbeing and job satisfaction in their everyday working lives.

A key conclusion from this chapter is that existing approaches provide only a partial account of HCWs' experiences within the regional healthcare context. Workplace experiences are shaped by institutional structures, professional hierarchies, and sociocultural dynamics that are not easily captured through standardised quantitative measures alone. The limited use of qualitative methodologies and the narrow representation of professional groups within the GCC literature therefore restrict understanding of how HCWs interpret wellbeing, satisfaction, pressure, and support within their own working environments.

These conceptual, methodological, and population-related limitations provide a clear rationale for the qualitative and interpretivist approach adopted in this thesis. The following chapter therefore outlines the methodological framework developed to explore HCWs' experiences of job satisfaction and wellbeing in greater contextual and experiential depth through semistructured interviews and reflexive thematic analysis.

Chapter 4: Methodology

Introduction

This chapter describes and justifies the methodology and research methods employed in this study. As established in the literature review (Chapters 2 and 3), the existing literature on job satisfaction and wellbeing among healthcare workers (HCWs) in the Gulf Cooperation Council (GCC) and Kuwait in particular, is dominated by quantitative designs and single-profession

samples. These studies also relied largely on Western-developed scales and questionnaires, often applied with little cultural adaptation. These limitations are not only empirical but methodological, as they restrict the ability of existing approaches to capture how HCWs themselves interpret and experience job satisfaction and wellbeing within the Kuwaiti public healthcare context. In response, this study adopted a qualitative, interpretivist approach, using semi-structured interviews for data collection and reflexive thematic analysis for data analysis.

The chapter begins with a description of the study design, setting, and study population, with justifications for each. The sampling approach and recruitment process are then detailed, including the role of the gatekeeper. The chapter next outlines the data collection procedures and justifies the use of semi-structured interviews as the primary method of data collection. Reflexive thematic analysis (RTA) is then presented as the analytic approach used to interpret the data, with an explanation of how it was applied in this study. A discussion of the ethical considerations relating to data collection, storage, and analysis follows, alongside a section on researcher reflexivity. The chapter concludes by describing the practical and methodological challenges encountered during the study.

Research design and methodology

This study adopts an interpretivist paradigm and is conducted as applied qualitative research, underpinned by a contextualist ontological position. It builds directly on the gaps identified in Chapter 2 and 3, where the literature on HCWs' job satisfaction and wellbeing in the GCC, and Kuwait in particular, was shown to be dominated by quantitative designs, single-profession samples, and the use of Western-developed measurement tools with limited cultural adaptation. These approaches often treat job satisfaction and wellbeing as stable, universally understood constructs, with insufficient attention to the social, cultural, and institutional contexts in which healthcare work is embedded. The study design and analytic approach are described in detail below.

The aim of this research was to explore how HCWs in a Kuwaiti public hospital experience and make sense of job satisfaction and mental wellbeing in their everyday working lives. In addition, the study sought to examine whether these experiences and understandings vary across different professional and demographic groups, including professional role, nationality, and gender. My own position as a physician working within the Kuwaiti public healthcare system informed both the design of the study and my engagement with participants, an issue returned to later in the reflexivity section.

I adopted an interpretivist stance because it assumes that experiences of work and wellbeing are not fixed or universal but are understood and negotiated through individuals' interactions

with their social and organisational environments (Schwandt, 1998; Braun and Clarke, 2019). This stance is underpinned by a contextualist ontology, which treats participants' accounts as reflecting real and consequential experiences, while recognising that these experiences are always shaped by broader institutional, cultural, and power structures rather than existing independently of context (Braun and Clarke, 2019). This perspective was particularly important in the context of Kuwait's public healthcare system, where professional role, nationality, contractual security, gender, and hierarchical position strongly influence how work is experienced, talked about, and emotionally processed. In line with this position, job satisfaction and wellbeing in this study were understood as dynamic and negotiated experiences shaped by organisational culture, workplace relationships, and institutional norms. Rather than aiming to produce statistically generalisable findings, the study sought to develop a contextualised understanding of how HCWs construct meaning around satisfaction and wellbeing within their own workplace, while generating insights that may be transferable to similar public healthcare contexts characterised by comparable institutional and cultural dynamics.

The study was explicitly applied in orientation. In addition to contributing to academic discussions about job satisfaction and wellbeing, the research aimed to generate contextually grounded insights that could inform organisational understanding and future practice within the Kuwaiti healthcare system. In line with applied qualitative research traditions, the emphasis was therefore on depth of understanding, attention to context, and practical relevance, while maintaining analytic rigour.

This applied orientation was informed by the framework developed by Ritchie and Spencer (1994), who describe four types of applied qualitative research: contextual, diagnostic, evaluative, and strategic. The decision to use an applied qualitative approach was also shaped by my hope that the findings could support reflection and dialogue within the health system. I wanted to create space for the voices of HCWs and to present insights that could contribute to improving working conditions and wellbeing within Kuwait's public healthcare sector. The present study sits primarily within the contextual category, as it focuses on how HCWs in a large Kuwaiti teaching hospital make sense of job satisfaction and wellbeing within their workplace. There was also a diagnostic element. Many participants described underlying organisational issues that contributed to dissatisfaction and emotional strain, such as perceived unfair treatment, lack of managerial support, and feeling undervalued. Some participants also offered suggestions for improvement, including raising awareness of mental wellbeing and developing fairer work schedules, introducing a limited strategic dimension in terms of participant reflections on possible improvements. The evaluative category, which focuses on assessing the effectiveness of existing interventions or services, was not relevant to the aims of this research and was therefore not adopted.

Within this broader interpretivist and applied qualitative framework, I adopted reflexive thematic analysis (RTA) as the analytic method that best matched the research questions, the nature of the data, and the level of analysis required, particularly the need to examine patterned meaning across diverse professional and demographic groups. The rationale for this decision, and for rejecting alternative methodological approaches, is outlined below.

Analytic approach: Reflexive thematic analysis

Within the interpretivist and applied qualitative framework outlined above, I used RTA as the method for analysing the interview data. While Thematic Analysis is sometimes described as a methodology, Braun and Clarke emphasise that it is best understood as a theoretically flexible analytic method that becomes infused with epistemological and theoretical assumptions when enacted within a particular study (Braun and Clarke, 2019; Braun and Clarke, 2020). In this research, RTA was enacted within an interpretivist, contextualist framework, which shaped how meaning was understood, how themes were constructed, and how participants' accounts were interpreted (Braun and Clarke, 2020).

RTA was selected because it is explicitly designed to identify and interpret patterned meaning across a dataset, rather than prioritising idiographic depth or theory generation (Braun and Clarke, 2019; Braun and Clarke, 2020). This made it particularly well suited to the aims of the study, which required examining shared and divergent experiences across a diverse group of HCWs operating within the same institutional system.

The reflexive orientation of RTA was especially important given my position as a Kuwaiti physician working within the same healthcare system as the participants. My insider status shaped how interviews unfolded, how trust developed, and what participants felt comfortable sharing, particularly in relation to hierarchy, nationality, and perceived power differences. RTA provided a coherent analytic framework in which this positionality could be acknowledged and worked with explicitly, rather than treated as a source of bias to be minimised or bracketed out (Braun and Clarke, 2019; Braun and Clarke, 2020). Subjectivity was therefore approached as an analytic resource, supporting sensitivity to context, unspoken norms, and the emotional weight of participants' accounts.

The analysis was primarily semantic and inductive, focusing on what participants explicitly said about their experiences of work, job satisfaction, and wellbeing. In line with Braun and Clarke's typology, the analysis can be characterised as semantic, inductive, experiential, and broadly essentialist (Braun and Clarke, 2022). Participants' accounts were treated as reflecting real and consequential aspects of their working lives, while recognising that these experiences are always shaped by their institutional and cultural context.

As outlined in the Introduction (Chapter 1), this study was guided by two overarching aims: first, to explore the factors shaping job satisfaction and mental wellbeing among HCWs in Kuwait, as understood through their day-to-day work experiences; and second, to examine whether these experiences varied across professional and demographic groups. These aims informed the choice of a qualitative, interview-based design and the use of reflexive thematic analysis to capture both shared and divergent patterns of experience. Having outlined the analytic approach adopted in this study, the following section explains why alternative qualitative methodologies were considered but ultimately not selected.

Alternative methodologies considered

At the design stage, several qualitative methodologies were explored to ensure strong alignment between the research aims, the anticipated data, and the analytic approach. This included phenomenology, particularly Interpretative Phenomenological Analysis (IPA), grounded theory, framework analysis, and ethnography. Each offered valuable tools, but none ultimately provided the best fit for the study as it developed.

Phenomenology, most likely in the form of IPA, was the originally intended methodological approach at the outset of the project. This initial choice was driven by the study's focus on experience, meaning, and wellbeing, and by phenomenology's emphasis on understanding how individuals make sense of their lived worlds.

However, as data collection progressed and I began to engage closely with the interview material, it became clear that a phenomenological approach was not well suited to either the dataset or the analytic aims of the study. Phenomenological methodologies, including IPA, are explicitly idiographic. They prioritise detailed, case-by-case analysis and seek to develop rich interpretations of individual meaning-making before moving to cross-case patterns (Smith et al., 2009). As such, they are best suited to small, relatively homogeneous samples.

In contrast, this study involved a heterogeneous group of participants from different professional backgrounds, nationalities, and institutional roles working within the same organisational system. Participants frequently framed their experiences in collective and systemic terms, focusing on management practices, organisational policies, inequities, and workplace culture, rather than on individual existential meaning-making alone. The central analytic task was therefore to identify shared patterns across diversity, not to produce detailed idiographic accounts of individual experience or to identify the essence of job satisfaction or wellbeing.

Attempting to impose an idiographic phenomenological framework on these accounts would have required narrowing the analytic focus in ways that obscured the organisational and structural dynamics central to the research questions. The decision to move away from

phenomenology was therefore a reflexive methodological decision driven by engagement with the data, rather than a post hoc rationalisation.

Grounded theory methodologies are oriented towards theory generation and typically require iterative cycles of data collection and analysis alongside theoretical sampling (Charmaz, 2014). This study was not designed to generate a new formal theory of job satisfaction or wellbeing. Instead, it aimed to explore and interpret how HCWs experience these phenomena within a specific organisational and cultural context and to relate these experiences to existing conceptual frameworks. The fixed timeframe and defined sample of a doctoral study conducted within a single hospital were also incompatible with the open-ended sampling strategies required by grounded theory approaches.

Framework Analysis was considered because of its established use in applied health and policy research and its emphasis on systematic comparison across cases and stakeholder groups (Ritchie and Spencer, 1994). The approach typically involves the early construction of an analytic framework and the organisation of data into matrices to facilitate comparison and applied outputs. While this structure can be advantageous for studies designed to inform service delivery or policy development, it also carries a risk of flattening participants' accounts by prioritising categorisation and comparability over depth of interpretation. Given this study's relatively small sample and single hospital setting, the use of Framework Analysis was considered less appropriate, as the design did not aim to generate policy ready outputs or formal cross case comparison. Instead, the study prioritised analytic flexibility, reflexive engagement, and interpretive depth, making Framework Analysis a less suitable methodological fit.

Ethnographic approaches were briefly considered given the study's interest in organisational culture and workplace dynamics. However, ethnography requires prolonged immersion and sustained participant observation (Hammersley and Atkinson, 2019). Although my professional background as a Kuwaiti physician provided insider contextual knowledge, the study was not designed around long-term observation, and data collection was limited to semi-structured interviews. An ethnographic approach was therefore methodologically inappropriate.

Study setting

This study was carried out at Mubarak Al-Kabeer Hospital, one of Kuwait's main public healthcare facilities operated by the Ministry of Health (MOH). Located in the Hawalli governorate, it serves a densely populated area and functions as a referral centre for multiple districts. It is also the designated teaching hospital for Kuwait University's Faculty of Medicine. A physical bridge connects the hospital and university, reflecting their long-standing collaboration in clinical training and academic research. This close relationship has created a researchfriendly

environment, where staff are generally familiar with the expectations and procedures of healthrelated studies.

I chose Mubarak Hospital as the study site for several reasons. First, the hospital has a wide range of specialties which gave me access to a diverse sample of HCWs. Second, the workforce reflects the broader MOH system in terms of gender, nationality, and professional roles, including both clinical and administrative staff. This made it a useful site for developing insights that could resonate with experiences across the wider public healthcare system in Kuwait. Third, as a teaching hospital with an established culture of research and its proximity to the university, Mubarak was institutionally accessible. My own employment within the Ministry and the formal ethical approvals from both the University of Sheffield and the Kuwait Ministry of Health Research and Ethics Committee made the process of access and recruitment more straightforward than it might have been elsewhere.

Study population

The participants in this study were HCWs employed in the public healthcare system under the MOH. The MOH workforce included approximately around 70,000 employees across a range of professions, including doctors, nurses, pharmacists, lab technicians, dentists, and administrative staff (Ministry of Health Kuwait, 2022). Kuwait's health sector is known for its professional and demographic diversity. Many roles, especially in medicine and nursing, are held by expatriates, most commonly from countries like India, Egypt, and the Philippines, while administrative and technical positions are more likely to be filled by Kuwaiti nationals (AlJarallah et al., 2009). This diversity shaped how I approached sampling for the study, including the deliberate inclusion of both Kuwaiti and expatriate healthcare workers.

A central aim of the research was to explore how job satisfaction and mental wellbeing are experienced across different roles, nationalities, and genders within the public hospital system. Most previous studies in Kuwait have focused on specific professions, often nurses or physicians, and relied on survey methods (Shah et al., 2001; Al-Enezi et al., 2009). In contrast, I purposely included participants from a broad range of job categories: nurses, physicians, pharmacists, technicians, and administrative staff. This allowed me to capture a wider range of perspectives and to explore how satisfaction and wellbeing are shaped by institutional hierarchies, professional identity, and social background.

Sampling and recruitment

This study used purposive sampling with the intention of achieving maximum variation across healthcare professions, nationalities, genders, and job roles within Kuwait's public healthcare

system. The sampling strategy was designed to include participants occupying different institutional positions within a public hospital, rather than to achieve statistical representativeness. In practice, recruitment was also shaped by participants' availability and willingness to take part, meaning that the final sample reflected a pragmatic balance between purposive selection and elements of convenience. This approach aimed to generate a rich, context sensitive understanding of how job satisfaction and mental wellbeing are experienced and interpreted within a specific organisational setting, consistent with an interpretivist and contextualist orientation in which meaning is understood as situated within particular social and institutional environments (Schwandt, 1998).

An initial sample size of 30 participants was set in consultation with my supervisors as a planning estimate. By the twentieth interview, the dataset was judged to be sufficiently rich to support analytic development, and further recruitment was considered unlikely to substantially extend interpretive insights. This judgement was made reflexively and discussed with my supervisors, in line with Braun and Clarke's (2020) position that adequacy in reflexive thematic analysis is defined by depth, meaning, and analytic engagement rather than numerical thresholds. Recruitment continued beyond this point in order to reach the initially set target; however, no further participants came forward despite ongoing efforts. At the same time, delays in ethics approvals and practical recruitment challenges shaped the pace and scope of fieldwork and are discussed later in this chapter.

Participants were recruited based on the following inclusion criteria:

- Physicians
- Nurses
- Pharmacists
- Laboratory technicians
- Administrative staff
- Nationality: Kuwaiti and non-Kuwaiti
- Gender: Male and female

Although the sampling strategy aimed to achieve broad representation across professional groups within the hospital, the final sample was unevenly distributed across professions.

Physicians and nurses were more strongly represented within the dataset, while professions such as pharmacy and laboratory services were represented by fewer participants. These differences reflected practical recruitment challenges and participant willingness to take part, despite continued efforts to recruit across diverse professional groups. Nevertheless, the final sample still reflected diversity across nationality, gender, and professional background.

Recruitment was facilitated through a hospital administrator who acted as the gatekeeper for the study. Following institutional approval, a departmental memo was circulated through the hospital's internal administrative system using formal paper-based notices distributed to departments, reflecting the limited use of institution-wide email communication for staff announcements within the Kuwaiti public healthcare context. The memo introduced the study, confirmed approval from the Ministry of Health and hospital administration, and invited healthcare workers to express interest in participating. It included a QR code and contact details allowing interested staff to contact me directly. The memo was available in both Arabic and English to reflect the linguistic diversity of the hospital workforce.

In addition to this general circulation, I approached healthcare workers in person within their departments while distributing the study memo, introduced myself as a researcher, and requested permission to contact them regarding the study. Contact details were provided directly by potential participants on a voluntary basis, after which individual invitations were sent via WhatsApp. This formed part of the purposive sampling strategy described above, with the aim of ensuring representation across different professions, nationalities, and genders. Some participants were professional colleagues known to me prior to the study; however, none were individuals over whom I had managerial authority, and participation was emphasised as entirely voluntary.

Healthcare workers who expressed interest were provided with a detailed participant information sheet, available in Arabic and English, outlining the study's aims, what participation would involve, and how data would be handled, including arrangements for confidentiality and anonymity. Interested participants contacted me directly using a dedicated mobile phone number used exclusively for the study, which helped maintain professional boundaries, limit access to identifiable contact information, and ensure that participant communications were kept separate from personal and clinical correspondence. The gatekeeper was not informed of who chose to participate.

Interviews were arranged directly with participants via WhatsApp or text messaging for scheduling purposes, at a time and location of their choosing. Where no preference was expressed, I suggested quiet and private spaces within the hospital to support open and confidential discussion. Interviews were typically scheduled several days in advance, and in some cases, reminders were sent beforehand. Written informed consent was obtained from all participants prior to the interview. Most participants signed and returned the consent form electronically before the interview day, while others preferred to sign at the start of the interview itself. As with all study materials, consent forms were available in both Arabic and English.

Gatekeeping

Access to the study site was obtained through the formal research approval process required by the Kuwait MOH. Although I was employed as a physician within the Ministry, I had no personal or professional ties to Mubarak Al-Kabeer Hospital's leadership. This meant that access was secured through official channels, not through prior relationships. Once ethical and institutional approvals were granted, I reached out to the designated administrative gatekeeper at Mubarak Hospital, who served as the liaison for coordinating approved research activities.

The gatekeeper's role was strictly limited to facilitating institutional access. This included confirming internal permissions, providing approval for the use of hospital spaces when needed, and circulating a general study invitation through the hospital's internal communication system. This was done via a printed memo that was posted in each department's communal office area, or in the head of department's office where no dedicated shared space existed. The memo was a general invitation visible to staff who used those spaces, though it may not have reached those who rarely visited the office areas, such as staff on leave or those working primarily in clinical spaces away from administrative areas. No individuals were named or specifically targeted. The gatekeeper did not participate in identifying or recruiting participants. Instead, HCWs who were interested in the study were invited to contact me directly. This ensured that participation remained entirely voluntary and free from institutional pressure.

This separation between institutional access and participant engagement was intentional. It reflected both ethical good practice and the sensitivity of the study topic, which explored personal experiences of job satisfaction and mental wellbeing in the workplace.

By keeping a clear boundary between access and recruitment, the gatekeeping process helped protect the integrity of the study and supported a respectful, ethically sound approach to engaging with the hospital community.

Data collection method

Semi-structured interviews

I chose semi-structured interviews as the main method of data collection, guided by the study's interpretive orientation, applied focus, and the practical realities of research in the Kuwaiti public healthcare system. This format offered a balance between structure and openness, allowing participants to speak freely while ensuring coverage of key topics through the use of an interview guide that could be adapted to probe responses and follow issues raised by participants. This approach is well suited to exploring personal experiences of complex and emotionally sensitive issues such as job satisfaction and mental wellbeing (DeJonckheere and Vaughn, 2019).

The format also worked well in a diverse and hierarchical hospital setting. Given the wide range of professions, nationalities, and social roles among participants, a method that was both flexible and respectful of local dynamics was essential. Interviews allowed space for participants to introduce concerns that mattered to them, while still engaging with the study's core areas of interest. This flexibility is especially important in cross-cultural research, where researchers must attend to both the interpretive nature of translation and the influence of power and positionality (Temple, 2002; DeJonckheere and Vaughn, 2019).

Before settling on semi-structured interviews, I considered several other data collection methods. Participant observation was discussed early on, but it was not feasible within clinical spaces where privacy, patient safety, and institutional restrictions limit the presence of non-staff observers. In addition, key aspects of job satisfaction and mental wellbeing are lived and interpretive experiences rather than directly observable phenomena; understanding them requires attention to how individuals define and make sense of their own situations (Schwandt, 1998). Focus groups were also explored but ultimately rejected. Given the sensitive nature of topics such as stress, mental health, and workplace dissatisfaction, participants may have been reluctant to speak openly in front of colleagues or supervisors. Strong professional hierarchies within Kuwaiti public hospitals, combined with the multicultural composition of the workforce, increased the risk of social desirability bias and unequal participation (Kitzinger, 1995).

Documentary sources, such as policy manuals or hospital protocols, were considered only as supplementary context rather than a primary data source. These materials tend to present formal institutional expectations rather than the lived experiences of HCWs and were therefore not suitable for answering my research questions. Because my aim was to understand how staff make sense of their everyday working lives, I needed a method that allowed them to speak in depth and in their own terms.

For these reasons, individual interviews became the most appropriate approach. Within that, I avoided both extremes. Fully structured interviews would have been too rigid for participants with diverse backgrounds and roles, while unstructured interviews risked becoming too diffuse for the analytic aims of this study. Semi-structured interviews provided enough structure for comparison while remaining open enough to capture diverse experiences and meaningful personal narratives (DeJonckheere and Vaughn, 2019).

Interview procedures and fieldwork process

The interview guide was developed to reflect the aims of the study and was shaped by the literature on HCW wellbeing and practical knowledge of the Kuwaiti public healthcare context, with an emphasis on capturing participants' everyday work experiences. The questions were grouped into four broad areas: (1) the physical and relational aspects of the workplace; (2)

sources of satisfaction and dissatisfaction; (3) experiences and perceptions of mental wellbeing and (4) how workplace conditions influenced psychological outcomes. The guide did not include a conceptual dimension asking participants to define terms such as ‘job satisfaction’ or ‘wellbeing’; instead, these were treated as experiential concepts to be explored through participants’ own descriptions. These domains helped structure the interviews, but the conversations were kept open-ended to allow participants to focus on what mattered most to them (Turner, 2010). The full guide is provided in Appendix F.

As described in the recruitment section, participants received information sheets and provided written consent prior to interview. I explained that they could skip any question, withdraw at any point, or ask for any part of their interview to be excluded from the record. Written informed consent was obtained in line with the University of Sheffield’s ethical procedures and the Kuwait Ministry of Health (ethical considerations are discussed below). I aimed to maintain a relaxed, conversational tone, framing the interview as a reflective exchange rather than a formal assessment. This tone, along with my shared professional background, helped ease some of the power dynamics and encouraged more open responses (DeJonckheere and Vaughn, 2019).

Between July 2024 and January 2025, I conducted 20 interviews. Eighteen were held in person in quiet locations chosen by participants, typically hospital offices, on-call rooms, or empty outpatient clinics. The remaining two were done remotely over Zoom. Participants chose whether to speak in Arabic or English and were encouraged to use whichever language they felt most comfortable with. Details of the transcription and translation process are provided in the analytical process section below.

Throughout, I paid close attention to tone, cultural nuance, and meaning to preserve the integrity of participants’ voices (Temple and Young, 2004). This included attending to local idioms, pauses, and vocal tone that carried meaning beyond the literal words. For example, Kuwaiti Arabic has a distinctive form of dry sarcasm that can be missed even by other Arabic speakers outside the Gulf region. Additionally, many participants interspersed their speech with religious phrases which, if translated literally, would lose their conversational function as expressions of hope, resignation, gratitude, or even resentment. One such example is the phrase “Hasbuna Allah Wa Neima AlWakeel,” which literally translates to “Allah is sufficient for us and the best disposer of affairs.” Its meaning is entirely dependent on tone and context. In everyday Kuwaiti speech, it can signal quiet acceptance, a quiet appeal for fairness or justice, restrained frustration, or a simple acknowledgment that a situation is beyond one’s control. Paying attention to how such phrases were delivered was therefore essential for accurate interpretation, since the emotional meaning often sat in the tone rather than the literal wording.

Interviews lasted between 45 and 60 minutes and were recorded with participant consent using a secure, encrypted device. Each recording was anonymised and given a random code. During transcription, I made notes on non-verbal cues such as pauses, laughter, or changes in tone, and I revisited the audio files as part of the familiarisation process. These steps helped ensure that important emotional or contextual details were not lost in the written transcript.

Early in the process, I stuck closely to the interview guide, but with time and supervisory feedback, I became more confident in asking follow-up questions like “Can you explain more?” or “How did that feel for you?” This shift resulted in more open, emotionally rich accounts.

Participants varied in how much they chose to share. Some gave short responses even when prompted, while others were deeply reflective and articulate. The latter provided important insight into institutional dynamics and personal coping strategies.

Data analysis: Reflexive thematic analysis

This section describes how I analysed the data using RTA, following the approach developed by Braun and Clarke (2006). RTA was a good fit for the study’s interpretivist stance, as it focuses on how people make meaning in context. It also matched the aim of exploring how HCWs in Kuwait understand and experience job satisfaction and mental wellbeing within their institutional settings.

RTA is especially useful in applied health research because it allows for depth, flexibility, and attention to context (Braun and Clarke, 2020). My approach to analysis was inductive and datadriven rather than shaped by a predefined hypothesis. I did not treat themes as something to be found in the data but as something constructed through active and repeated engagement with the material. This included attention to emotional tone, contradictions, and how individual accounts reflected broader institutional dynamics. Meaning, in this approach, is not fixed; it is shaped through interpretation. RTA supports this kind of work by giving space for researcher subjectivity while maintaining coherence and depth in the analysis (Terry et al., 2017). The next section outlines how I moved through the stages of analysis, the tools I used, and the role of reflexivity in shaping the final themes.

Thematic analysis methods considered

During the early stages of the project, I reviewed other approaches to thematic analysis. The coding reliability model was dismissed first. This approach typically involves the use of multiple coders, standardised coding frameworks, and measures of inter-rater reliability to ensure consistency (Braun and Clarke, 2006). It was ultimately rejected because, in addition to being a single-researcher project with no additional coders available, it aligns with a post-positivist worldview that treats themes as fixed entities that can be objectively identified in the data (Madill

et al., 2000). This assumption did not align with the interpretivist and context-sensitive aims of the study.

Reflexive Thematic Analysis was ultimately chosen because it allows for conceptual depth, transparency, and analytic flexibility. Rather than relying on inter-coder reliability or fixed coding frameworks, RTA foregrounds the researcher's active role in constructing meaning through engagement with the data (Braun and Clarke, 2019). Themes were developed over time through immersion in the dataset, reflective discussions with supervisors, and repeated rereading of transcripts. This approach was essential for engaging with the emotional complexity of the topic and for capturing layered perspectives across nationality, profession, and gender. RTA's emphasis on reflexivity and meaning-making made it the most appropriate analytic approach for the aims of this study (Terry et al., 2017).

Analytical process

Data analysis was conducted using RTA. The analytic process drew on the six phases outlined by Braun and Clarke, namely familiarisation with the data, initial coding, theme development, theme review, theme definition, and analytic writing (Braun and Clarke, 2022). These phases were not followed in a strict or linear order. Instead, analysis involved moving back and forth between different stages as ideas were refined through ongoing engagement with the data, analytic note making, and supervisory discussion. This approach reflects Braun and Clarke's description of reflexive thematic analysis as a flexible and non-linear process, in which meaning is developed progressively rather than through a fixed sequence of steps (Braun and Clarke, 2006; Braun and Clarke, 2019).

Familiarisation with the dataset began alongside transcription and continued throughout the analytic phase. Most interviews were transcribed by me, with a small number transcribed by the University of Sheffield's approved transcription service under confidentiality agreements. Each interview recording was listened to at least twice to confirm transcription accuracy and to remain attentive to tone, pauses, and emphasis. Transcripts were then read in full, with return to the audio where meaning felt unclear or incomplete. During this stage, handwritten notes were made in the margins of transcripts to capture initial observations, emotional cues, and early analytic thoughts, supporting close engagement with both content and context.

Initial coding was conducted in a line-by-line manner using short, descriptive labels that remained close to participants' accounts. Coding was inductive and data driven, with no predefined coding framework. NVivo, a qualitative data analysis software commonly used to support the organisation and management of qualitative datasets, was used briefly at the outset of analysis (QSR International Ltd., 2020). However, I subsequently moved away from softwarebased coding in favour of manual methods using pen and paper. This decision reflected

a preference for a more tactile and immersive form of engagement with the data, which supported sustained focus on individual transcripts and deeper analytic reflection. Across the dataset, approximately 25 initial codes were generated. These codes were treated as provisional analytic tools rather than fixed entities, and their value lay in supporting interpretive engagement rather than in their number.

As analysis progressed, codes were repeatedly reviewed, compared, and reorganised. Overlapping codes were merged, some were renamed to better capture their underlying meaning, and others were grouped into broader conceptual clusters. This stage marked a shift from descriptive coding towards more interpretive engagement with patterns across the dataset. To support this process, large sheets of paper and sticky notes were used to visually map relationships between codes and emerging themes. Separate sheets were used to explore early thematic ideas, test alternative groupings, and track changes over time. This visual and spatial approach allowed themes to be actively worked through, questioned, and refined rather than simply categorised.

Themes were understood as analytic constructions developed through sustained engagement with the data rather than as entities discovered within it (Braun and Clarke, 2022). Several themes evolved substantially as their boundaries and focus were reconsidered. For example, issues such as staff shortages, patient behaviour, and the impact of social media were initially coded as separate concerns but were later reorganised as interconnected elements of a broader work environment theme, reflecting how participants described these pressures as part of their everyday working conditions. Similarly, experiences relating to unequal treatment of Kuwaiti and non-Kuwaiti staff and gender specific stressors were initially clustered under leadership and management. Through further analytic reflection and discussion with supervisors, these issues were re-examined and developed into a distinct theme on workplace inequities, reflecting their prominence across participants' accounts and their significance within the wider literature.

Writing was treated as an integral part of the analytic process rather than a final stage of reporting. Drafting the Findings (Chapter 5) involved continued movement between the written text, the coded data, and the developing themes, with theme boundaries, labels, and analytic emphasis refined through the act of writing itself. This process supported clarity, coherence, and analytic depth, and helped ensure that themes were clearly articulated, conceptually distinct, and grounded in participants' accounts. Consistent with Braun and Clarke's approach, writing was therefore understood as a further site of analysis, where meanings were clarified and analytic decisions were consolidated (Braun and Clarke, 2022).

Reflexivity was embedded throughout the analytic process. As a HCW within the same system, I was often able to recognise institutional dynamics, professional hierarchies, and unspoken norms quickly. At the same time, I remained attentive to the need to question assumptions and to ground interpretations in participants' accounts rather than in professional familiarity alone. Reflexive engagement involved repeatedly returning to the data to check emerging interpretations against participants' words and considering how my positionality shaped analytic decisions. Supervisory input played a particularly important role at later stages of analysis, especially in challenging early theme boundaries, clarifying analytic focus, and supporting decisions about theme refinement and naming. This collaborative reflection strengthened the coherence, transparency, and credibility of the final thematic structure.

Ethical considerations

Ethical considerations were central at every stage of this study, given the involvement of human participants and the sensitive nature of workplace experiences and mental wellbeing. Ethical approval was obtained from the University of Sheffield's School of Medicine and Population Health Ethics Committee on 19 July 2024, as well as from the Kuwait Ministry of Health. Formal access to the study site was also granted by Mubarak Al-Kabeer Hospital following submission of the research protocol, participant information sheets, consent forms, recruitment materials, and a data management plan.

The study was designed to uphold core ethical principles, including voluntary and informed participation, with careful attention to confidentiality and anonymity. Each participant received a detailed information sheet outlining the purpose of the study, what participation would involve, their right to withdraw at any time without consequence, and how their data would be protected. Written informed consent was obtained prior to each interview using forms approved by the University of Sheffield (see Appendices E and F).

Participants were given autonomy over the timing and location of their interviews. Most chose quiet hospital offices or clinic spaces, while others preferred to meet outside working hours. At the beginning of each interview, participants were reminded that they could skip any question or end the interview at any point, without needing to provide a reason.

Confidentiality was ensured by protecting participants' identities and personal information. Names, contact details, and any identifying administrative information were accessible only to me as the researcher and were not shared with the gatekeeper, hospital management, or participants' supervisors. Anonymity was maintained at the level of data presentation. Participants' spoken accounts were retained for analysis, but were presented using participant codes rather than names, and identifying details within quotations were removed or altered to reduce the risk that individuals could be recognised from their own words.

All data were stored securely using encrypted University of Sheffield systems, including accessrestricted university servers. Access to the data was limited to me and approved transcribers within the School of Medicine and Population Health. Audio files, transcripts, and consent forms were stored separately, and my personal laptop was password-protected and secured in accordance with the university's IT code of connection. Data handling procedures were conducted in line with General Data Protection Regulation (GDPR) requirements (Information Commissioner's Office, nd). These measures were intended to protect participants' privacy and ensure that their contributions were handled responsibly throughout the research process. The delays encountered during the ethical approval process, including navigating evolving requirements from the Kuwait MOH, are discussed in the Challenges section of this chapter

Methodological rigour and trustworthiness

In keeping with the interpretivist orientation of this study and the use of RTA, methodological rigour was not approached through criteria such as reliability, reproducibility, or inter-coder agreement. Such criteria are rooted in post-positivist assumptions about objectivity and fixed meaning and are not aligned with reflexive approaches to qualitative analysis (Braun and Clarke, 2019; Braun and Clarke, 2022). Instead, rigour was understood in terms of transparency, reflexivity, and coherence between the study's epistemological position, analytic approach, and research aims.

Analytic rigour was supported through sustained and in-depth engagement with the dataset, including repeated listening to interview recordings, iterative reading of transcripts, and reflexive coding and theme development. Decisions made during analysis were documented through analytic notes, visual mapping of codes and themes, and ongoing reflection on how interpretations were developed and refined over time. Themes were treated as analytic constructions rather than as entities discovered within the data, and their development involved careful consideration of internal coherence and distinction between themes, consistent with guidance on reflexive thematic analysis (Braun and Clarke, 2022).

Regular supervisory discussions also played an important role in strengthening analytic quality. Feedback from supervisors prompted critical reflection on early interpretations, challenged assumptions, and supported refinement of theme boundaries and labels. These practices contributed to a transparent and theoretically coherent analytic process, providing confidence that the findings presented are well grounded in participants' accounts while acknowledging my interpretive role.

Researcher reflexivity and positionality

This section reflects on my positionality as a researcher and how my background, values, and institutional role shaped the research process. Working within the interpretivist tradition of qualitative research, I recognise that knowledge is co constructed through the interaction between researcher and participant, shaped by our shared cultural and institutional context. Rather than viewing reflexivity as a source of bias, I approached it as a strength that could deepen understanding and enhance ethical awareness (Finlay, 2002).

As a Kuwaiti physician who has worked within the MOH since 2013, I brought a dual perspective to this study. My clinical career began with a training rotation at Al-Sabah hospital. Following this, I worked for five years at the Kuwait Centre for Mental Health (KCMH), followed by a short period at Mubarak Al-Kabeer Hospital. Although my time at Mubarak was brief, I knew some staff there, including my brother who works at the hospital and a few colleagues from earlier in my career. These experiences gave me firsthand insight into the emotional and structural challenges faced by HCWs, and they strongly influenced my motivation to focus on job satisfaction and wellbeing. Working in psychiatry also taught me emotional regulation, empathy, and the importance of managing my own responses while remaining present for

others.

This doctoral research also builds on my master's dissertation, which was developed as a research proposal at the University of Leeds and focused on the mental health impact of COVID-19 on HCWs in Kuwait. Although framed around the pandemic, the study indicated that many issues relating to job satisfaction, wellbeing, and organisational support pre-dated COVID-19.

My professional identity helped shape the way participants related to me. Many, particularly fellow physicians and Kuwaiti staff, saw me as a peer, which facilitated openness during interviews. This dynamic may have been less present for non-Kuwaiti participants or those in other professional roles. Conversations often felt natural, and participants frequently assumed I would understand their concerns without needing detailed explanation. At the same time, I was conscious that my role might create perceived power dynamics, especially for those in more vulnerable employment positions, particularly expatriate (non-Kuwaiti) HCWs whose employment contracts often offer less job security than those of Kuwaiti nationals, as discussed further in the findings and discussion chapters. Some participants were initially hesitant, particularly those unfamiliar with research or in vulnerable roles. I addressed this during the consent process, making clear that participation was confidential, no identifying information would be recorded, and supervisors would not be informed of their participation. These reassurances seemed to reduce anxiety and encourage participation.

While my insider status enabled trust and rapport, it also required careful self-awareness. I entered the study with certain assumptions based on my own experience, such as the belief that many HCWs in Kuwait lacked emotional support, recognition, or adequate working conditions. I remained open, however, to hearing different or unexpected perspectives.

Language use was also important. Kuwaiti participants often switched between Arabic and English, while most non-Kuwaiti Arabs preferred Arabic. Staff from South and Southeast Asia usually spoke in English. My ability to communicate in both Arabic and English allowed me to adapt to each participant's preferred language, helping preserve nuance and intent throughout the interviews. This included recognising when participants switched languages for emphasis, comfort, or clarity. For instance, several Kuwaiti participants described stressful events in Arabic but shifted to English when talking about technical procedures or hospital policies. Some nonKuwaiti Arab staff used formal Arabic for sensitive topics then moved into their dialect when sharing personal emotions. South Asian participants often relied on simple English phrases that carried specific meanings in their workplace context, such as using short expressions like "too much stress" or "no support" to summarise complex experiences. Attending to these shifts helped me understand not only what was said but how participants framed their experiences through the languages available to them.

To remain reflexive, I made brief observational notes after each interview, focusing on tone, body language, and signs of discomfort. These helped me interpret what was said and how it was said. These notes served two purposes: during analysis, I returned to them alongside the transcripts to contextualise participants' words; and during writing, they helped me select quotations that captured not just content but emotional weight. For example, one nurse described a challenging interaction with a senior doctor but delivered her account with noticeable hesitation, lowered voice, and repeated assurances that the situation was 'not a big issue.' In my notes, I reflected on the possibility that my identity as a physician may have contributed to her guardedness, given the strong medical hierarchies in Kuwaiti public hospitals. Recognising this, I treated her pauses, tone, and indirect phrasing as meaningful data in themselves, rather than omissions. This reflexive awareness helped me interpret such accounts with greater sensitivity to the power dynamics that shape what participants feel able to say.

Challenges

Ethical approval process

After completing the formal doctoral upgrade process from MPhil to PhD in November 2023, I began preparing for data collection, which required obtaining ethical approval from both the Ministry of Health in Kuwait and the University of Sheffield.

Once back in Kuwait with the necessary documents in hand, I visited the MOH in person on multiple occasions to submit paperwork and to follow up on the progress of my application. The MOH does not operate an email-based or electronic submission system for research approvals, and all documentation had to be submitted by hand. Initially, my documents were accepted and I was provided with additional forms to complete, which I returned promptly. However, I was not formally informed of the status or outcome of my application, and no updates were communicated by phone or email. During subsequent in-person follow-up visits, I was informed that a new research department had been established and that the approval process had changed. Under the revised rules, any research conducted under a foreign university was required to include a co-researcher employed by the Ministry in the same field.

I explained that I already had three academic supervisors and that bringing in someone unrelated to the project would affect its integrity. Still, the Ministry insisted that no application could proceed without this requirement. One staff member quietly assured me that this rule was mostly procedural and that no one would interfere with the actual data collection, but there was no official flexibility. To satisfy this requirement, I asked a colleague working in the MOH to serve as the named co-researcher on the application, though they did not have any active involvement in the research itself.

By January 2024, a further obstacle emerged. This requirement was not formally communicated, and I became aware of it only after repeatedly following up on the status of my application in person. The MOH now required my workplace supervisor, a different individual from the designated co-researcher, to approve the proposal. He had already signed the original version of the project, which focused on the mental health impact of COVID-19 on healthcare workers; however, this approval was no longer considered valid because the project title and focus had evolved since the initial submission. I made several attempts to schedule a meeting to obtain renewed approval. After persistent follow-up, I eventually met him in person and obtained the required signature.

When I returned to the Ministry, I was told the process would take around one month. However, when I followed up in late February, I was informed of further delays due to the national and liberation day holidays. Another month passed, and I was told that the head of the research department was on leave. In her absence, nothing could be processed.

At this point, I had to return to Sheffield for supervision. My academic team wrote a letter of support highlighting how the delays were affecting my project timeline. I hand-delivered this letter when I returned to Kuwait. One official acknowledged the situation but explained that many researchers were facing the same delays and that there was little they could do. I decided to file a formal complaint with the minister of health. I was joined by another Kuwaiti PhD

student based at another UK university who had been experiencing similar problems. When we followed up, we were advised informally to meet the minister in person, as written complaints were unlikely to be prioritised.

Meanwhile, I returned to the research department in Kuwait to clarify the issue. They told me that my application needed to pass through four different departments before reaching the research committee, which only met once a month. These departments included:

- The public health department
- The occupational and environmental health department
- The Kuwait centre for mental health
- The legal affairs department at MOH

I visited each of these departments myself to track the progress. At the Kuwait Centre for Mental Health, I was told that my documents had gone missing. The department head remembered reviewing and signing them but was unable to locate them. I had to obtain new copies, get them re-signed, and resubmit them, which caused another two-week delay.

Eventually, the documents reached the central research committee. It took another month to receive final approval, followed by three more weeks to secure ethical clearance from the University of Sheffield, which was granted on the 19th of July 2024.

In total, the approval process took about six months. It was stressful, emotionally draining, and at times deeply frustrating. A key challenge was the requirement to submit and follow-up on documents in person. There was no formal email tracking system, so I had to be physically present to move the process forward. This was particularly difficult for me, since I was travelling back and forth between Kuwait and the UK during this period.

Data collection obstacles

At first, I was encouraged by how smoothly data collection began. In the early weeks, I was conducting two interviews per week. But over time, recruitment slowed considerably. Since communication in Kuwait is rarely conducted over email, I worked closely with the hospital gatekeeper to explore more culturally appropriate methods. In Kuwaiti professional contexts, text messaging and instant messaging platforms such as WhatsApp are the norm; formal letters are rarely used, and even email is uncommon.

As described earlier in recruitment section of this chapter, recruitment was supported by a formally approved printed memo circulated across hospital departments. While this approach provided institutional legitimacy, it did not fully overcome staff hesitations, particularly among

non-Kuwaiti HCWs, many of whom expressed concerns about confidentiality and potential repercussions. These concerns shaped both the pace and reach of recruitment.

Although interest was initially strong, responses began to drop. I shifted to a more proactive approach, visiting departments in person and speaking directly with staff from different professional and demographic groups. This helped, but several challenges remained.

Two non-Kuwaiti nurses cancelled at the last minute. One cited discomfort with the subject matter and fear of repercussions. The other did not give a reason. Senior administrative staff expressed support but repeatedly postponed their interviews due to time constraints. I managed to interview only two of the five I approached, both later than expected, after the analysis phase had already begun.

Even after I explained the audio recording process and data encryption, some were uneasy about participating. This concern was particularly common among non-Kuwaiti staff, who worried that their words could be traced back to them even with anonymisation.

Despite the study being conducted in a teaching hospital with an established culture of research, this did not necessarily translate into confidence among all HCWs in the value of academic research. Some Kuwaiti HCWs expressed uncertainty about the ability of research to bring about meaningful change within the public healthcare system. Several potential participants indicated that they did not see the point of contributing, as they felt their input was unlikely to lead to tangible improvements in working conditions or organisational practice.

After the initial recruitment phase ended and participants stopped contacting me in response to the departmental memos, I approached ten additional people directly. Some were targeted for their specific profession to ensure diversity, while others were approached to strengthen the depth and breadth of the dataset as analysis progressed. Some initially agreed, gave me their contact details, then never responded to follow-up messages or declined when asked to schedule.

My initial goal was to interview thirty participants. After extended efforts and consultation with my supervisors, we agreed that sufficient thematic depth had been achieved at twenty interviews, and that the limited timeframe available within the scope of a doctoral project did not allow for further recruitment. I formally ended data collection and moved on to the analysis phase.

The uneven participation across professional groups and the hesitancy expressed by some participants have implications for the transferability of the findings. Although the study achieved diversity across nationality, gender, and professional background, lower participation from certain professional groups and concerns around participation among some non-Kuwaiti staff may have influenced the range of perspectives captured. While the study did not aim for

statistical representativeness, these differences in participation are important to acknowledge when considering the contextual scope of the findings across different healthcare settings and professional groups.

Conclusion

This chapter has shown why an interpretivist qualitative design, supported by semi-structured interviews and reflexive thematic analysis, was the most appropriate framework for this study. The methodological approach was developed in response to limitations in the existing literature on HCWs' job satisfaction and wellbeing in Kuwait and the wider GCC, particularly the dominance of survey-based research and the limited attention given to lived experience, context, and meaning.

The use of purposive sampling enabled the inclusion of participants from diverse professional, national, and gender backgrounds, allowing the study to examine both shared and divergent workplace experiences within the same institutional setting. At the same time, the chapter has shown that qualitative research within Kuwait's public healthcare system is shaped by practical, institutional, and relational challenges. These included recruitment constraints, gatekeeping, confidentiality concerns, ethical access, and participants' differing levels of comfort in discussing workplace experiences. Rather than undermining the study, engagement with these challenges formed an important part of the reflexive and context-sensitive approach adopted throughout the research process.

The chapter also demonstrates that reflexivity was not treated as a procedural requirement, but as an integral part of data collection, interpretation, and analysis. My positionality as a Kuwaiti physician working within the same healthcare system shaped both the opportunities and challenges of the research process, influencing rapport, interpretation, and sensitivity to organisational and cultural dynamics. These methodological choices shaped the analytic depth and contextual orientation of the study and informed the development of the findings presented in the following chapter. The following chapter therefore presents the study findings and interprets participants' accounts of job satisfaction and wellbeing within Kuwait's public healthcare system.

Chapter 5: Findings

Introduction

The previous chapter outlined the methodological approach adopted for this study, including the use of reflexive thematic analysis (RTA) to explore the lived experiences of healthcare workers

(HCWs) in Kuwait. This chapter presents the findings of that analysis and brings forward the voices and accounts of the participants to address the research aims of understanding the factors that influence HCWs' job satisfaction and wellbeing within Kuwait's public healthcare system. This chapter therefore presents the findings constructed through the analytic engagement with those interviews.

Throughout the interviews, I sought to understand how each participant conceptualised and experienced their workplace, paying particular attention to their interpretations of job satisfaction and wellbeing. In exploring these accounts, I found that while each participant held their own perspective, common themes took shape through my interpretation, revealing both positive and negative influences on their professional lives. It became evident that many HCWs faced similar stressors; however, some stressors appeared to be more prevalent among specific groups or genders, for example, differences in treatment experienced by non-Kuwaiti HCWs or genderspecific challenges.

Drawing on these shared patterns, the accounts discussed in this chapter contain both challenges and rewards that participants reported experiencing. This chapter describes five main themes: Leadership and Management, Workplace Relationships, Work Environment, Workplace Inequities, and Effects of Work-Related Stress. Each theme has sub-themes that provide deeper insight into HCWs' lived experiences. In Chapter 7, these findings will be examined in relation to the available literature, using the Job Demands-Resources (JD-R) model as the primary interpretive lens, alongside consideration of wider social and cultural factors.

Figure 10 presents a thematic map summarising the five main themes and associated subthemes developed through the analysis.

Figure 10: Thematic map of HCWs' job satisfaction and wellbeing

This thematic map presents the five main themes and associated sub-themes developed through Reflexive Thematic Analysis, illustrating the organisational, relational, environmental, and structural factors that shape HCWs' job satisfaction and wellbeing. The map is intended as an orienting visual summary of the findings rather than a causal model, with relationships between themes explored in the accompanying narrative.

For reference, Table 7 provides an overview of the five themes and associated sub-themes.

Table 7: Themes and sub-themes overview

Theme	Sub-themes
Leadership and management	- Management style
	- Valuing HCWs
	- Training programmes
Workplace relationships	- Teamwork and cooperation
	- Professional respect and communication
Work environment	- Patients' behaviour

	- Social media effect
	- Work demand, staffing situation, and quality of care
	- Lack of resources
Workplace inequities	- Unequal treatment based on nationalities
	- Gender-specific challenges
Effects of work-related stress	- Effects on personal lives
	- Effects on work performance

The study included 20 HCWs from diverse professional backgrounds, as detailed in Table 8 and Table 9.

Table 8: Participant demographics

Profession	**Number**	**Male**	**Female**	**Kuwaiti**	**Non-Kuwaiti**
Physicians	**10**	**6**	**4**	**9**	**1**
Nurses	**5**	**1**	**4**	**0**	**5**
Lab. technicians	**4**	**0**	**4**	**2**	**2**
Pharmacists	**1**	**0**	**1**	**1**	**0**
Total	**20**	**7**	**13**	**12**	**8**

Table 9: Detailed participant characteristics

Participant no.	**Profession**	**Gender**	**Nationality**
1	Lab. technician	Female	Kuwaiti
2	Lab. technician	Female	Kuwaiti
3	Nurse	Female	Non- Kuwaiti

4	Physician	Female	Kuwaiti
5	Nurse	Male	Non- Kuwaiti
6	Nurse	Female	Non- Kuwaiti
7	Nurse	Female	Non- Kuwaiti
8	Lab. technician	Female	Non- Kuwaiti
9	Physician	Female	Kuwaiti
10	Clinical pharmacist	Female	Kuwaiti
11	Physician	Male	Kuwaiti
12	Lab. technician	Female	Non- Kuwaiti
13	Nurse	Female	Non- Kuwaiti
14	Physician	Female	Kuwaiti
15	Physician	Male	Non- Kuwaiti
16	Physician	Male	Kuwaiti
17	Physician	Male	Kuwaiti
18	Physician	Female	Kuwaiti
19	Physician	Male	Kuwaiti
20	Physician	Male	Kuwaiti

The following sections present each theme in turn, drawing on participants' accounts to illustrate the factors shaping their experiences of job satisfaction and wellbeing.

1. Leadership and management

This theme explores how leadership and management approaches impacted HCWs' performance and satisfaction. It captures the participants' positive and negative experiences

related to administrative policy, decision-making, appreciation, and the availability of training programmes. By understanding the participants' experiences, this theme demonstrates the importance of effective and supportive leadership and management in HCWs' professional lives. This theme comprises three sub-themes: Management Style, Valuing HCWs, and Training Programmes.

1.1. Management style

In this study, participants often used the term "management" broadly to refer to individuals in senior or supervisory positions, including supervisors, heads of units, hospital administrators, and managers within the Ministry of Health hierarchy. Analytically, however, participants' accounts reflected both leadership and management. Leadership was primarily reflected through interpersonal and relational practices, such as listening, communication, support, encouragement, and recognition, whereas management was reflected through organisational systems, administrative decision-making, policy implementation, and performance monitoring.

Participants described how both these relational and structural dimensions shaped their work experiences, wellbeing, and job satisfaction, both positively and negatively.

Generally, the positive experiences of the participants all stemmed from them being heard or listened to, which made them feel valued. One nurse captured this sentiment:

> "The direct manager in my department is very kind and responsible, she listens to us and appreciates our work, we feel that we are supported." (Participant 6)

This was expanded on by another nurse who added that supervisors did more than merely listen and tried their best to accommodate requests:

> "The supervisors are good, listen to our complaints and they take action as much as they can." (Participant 5)

This was corroborated by a pharmacist colleague who added that supportive supervision provided confidence and motivation:

> "My supervisors at the pharmacy are nice, they are understanding, you can talk to them and discuss anything related to work, they'll give you full support when you face any problem and this gives us, as pharmacists, confidence and encouragement." (Participant 10)

However, not all participants shared such positive experiences. Many of the negative experiences with management seemed to stem from issues with communication between management and the participants. Having management that just gave orders without listening to

the participants' concerns was a common source of frustration. It made many of the participants feel undervalued and untrusted. As one of the nurses put it:

> "Do you know that we are the only department in MOH that has no Kuwaiti nurses!" When I asked about the reason she answered: "many strict rules, instructions, military treatment, they just give orders." (Participant 6)

The next example highlighted the common complaint of inconsistent management and treatment. This was not only due to different management styles in different hospitals but also due to high turnover. This participant described how frequent changes in hospital management created confusion over policies and how different managers had varying understandings of clinical work. When managers appreciated the nature of the work, policies were applied smoothly; when they lacked understanding, staff struggled with unclear expectations and unstable outcomes:

> "Here in Kuwait every few months they change the hospital manager and each one of them has her/his own understanding for our work, so if the manager appreciates what we are doing everything will go easy and our policies and instructions are strictly applied in the hospital, while if the manager has poor understanding for what is the nature of our work, we struggle to deal with her/him. So unstable administration for the hospital results in unstable work outcome." (Participant 3)

Once again, this demonstrates how effective bilateral communication can impact the HCWs' experiences. The absence of such communication often led to unpopular policies that had major detrimental impact. One such policy was the attendance monitoring, which was a common complaint amongst the participants such as in this account by one of the physicians:

> "Cancel the morning meeting! I feel it has zero outcome and that we are coming to a school every day not to a hospital. I must attend to hear about the previous day's on-call cases that we already have discussed in our work WhatsApp group. So, what's the point? And it is compulsory to attend it every day at 7:30 am, and we are the only department in my specialty who are doing morning meetings! Similar specialties in other hospitals don't have morning meetings!" (Participant 4)

This frustration with inconsistency across departments was also evident among other professional groups. A lab technician reported how management prioritised strict punctuality over quality or even amount of work:

> "Working hours should be more flexible. Sometimes I arrive at work five minutes late, and I work until after the specified working hours to finish my work, why do they mark me as late in my official records? It will affect my evaluation! I wish they focus on our work

> and work results and the quality of it not our arriving and leaving time, I feel that they are watching us, it's not fair." (Participant 1)

This surveillance-oriented attendance monitoring system risks intensifying over time. A highly unpopular new attendance monitoring method had been implemented for most HCWs at the time of data collection, with the exception of physicians who would soon follow. As one of the physicians put it:

> "They want us to sign in, out and in between with face recognition application! This is neither practical nor fair to us as physicians, how can we leave our patients in the middle of consultation to go and look for a signal that gives our correct location to prove that we are at work and then sign-in." (Participant 9)

While the sign-in and sign-out was already implemented previously for most HCWs, the main new additions that were causing the most problems were the third mid-day sign-in, and the use of phone software dependent on GPS and facial recognition as opposed to stationary fingerprint authentication points. The GPS needed satellite line of sight and therefore did not work inside the hospital, which was exacerbated further by the mid-day sign-in requirement. The frustration with this was best described by the following clinical pharmacist's comment:

> "The sign in and out system gives me a feeling that we are working in a military institution not in a hospital. So, I'm done with my work, but I cannot leave until the sign out timing! The MOH does not evaluate us according to our work productivity but only according to our working hours! Even if I'm doing nothing at work and just sitting there checking my phone! What about our effort and quality of work? This is really disappointing! Additionally, the new three checks system, one more check in between in addition to signing in and out! So, what's happening now is the new check starts at 9:00 am or 9:30 and ends an hour later. That's exactly the time of ward rounds with the medical team, so I have to leave them to go sign and come back! And of course, I will miss many cases just to prove that I am at work. If I miss that check the MOH will consider me not at work and a certain amount of money will be deducted from my income." (Participant 10)

This detailed account illustrates how administrative policies, while perhaps well-intentioned, could create practical barriers that undermined clinical work. Finally, there was a complaint by one of the physicians about out-patient clinic schedules being overruled by senior hospital staff, affecting the quality of healthcare provision. While only one of the participants made this comment, I did witness this occurrence while conducting my interviews more than once, with many HCWs becoming quite accustomed to it:

> “The manager always allows people who come with no previous appointment to come and register on the spot and enter the clinic! Either because he knows them personally or somebody asked him for a favour, he accepts the walk-in without getting permission from us or from the patients who have previously booked. We end up seeing more patients in a very short time, which is not fair to us or to patients who already have appointments.” (Participant 4)

Some accounts reflected an overlap between authoritarian leadership behaviours and punitive management practices. These experiences created feelings of surveillance, instability, and lack of professional trust. A non-Kuwaiti physician described a hostile working environment marked by erratic decisions and punitive oversight:

> “This period of my professional life was a nightmare! The direct supervisor was a lady that is obsessed with the timing! She has spies who record when the employees come and leave! You feel that you are under surveillance! The manager has a very weak personality and can’t control her or at least put a professional limit! We are physicians not students! We work for the MOH, she didn’t hire us to work for her own business! If there is any shortage of us as employees just resort to the legal ways, don’t treat us like we are your own employees! She can call any one of us and say you are transferred to work in another hospital, just like that, suddenly with no previous notice or clear reason! The Kuwaiti physicians in this department can be counted on one hand, no one wants to work with them, their way of management and dealing with the employees is just a failure.” (Participant 15)

This account exemplifies how authoritarian management approaches could create hostile working environments. The behaviour of senior colleagues could also create significant pressure on junior staff. One nurse described how some seniors had an unforgiving approach to minor errors:

> “Some of the seniors don’t accept any tiny mistake and they make a big problem and put people in trouble. This added huge pressure on us! But some seniors are understandable and put time and effort to explain to us how to avoid this mistake in the future and look at the difference!” (Participant 3)

1.2. Valuing HCWs

This sub-theme captures how participants interpreted and experienced recognition within their workplace. Feeling appreciated emotionally and financially is essential to maximise HCWs’ performance. Many participants felt undervalued in one way or another. Some complained

about being underpaid or unfairly compensated for the work they did, such as the following account by one of the lab technicians:

> “Financially, for my field, I do not get enough. We are underrated; in other countries the medical laboratory staff is on top, but here I feel we are not appreciated. Even my Kuwaiti colleagues have the same complaint.” (Participant 8)

One of the physicians complained about unpaid additional work that was beyond the scope of their job description and expressed frustration about not being able to opt-out:

> “The administration requires us to participate in different committees on top of our work, and imagine no compensation, no bonuses, no appreciation. There should be a reward system for hardworking employees, even if the reward is something simple like a trophy or a chocolate box. Other than that, the job description for us is not something applied in reality here! It’s our right to refuse any additional work beyond our job description, we should be heard and there should be a system that delivers our voice to the higher authorities in the MOH.” (Participant 9)

It was not just financial undervaluing that was the problem. The following lab technician described issues with a lack of appreciation in promotions and subsequent career stagnation: “The MOH itself doesn’t appreciate us at all as lab technicians, no promotions, no upgrade, nothing at all! But to be fair the physicians in charge really appreciate us; they take us to big conferences and workshops, and that’s great because I want to work. You know, in general when I was in Ireland doing my bachelor’s degree, they made me feel that what I’m studying is extremely important and critical: they really appreciated us; but here, no.” (Participant 1)

This problem with feeling unappreciated was also shared by the following clinical pharmacist who described feeling untrusted and not having autonomy. In the UK, clinical pharmacists are trained and authorised to adjust prescriptions within their scope of practice:

> “There should be a policy that gives us as clinical pharmacists the authority to fix or adjust the prescribed medicines without going back to the physicians to approve it, like in the UK where I did my PhD. We will not do that unless we are very sure that this change is for the patient’s benefit; they should trust us, this is our specialty.” (Participant 10)

1.3. Training programmes

Training and specialty programmes, such as physician board certifications and residency programmes, were very important in the healthcare field. Without those, physicians would remain general practitioners and would not have the necessary training to become specialists in any field. In Kuwait, this meant that they had no prospects for promotions and would remain almost at the same pay grade regardless of how long they worked. This also applied to most

HCWs with different training programmes. Some of the participants reported difficult experiences related to the neglect of these essential programmes, while others noted that their departments actively supported their professional development.

Perhaps the most comprehensive accounts of the struggles faced by HCWs in advancing their careers came from the physicians. They reported frustrations with the application and acceptance criteria, perceived bias and favouritism which in Arabic called (*Wasta*-واسطة) in the selection of candidates, uncertainty in availability of positions, and an overall mismanagement of the training programmes. This left them feeling lost with no clear career path and unable to plan their future:

> "Honestly, before I got accepted in this program, I was very disappointed and upset. I felt that I lost my future as it didn't seem clear. I was always worried because I had been working as an assistant registrar for a very long time with no postgraduate medical qualifications! I applied many times but got rejected. I wouldn't wish this on any of my colleagues and such programs should be available for all physicians. They should accept a reasonable number of candidates each year and, more importantly, the approval or acceptance in such programs should be on a fair basis and not according to the candidate's connection with the board members." (Participant 4)

Compounding these frustrations about uncertainty were the unprofessional and sometimes even petty reasons behind the lack of availability of training programmes. This was best expressed by the following physician who changed her entire career path and left a field that she loved and devoted many years to due to leadership power struggles:

> "I worked many years in this field, this is my favourite field, and I can honestly say that it is my passion. However, the constant delays in enrolment and uncertainty about availability of seats for years made me change my professional path! When I was working in this specialty there wasn't a board-certified program for us for years. It was paused for years because of administrative instability and disagreement on who should lead the program! When they finally restarted the program 5 years later, they provided only two seats while the applicants were around 12! This was not fair at all." (Participant 14)

It was not just uncertain prospects and unclear career paths that were reportedly affected by the lack of training. According to the following team leader, having staff that did not receive the required training wasted valuable time, as they needed constant guidance and explanation. We also see once again how unresponsive administration was blamed for the struggles faced by the participants:

> “I am struggling with my team members, sometimes I feel frustrated because they don’t understand what I want them to do, but actually this is not their fault, they just don’t know. They need official training programs and educational lectures before coming to this field. I asked the administration to do that but received no response! I am doing my best to explain to them what to do every time, but this is exhausting and wastes time.” (Participant 18)

Even when the participants felt that they were receiving the appropriate training in matters related to their work, they did feel that they needed more supportive sessions that addressed their wellbeing and other related struggles:

> “Our departments are organizing somewhat regular teaching sessions and workshops all related to our work as pharmacists, but I really believe that we need a regular wellbeing lecture, or lectures related to burnout and how to overcome work related stress as well as HCWs’ rights lectures.” (Participant 10)

2. Workplace relationships

This theme examines the influence of peer-to-peer professional relationships on HCWs’ job satisfaction and overall wellbeing. It explores how participants’ lived experiences, whether positive or negative, shaped their emotional resilience, commitment to their roles, and ability to deliver high-quality care. In particular, it considers how mutual respect, effective communication, and collaborative teamwork can support professional performance and service quality, while their absence may lead to stress, dissatisfaction, and reduced care standards. This theme comprises two sub-themes: Teamwork and Cooperation, and Professional Respect and Communication.

2.1. Teamwork and cooperation

Many participants commented on the importance of teamwork and cooperation, and how these aspects affected their work performance. They shared both positive and negative experiences. Participants’ positive experiences consistently centred around cooperation in various forms. Simply having cooperative colleagues appeared sufficient for participants to enjoy their work and describe their relationships positively:

> “All the staff are friendly here, they are ready to help, which is a big plus. They are cooperative.” (Participant 12)

This was also the case for one of the nurses who valued cooperative teamwork so much that she described her current job as her best work experience yet:

> “Thank God! This is one of the best places I have ever worked in because of our direct supervisors in the hospital here. We have great teamwork, and we help each other.” (Participant 7)

Supportive supervisors were a common factor in the positive teamwork experiences. One physician described how cooperation from supervisors created a family-like work environment and a sense of professional encouragement:

> “I believe I have a very cooperative and understanding team and it feels like we are one family. The head of the department is a very amazing person who recommended me to be one of the teaching staff in the training program. That was very encouraging.” (Participant 11)

Even when the participants did not get along with some of their team members, good leadership created an overall pleasant teamwork experience as described by the following physician:

> “I am blessed to work with amazing cooperative colleagues; we all get along well. Of course, there are going to be one or two colleagues that you don’t agree with, but we try as much as possible to improve the workflow dynamics. Our seniors are extremely cooperative and understanding, and they care about the people who are working with them.” (Participant 9)

This emphasis on cooperation was also echoed by a more senior nurse who highlighted her commitment to supporting others:

> “Honestly, my relationship with my colleagues is very good, I’m one of the oldest employees in the department, so they come to me if they need help, and I always help them. They are very good people. Actually, what I like about my job is teamwork and cooperation.” (Participant 6)

However, this sense of collegiality was not universal. Negative experiences were attributed to a variety of factors by the participants. A lack of cooperation was pivotal in shaping the negative work experiences, with most complaining of uncooperative team members as the source of their discontent. Some participants claimed that younger and more inexperienced HCWs were less cooperative than their experienced colleagues:

> “Older colleagues are more cooperative than the new ones; they feel responsible and are appreciative at work. Being cooperative and kind is very important, the new ones only do their work, they don’t help others or cooperate. They just finish their work and don’t offer to help even if they see you struggle with what you are doing. They instead check their phones and chat. This is a real problem that makes the work environment unfriendly.” (Participant 2)

Although her colleagues fulfilled their basic work duties, she felt that their lack of cooperation when she struggled made for a hostile work environment. Some work demanded a higher level of cooperation, as explained by another lab technician who described the work as an iterative process requiring a highly cohesive and cooperative team:

> "Actually, some of the staff are cooperative while others are not. We have very irresponsible and uncooperative people that know nothing about teamwork and patient care. I maybe becoming harsh, but this is the truth, if I receive a sample I should do a certain step, then I will pass the sample to my colleague to continue the next step and so on, each step depends on the previous one. So, if there is a mistake in the sample that reaches you, you should comment on that and return it to the person that made the mistake to fix it. Some of them don't care, they refuse to fix and say as long as the sample is in your hand you should fix it. This is not fair. It's not my mistake; you should double check before passing the sample to your colleague. So, I will do my job and my colleague's job as well? Why? This is not teamwork. Everyone should be responsible.
>
> When I'm free I go and I offer help to others, but some of the people here, even if you are bleeding in front of them, they will not help (laughing)." (Participant 8)

Her final comment was likely intended as a joke; however, it does highlight the impact that a perceived lack of cooperation had in shaping HCWs' experiences. This frustration with uncooperative colleagues was also expressed by another lab technician who described having to fix others' mistakes to avoid conflict:

> "If the person is stressed, the chance of doing work-related mistakes is much more. I am really stressed because I'm doing more than I should do. I'm trying to avoid problems with my colleagues; they are not cooperative. Sometimes I receive a sample with a mistake, and I fix it myself even if it's not my work, just to avoid talking to them, therefore avoiding problems." (Participant 2)

For those in leadership positions, managing staff who lacked initiative presented its own challenges. A physician who served as a high-level administrator described the difficulties of motivating reluctant team members:

> "I strive to create a cooperative environment, but sometimes I feel some colleagues need additional encouragement to take more initiative. You should keep asking them to do their work as it should be every now and then." (Participant 20)

Professional rivalry or even perceived jealousy was attributed to the uncooperative behaviour described in this last example:

> “I will mention some of the unprofessional behaviour in our department that I didn’t personally experience but my colleague did. The problem arises when there are two clinical pharmacists in one unit. While discussing our opinion as pharmacists with the medical unit, one of the pharmacists will always take the physicians’ side and totally ignore her colleague’s opinion with no valid reason except to make her feel bad! No teamwork or cooperation. I don’t know how to explain it accurately, maybe it is unhealthy competition or like jealousy.” (Participant 10)

This is not exactly a first-hand account but does highlight how important cooperation was to the participants. In this instance, a difference of opinion was interpreted not as routine disagreement, but as evidence of jealousy, emphasising the importance of cooperation to participants’ expectations of workplace relationships.

2.2. Professional respect and communication

Many participants shared concerns about the lack of mutual respect and poor communication between colleagues in their work environments. These issues were often linked to unclear roles, undervaluing of certain professions, and interpersonal difficulties which adversely affected communication and collaboration.

A common complaint was the disrespect that some nurses felt from physicians, especially when raising important clinical points. One of the nurses expressed frustration with how her reminders regarding infection control were sometimes met with hostility:

> “Sometimes you have to deal with physicians that will not accept your comments because you are a nurse! So, for example, if I tell physicians please don’t forget to wear gloves before entering the isolation room, they just look down at me and some of them complain! It is really annoying that I’m just doing my work. Another issue is that when something happens between a nurse and a physician, they the administration don’t listen to us! To take a decision you should listen to both sides, they should not act towards any one of us because one physician complained about us, this is not fair they should call us and listen to us.” (Participant 7)

Similarly, one of the pharmacists highlighted the limited authority and recognition given to clinical pharmacists, even though they were doing their jobs and giving evidence-based recommendations:

> “I remember that one of the physicians was not okay with the clinical pharmacists being in his team! So, the pharmacist complained to his direct supervisor who contacted the head of the medical department to solve this problem, and he did. We do daily rounds with the medical team, and we give our recommendations regarding the prescribed

> medicine for each patient, most of the physicians don't take our recommendations seriously although its evidence-based recommendations its disappointing! Especially when they discharge the patients with a prescription that we comment on (for example adjusting the dose or notes about possible drug interaction) and the physicians ignored our comments, coming again to the hospital because of his/her medication side effects! Look it doesn't happen all the time, but it happened. I did my PhD in the UK. The pharmacists there are respected and have the authority to fix or correct the prescription without going back to the physicians to seek their approval, we don't have this here, but I have a hope that one day we will." (Participant 10)

This account reveals the professional tensions that could arise when clinical recommendations were not valued.

Poor interpersonal dynamics made work difficult for some team leaders. The following physician described the emotional toll that working with staff who resist feedback carries:

> "Many employees are good, but some of them are very hard to communicate with, they don't respect others' opinions, and they are not trained well, they drain my energy at work." (Participant 18)

Other participants attributed strained communication to a lack of understanding about certain specialties. As one of the physicians describes colleagues' unfamiliarity with the unique demands of her specialty created communication barriers:

> "The unfamiliarity of medical colleagues about the mental and intellectual challenges of this particular specialty is very frustrating and makes communication with them harder, we also have less attention by the higher administration!" (Participant 16)

One lab technician described supervisors who lacked the confidence to communicate directly with staff:

> "We have three supervisors in the lab, one of them has a weak personality, he feels embarrassed talking to the employees in the lab, so you have the authority to discuss and change things just use it! Sometimes he asks me to go and talk to my colleague to comment on her/his work, he always insists on me to do that, and when I go and deliver his message my colleagues become annoyed, and he puts me in an embarrassing situation! Another supervisor doesn't respect my privacy, so when I go to him and discuss any issue with him, he tells my colleagues about our discussion! This is not acceptable." (Participant 2)

The disrespect experienced by some participants extended to bullying behaviours. This nurse described a troublesome physician whose harsh attitude was well known in the department:

“The physician is known in our department that she is a troublemaker, and she has many problems with other HCWs, and we reported her harsh attitude to the head of the department but surprisingly the administration did not take any action towards her. Our right to dignity should be respected.” (Participant 7)

These accounts demonstrate how the absence of mutual respect and ineffective communication can erode professional relationships, undermine morale, and hinder the quality of healthcare delivery.

3. Work environment

This theme explores the environmental factors and workplace dynamics that influenced HCWs’ performance. Participants shared experiences of challenging behaviour and unrealistic expectations from patients and how this affected them. They discussed the impact of social media on the overall work environment. There was concern among participants about the shortage of staff and resources that contributed to an unhealthy work atmosphere. This theme comprises four sub-themes: Patients’ Behaviour, Social Media Effect, Work Demand, Staffing Situation, and Quality of Care, and Lack of Resources.

3.1. Patients’ behaviour

Participants’ accounts highlighted how interactions with patients shaped their daily experiences in ways that extended beyond clinical duties. Several participants described the significant impact that patients’ behaviour could have on their daily work experiences. A common complaint was having to deal with aggressive patients who had a sense of entitlement and a complete disregard for rules. Such patients caused disruptions in the workflow and made the HCWs feel unsupported and disrespected.

A recurring issue raised by physicians involved the inappropriate seeking of sick leave. One physician detailed how a system designed to streamline the process had unintentionally created conflict when patients exceeded the app-based self-service limit and sought additional leave from doctors in person:

> “We have a very nice governmental application that can be downloaded in everybody’s mobile phones called Sahel, which has an option to apply for sick leave while you are at home with a limit of three sick leaves per month. After exceeding this limit of three sick leaves/month anyone that needs extra sick leave should go the polyclinic or to the hospital to get it. So, the patients come to us to get the sick leave. We have two types of patients here, some that pretend to have for example a flu or any condition, and others that come to you and say I’m fine I just want a sick leave. If you give your medical opinion that the patient is fine and therefore, I can’t give him/her a sick leave, most of the

> patients will argue, insist, become aggressive, and threaten that they will file a complaint against you. This is a daily scenario! It is really exhausting. After that I feel I am not ready to see the next patient, it is just disturbing." (Participant 9)

The Civil Service Commission is the entity that oversees all public sector employment. As per their regulations, an employee is entitled to a total of 15 fully paid sick leaves per year from the outpatient department. Hospitalisations for serious illness and surgical procedures carry no limit. After an employee has exceeded their 15 sick leaves, they are still eligible for sick leaves but either with reduced pay or no pay at all for those days. Employees still need to provide them even if they are unpaid to avoid termination for unexplained absence. Prior to the launch of 'Sahel', all sick leaves had to be issued by a physician. As the above participant explains, one can now apply for 3 sick leaves a month electronically without visiting a physician, but this has not been enough to curb the aggressive behaviour.

The emotional strain caused by patient aggression was also echoed by others. One physician described how disorderly conduct and a disregard for clinic procedures slowed her work and left her feeling unsupported by management:

> "The mess and noises that the patients make while I'm in the clinic seeing another patient! They distract me by knocking the door, while there is a big sign stating that they shouldn't knock on the door! I lose track when this happens. Honestly, the type of patients makes a difference in workflow and workload as well. With all due respect to everyone, but patients who are less educated and living in certain areas usually don't follow the rules. They do anything they want no matter what and nobody can stop them! They will shout and make a big scene and mess if they don't get the treatment or appointment they wanted. Imagine this: if they see a physician and they didn't like his/her opinion they will simply walk out of the clinic and go to the next-door clinic to listen to another opinion at the same time and in the same hospital without taking permission or appointment!! It is really hard to deal with them, and when you report that to the administration they usually don't respond. I feel they are encouraging such patients as they are allowing them to see physicians without previous appointments." (Participant 4)

This account demonstrates how patient behaviours could disrupt clinical workflows and leave HCWs feeling unsupported. Even administrators complained about similar entitlement and demands from patients, with total disregard to rules and regulations or even to what was possible:

> "Usually patients have very high expectations, and they talked to me like I am the one who can put new rules and policies and have control over everything in the hospital.

> They get upset if you tell them the truth, they just want you to say yes to everything they say! However, there is usually little I can do." (Participant 19)

This collection of experiences highlights how such behaviours could impact HCWs and leave them feeling emotionally drained and without support. Participants attempted to maintain their professionalism, but many described feeling overwhelmed and frustrated especially due to a lack of acknowledgement by management.

3.2. Social media effect

Several participants reflected on how social media had changed the way patients behaved and interacted with HCWs. Some felt that it had raised patient expectations in unrealistic ways and made administrators more hesitant to take action when staff were mistreated. Others, however, commented on its potential use as an outlet to educate the public and reduce unnecessary clinic visits.

One physician believed that when used properly, social media could shift from being a source of pressure to a tool for patient education:

> "We can use social media in a good way, to teach the patients why and when they should see a physician if they have flu, how to take care of themselves in such situations instead of coming to the hospital, taking other patients' place and time." (Participant 9)

But this more hopeful view stood in contrast to others who had seen social media used as a threat. One participant described how the fear of negative social media coverage made administrators reluctant to enforce rules:

> "Some patients threaten the people in charge of the hospital to post something bad about us on social media and the reputation of the department will be affected! Yes, definitely this is one reason why the administration is not doing anything to stop them." (Participant 4)

3.3. Work demand, staffing situation, and quality of care

An almost universal concern among participants was the excessive workload caused by staff shortages. They complained of long work hours and additional duties which led to a diminished quality of care. The following lab technician described having to work weekends to manage the volume of samples and that made her specialty more demanding than others:

> "We really have a shortage. I come to the hospital on the weekends to cover the work. Sometimes I feel they don't understand the workload we are doing. I don't underestimate the work in other labs, but seriously, their work is much easier than ours. Like one sample in our lab equals 40 samples they are working on." (Participant 1)

Even when the workload in one place of work was manageable, some nurses were expected to cover more than one location. They could not even ask for help because they knew it was a universal issue:

> “The workload definitely makes me unsatisfied! We are a few nurses covering many wards and polyclinics outside the hospital as well. And I am the only nurse who covers the polyclinics in different areas! Everyone is stressed at work. Sometimes you can’t even ask for help because you’ll feel selfish! The shortage of staff is a big problem.” (Participant 6)

Even those in senior positions experienced workload pressures. A team leader described the frustrations of long hours without breaks:

> “I don’t like that I am unable to choose my team members or that my salary is low and doesn’t meet my qualifications or efforts. I don’t like that my work starts too early in the morning, I don’t have an official break time even to have my breakfast.” (Participant 18)

According to the following nurse, the workload was getting progressively worse:

> “More tasks to be done, more paperwork and field work added by the administration as they update their policies. The workload increases while we have the same number of staff! Imagine the same number of staff with double the workload!” (Participant 3)

A physician explained that the shortage was made worse due to improper distribution of staff among hospitals:

> “We have only three junior physicians with a heavy number of samples, while another hospital has seven junior physicians although it is not a busy hospital!” (Participant 11)

There was a shortage in senior physicians as well. As this junior physician explains, this affected the quality of the care provided:

> “Workload! Yes. Like seeing more than 20 patients in less than 6 hours is just not fair. I have my way of dealing with my patients; I have to explain to them their cases and management plan and write down how and when to take their medications step by step. I love to do my job perfectly, but with the workload I can’t! When I am overloaded, I can’t give each patient the required care and that makes me upset and stressed… There is a shortage of senior physicians. Some medications cannot be prescribed by juniors, and we struggle to find a senior physician to sign the prescription while the patient is waiting! Also, why is there no accompanying nurse with me in the clinic? This is not ethical. We have a shortage of nurses as well.” (Participant 4)

This account illustrates the tension between professional ideals and workplace realities. The participant's stated desire to deliver quality care stands in contrast to the constraints imposed by excessive patient numbers, suggesting that for this physician, the inability to meet preferred standards was itself a source of distress.

This was not the only participant that raised the issue of decreased quality of care:

> "Because of the shortage of staff, they are not always able to finish [work] properly, and sometimes they just want to finish it. So, the quality of care is coming down." (Participant 13)

Another participant described the same deterioration but on the healthcare system as a whole:

> "Staff number is definitely not adequate for the workload and not only in my department, everywhere. It's affecting the healthcare system, and it is a big issue." (Participant 18)
> Across both administrative and clinical roles, the shortage was described as deeply disruptive:

> "Sometimes the number of specialized staff is not enough for the workload in the administration, which increases the burden on the core management… It affects the quality of services for both HCWs and patients." (Participant 20)

Staffing issues extended across specialties and facilities. A lab technician described an overflow of cases due to a lack of specialists elsewhere:

> "We are overloaded with the Operation Theatre (OT) in our hospital and from other hospitals' OT samples! We receive from other hospitals because one of the senior physicians here has a rare sub-specialty and we don't have many physicians with this sub-specialty in Kuwait." (Participant 8)

As one participant put it, this was a global issue and not just limited to the Kuwaiti context:

> "The staff level is not sufficient at all; it is likely because of the global shortage of physicians in our specialty." (Participant 16)

Others noted how the situation had worsened since COVID-19:

> "I can say that I was satisfied with my job before COVID-19. After COVID-19 and the shortage of staff, I am less satisfied. The workload! You will be assigned to more patients which makes it very difficult to give quality care." (Participant 5)

For many participants, the solution seemed straightforward:

> "The workload in my department will be decreased by hiring more staff." (Participant 17)

The impact of workload stress on concentration and performance was also described:

> “We are stressed at work. We are really cooperative, but the workload makes this difficult. Stress can lead to work mistakes. Our work needs a calm person who can communicate with others. Stress affects our concentration, and our work is all about concentration.” (Participant 6)

3.4. Lack of resources

The shortages were not just limited to staff. Many participants described a lack of essential resources. These shortages made it difficult to perform basic tasks, was frustrating, and affected the quality of healthcare provision.

One physician described the operational difficulties caused by inadequate administrative support. The lack of qualified typists and discontinued overtime added to the burden: “We have an issue with the typists, or lack thereof. We used to have two typists, but they left. Even when they were available, they didn’t have medical backgrounds and couldn’t accurately type up the reports which meant we should either review the reports after them or type all the patients reports ourselves, which is the current situation! There is going to be delays in reporting cases, I really dislike that the management is not helping us. Even when we requested overtime to do them, they didn’t grant us; actually, they did so for two months, and then they discontinued it. Actually, almost all hospitals in our specialty have overtime, I’ve spoken to colleagues in different hospital they say they do receive overtime! We come to work in the weekend when we are not required by the government to do so but receive no compensation!” (Participant 11)

A lab technician noted that unique testing capabilities that were only available at the hospital attracted an excess of samples from across Kuwait:

> “You know that we receive samples from all hospitals in Kuwait, not only Mubarak Hospital! There is another lab in Al-Sabah hospital, but they don’t have the essential and specific test that we do have. This adds more workload and pressure on us here.” (Participant 1)

Several nurses described being asked to enforce infection control protocols while lacking basic medical supplies:

> “We go every day to the same wards and give the same comments, and we are expecting them to do changes within 24 hours? How?! Like asking them to use gloves while going to see a patient in the isolation rooms while there are no gloves in the hospital! The administration should ensure that all the essential supplies are available.” (Participant 7)

> “The unavailability of the patient care supplies, and shortage of staff makes me not satisfied. I’m doing my job at my best level, but if the resources are not available, we cannot do anything!” (Participant 13)

A physician also recalled how hygiene was compromised due to recurring basic supply shortages:

> “I remembered when I used to go to observe the clinical environment in the wards and in the neighbouring polyclinics and see that the gloves and tissues are running out… I was shocked and embarrassed. We talked many times to the administration, and they offered it after quite a long time! This happens from time to time!” (Participant 14)

Others spoke of overcrowded workspaces and lack of equipment:

> “Imagine this: we are 11 physicians distributed in 5 rooms in the lab! Some consultants don’t come because they don’t have a place to sit. I used to sit in a room with 6 physicians! This is distracting and unhealthy. A colleague had the flu and passed it on to others even though she was wearing a mask! Another thing is the lack of microscopes. Even when we request, there is always a delay in responses.” (Participant 11)

4. Workplace inequities

This theme sheds light on the inequities within healthcare institutions in Kuwait taking Mubarak Hospital as an example. The participants shared their experiences and feelings towards nationality-based treatment and recognition, and towards gender challenges. This theme comprises two sub-themes: Unequal Treatment Based on Nationalities, and Gender-Specific Challenges.

4.1. Unequal treatment based on nationalities

Participants described unfair treatment of non-Kuwaiti HCWs. Both Kuwaiti and non-Kuwaiti participants reported that non-Kuwaiti staff were subjected to double standards, higher expectations, and greater scrutiny. They also described unprofessional and sometimes even discriminatory treatment from colleagues and patients. This was not limited to a certain job or department, and affected their morale, job satisfaction, and perception of fairness at work.

Several Kuwaiti participants spoke up about what they had observed. One Kuwaiti physician described the differential treatment experienced by non-Kuwaiti colleagues:

> “We have physicians from different nationalities. What I have noticed is there’s a lot of tension put on those physicians. There is a difference in treatment between us and other nationalities. I’m going to voice a lot of words that my colleagues told us; they said that they are unappreciated by the physicians in charge. Instead of highlighting their

> achievements, they focus on unnecessary things! For example, let's talk about sick leaves. A lot of patients believe it is their clinical right to take it. So, the non-Kuwaiti physicians usually avoid refusing such requests, as some patients can be very aggressive if the non-Kuwaiti physicians refuse! There's a regular check on the number of sick leaves each physician gives. If they exceed the limit, they'll be questioned and possibly punished. And most likely, the non-Kuwaiti physicians will be punished as they give more sick leaves to avoid difficult patients! Kuwaiti patients are gentler with Kuwaiti physicians (not always), but this is not the non-Kuwaiti physicians' fault! They are doing this to protect themselves." (Participant 9)

In this account, a Kuwaiti participant offers an insider perspective on the differential treatment of non-Kuwaiti colleagues. The observation that non-Kuwaiti physicians may alter clinical decisions 'to protect themselves' suggests that nationality-based vulnerability could shape practice in unintended ways, highlighting how structural inequities permeated everyday work.

Another Kuwaiti physician commented on the discriminatory treatment towards the nursing staff:

> "Frankly speaking, I witnessed many times unprofessional treatment from some of my Kuwaiti colleagues to the non-Kuwaiti nursing staff. Like ordering them to do things with some disrespect! Especially if they are new and they make some little mistakes, they don't guide them or correct their mistakes, they just yell at them." (Participant 14)

The following non-Kuwaiti nurse corroborated this account:

> "Some of the Kuwaiti colleagues become harsh with non-Kuwaiti staff. They should be more helpful and kind with the new nurses. They should be easy on them as they are not aware of the type of work and culture. As you know, some of the non-Kuwaiti staff come from completely different backgrounds." (Participant 5)

The following nurse described how much this discrimination affected her and the difficulties in overcoming such behaviour:

> "Some of the Kuwaiti physicians treat us badly because we are non-Kuwaitis. There are racist people around. One time I heard a Kuwaiti physician saying: 'The [nationality] is coming to give us orders!' It was about me coming into the ward! It is really annoying. To be honest, it affected me badly. I always feel that my work performance decreases when I face such situations, but I try to overcome the bad feelings and move forward." (Participant 7)

This extract captures the personal toll of discriminatory treatment. The participant's acknowledgment that such experiences 'affected me badly' and decreased work performance

illustrates how racism operated not only as interpersonal harm but as an occupational stressor with tangible consequences for wellbeing and professional functioning.

It was not always like that and had been worsening over time according to this nurse who reflected on how attitudes had changed over her years of service:

> "I've been working in Kuwait for 16 years. Kuwaiti people have changed! Before they were nicer, everyone could open up and talk, but now it's different. Even in the hospital, the young generation of the Kuwaiti HCWs is different from the old ones! They are not accepting anything from us, the non-Kuwaiti staff. When I tell them you should, for example, follow the hand hygiene steps, they ignore me, or they say OK and then they don't do it!" (Participant 13)

This also extended beyond interpersonal issues. It was systemic, with institutional policies of unequal compensation affecting things like salaries and bonuses:

> "Financially, as non-Kuwaiti, for my field our income is not enough! We are underrated! In other countries, the medical staff is always on top of other professions, but here we are not appreciated! And there is no reward! For example, every year some of the top employees should get rewarded (they will receive nearly double their monthly income as a reward). We are 18 employees in the lab (without the seniors) and only two of us will get the reward upon the head of the lab's decision. This is not fair! At least five of us should be rewarded! And guess what? This year the MOH decided that only Kuwaiti employees have the right to receive this reward, and non-Kuwaitis have no right to receive it! Unfair!" (Participant 8)

It was not just the non-Kuwaiti staff that described nationality-based treatment. One Kuwaiti participant noted a reluctance in sharing knowledge and competitive behaviour by a non-Kuwaiti colleague which they attributed to possible job insecurity:

> "Sometimes, when there is a Kuwaiti and a non-Kuwaiti pharmacist in the same medical unit, you will see the non-Kuwaiti refusing to share information with his/her Kuwaiti colleague! As he/she wants to be the primary or the leading reference for the physicians in the unit! I think because they don't have job security and they feel that they can be fired anytime from their jobs, so they want to secure that by being dominant and the closest to the medical team. I mentioned this situation as it happened to three different Kuwaiti pharmacists I know." (Participant 10)

4.2. Gender-specific challenges

These experiences reveal the ways in which gender intersected with professional identity and home responsibilities. Many female HCWs described challenges that they felt were unique to

their gender such as the complexity of balancing work and parenting, the stress of trying to remain strong for their families and appear fine, and the tensions that accompanied working in mostly female environments. Their experiences shed light on how gender did not only affect how one was treated at work, but also how they felt and how that affected their job performance.

The working mothers in particular shared how the stress of their workday did not end when they left the hospital but followed them home and affected their roles as mothers. They described a sense of exhaustion that followed them home and prevented them from being fully present with their families:

> "I have three kids. I go back home with no energy; I don't even want to hear their voices. I feel so exhausted. My kids are young, like between 3-9 years old. They want to play and talk. When you come home after a stressful workday, you don't want to hear their fights and screaming. You know, sometimes when I arrive home, I stay in the car for 10 to 15 minutes to take a short break! My husband asks me, 'Why are you late today?' I tell him I was taking a break in the car before entering home. He will directly understand that I'm not okay." (Participant 8)

Another participant described how the burdens of work and being a single mother gave her the feeling of prematurely ageing:

> "Sometimes I go home from work with an old lady soul! I don't know how to explain it! But I really feel tired. One time my child came to me and wondered why I am always tired! At that moment, I felt I should take care of myself more. I am a single mother before being an employee, I need to take care of myself and of my child." (Participant 1)

Adding to the burdens of balancing work and home life was the stress of feeling like one is falling short as a parent that one of the working mothers expressed:

> "When I go back home, I feel I am not doing my role as a mother. I feel not okay, exhausted, in a bad mood, and the kids need all the opposite." (Participant 3)

The next participant even tried to hide her exhaustion from her children compounding her stress:

> "I wish I could leave the stress at work, but sometimes after reaching home, I still feel stressed and not okay. I try to hide it from my children and to calm myself down to take care of them as a mother, but of course, it is not easy all the time." (Participant 13)

Pregnancy brought added vulnerability. A female physician recalled a time when stress and overwork put her and her pregnancy at serious risk:

> "I remember when I was pregnant, and I had an on call. There were many cases to be seen in emergency and in the wards. There was a severe shortage of physicians in our

> specialty (until now), so I was the only physician to cover this shift that day. I didn't sit in one place, was so stressed that I almost forgot that I am pregnant and should take care of myself! I came home with bleeding, I was in my first trimester, I went to the hospital and there was a threatened miscarriage. After that I had a complete bed rest for a month!" (Participant 14)

Parenting challenges aside, some of the participants had difficulties with working in femaledominated environments. The following participant described a more unpleasant experience with female colleagues compared to male ones:

> "Working in an environment with mostly female employees is a headache! I believe they like gossiping, creating problems, and sometimes even fights more than male employees. I'm living this now here in the lab." (Participant 2)

Others expressed frustration with gender dynamics in leadership. One clinical pharmacist reflected on the contrast between working under female versus male supervisors. While this quote raises complex issues around gender and leadership styles, it reflects the participant's lived experience:

> "I worked in two different places, one where my supervisor was a woman, and the other was a man. I see that the woman in leading positions focuses in a very detailed and precise way on everything related to the employee! For example, focuses on my attending time but not on my quality of work. But men usually focus on your overall work output, and that is encouraging. The women in leading positions will add more stress to the employee because of her constant comments on every little thing. In contrast, men will comment on the big issues that affect the work. Working with a male supervisor is less stressful!" (Participant 10)

All in all, these accounts portray how the pressure of balancing work and gendered family expectations took significant tolls on the female participants. Many reported feelings of emotional exhaustion, guilt, and a sense of not doing enough either at work or at home.

5. Effects of work-related stress

In the previous sections, participants shared various sources of stress in the workplace. These ranged from lack of resources and understaffing to poor management, gendered challenges, and difficult patients. This theme focuses specifically on how these stressors impacted the HCWs' personal lives and their job performance. The participants described the emotional and physical tolls of their jobs and what strategies they developed to manage them.

5.1. Effects on personal lives

Participants shared how their work-related stress spilled over into their personal lives with difficulties in establishing boundaries. For many of them, their struggles did not stop once the workday was over but followed them home in the shape of exhaustion, health issues, and strained personal relationships.

Some had found ways to cope. This physician described the steps he took to protect his wellbeing and the quality of his time with his family:

> "I have made a weekly routine of going to my therapist to ventilate and complain so he is helping me to think in a positive way, and I also cope by exercising, that's help a lot. One more thing, I stopped coming to work on the weekends if I don't have to, even if there are many samples, I wait for working days to finish them. This was preventing me from spending time with my kids and it's not worth it at all." (Participant 11)

This next participant pointed to the importance of supportive workplace environments and how a supportive team and healthy work culture helped keep her stress-levels in check:

> "I don't feel that my work is negatively affecting my personal life currently. I maintain good relationship with my colleagues and that is very important. I always say to everyone once the people around you at work are not good, try to change your workplace. The other important thing is my department: thank God they are supportive and encouraging currently. I don't know what changes may happen tomorrow (laughing)." (Participant 10)

Others however were not quite as fortunate especially those that worked under difficult supervisors or in high-pressure environments. This nurse explains the difficulties she faced working under a troublesome supervisor and how it affected every aspect of her home life:

> "I was not able to take care of my home, not able to clean it properly, just doing little tasks. It was a big problem to me as I always like my home sparkly clean, so I became upset because of that! It also affected my relationship with my husband, as I was on the edge and easily provoked. The source of all that was the physician in charge in my previous workplace, she was not stable and unbearable!" (Participant 7)

In this account, the spillover from work to home is portrayed in concrete, domestic terms. The inability to maintain everyday tasks becomes a marker of how workplace stress consumed the participant's capacity for life outside work. The attribution of these difficulties to a specific supervisor highlights how individual managers could become focal points for broader experiences of occupational strain.

The following nurse reflected on how even the smallest mistakes stayed with her and affected not just her mood but her family and health:

> "I usually carry work problems to home; I go home feeling sad and grumpy. Even if I do a small mistake, I carry this with me and I feel not okay the whole day. It affects my kids and my physical health as well. I'll tell you an incident: once I was very stressed because of a problem happened at work. I went home upset and not feeling fine. As I already complain of a problem in my uterus, I got heavy bleeding and admitted to the hospital, and my kids were worried and nervous all the time." (Participant 6)

Several participants also described how hard it was to leave their stress at the hospital door:

> "If I got angry in the clinic, I will be angry at home as well. I will be in a bad mood the whole day; I am one of the people who cannot separate their work from their personal life." (Participant 4)

This blurring of lines did not just impact the HCWs themselves, it was noticed by family members as well:

> "If I face difficult cases or problems at work, I feel not okay for a long period of time after work, I feel sad and tired. My family notice this as well! I feel I go home after work with an old lady soul." (Participant 1)

Others described the difficulty of keeping emotional boundaries intact. As this participant admitted, work often bled into his home life despite his best efforts to separate the two:

> "I always try not to carry work problems to my personal life. However, sometimes it is out of control, and it spills in our personal life!" (Participant 19)

For those in leadership roles, the inability to disconnect seemed even more entrenched. As this administrator describes, he does not get any true rest and has to answer work-related calls at home:

> "Stress from work spills over into my personal life because of the constant work-related phone calls and lack of clear boundaries between work and rest time." (Participant 20)

Another physician who is a team leader shared a similar struggle:

> "My team members keep calling and texting me day and night, after official working hours. I can't take a break and stop thinking about the work and its problems. It's affecting me enjoying my personal life." (Participant 18)

This account represents perhaps the most acute example of work-related stress affecting personal wellbeing. Overall, these accounts of stress spillover indicate that for many

participants, the boundaries between work and personal life were permeable and often painfully so.

5.2. Effects on work performance

In this sub-theme, the participants described how stress in the workplace disrupted their emotional wellbeing and affected their ability to perform effectively. They spoke about feeling mentally drained and less able to deliver the kind of healthcare they wanted due to chronic pressure and an unsupportive work environment.

Some highlighted how stress built up gradually, leaving them emotionally depleted and less capable of performing at their best:

> "My job affects my mental wellbeing. Periods of achievements boost my energy, but the accumulation of pressure without breaks leads to mental and emotional exhaustion. It is affecting my work performance as well." (Participant 20)

Others pointed to specific times in the work calendar that were particularly overwhelming:

> "I am stressed at work too much, all the time. Especially at the end of each month as we must send the paperwork to the administration. It's a lot of work! All of us become stressed and we just want to finish this job." (Participant 3)

Several spoke about how their desire to provide high-quality care was compromised by the sheer volume of responsibilities:

> "I have my way of dealing with my patients, like I have to explain to them their cases and management plan and write down to them how and when to take their medications step by step. I love to do my job perfectly, but with the workload I can't. When I am overloaded, I can't give each patient the required care, and that makes me upset and stressed." (Participant 4)

Interactions with patients were another source of emotional fatigue. One participant described the experience as being emotionally drained by demanding individuals:

> "We see patients who take your energy like a vampire, very difficult patients. After seeing these types of patients, your mood will be affected, and you will not give the next patient your full attention." (Participant 9)

This vivid metaphor of patients as 'vampires' who drain energy captures the emotional labour involved in caring for demanding individuals. The participant's description of needing 'a long time to recover' suggests that certain patient interactions-imposed costs that extended well beyond the clinical encounter itself.

For some, even minor feedback could trigger prolonged periods of self-doubt that affected their ability to move on and focus:

> “I am a person who gets upset very fast, even when I hear any comments on my work from my seniors. So, if I do my work perfectly and they just give a small comment, I’ll stay for like a whole two or three days asking myself why I did this tiny mistake! And how possible I made this mistake with my whole experience! I think it is all about the personality. Some colleagues are very practical, they will accept any comments and go to their home like they didn’t hear, but others like me are different!” (Participant 12)

A few participants described how prolonged exposure to stress, particularly in environments characterised by poor leadership and lack of respect, led not only to emotional exhaustion but to a marked deterioration in their ability to function at work:

> “I was so stressed. I felt not appreciated. I decided that going to work in this toxic environment is not worth it. Actually, I tried many times to go and do my best, but each time I go there, I experience chest tightness and stress, so I don’t do anything there. Until I took a decision that I am not going to work in this department, and I asked for a transfer. It was very difficult and took a long time. During that period, I didn’t go to work.” (Participant 15)

In some cases, this deterioration extended beyond reduced performance to an inability to work at all. Another nurse described how the lack of respect and cooperation from the physician in charge created an intolerable work environment:

> “I was working in another hospital with the most uncooperative physician in charge. I worked there for 4 years, and it was hell. I was pulling myself to go to work, skipping work many times, and even psychologically I wasn’t able to work and didn’t want to do anything. Everyone around me knows how I love my work and how responsible I am, but at that period it was out of my hand. I transferred to this hospital, and I am back to who I am.” (Participant 7)

Not everyone saw work-related stress in a purely negative light. One participant offered a more reflective take, describing how the nature of stress evolved over time:

> “I was stressed more when I started my career. It was a different source of stress. Before, it was from the night shifts and lack of sleep. Now, it may come from patientrelated adverse events or pressure from an overbooked schedule. In general, my work now has a positive impact due to routine hours and having a sense of fulfilment in helping people. Having good stable income also helps with quality of life and leisure activities.” (Participant 17)

Across these accounts, we see a clear picture of how chronic workplace stress eroded HCWs' performance and morale. Participants reported feeling mentally drained and struggling to focus. Many lost their passion at work and just went through their shifts mechanically. This was due to the cumulative effect of constant pressure and lack of support as well as unmanageable workloads. Additionally, a toxic environment and continuous disrespect made some of the participants' jobs unbearable.

Conclusion

The findings presented in this chapter demonstrate that HCWs' job satisfaction and wellbeing within Kuwait's public healthcare system are shaped through the interaction of organisational, relational, and sociocultural conditions. The analysis indicates that workplace wellbeing is not experienced as an isolated individual state, but as something embedded within everyday institutional practices, including leadership approaches, professional relationships, workload pressures, and perceptions of fairness and recognition.

Leadership and management practices emerged as particularly influential in shaping how HCWs experienced support, stability, professional value, and emotional strain within the workplace. Workplace relationships, staffing pressures, patient interactions, and broader organisational conditions also influenced whether participants experienced their working environments as supportive, manageable, or emotionally exhausting. The analysis further indicates that workplace inequities relating to nationality and gender were not experienced as isolated concerns, but as ongoing structural dynamics shaping professional identity, belonging, and workplace morale.

The chapter also shows that work-related stress was rarely contained within the workplace itself. Participants described forms of emotional spillover in which workplace pressures extended into home life, recovery, and broader psychological wellbeing. This means that HCWs' wellbeing cannot be understood solely through individual coping or mental health outcomes. It must also be examined in relation to the organisational and institutional contexts in which healthcare work occurs.

These findings support the need for a conceptual framework capable of accounting for the interaction between workplace demands, organisational resources, relational dynamics, and wellbeing outcomes. The following chapter therefore introduces the Job Demands-Resources (JD-R) model as an interpretive lens through which these patterns can be further organised and discussed.

Chapter 6: The Job Demands-Resources model

Introduction

This section introduces the Job Demands-Resources (JD-R) model, which I use as a conceptual tool to support the interpretation of my findings. The JD-R model has been widely used in organisational research, including healthcare settings, to explore how different features of the work environment shape employee wellbeing and job satisfaction (Bakker and Demerouti, 2017; Lesener et al., 2019; Schaufeli and Taris, 2014). Although my research was based on reflexive thematic analysis (RTA) within an interpretivist framework, I found that the JD-R model provided a clear and useful way of organising the different pressures and supports described by healthcare workers (HCWs) at Mubarak Al-Kabeer Hospital. In the sections that follow, I outline the key components of the model, explain how they relate to participants' accounts, and briefly justify why JD-R was selected over other theoretical approaches. I also reflect on the strengths and limitations of the model, particularly in relation to the context and data of this study.

Overview

The Job Demands-Resources (JD-R) model was first developed by Demerouti and colleagues (2001) and later refined by Bakker and Demerouti (2007, 2017) to explain how different job characteristics influence employee wellbeing and motivation. It organises work-related factors into two broad categories: job demands and job resources. Job demands refer to aspects of a role that require sustained physical, emotional, or mental effort. In the context of this study, participants described these demands in terms of high workloads, tight deadlines, emotional strain from patient care, and organisational constraints such as rigid attendance monitoring or inefficient administrative systems. Job resources, in contrast, are the supportive elements of a job that help workers achieve goals, reduce strain, or grow professionally. In my data, these included supportive supervisors, a degree of autonomy in decision-making, recognition for contributions, and access to meaningful training opportunities.

The central premise of the model is that high job demands, if not balanced by adequate resources, can lead to stress and burnout. Conversely, sufficient resources can buffer or even reverse the negative effects of high demands, promoting motivation, engagement, and wellbeing (Bakker and Demerouti, 2017). The JD-R model also recognises that job demands and resources vary across occupational and organisational contexts, and that their meaning may differ depending on how work is organised (Demerouti and Bakker, 2011). Although originally developed in European organisational psychology (Bakker and Demerouti, 2017), the JD-R model has since been applied across a wide range of healthcare settings internationally (Lesener et al., 2019). Its adaptability makes it a useful starting framework for studies like this

one, where the interaction between structural constraints and how staff experience and manage job demands is central, even though its conventional applications often require contextual refinement. A meta-analytic review of longitudinal JD-R studies identified a range of harmful job demands and protective job resources, including workload, organisational support, leadership, autonomy, and social support, which closely align with the model's core categories (Lesener et al., 2019).

The JD-R model has also been applied in non-Western and Middle Eastern contexts, including Kuwait. For example, Ali (2016) used the JD-R framework to examine work adjustment among expatriate and local nurses in Kuwait, demonstrating its relevance for understanding how job demands and resources operate within a culturally and institutionally specific healthcare workforce. More recently, JD-R has been employed in Kuwaiti research on burnout among social workers, where job demands and resources were used to interpret patterns of emotional exhaustion, depersonalisation, and personal accomplishment (Alkhurinej et al., 2025). Although these studies sit largely within management and social science traditions rather than public health research, they provide clear precedent for the contextual application of the JD-R model within Kuwait. In this study, the JD-R framework offered a way to interpret how HCWs described the interplay of these pressures and supports, linking them to broader questions of engagement, retention, and wellbeing.

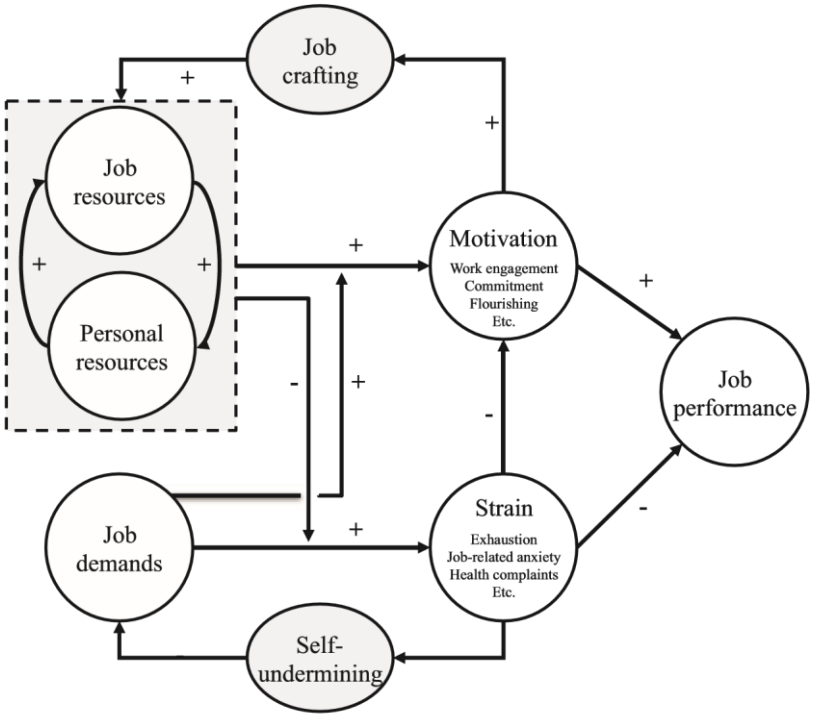
I draw on the expanded 2017 version of the JD-R framework, as it aligns more closely with my dataset. This version incorporates personal resources, such as self-confidence, resilience, and optimism, which were clearly visible in my findings. For example, some participants drew on their own perseverance, adaptability, or a strong sense of professional commitment to continue working despite structural constraints. The expanded framework also highlights multi-level resources, such as team cohesion and organisational justice, which in this study emerged in accounts of collaborative departments where equitable treatment and mutual respect reduced the strain of high patient volumes.

Another important refinement is the recognition of gain and loss spirals (Bakker and Demerouti, 2017). In a gain spiral, resources accumulate over time, reinforcing engagement and resilience, for instance when supportive leadership fostered a positive team culture that encouraged mutual assistance and improved morale. In a loss spiral, demands intensify and resources deplete, creating a cycle of fatigue and disengagement. This pattern was evident in accounts from departments where chronic understaffing led to increased workloads, reduced time for training, reduced cooperation, and eventual demotivation.

The 2017 update also incorporated the concept of job crafting, referring to the proactive ways employees adjust their own job demands and resources to better align with their strengths,

needs, and preferences. Although constrained by the rigid structures of Kuwait's public healthcare system, some participants described small acts of job crafting. These included rearranging task priorities to manage peak workloads more effectively or relying on supportive colleagues and teamwork to manage competing demands. Such behaviours, while modest, reflect the model's recognition that employees are not passive recipients of their work environment but can, within limits, shape it to better support their wellbeing.

Figure 11: The Job Demands-Resources (JD-R) model (adapted from Bakker and Demerouti, 2017)



This version of the model outlines two main pathways through which work characteristics influence outcomes (Bakker and Demerouti, 2017). The strain process describes how excessive job demands can lead to stress, burnout, and other negative effects. The motivational process, by contrast, highlights how job and personal resources support engagement, performance, and wellbeing. The expanded framework also incorporates personal and multi-level resources, gain and loss spirals, and job crafting, recognising that employees both respond to and actively shape their working conditions (Bakker and Demerouti, 2017). In this study, disengagement refers to participants describing emotional withdrawal, reduced motivation, or a sense of becoming detached from their work overtime. The diagram helps visualise how individual, team, and organisational factors within Kuwait's public healthcare system interact to shape experiences of strain, disengagement, or sustained motivation. This diagram is further refined in the discussion chapter (chapter 7) to reflect the hierarchical, stratified, and culturally embedded nature of the system, including the multi-positional role of leadership and the importance of

relational and symbolic resources. This need for refinement reflects the discussions in Demerouti and Bakker (2011) paper about the importance of considering organisational and hierarchical context when applying the model.

Relevance to the present study

The JD-R model provides a flexible theoretical framework for exploring the complex interactions between workplace characteristics and employee experience (Bakker and Demerouti, 2017). In this study, the model was introduced only after themes had been developed through reflexive thematic analysis (Braun and Clarke, 2020). This sequencing was intentional. Introducing the framework earlier would have risked shaping the analysis around predefined categories, which would have conflicted with the inductive aim of allowing participants' perspectives to guide them development. By applying the JD-R model after the themes were established, the analysis remained grounded in participants' own accounts before being interpreted through a theoretical lens. At this stage, the model functioned as a flexible interpretive tool rather than a coding framework, supporting explanation without constraining the analysis.

I did not approach job satisfaction or wellbeing as fixed or universal outcomes, but as concepts whose meanings are shaped by Kuwait's public healthcare context. Factors such as leadership practices, nationality-based hierarchies, and the distribution of resources influenced how demands and resources were experienced and understood by participants. While qualitative and mixed-methods applications of the JD-R model have varied in how and when the framework is introduced, studies conducted in healthcare settings across Asia, Europe, and the Middle East demonstrate that the model's core categories can be adapted to local organisational cultures without undermining qualitative depth or contextual sensitivity (Chua et al., 2024; Kaihlanen et al., 2023; Seinsche et al., 2023; Zeinolabedini et al., 2022). These examples supported my decision to apply the JD-R framework in a way that complemented inductive theme development and reflected the institutional and cultural realities of Kuwait's public healthcare system.

The decision to adopt the JD-R model was therefore not based on the assumption that it captures every aspect of HCWs' experiences. Rather, it was selected for its ability to bring together micro-level factors, such as leadership interactions, team support, and daily workload, with broader structural influences, including policy frameworks, institutional hierarchies, and systemic inequalities. Although the distinction between demands and resources can appear simplified in theory, in this study these categories served as organising reference points around which richer, contextually grounded accounts could be interpreted. This balance of structure and flexibility allowed the inductively developed themes to remain sensitive to lived experience.

At the same time, it supported interpretation at the level of organisational and policy discussion within Kuwait's public healthcare system.

The findings presented in Chapter 5 illustrate a persistent imbalance between high job demands and limited resources in the everyday working lives of HCWs at Mubarak Al-Kabeer Hospital. Participants' accounts showed how structural and organisational pressures, including lengthy administrative processes, strict attendance monitoring, and chronic understaffing, often outweighed the support available to them. The JD-R model provides a useful way of organising these experiences by making explicit the relationship between workplace pressures and the resources available to address them. Within this framework, rigid attendance requirements, heavy administrative workloads, and the emotional demands of patient care can be understood as job demands, while autonomy, recognition, and access to training function as key job resources. This categorisation highlights not only the presence of demands and resources, but how their relative imbalance shaped participants' experiences of stress, wellbeing, and work performance.

The model also draws attention to how variations in available resources influenced how demands were experienced. As described in the Findings (Chapter 5), participants working in departments with approachable and responsive leadership often reported a reduced sense of strain, despite facing similar workloads and procedural requirements. Within the JD-R framework, this can be understood as a buffering effect, where supportive leadership mitigated the impact of high demands. Participants who described such environments were less likely to emphasise the negative effects of rigid administrative policies and more likely to describe coping effectively with work-related stress, including limiting its spillover into their personal lives. These accounts illustrate how differences in local leadership and support shaped everyday experiences of work, even within the same organisational context.

Viewed through this lens, the JD-R model helps connect the micro-level realities of daily working life, such as frustrations with time monitoring or the benefits of supportive team relationships, with broader organisational patterns within Kuwait's public healthcare system. This framing reinforces the idea that job satisfaction and wellbeing are not solely individual or emotional states, nor purely matters of personal resilience. Rather, they emerge from the ongoing interaction between workplace demands and the resources available to meet them. Using the JD-R framework in this way supports a more integrated understanding of how organisational conditions shape HCWs' experiences, without reducing those experiences to individual-level explanations.

None of the alternative frameworks considered offered the same combination of conceptual clarity, flexibility, and capacity to link individual accounts with wider structural conditions. The

JD-R model allowed diverse and sometimes contrasting participant experiences to be interpreted within a coherent structure, without forcing them into rigid or reductive categories. For these reasons, it was selected as the most appropriate conceptual lens for interpreting the findings in this study.

Other models considered

I considered a number of theoretical models that could potentially support interpretation of the findings. While several offered useful insights for specific aspects of the data, none provided a strong fit across the full range of experiences shared by participants. Many were either too narrow in focus or too rigid in structure to reflect the diversity and complexity that emerged across different professions, nationalities, and departments within the hospital.

One model considered was the Effort-Reward Imbalance (ERI) model (Siegrist, 1996), which explains work-related stress as arising when high levels of effort are not matched by adequate rewards, whether financial, emotional, or professional. This dynamic was evident in parts of the dataset. For example, a Physician described being expected to serve on multiple committees “without any compensation or appreciation,” while another participant spoke about working overtime with no recognition. These accounts align closely with the core premise of ERI and help explain why such experiences were perceived as unfair and demoralising.

However, ERI has notable limitations in relation to this study. It offers little insight into other factors that were prominent in participants’ accounts, such as leadership practices, team dynamics, or access to training and career development. It also frames workplace stress primarily in terms of perceived unfairness, whereas many participants described more layered frustrations, including micromanagement, exclusion from decision-making, and uncertainty about career progression. Although ERI was useful for interpreting some experiences, it did not offer the scope or flexibility required to account for the dataset as a whole.

I also considered the Demand-Control-Support (DCS) model (Karasek and Theorell, 1990), which proposes that stress emerges when high job demands are combined with low control, unless offset by strong social support. Elements of this framework resonated with the data. Several participants described having little control over their schedules, feeling powerless when clinic rules changed without consultation, or experiencing a lack of support from leadership. These experiences align with the central assumptions of the DCS model.

At the same time, the simplicity of the DCS model is also its main limitation. By focusing on only three dimensions, demand, control, and support, it assumes a level of consistency across work settings that was not reflected in participants’ accounts. Their experiences were shaped by unstable leadership, rigid hierarchies, nationality-based inequalities, and sustained emotional

strain. The model also offers limited space to explore positive features such as effective teamwork or compassionate supervision, which emerged as important protective factors for some participants. As a result, it was not sufficient for capturing the full complexity of the findings.

Other frameworks were also considered during the design stage, including Person-Environment Fit models and Role Theory (Edwards, 1998; Kahn et al.,1964). These approaches focus on how well individuals feel aligned with their job roles or organisational environments. Some elements of these models resonated with the data. For instance, a lab technician described feeling more respected and valued when working abroad compared to her current role, while another participant spoke about feeling invisible due to a lack of clarity around her responsibilities. These accounts point to mismatches between individuals and their work environments.

However, these frameworks focus primarily on individual alignment and provide limited insight into the wider organisational and structural conditions shaping workplace experience. They offer little explanation for issues such as poor management, rigid hierarchies, unstable leadership, or unequal access to training. Given that this study sought to understand both personal and institutional influences on job satisfaction and wellbeing, these models were not sufficiently comprehensive to support the analysis.

I also considered Herzberg's Two-Factor Theory (Herzberg et al., 1959), which distinguishes between "hygiene" factors, such as pay, supervision, and working conditions, and "motivators," such as recognition, achievement, and opportunities for growth. This distinction was reflected in the data. Some participants described frustration with low pay, inflexible schedules, or unsupportive management, yet continued to take pride in their work when it was recognised or when they were able to provide meaningful patient care. Others described feeling motivated by training opportunities or constructive feedback, even when other aspects of their job were challenging.

Nevertheless, the separation of satisfaction and dissatisfaction into independent categories limits the usefulness of Herzberg's model in this context. Participants' accounts suggested that the same factor could function as both a motivator and a source of dissatisfaction depending on how it was experienced. For example, training could enhance engagement when accessible and well organised but generate resentment when perceived as unfair or poorly managed. The model also does not adequately account for the interaction between pressures and supports, or for the influence of systemic issues such as nationality-based hierarchies and institutional rigidity. While it offered helpful language for distinguishing different workplace influences, it lacked the flexibility needed to capture the full complexity of participants' experiences.

The Conservation of Resources (COR) theory (Hobfoll, 1989; Hobfoll, 2001) was also considered. This theory explains stress as arising when individuals lose valued resources, feel under threat of loss, or are unable to recover what has been depleted. Participants' accounts frequently reflected this process. For example, one Physician described losing hope in her career after repeated rejection from training programmes, while another spoke of emotional exhaustion resulting from ongoing responsibility without recognition. Others described a gradual erosion of motivation after prolonged exposure to unsupportive work environments or perceived loss of professional dignity.

COR theory is particularly helpful for understanding emotional burnout and the cumulative impact of sustained strain. It also offers insight into why some participants appeared to withdraw or stop attempting to initiate change, as continued resource depletion can lead to disengagement over time. However, the theory focuses primarily on individual experiences and coping processes and engages less with the organisational and systemic conditions shaping those experiences. In contrast, the JD-R model integrates both personal and structural dimensions of work. It enabled links to be drawn between individual exhaustion and wider organisational patterns within the hospital that could, in principle, be addressed at a system level.

Overall, while these alternative frameworks offered valuable insights into specific aspects of the data, none matched the breadth and adaptability of the JD-R model. JD-R was able to integrate individual and organisational factors, encompass a wide range of demands and resources, and link these to outcomes in a way that supports both understanding and policy-relevant interpretation. For these reasons, it was selected as the most appropriate conceptual framework for interpreting the findings of this study. At the same time, applying JD-R in this context also highlighted important limitations, particularly in relation to cultural and structural specificity, which are examined in the following section.

Limitations and critical reflections

While the JD-R model offers a useful way of organising and interpreting the findings, it also has important limitations that must be acknowledged when applying it to this study. The JD-R model organises workplace factors into two broad categories: job demands and job resources as a way of structuring analysis. In practice, however, many aspects of work are more fluid and context-dependent than this binary distinction allows. For example, training may be experienced as a demand when it is poorly organised, introduced during periods of high workload, or delivered without adequate support. The same training can function as a valuable resource when it is relevant, well structured, and supported by management. Within the JD-R model, the meaning of specific job characteristics is not fixed but shaped by context, timing, and delivery

(Demerouti and Bakker, 2011). This variation in how training is experienced shows that the model's categories do not always capture the complexity of HCWs' lived experiences.

The JD-R model also assumes a degree of organisational flexibility and responsiveness that may not exist in more rigid or hierarchical systems. In Kuwait's public healthcare sector, participants frequently described inflexible rules, limited autonomy, and slow or absent institutional responses to staff concerns. Such rigidity can itself be understood as an additional demand, as it restricts workers' ability to manage pressures or influence their working conditions. Where inflexibility is a persistent feature of the system, the model's underlying assumption that demands and resources can be readily adjusted becomes less applicable. The JD-R model assumes that organisations can adjust demands and resources, an assumption that may not hold in highly structured settings where employees have limited influence over their working conditions (Demerouti and Bakker, 2011). This limitation is not unique to Kuwait and has been noted in other highly structured healthcare systems, but it is particularly visible in this context. Without acknowledging this constraint, there is a risk of overstating the practical feasibility of organisational changes implied by JD-R analysis.

A further and particularly significant limitation is that the JD-R model does not explicitly address structural and cultural inequalities, including nationality-based hierarchies and gendered power relations. In this study, these were not simply issues of high demands or limited resources but reflected embedded institutional practices that shaped how individuals were valued, supported, or excluded.

Finally, the JD-R model is grounded in a transactional view of wellbeing, where the negative effects of strain can be offset by sufficient resources. While this logic helps explain several patterns in the data, it does not fully capture deeper experiences described by participants, such as loss of professional identity, feelings of futility, or the emotional toll of repeated moral compromise. These experiences go beyond an imbalance between demands and resources and point to a more fundamental erosion of meaning and purpose. Other frameworks considered earlier in this chapter offered partial insight into these issues, but none fully resolved this limitation. For example, being denied access to training or promotion on the basis of nationality could be described in JD-R terms as a lack of resources. However, such framing risks stripping away the moral, political, and cultural dimensions of the experience. It can understate the injustice involved and obscure the power relations that normalise these practices. Similar critiques have been raised in other contexts, where JD-R has been found to offer limited insight into deeply embedded inequalities unless supplemented by more critical or interpretive perspectives. While organisational conditions are recognised as shaping job demands and resources, the JD-R framework offers limited guidance for engaging with how

deeply embedded structural inequalities shape workplace experience (Demerouti and Bakker, 2011). As such, the JD-R model is best understood as a starting point for interpretation rather than a comprehensive explanatory framework.

For these reasons, the JD-R model is used here as a flexible interpretive lens rather than a definitive account of HCWs' wellbeing. It brings clarity to many aspects of the findings, particularly in linking workplace pressures and supports to observed outcomes, but it does not replace the lived realities, cultural contexts, or emotional complexities described by participants. Recognising both its strengths and limitations allows the model to be used productively, without overstating its explanatory reach.

Conclusion

The JD-R model provided a practical and conceptually clear way to interpret the findings of this study. Its core categories, job demands and job resources, aligned closely with the experiences described by participants, particularly in relation to workplace pressures, available supports, and the wider organisational conditions within Kuwait's public healthcare system. The framework offered a way to connect HCWs' lived experiences to broader institutional and policy-level contexts without losing the specificity or nuance of their accounts.

Meta-analytic evidence supports the JD-R model as a robust framework for understanding both burnout and engagement among HCWs (Lesener et al., 2019), and the findings of this study further illustrate its value in interpreting the interaction between pressures and supports. At the same time, its application highlighted important limitations, particularly in relation to structural inequalities, cultural hierarchies, and issues of meaning and professional identity that shaped participants' working lives. While these dimensions can be approached through the model's categories, they risk being underemphasised if the framework is applied without careful interpretive attention.

In the next chapter, I build on this conceptual foundation to examine the wider implications of the findings. I consider how the balance, or imbalance, between demands and resources reflects deeper cultural and systemic conditions, and how these shape job satisfaction, professional identity, and wellbeing within Kuwait's public healthcare workforce.

Chapter 7: Discussion

Introduction

This chapter interprets the findings of this study to understand how job satisfaction and wellbeing were shaped within Mubarak Al-Kabeer Hospital, Kuwait's main public teaching

hospital. In doing so, the chapter builds directly on the conceptual framing established in Chapter 1, which positioned job satisfaction and wellbeing as experiences produced through the interaction of organisational structures, workplace relationships, and wider sociocultural conditions. I move beyond the descriptive themes presented in the Findings (Chapter 5) to examine the deeper structural, relational, cultural, and emotional mechanisms that gave meaning to healthcare workers' (HCWs) experiences in this study. In doing so, the focus shifts from describing what participants reported to interpreting why these experiences carried significance within their organisational and cultural environment.

In this chapter, I analyse the organisational, relational, cultural, and structural pressures and resources that shaped the wellbeing of HCWs I interviewed, and I explore how these experiences differ across professional, nationality, and gender groups. These differences matter because job satisfaction and wellbeing are interpreted and lived in distinct ways depending on workers' roles, identities, and positions within the institutional hierarchy.

Aims, objectives, and research question

These aims, objectives, and the central research question are restated here for clarity and coherence, to explicitly anchor the interpretive discussion that follows to the study's original framing as set out in the Introduction (Chapter 1).

This study was guided by two overarching aims:

- To explore the key factors that influence job satisfaction and mental wellbeing among HCWs in Kuwait, as constructed through their day-to-day work experiences.
- To examine whether different professional and demographic groups, including distinctions related to role, nationality, and gender, define or experience job satisfaction and wellbeing differently.

To address these aims, the study pursued the following research objectives:

- To conduct a comprehensive review of the literature on job satisfaction and wellbeing among HCWs in Kuwait and the wider Gulf Cooperation Council (GCC) region.
- To undertake in depth, semi structured interviews to capture HCWs' perspectives and lived experiences.
- To analyse these accounts thematically in order to identify the conditions participants considered most influential for their wellbeing.
- To synthesise the findings into context specific organisational reflections aimed at supporting staff wellbeing and retention.

These aims and objectives were developed to address the following central research question:

- How do HCWs in Kuwait's public healthcare system interpret and experience the factors that influence their job satisfaction and wellbeing?

Chapter 5 identified five main themes shaping staff wellbeing: (1) Leadership and Management; (2) Workplace Relationships; (3) Work Environment; (4) Workplace Inequities; and (5) WorkRelated Stress and Spillover. These themes showed that wellbeing emerges not from isolated organisational features but from the interaction of structural, relational, cultural, and external forces.

Building on this foundation, this chapter moves beyond the descriptive themes presented in Chapter 5 to interpret how and why these patterns mattered to participants. Rather than treating organisational demands, relational dynamics, cultural expectations, and emotional realities as separate categories, I integrate them into a set of interconnected conceptual arguments. This reflects how participants themselves experienced the system: as overlapping and mutually reinforcing forces shaping their wellbeing.

Throughout this chapter, the Job Demands-Resources (JD-R) model is used as the primary theoretical lens. As outlined in Chapter 6, the model is introduced and critically examined as an interpretive framework rather than as a guide for data collection or analysis, and is applied here to integrate and interpret the study's findings. The model helps explain how demands accumulate, how resources support or fail to support staff, and how these interactions shape wellbeing. At the same time, my findings reveal contextual dynamics that challenge several assumptions of the standard JD-R formulation. Accordingly, the analysis both applies and refines the model, proposing conceptual extensions suited to labour-stratified and culturally complex healthcare systems such as Kuwait's public sector. The discussion is organised to reflect how strain is produced and experienced in daily practice. It begins with the organisational environment and the structural pressures that shaped routine work. It then examines the relational and symbolic factors that influenced wellbeing, followed by the external social and cultural forces that extended emotional labour beyond the hospital setting. Work-home spillover, a well-established idea in organisational psychology, describes how pressures from work extend into personal and family life (Bakker et al., 2014). This concept helps explain why the daily demands described in this study had emotional and physical consequences beyond the workplace. After discussing spillover, the chapter examines the findings through the JD-R model and then develops the theoretical contribution in the following section. It concludes with implications for practice, followed by strengths and limitations and directions for future research.

Across the chapter, four overarching arguments organise the interpretation:

1. Organisational structures function as dynamic systems of demands and resources. Leadership behaviour, leadership instability, bureaucratic processes, staffing shortages,

and structural inequities actively shape emotional experience by altering the balance of demands and resources available to staff.

2. Wellbeing is strongly shaped by relational and symbolic conditions. Teamwork, respect, communication, voice, recognition, and everyday interactions influenced workers' sense of dignity, identity, motivation, and psychological safety.
3. External social and cultural forces place significant emotional demands on staff. Patient expectations, public behaviour, family involvement, social media pressures, and *wasta* extend emotional labour beyond formal job boundaries.
4. Work-home spillover is the core mechanism of impairment. Spillover transfers structural, relational, and external pressures into personal and family life, producing cumulative and long-lasting impacts on wellbeing and performance.

Before developing these arguments, the chapter returns to key elements of Kuwait's organisational and cultural environment introduced in Chapter 1. This section does not restate the broader system context, but selectively synthesises those features most relevant for interpreting the study's findings.

As established in Chapter 1, the experiences described in this study are inseparable from the structural, cultural, and institutional conditions that shape healthcare work in Kuwait's public sector. Public hospitals operate within a centralised civil service system characterised by regulatory rigidity, hierarchical authority, and frequent rotations of leadership positions. Authority flows through bureaucratic channels, and staff often have limited influence over organisational decisions. These structures shape both the practical and emotional dimensions of work.

The workforce is highly multinational. Kuwaiti, Arab expatriate, South Asian, and Southeast Asian HCWs share responsibilities but do so from unequal starting positions. Nationality influences contract type, job security, access to benefits, and opportunities for training and promotion. Kuwaitis are governed by civil service regulations, while most expatriates are employed on ministry contracts with different rights and career pathways. These disparities create structural inequities that function as constant background demands for many staff.

Cultural expectations around authority, respect, gender roles, and family shape daily interactions. Cultural expectations around hierarchy and authority shaped everyday communication, often limiting voice for junior staff and creating emotional pressure for those who felt unable to question decisions. Gendered expectations create additional pressures for women, especially around recovery, domestic responsibilities, and managing patient or family behaviour. *Wasta* operates as a parallel system of influence; although not always explicitly discussed, its presence shapes perceptions of fairness, protection, and moral responsibility.

Kuwait's public healthcare system is deeply intertwined with wider societal expectations. Patients and families often expect extended emotional availability, rapid service, and personalised attention. Social media increases public scrutiny and creates a sense of being observed or evaluated, which generates anticipatory anxiety about being filmed or publicly criticised. These factors position HCWs within a wider sociocultural environment that continuously shapes their emotional experience.

These structural and cultural features set the stage for understanding how job demands and resources are interpreted in this environment. They provide the backdrop against which organisational practices, workplace relationships, and external pressures gain their emotional significance.

Organisational structures

Participants described their work environment not as a neutral context but as an active system that shaped their emotions, identity, and sense of stability. Organisational structures created both demands and resources. Much of the global literature identifies leadership quality, workload, teamwork, recognition, autonomy, and organisational justice as central determinants of staff wellbeing (Maslach & Leiter, 2016; Shanafelt et al., 2015). Studies from the Gulf region similarly emphasise staffing shortages, hierarchical management practices, limited professional voice, and inequities in promotion and appraisal systems (Al-Omar, 2003; Alotaibi et al., 2020). While my findings align with these broad patterns, they also reveal important contextual dynamics that are underdeveloped or absent in existing research.

These structures included leadership behaviour and continuity, bureaucratic governance patterns, staffing arrangements, and structural inequities based on nationality and gender. These conditions shaped how HCWs interpreted their daily experiences and how they appraised demands.

Although participants frequently referred broadly to "management" throughout their accounts, the findings reflected both leadership and management as related but analytically distinct organisational dimensions. In healthcare settings, leadership is commonly understood as a relational and behavioural process centred on influencing, motivating, supporting, and guiding others, and is not necessarily limited to those occupying formal managerial roles (Ellis and Abbott, 2013; Scott, 2023). By contrast, management is more closely associated with the coordination and administration of organisational systems, including policy implementation, supervision, performance monitoring, staffing arrangements, and operational control (Scott, 2023). This distinction is important because participants' experiences were shaped both by leadership behaviours, such as communication, recognition, and emotional support, and by

management processes, such as attendance monitoring, workload distribution, and administrative decision-making. While these dimensions frequently overlapped in practice, distinguishing between them analytically helps clarify how different organisational processes influenced HCWs' wellbeing and job satisfaction.

Leadership

Leadership came through as the single most influential organisational element affecting wellbeing. Participants' accounts primarily reflected leadership as a relational influence shaping trust, psychological safety, communication, and emotional support, rather than management in its narrower administrative sense. My findings suggested that leadership could not be understood as a single or simple influence. Instead, leadership occupied several positions simultaneously:

1. Leadership as a resource. Supportive leaders provided clarity, protection, recognition, and psychological safety. Staff described these leaders as buffers against organisational strain. A single effective supervisor often transformed an entire department into a stable emotional environment, even when workload was heavy.
2. Leadership as a hindrance demand. Authoritarian, inconsistent, or punitive leaders created emotional strain. Participants described feeling undervalued, monitored, or dismissed. These leaders magnified existing tensions and sometimes introduced new demands through erratic decision making, poor communication, and unfair task allocation.
3. Leadership as a meta-moderator. Leadership behaviour shaped how all other demands were appraised. The same workload, patient pressure, or staffing shortage became manageable or overwhelming depending on whether staff trusted their supervisors. Leadership quality influenced whether workers felt protected or exposed.

A clear example of leadership's moderating role was the biometric attendance monitoring system. For some staff, it was viewed as routine oversight and accountability. For others, particularly when trust in management was lacking, it was perceived as "military-style surveillance." One Physician described being forced to leave a patient mid-consultation to "chase a GPS signal," turning patient-care time into compliance time. This illustrates how leadership acted as a moderator: in environments characterised by relational trust, the system was interpreted as accountability, whereas in contexts of mistrust it was experienced as punitive or disciplinary. These differing appraisals align with international research showing that monitoring and digital tracking systems, when experienced as punitive or distrustful rather than supportive, can undermine workers' autonomy and heighten emotional strain (Ball, 2010; Sewell

and Barker, 2006; Glavin et al., 2024). In the Gulf region, existing studies acknowledge hierarchical oversight but rarely examine digitalised attendance systems or GPS-based tracking in depth. My findings contribute a context-specific insight by showing how surveillance was interpreted through cultural meaning, professional identity, and trust in leadership.

4. Leadership instability as a distinct structural demand. Frequent leadership rotations created by civil service governance functioned as a chronic background pressure. Participants experienced each rotation as an emotional reset requiring new adaptation. Sudden changes brought shifts in expectations, workplace dynamics, and decisionmaking patterns. This instability disrupted continuity and weakened staff's ability to predict their work environment.

Notably, participants' accounts also suggested that different layers of leadership interacted with one another. In some departments, supportive immediate supervisors appeared to buffer the negative effects of more distant or unstable senior leadership. This layering meant that the emotional impact of leadership instability was not uniform; it depended partly on whether staff had access to protective relationships at the departmental level.

Leadership turnover also generated a form of organisational memory loss. Each rotation disrupted established norms, erased prior relationship building, and required staff to reorient themselves to new expectations. Participants described feeling that departments repeatedly "started from zero," with past improvements forgotten and momentum lost. This erosion of institutional continuity transformed leadership change into an emotional demand, contributing to uncertainty and diminishing the sense of long-term progress.

These findings align with international literature, which consistently describes leadership as one of the strongest predictors of job satisfaction, burnout, and engagement, with transformational and supportive styles associated with more positive outcomes (Wong and Laschinger, 2015; Aiken et al., 2012). Much of the existing GCC leadership literature assumes relative stability in supervisory structures and focuses mainly on leadership style and its relationship with staff satisfaction and retention. For example, survey-based studies in public healthcare settings have described leadership largely in terms of whether managers use more supportive or more directive approaches, rather than examining the organisational or governance contexts in which leadership is enacted (AbuAlRub & Alghamdi, 2012). In contrast, my findings suggest that leadership continuity mattered as much as leadership style, and that uncertainty about leadership direction became an emotional demand in its own right, weakening trust, limiting psychological safety, and constraining voice.

Bureaucracy

Kuwait's civil service structure created a work environment characterised by procedural rigidity and hierarchical control. Participants described how decisions moved through multiple layers of administrative authority, limiting their ability to influence policies or resolve problems quickly. This rigidity shaped emotional experience in several ways and reflected management processes associated with organisational control, procedural governance, and administrative oversight, rather than the more relational dimensions of leadership discussed earlier.

Bureaucratic procedures frequently slowed decision-making. Staff described waiting for approvals, signatures, or committee outcomes that delayed patient care or hindered professional autonomy. Junior physicians, for example, spoke of having to "struggle to find a senior Physician to sign the prescription while the patient is waiting" (Participant 4), while pharmacists expressed frustration at needing to "go back to the Physicians to approve" medication adjustments they felt confident making themselves (Participant 10). These delays created frustration, reduced feelings of competence, and generated a form of temporal strain. Time felt compressed, momentum was lost, and staff often had to rush tasks once approvals finally arrived. This made workers feel powerless over the pace of their own work and signalled that their time held little organisational value. In this way, bureaucratic delay acted as a demand in its own right, consuming emotional energy even before clinical work began.

Knowledge-based hierarchies shaped whose expertise was valued in decision-making. Physicians' views tended to hold more weight than those of nurses or allied health professionals, even in areas where the latter had specialised expertise. Nurses described physicians who "will not accept your comments because you are a nurse", with some responding to infection control reminders by looking "down at me" and complaining rather than engaging with the clinical concern (Participant 7). This dismissal extended beyond individual encounters into formal processes. When conflicts arose between nurses and physicians, "the administration don't listen to us", with decisions made based on physician complaints without hearing "both sides" (Participant 7).

This reflects what Fricker (2007) terms epistemic injustice: the systematic undervaluing of certain groups' knowledge claims. The pattern operates at two levels. First, clinical expertise was dismissed in everyday practice, visible when patient safety concerns were ignored or met with condescension. Second, credibility was unevenly allocated during conflict resolution, with administrative processes privileging physicians' accounts over those of nurses. When staff felt their knowledge or testimony was overlooked, this was experienced not simply as a professional slight but as an emotional drain that undermined identity, motivation, and trust in organisational fairness. Pharmacists described similar experiences, noting that physicians did not take

recommendations seriously “although it’s evidence-based recommendations, it’s disappointing!”, with patients sometimes returning to hospital with medication side effects after “the physicians ignored our comments” (Participant 10). These dynamics contributed to a broader sense of invisibility or being undervalued, echoing evidence from other stratified healthcare systems where rigid hierarchies suppress voice and limit participation (Mannion et al., 2005).

Procedural control was further evident in the expanded attendance monitoring system, which several participants felt carried a deeper meaning beyond administrative record-keeping, extending bureaucratic control from decision-making into everyday presence at work. Rather than being experienced as neutral oversight, the system was widely interpreted as a signal of surveillance and limited trust. The introduction of a third mid-day sign-in, followed by a GPSbased mobile application, was described as intrusive and poorly aligned with clinical workflow.

Staff described the system as creating a feeling of “working in a military institution not in a hospital”, with evaluation focused on “working hours” rather than “work productivity” or “quality of work” (Participant 10). The timing of the mid-day check-in coincided with ward rounds, forcing staff to abandon clinical teams to sign in, leading to missed cases “just to prove that I am at work” (Participant 10). Physicians described the GPS-based system as “neither practical nor fair”, questioning how they could “leave our patients in the middle of consultation to go and look for a signal that gives our correct location to prove that we are at work” (Participant 9). This created a fundamental contradiction in which staff could be considered absent while actively engaged in patient care.

Such systems therefore carried strong emotional meaning, signalling mistrust, heightened scrutiny, and the prioritisation of visibility over professional judgement. Surveillance functioned not only as a bureaucratic demand but also as a challenge to autonomy and dignity, intensifying the emotional impact of existing hierarchies. This aligns with organisational signalling theory, which suggests that workplace systems influence staff not only through formal rules but through the messages they convey about trust, value, and expected behaviour (Bowen and Ostroff, 2004).

Structural inequity

Structural inequities based on nationality, contract type, and gender formed a continuous emotional burden for many expatriate and female staff. These inequities were built into the wider system and influenced daily interactions, access to resources, and perceptions of fairness.

For expatriates, inequity was experienced through limited job security, restricted mobility, unequal access to training, and disparities in grievance procedures. Several participants described how their complaints were deprioritised, especially when conflicts involved Kuwaiti colleagues. Institutional inequity was also evident in reward systems, with one participant describing how “this year the MOH decided that only Kuwaiti employees have the right to receive this reward, and non-Kuwaitis have no right to receive it! Unfair!” (Participant 8). This reinforced feelings of vulnerability and shaped a persistent sense of being unprotected.

For women, inequity was experienced through the demands of balancing workplace pressures with domestic responsibilities. Working mothers described returning home exhausted, struggling to be present for their children, and carrying feelings of guilt about falling short in both roles. As one participant put it, she would arrive home with “an old lady soul,” too drained to engage with her family (Participant 1). Another described sitting in her car for fifteen minutes before entering her home, needing time to decompress before facing her children’s needs (Participant 8). These pressures cumulatively reduced opportunities for psychological recovery, the time and mental space needed to rest, detach from work, and replenish emotional resources between shifts, and increased emotional load. These patterns were not episodic stressors but persistent background conditions that shaped how all other demands were appraised.

For expatriates, visa dependency and contract insecurity created a constant background pressure that reduced their sense of optimism, control, and confidence. This was not merely the absence of resources but the active presence of structural demands that undermined both energy and trust. These inequities operated through similar mechanisms: they undermined trust in the organisation and eroded fairness as a resource. Staff who felt excluded from promotions, training, or dignity protections described disengagement and cynicism. It also underscores that resources and demands are not only psychological but also institutional, embedded in the structures that govern everyday work.

Nationality-based inequities are well documented in GCC healthcare literature (Al-Omar, 2003). Prior studies highlight persistent disparities in job security, access to training, involvement in decision-making, and the transparency of disciplinary systems. My findings not only confirm these patterns but show how they function as chronic emotional demands. Expatriate staff described heightened caution, fear of complaint, and limited recourse when they were mistreated, creating pressures that shaped daily interactions, constrained voice, and influenced confidence and emotional expression. Whereas regional research often treats nationality stratification as an organisational feature, my findings demonstrate how it becomes an everyday emotional environment that produces continuous background anxiety and undermines psychological safety. International evidence from the UK healthcare system similarly shows that

structural inequities and minority status are associated with heightened perceptions of discrimination, reduced confidence in speaking up, and persistent vulnerability, even when occupational role and seniority are controlled for (West et al., 2015). These dynamics suggest that inequity operates not only through formal policy arrangements but through everyday relational climates that shape vigilance, trust, and voice. Such patterns closely reflect findings from Kreedi's (2022) qualitative study, which showed that Kuwaiti and expatriate nurses experienced workplace structures differently, with expatriate staff reporting greater vulnerability, weaker protection, and heightened sensitivity to unfair treatment. Bringing these relational and affective dynamics into focus offers a more complete understanding of how inequity is experienced, embodied, and reproduced in everyday practice.

Resources and training

Staffing shortages were described across professions. Nurses, physicians, technicians, and pharmacists reported chronic understaffing and uneven distribution of tasks within departments and between hospitals. Participants linked these shortages to emotional exhaustion, reduced morale, and decreased capacity for compassionate care. Similar patterns are widely documented in nursing and medical workforce research, particularly in Gulf settings (Aboshaiqah, 2016). These challenges are widely documented in global and regional workforce analyses, including the World Health Organisation's (WHO) state of the world's nursing report, which identifies gaps in continuing professional development, orientation, and the availability of appropriately trained and experienced staff, particularly affecting migrant health workers (WHO, 2020).

Skill gaps further intensified workload, senior staff reported spending significant time compensating for inadequately trained colleagues. This pattern appeared to stem from a combination of recruitment challenges, limited orientation programmes, and uneven access to continuing professional development. This not only increased task load but also consumed emotional energy through constant guidance, conflict management, and supervision.

Workload and staffing pressures are widely documented challenges in healthcare systems globally (Aiken et al., 2012), and they appear prominently in studies from Kuwait and neighbouring states (Al-Omar, 2003; Alotaibi et al., 2019). Yet my findings offer a more layered interpretation of what "shortage" means in practice. UK workforce research has similarly argued that staffing shortages should not be understood solely in numerical terms, but also in relation to skill mix, workforce deployment, and the conditions under which staff are expected to work (Buchan and Aiken, 2008).

My findings show how these structural conditions were experienced in everyday practice, as participants described not only numerical shortages but also disparities in skills, uneven training

across teams, and the emotional burden of repeatedly compensating for gaps in competence or experience. Team leaders described staff who “don’t understand what I want them to do” not because of unwillingness but because “they just don’t know”, requiring constant guidance that was “exhausting and wastes time” (Participant 18). These aspects are rarely captured in quantitative workload studies, which tend to focus on staffing ratios rather than the relational, emotional, and moral consequences of sustaining safe care under conditions of constrained competence. My findings therefore highlight how staffing pressures functioned not merely as operational barriers but as ongoing sources of moral strain, frustration, and identity conflict.

Training opportunities carried practical and emotional importance, participants interpreted access to training as a sign of organisational value and investment in their future. When training was provided equitably, it strengthened optimism and deepened commitment. When it was withheld, staff interpreted the absence as devaluation, leading to frustration and reduced engagement. Training also functioned as a structural resource by enhancing autonomy and competence. Clinical pharmacists described how specialised training improved their ability to contribute to patient care, yet the lack of authority to apply their expertise created emotional tension. This mismatch between qualification and responsibility acted as a hindrance demand that shaped motivation, identity, and perceptions of fairness.

Foundations of wellbeing

While structural conditions shaped the broader environment, the emotional texture of daily work was most directly shaped by relational and symbolic experiences. By symbolic, I refer to gestures or acts that carry meaning beyond their material value: forms of recognition that signal respect and appreciation. Participants emphasized that reward systems should recognize hardworking employees “even if the reward is something simple like a trophy or a chocolate box” (Participant 9). What mattered was not the cost of the reward but the message of appreciation it carried. Participants repeatedly described how teamwork, recognition, respect, voice, and interpersonal climates influenced their sense of dignity, identity, belonging, and psychological safety. These relational conditions acted as critical resources or drains, and their emotional significance extended far beyond the practical tasks of clinical work.

Teamwork

Team culture was a defining feature of wellbeing. Supportive colleagues who collaborated, shared knowledge, and offered emotional backing transformed difficult shifts into manageable experiences. Participants described certain teams as tightly connected units where individuals felt valued and supported. These teams offered a psychological space in which staff could recover briefly during difficult days (Edmondson, 1999).

However, when teamwork broke down, the emotional effects were immediate and intense. Some participants described colleagues who resisted feedback, created conflict, or dismissed others' contributions. Team leaders described such colleagues as those who "don't respect others' opinions" and who "drain my energy at work" (Participant 18). These experiences mirror evidence that poor interpersonal relationships and conflict contribute to emotional exhaustion among hospital staff (Laschinger et al., 2010). Poor teamwork also undermined identity and confidence, particularly when staff felt isolated or unsupported within their own departments.

Recognition, identity and justice

Recognition appeared as one of the most emotionally powerful resources across all professional groups. Staff described recognition in broad terms that went beyond formal reward. Verbal appreciation, symbolic gestures (such as the "trophy or chocolate box"), fair treatment, and acknowledgement of contribution were profoundly meaningful. Even small gestures carried emotional weight because they affirmed dignity, identity, and belonging. Recognition functioned as more than appreciation; it was closely tied to professional respect and to how staff interpreted their value within the organisation. When recognition was absent, work became experienced as invisible labour, which eroded motivation and contributed to feelings of withdrawal and cynicism.

Recognition and organisational justice are well established in the literature as predictors of engagement and satisfaction (Laschinger et al., 2014). Regional research also notes dissatisfaction with promotion systems, limited career progression, and weak appraisal mechanisms (Almalki et al., 2012). However, my findings demonstrate that recognition in Kuwait carries symbolic and relational significance that extends beyond formal rewards or praise. Similar dynamics have been reported in Kuwaiti qualitative research; for example, Kreedi et al. (2022) found that newly graduated nurses interpreted recognition and respect as fundamental to professional identity, and that the absence of these signals contributed to feelings of marginalisation and diminished self-worth. Participants in my study interpreted acts of recognition as indicators of dignity, belonging, and professional worth, while the absence of recognition, particularly when combined with unequal treatment, was experienced as emotionally distressing. This interpretation is consistent with social psychological research suggesting that fair and respectful treatment functions as a signal of an individual's status and inclusion within a group, shaping identity and self-worth even when material outcomes remain unchanged (Lind and Tyler, 1988). These insights highlight that recognition and fairness are relational concepts embedded within cultural and hierarchical norms, rather than merely procedural constructs.

Among pharmacists, recognition was closely linked with autonomy, particularly their ability to exercise clinical judgement within interprofessional dynamics. When that authority was constrained, the gap between their expertise and their scope of practice generated emotional strain and undermined professional identity. Clinical pharmacists expressed frustration that physicians should “trust us, this is our specialty” rather than requiring approval for adjustments they were trained to make independently (Participant 10). Across the workforce, departments characterised by everyday gestures of appreciation, advocacy, and verbal acknowledgement were described as emotionally safer. These micro-climates of respect acted as buffers against broader organisational pressures and helped maintain engagement despite structural constraints. They shaped emotional safety, motivation, and interpretations of professional worth. Their absence led to cumulative strain over time, deepening emotional exhaustion and vulnerability. These patterns shaped how strongly staff responded to experiences of fairness, inclusion, and recognition.

By justice, I refer primarily to procedural and relational fairness. For example, whether organisational processes were fair and transparent, and whether staff were treated with dignity in their daily interactions. This was reflected in experiences such as being repeatedly overlooked for training or promotion, perceiving that favoured individuals received greater protection or opportunities, or feeling that concerns were taken seriously only for certain staff. When relational justice was missing, staff described heightened vulnerability, frustration, and erosion of trust.

For some groups, particularly laboratory technicians, the strain was not only disrespect but professional invisibility. Their work was essential yet largely unseen by patients and sometimes misunderstood by colleagues. Several described feeling that their expertise was hidden behind the walls of their department, leading to limited recognition, unclear career development, and little understanding of their contribution. Similar findings have been reported in international research; medical laboratory technologists are frequently described as “hidden” and underrecognised within healthcare systems, a lack of visibility that contributes to low morale, emotional strain, and feelings of marginalisation (Dignos et al., 2023). This invisibility carried emotional weight by weakening professional identity and reducing opportunities for affirmation. It also shaped how some participants interpreted other demands, such as workload or scheduling pressures, making them feel replaceable or marginalised within the wider system.

Patterns in the data suggested that justice operated as a core emotional and structural resource, particularly for expatriate staff who were highly sensitive to unequal treatment. When organisational processes lacked impartiality or transparency, staff described heightened vulnerability and a diminished sense of institutional trust. Justice was closely tied to dignity, and

its absence left workers feeling unseen and exposed within the organisational hierarchy. Voice emerged alongside justice as a critical emotional resource; when staff felt unable to raise concerns or challenge unfair behaviour, this generated emotional strain, anticipatory anxiety, and ongoing mental preoccupation. In contrast, environments that enabled feedback and participation fostered belonging and ownership.

Cultural norms

Cultural norms shaped how staff interpreted disrespect, authority, and recognition. Expectations around hierarchy meant that challenging decisions or expressing concerns could be perceived as disrespectful, both by those in positions of authority and by those considering whether to speak up. This created emotional tension, particularly for expatriate staff who felt that direct communication might risk their job security.

Cultural expectations around gender also shaped emotional experience. In the accounts of female staff, this was most evident in the cumulative emotional load associated with balancing workplace pressures alongside family and caregiving responsibilities. Working mothers described returning home exhausted, struggling to be emotionally present for their children, and requiring deliberate time to regulate their emotions before engaging in family life. The ongoing effort this demanded was captured by one participant who described trying to “hide it from my children and to calm myself down to take care of them as a mother”, acknowledging that “it is not easy all the time” (Participant 13). These pressures compounded stress and intensified the need for ongoing emotional regulation across the day, reducing opportunities for psychological recovery between shifts. As Halligan (2006) found in Saudi Arabia, cultural expectations around respect, modesty, and deference can make emotion regulation a structural feature of everyday healthcare work rather than an individual coping choice.

Cultural interpretation influenced how demands were appraised. For example:

- disrespect carried deep emotional resonance because it challenged expectations of dignity
- patient aggression was interpreted through norms of hospitality and service
- digital criticism triggered fear of public shame
- unfair treatment was experienced as moral harm

These patterns demonstrate that emotional responses were not purely individual reactions but culturally shaped interpretations. This aligns with cross-cultural research showing that emotional experience is structured by culturally normative models of self and relationship, which shape how events are appraised, which emotions are expressed or suppressed, and how emotional

reactions are judged as appropriate or risky within a given context (Mesquita and Walker, 2003). Expectations around authority, respect, gender, family roles, and public behaviour therefore influenced how staff interpreted demands, shaping emotional responses, vulnerability, and the perceived severity of stressors.

In Kuwait's strongly hierarchical work setting, communication norms often intensified the emotional demands of work. Staff were expected to show respect to senior colleagues, manage conflict indirectly, and raise concerns through intermediaries rather than speaking directly. This section therefore moves beyond how cultural norms shape the meaning of workplace experiences to consider who carries the emotional cost of these norms, and why. This asymmetrical flow of emotion and power illustrates that emotional life at work is not evenly shared but patterned by hierarchy, particularly in contexts where unequal authority relations are widely accepted (Hofstede, 2001). Staff with less authority carried a greater burden of selfmonitoring, adjusting tone, suppressing frustration, and displaying respect to avoid conflict and protect their position. Those with more authority, by contrast, generated many of the emotional demands that shaped everyday experience through directives, expectations, judgement, and the risk of negative evaluation. In such settings, emotion management became a structural requirement rather than a personal choice, reinforcing the very hierarchies that produced it.

Emotional labour

Emotional labour, according to Hochschild (1983), refers to the effort involved in managing one's own feelings to create a facial or physical display that is acceptable to the public. In this study, emotional labour was a consistent feature of everyday work. Staff described regulating their emotions in response to various pressures, including:

- demanding or aggressive families
- *wasta* (personal networks or social connections) related pressure
- patients filming them
- leadership instability
- disrespect from colleagues
- uncertainty about decisions
- public expectations

This continuous regulation consumed emotional resources and shaped how staff interpreted demands. Emotional labour shaped how heavily demands were felt and influenced how quickly strain accumulated. For example, staff often moderated their reactions to protect their

department's reputation or maintain relationships. This required self-control and composure, even when facing disrespect or aggression. Over time, emotional labour contributed to exhaustion, ongoing mental preoccupation, and reduced recovery.

Outside the workplace, participants engaged in what they referred to as "invisible recovery work". Following difficult shifts, they managed unresolved feelings through strategies such as crying, withdrawing, or seeking reassurance from family. Rather than restoring energy, this recovery work involved additional emotional and cognitive effort, which deepened strain over time and left some staff feeling that they never fully switched off. This aligns with recovery research showing that when individuals struggle to psychologically detach after work, emotional strain remains elevated into the evening and the next day, impairing recovery and increasing exhaustion (Sonnentag and Fritz, 2015).

These relational dynamics were experienced differently across professional groups, reflecting each profession's position within organisational hierarchies and their proximity to direct patient and family interaction. Nurses showed the most continuous and direct emotional load from patient families, they were often the first point of contact for questions, complaints, and demands, and families frequently directed frustration or anxiety toward nursing staff rather than physicians. This positioned nurses as emotional absorbers who managed relational tension on behalf of the wider clinical team. This pattern is reflected internationally; early-career nurses in particular experience heightened emotional exhaustion and relational strain because they are the first point of contact for patient and family frustrations (Laschinger et al., 2010). Pharmacists faced distinct relational pressures tied to outpatient queues and high-volume interactions. The tension between maintaining efficient throughput and providing clear, respectful communication created ongoing strain. Several pharmacists described feeling caught between institutional expectations for speed and patients' expectations for detailed explanation and personalised attention.

Physicians faced relational pressures linked to their position of clinical authority. These included managing high expectations for diagnostic accuracy, negotiating conflict between family members, mediating disagreements with nursing or administrative staff, and maintaining collegial respect within hierarchical professional norms. Physicians also described pressure to appear confident and decisive even when uncertain, which required continuous emotional regulation.

These differences demonstrate that relational strain is not evenly distributed across the healthcare workforce. It reflects the specific ways in which each profession interfaces with patients, families, colleagues, and institutional hierarchies. Understanding these

professionspecific relational dynamics is essential for interpreting the emotional impact of work and for designing targeted strategies to support staff wellbeing in complex, hierarchical, and culturally layered healthcare environments.

Relational conditions

The relational conditions and the meanings attached to everyday interactions formed a central part of how participants experienced their work. Teamwork helped staff share pressure and feel supported. Respect reinforced professional identity and personal dignity. Communication and opportunities to speak up created predictability, psychological safety, and a sense of influence.

This aligns with Edmondson's (1999) work, which shows that psychologically safe environments, where individuals can raise concerns without fear of embarrassment or negative consequences, strengthen team learning and reduce interpersonal anxiety. Recognition affirmed worth and signalled belonging. These relational conditions shaped the emotional tone of daily work and influenced how staff interpreted their environment. When relational conditions were strong, characterised by cohesive teams, mutual respect, transparent communication, and everyday recognition, staff were better able to manage organisational strain. Supportive colleagues and supervisors strengthened existing resources and softened the impact of structural pressures. Participants described coping with high patient loads, managing leadership instability, and sustaining motivation even when resources were limited because relational support made the environment feel more stable and manageable.

When these conditions were weak, marked by poor teamwork, limited voice, inequitable recognition, or disrespect, staff experienced emotional depletion, threats to identity, and progressive disengagement. Edmondson (1999) similarly found that when interpersonal respect and voice are constrained, employees become more cautious, less willing to speak up, and more vulnerable to withdrawal. Structural demands felt heavier, organisational shortcomings felt more personal, and frustration intensified. Without relational support, even routine tasks became emotionally taxing, leaving staff feeling isolated, undervalued, and exhausted in ways that went beyond workload alone.

These patterns show that everyday workplace relationships are not peripheral to wellbeing. Strengthening teamwork, recognition, voice, and respectful communication shapes how demands are understood and whether staff feel protected or exposed. Even departments with adequate staffing or resources may struggle to support wellbeing if relational conditions remain strained.

External social and cultural pressures

Participants described emotional pressures that extended well beyond their clinical roles or formal job descriptions. These external forces included patient behaviour, family expectations, digital visibility, the rise of social media scrutiny, and *wasta* as a parallel system of influence. These pressures required continuous emotional regulation and often shaped the moral, identity, and reputational dimensions of healthcare work. They also reveal that in the Kuwaiti context, the demand-resource balance is influenced by systems and actors outside the organisation.

Patient expectations

While the previous section examined how staff managed emotional demands internally, this section focuses on the culturally shaped patient expectations that generated many of those demands. Participants consistently described patients as a major source of emotional pressure, not only because of workload but because of the relational expectations attached to care. Patients were often perceived to expect immediate attention, leniency in sick leave requests, personalised treatment, or exceptions to procedural rules. When staff attempted to enforce clinical or administrative boundaries, these expectations frequently escalated routine encounters into emotionally charged interactions.

Physicians described how refusing sick leave requests created emotionally charged confrontations in which patients would “argue, insist, become aggressive, and threaten that they will file a complaint”. This pattern was described as a “daily scenario” that left staff feeling “exhausted” and “not ready to see the next patient” (Participant 9). Similar dynamics extended beyond physicians. Patients would “shout and make a big scene” when denied requested treatment or appointments (Participant 4), while administrators faced patients who “get upset if you tell them the truth, they just want you to say yes to everything they say” (Participant 19). These interactions required sustained emotional regulation and heightened vigilance, particularly in contexts where complaints were perceived as carrying professional or administrative risk.

International evidence reflects similar dynamics. Foley et al. (2012), in a qualitative study of general practitioners in Ireland, found that sickness certification was a recurrent source of conflict, with clinicians reporting pressure to comply with patient demands despite medical disagreement. Refusing certification was described as emotionally taxing and risky, as it could damage the doctor-patient relationship or prompt patients to seek a more compliant practitioner. These findings mirror the experiences described by participants in this study, suggesting that culturally shaped patient expectations can transform routine consultations into sites of emotional strain.

Family interference

In the Kuwaiti healthcare context, clinical encounters are often experienced as collective rather than individual interactions, shaped by wider social expectations around family involvement in care. This reflects the strong collectivist orientation documented in Kuwaiti society, characterised by close attachment to primary social groups and a passionate emphasis on family loyalty and shared responsibility in decision-making (Ali et al., 1997). While participants in this study did not always explicitly distinguish between patients and accompanying relatives in their accounts, they consistently described emotionally demanding interactions when expectations around treatment, sick leave, or procedural exceptions were not met. These encounters involved negotiation, persistence, and escalation through complaints, which staff experienced as challenging to manage.

Within this cultural setting, such pressures are commonly understood to be family-backed, reflecting broader norms of advocacy and collective responsibility for the patient. Staff therefore had to balance cultural norms of hospitality and respect with the need to maintain professional boundaries and enforce organisational rules. This balancing act intensified emotional labour, particularly where refusal or boundary-setting risked complaints or escalation. This interpretation aligns with evidence from GCC healthcare settings, where family members have been shown to bypass formal hierarchies or escalate concerns directly to senior management, leaving clinical staff, particularly nurses, feeling exposed and unsupported (Almutairi et al., 2014).

By contrast, in UK hospital settings, relatives' involvement is more commonly framed as a challenge of communication and time rather than authority. UK hospitals have introduced measures such as open visiting policies and structured information-sharing practices to manage expectations and reduce conflict arising from limited access to clinicians (Thornton, 2018). This contrast highlights that while family involvement creates pressures in both contexts, the nature of those pressures differs. In the UK, they are largely addressed through service design and communication strategies, whereas in Kuwaiti and Gulf healthcare settings they are shaped by collectivist social expectations that require staff to negotiate authority, credibility, and professional boundaries.

Digital exposure

From my analysis, social media exposure had become a noticeable source of pressure in daily work. Participants described situations in which "some patients threaten the people in charge of the hospital to post something bad about us on social media". Anticipation of public criticism created ongoing anxiety, with staff worrying that a short video or online complaint could be taken out of context and damage "the reputation of the department", their relationship with supervisors, or their future prospects (Participant 4).

This perceived risk shaped everyday practice. Staff described adjusting their tone, providing overly detailed explanations, and avoiding firm boundaries in order to prevent conflict and reduce the likelihood of digital escalation. Several participants felt that social media was the reason that “administration is not doing anything to stop them” (Participant 4). Digital exposure therefore functioned not only as a reputational threat but as a mechanism that altered power relations in patient encounters, shifting risk onto individual staff members and increasing emotional labour during routine interactions.

Evidence from Turkey highlights the wider relevance of these concerns. Senturk et al. (2025) demonstrate that indirect exposure to healthcare violence through social media constitutes a measurable psychosocial risk, with almost four out of five physicians and nurses reporting heightened anxiety when encountering such content online. Their findings show how social media amplifies incidents of conflict and narratives of institutional failure, increasing perceived risk through repeated exposure. In the Kuwaiti context, similar mechanisms appear to operate. Staff managed patient interactions with an awareness that negative digital attention could escalate rapidly, shaping how they communicated, set boundaries, and regulated their emotional responses even in the absence of overt confrontation.

Wasta

In Kuwait, *wasta* is commonly understood as the use of personal networks or social connections to obtain favours, priority, protection, or special consideration within organisational settings, and remains deeply embedded in everyday institutional life (AlBuloushi et al., 2025). It operates as an informal system that influences how decisions are made, often running alongside formal rules and procedures, and shapes expectations about access and entitlement.

Similarly, research from other Arab contexts has conceptualised *wasta* as an unwritten system of mediation and obligation through which family, tribal, social, or professional networks are used to influence decisions within formal institutions (Takruri et al., 2023). A mixed-methods study conducted in Palestine, combining a quantitative survey with qualitative interviews, describes *wasta* as a socially accepted form of intercession based on relationships and mutual obligation, particularly within public-sector and resource-constrained settings (Takruri et al., 2023).

In this study, *wasta* functioned as an external social force that shaped both organisational practices and staff experiences of work. Participants described pressure to accommodate requests from well-connected or influential individuals, whether these were people they knew personally or patients whose social standing or family connections conferred informal influence. In some cases, requests were communicated through intermediaries such as colleagues or administrators, signalling an expectation that exceptions should be made or decisions adjusted.

These situations carried significant emotional weight. Managers would “allow people who come with no previous appointment to come and register on the spot and enter the clinic” either because the manager “knows them personally or somebody asked him for a favour”, accepting walk-ins “without getting permission from us or from the patients who have previously booked” (Participant 4). Staff described anxiety about refusing such requests, fatigue from navigating situations that felt ethically uncomfortable, and frustration at the resulting inequality: “which is not fair to us or to patients who already have appointments” (Participant 4). For many participants, *wasta* created a direct clash between professional standards and social expectations, reinforcing perceptions of unfairness by privileging some individuals over others.

Overall, these accounts illustrate how culturally embedded practices such as *wasta* can operate as emotional demands within healthcare settings. Rather than isolated incidents, participants described these pressures as recurring features of everyday work, requiring ongoing negotiation between respect, politeness, and professional judgement. When these pressures conflicted with clinical standards, staff experienced heightened emotional strain, moral tension, and concern for their professional dignity and sense of fairness.

Work-home spillover

In the refined JD-R model developed in this thesis (Figure 12), spillover is conceptualised as a temporal transmission mechanism through which work-related strain persists beyond the immediate work setting and feeds forward to shape subsequent work experiences. Participants did not describe spillover as directly causing reduced quality of care, but rather as undermining recovery and regulatory capacity, thereby increasing vulnerability to future demands and emotional burden. This framing positions spillover within a loss pathway characterised by accumulation and depletion over time, rather than as a simple downstream outcome, and helps explain how chronic exposure to strain can erode wellbeing even in the absence of acute crises.

In my findings, spillover stood out not as a secondary outcome but as the primary mechanism through which structural, relational, and external pressures became personally impactful. Rather than strain ending with the workday, pressures followed staff home, disrupted recovery, and returned the next day as accumulated emotional load. Emotional strain, conflict, uncertainty, and exhaustion did not remain contained within the hospital. They entered family life, disrupted sleep, shaped mood at home, and prevented psychological detachment. Participants consistently described their wellbeing not only in terms of what happened at work but in terms of how these pressures crossed into their personal and domestic lives. For many, it was this ongoing intrusion, the inability to disconnect, that determined whether strain stayed manageable or became overwhelming. Spillover also affected professional performance. Participants described reduced empathy, difficulty concentrating, and impaired decision making during

subsequent shifts when the previous day's stress had not been resolved. These patterns highlight spillover as the mechanism linking daily pressures to longer-term emotional and functional consequences.

Spillover pressure

Spillover connected the different pressures described across the dataset. Leadership instability generated worry that continued into the evening, while unresolved patient encounters occupied staff long after shifts ended. Conflict with colleagues disrupted rest, structural inequities prompted ongoing concerns about fairness or job security, and digital visibility created fear of reputational harm outside working hours. Spillover therefore acted as the process through which pressures carried over from work into personal time, prolonging stress and limiting opportunities for rest and recovery. Similar patterns have been identified in qualitative research with HCWs in the UK, where stress was found to extend beyond shifts and to be reinforced by worries about upcoming work, especially when recovery time was limited by workload and staffing pressures (Suter and Kowalski, 2020).

What intensified spillover in this setting was the limited capacity staff had to interrupt it. Gendered expectations, domestic responsibilities, staffing shortages, and on-call duties restricted the time and space needed to switch off mentally, while cultural norms around availability and emotional vigilance made boundaries between work and home especially permeable. As a result, pressures that originated in the hospital extended into sleep, family interactions, and overall wellbeing, transforming everyday demands into sustained emotional strain.

Research consistently shows that when work stress spills into home life, recovery becomes harder, and psychological detachment, meaning the ability to mentally switch off from work, is essential for maintaining wellbeing (Sonnentag and Fritz, 2015). However, international models typically conceptualise recovery as an individual process shaped by personal coping strategies or resilience. My findings complicate that assumption by showing that recovery was structurally and culturally constrained. Leaders described receiving "constant work-related phone calls" that created a "lack of clear boundaries between work and rest time" (Participant 20), while team members reported that staff "keep calling and texting me day and night, after official working hours", preventing any opportunity to "take a break and stop thinking about the work and its problems" (Participant 18). These structural intrusions meant that even those who deliberately tried to disconnect found it "out of control" as work "spills in our personal life" despite efforts to maintain separation (Participant 19). These findings extend existing understandings by demonstrating that spillover is a process through which pressures persist over time when opportunities for recovery are systematically limited. This highlights a conceptual limitation in

many organisational stress models that focus primarily on individual coping and recovery, which tend to underemphasise the role of sociocultural context in shaping recovery pathways.

However, several studies from the Gulf have highlighted the role of religious and spiritual practices, such as prayer, reliance on faith, or seeking spiritual meaning, as coping mechanisms through which HCWs manage stress and maintain emotional balance (Alshammari and Alboliteeh, 2025). These forms of coping did not appear in my dataset. This absence may reflect the interview focus, as I did not ask directly about spirituality, but it may also indicate that staff prioritised structural and relational concerns when describing what shaped their wellbeing. The contrast with existing literature suggests that, in this setting, organisational and interpersonal pressures were experienced as more immediate and consequential than individual spiritual practices, at least in the context of discussing work-related strain.

Retroactive and anticipatory spillover

While the previous section describes how demands crossed into home life, this section examines the cognitive processes through which spillover continued to shape staff wellbeing outside work.

In my analysis, an important aspect of spillover was the mental effort that continued long after shifts ended. Rather than switching off, staff often found themselves thinking about conversations, decisions, or challenging interactions from earlier in the day. Administrators captured this inability to control mental boundaries: “I always try not to carry work problems to my personal life. However, sometimes it is out of control, and it spills in our personal life” (Participant 19). Some also monitored their tone or behaviour even after going home, wondering how certain interactions had been interpreted and how similar situations might unfold the next day. This tendency to go over situations in their mind made it difficult to rest. Anticipatory stress was also common. Staff spoke about worrying in advance about the next day, particularly when supervision felt unpredictable or when conflict with patients or families seemed likely. This forward-looking stress meant that strain was not only tied to what had already happened, but to what might happen next. Suter and Kowalski (2020) conceptualise this temporal pattern as comprising retroactive spillover, where strain is carried over from past work experiences, and anticipatory spillover, where stress arises from worrying about future work demands. While their analysis focuses on extended shift patterns, my findings suggest that these temporal processes also arise in everyday healthcare work through relational uncertainty, ongoing evaluation of interactions, and unpredictability in supervision. These patterns highlight that spillover in this context was cognitive as well as emotional. It was not only feelings that carried into home life but also thoughts, concerns, and imagined scenarios. In organisational psychology, rumination refers to repetitive thinking about work issues during non-work time, which prevents staff from

mentally switching off. This pattern aligns with established evidence that work-related rumination and worry maintain stress reactions beyond working hours (Sonnentag and Fritz, 2015). Recognising this mental dimension strengthens the argument that spillover is a central process shaping how strain accumulates over time.

Gender and nationality

In my analysis, spillover operated differently for women because work stress intersected with gendered expectations at home and within the workplace. Women in this study described carrying the emotional weight of their shifts into domestic spaces where rest was already limited by caregiving roles. This meant that their opportunities for psychological recovery were narrower from the outset, and work-related strain accumulated more quickly. This interpretation aligns with wider evidence showing that female healthcare professionals often experience a dual burden, in which domestic responsibilities and culturally embedded expectations interact with workplace demands to constrain recovery and intensify emotional strain (ALobaid et al., 2020). Research in Kuwait similarly notes that female HCWs often navigate demanding professional roles alongside culturally embedded expectations around domestic responsibilities, which intensify emotional strain and limit recovery (Kreedi, 2022).

The relational dynamics at work also shaped these experiences. Several female participants linked additional emotional effort to interactions with female supervisors or senior female colleagues, describing these relationships as more demanding or less forgiving. One clinical pharmacist contrasted her experiences with male and female supervisors, noting that women in leading positions “focus in a very detailed and precise way on everything related to the employee”, attending to “attending time but not on my quality of work”, whereas men “usually focus on your overall work output”. She described how women in leadership “will add more stress to the employee because of her constant comments on every little thing” while male supervisors “will comment on the big issues that affect the work”, concluding that “working with a male supervisor is less stressful” (Participant 10). This interpretation is also consistent with organisational research suggesting that women in supervisory roles often operate under heightened gendered expectations, such that participative or closely involved leadership styles may be interpreted by staff as increased oversight or expectations, particularly in demanding work environments (Eagly and Johnson, 1990). These dynamics were understood through the lens of gendered expectations about authority, behaviour, and emotional expression, which amplified the sense of scrutiny they experienced at work. When combined with cultural norms around patience, politeness, and attentiveness, these expectations added to the pressures that followed them home.

These patterns suggest that spillover for women was not just a matter of bringing work stress into family life; it reflected a broader set of gendered obligations that limited recovery and deepened emotional exhaustion. In this sense, the mechanism of spillover interacted with cultural and gender-based expectations, shaping the intensity and persistence of strain in ways that were not evenly distributed across the workforce.

Spillover also interacted with participants' employment status. Non-Kuwaiti staff described feeling more vulnerable when dealing with complaints, conflict, or uncertainty, because they believed the consequences for them would be more severe. This sense of limited protection meant that stressful encounters at work were harder to leave behind, and worries about fairness, job security, and institutional support often continued into their personal time. Regional evidence shows similar patterns, with expatriate HCWs reporting heightened vulnerability, fear of patient complaints, and limited institutional protection, which increases emotional burden and prolongs stress (Almutairi et al., 2014). These accounts show that spillover was shaped not only by daily demands but by broader structural conditions, particularly the unequal distribution of security and support within the workforce. For expatriate staff, this background vulnerability intensified the emotional load they carried home and reduced the space available for psychological recovery.

Several participants described the longer-term effects of carrying work home day after day. One physician captured this gradual depletion: "Periods of achievements boost my energy, but the accumulation of pressure without breaks leads to mental and emotional exhaustion. It is affecting my work performance as well" (Participant 20). Staff spoke about becoming less patient, finding it harder to show empathy, or feeling emotionally drained before a shift had even begun. Some described reduced motivation, difficulty concentrating, or a growing sense of detachment from their work. These changes did not appear suddenly; they developed gradually as stress accumulated without opportunities for recovery. This trajectory reflects wider evidence that emotional exhaustion and compassion fatigue accumulate over time when recovery is limited (Alshammari and Alboliteeh, 2025). These accounts show that spillover was not a shortterm reaction but a process through which daily pressures gained momentum. When work followed staff home, disrupted rest, and returned the next day as unresolved strain, the effects built over time.

Applying the JD-R model

This section uses the Job Demands Resources JD-R model as an interpretive framework for understanding the patterns identified in the qualitative findings, and for situating these patterns within existing research on healthcare work and wellbeing (Demerouti et al., 2001; Bakker and

Demerouti, 2017). Previous quantitative research conducted in Kuwait has already demonstrated the applicability of the JD-R model within public hospital settings. Most notably, a mixed methods doctoral study examining work adjustment among expatriate and local nurses across multiple government hospitals confirmed that the model's core pathways linking job demands and job resources to burnout, engagement, and adjustment outcomes remained intact within Kuwait's public healthcare workforce (Ali, 2018).

Building on this foundation, the present study adopts a qualitative, interpretivist approach to examine how JD-R constructs were experienced and negotiated in everyday working life. Rather than treating demands and resources as fixed variables, the model was used as a flexible conceptual guide to explore how workplace pressures and supports were understood, interpreted, and emotionally processed within the institutional and cultural realities of Kuwait's public healthcare system.

Leadership emerged as a central feature shaping participants' experiences of work. Supportive supervisors were described as providing stability, encouraging voice, and buffering the emotional impact of heavy workloads, while authoritarian, inconsistent, or absent leadership intensified strain and reduced psychological safety. Leadership practices influenced not only workload management but also perceptions of fairness, dignity, and trust, shaping how other pressures were experienced across the work environment.

Participants' accounts also highlighted the importance of relational and symbolic resources, including dignity, recognition, fairness, and professional respect. These experiences influenced motivation, belonging, and emotional safety, shaping how participants interpreted their value within the organisation. When such resources were present, they supported engagement and resilience. When absent, they contributed to withdrawal, cynicism, and emotional fatigue.

Structural conditions within the healthcare system further shaped how demands were experienced. Nationality based differentiation, limited contractual protection for expatriate staff, and gendered expectations created ongoing background pressures that influenced confidence, voice, and perceived safety. These conditions shaped both the strain and motivational processes described in the JD-R model, remaining influential even when other resources were available.

Participants also described a range of external pressures that entered their working lives from beyond formal organisational boundaries. Patient expectations, family involvement, digital scrutiny, and *wasta* functioned as daily relational demands that shaped emotional preparation, interactional behaviour, and recovery. These pressures contributed to emotional load despite originating outside the hospital's formal structures.

Emotional labour was a further feature of participants' accounts. Healthcare workers described continuous efforts to regulate emotion, avoid conflict, and maintain professional composure in the face of competing demands. These regulatory processes influenced how demands accumulated and how quickly strain developed across shifts.

Finally, spillover emerged as an important mechanism linking work and non work domains. Participants described work related stressors following them home, disrupting rest, and shaping subsequent workdays. Viewing spillover as an ongoing process rather than a downstream outcome helped explain how demands continued to drain resources beyond working hours, particularly in contexts characterised by limited recovery time and blurred work home boundaries.

Taken together, the JD-R model provided a useful interpretive framework for linking the diverse pressures and supports described by participants. At the same time, applying the model within this context highlighted the importance of attending to cultural, relational, and structural conditions that shaped how demands and resources were experienced in Kuwait's public healthcare system.

Theoretical contributions

This section articulates the theoretical contributions of the study by identifying how the findings refine and extend the Job Demands Resources JD-R model when applied to stratified public healthcare systems. While previous research has validated the JD-R framework within Kuwait, including mixed methods applications demonstrating that its core structure remains intact (Ali, 2018), the present study contributes new conceptual insights by examining how demands and resources are constructed, interpreted, and experienced within a hierarchical, multicultural institutional setting.

A central contribution of this study is the conceptualisation of leadership as a multi-positional construct. Rather than functioning solely as a job resource, leadership operated simultaneously as a source of support, a generator of demands, and a higher order influence shaping how other pressures were appraised. Leadership instability, driven by frequent rotations and shifting expectations, also functioned as a structural hindrance demand in its own right, producing uncertainty and emotional strain. This finding extends JD-R by demonstrating that leadership in civil service environments cannot be adequately represented as a single, stable resource, but must be understood as a dynamic structural condition shaping both strain and motivation.

The study also advances JD-R by foregrounding the role of symbolic and relational resources. Experiences of dignity, fairness, recognition, and professional respect were central to sustaining motivation, belonging, and emotional safety. When these resources were absent, participants

described withdrawal and cynicism. Integrating symbolic and justice related resources into the motivational pathway strengthens the model's ability to account for wellbeing in hierarchical and multicultural settings, where emotional safety depends on more than instrumental support.

Another key contribution lies in conceptualising inequity as a chronic structural demand. Nationality based differentiation, limited contractual protection for expatriate staff, and gendered expectations created persistent emotional burdens that shaped confidence, voice, and perceived safety. While prior research has documented these disparities in Kuwait's healthcare workforce (Ali, 2018), this study extends existing work by showing how inequity functioned as an ongoing demand that shaped everyday interpretations of leadership behaviour, access to support, and psychological safety.

External sociocultural forces also emerged as systemic emotional demands. Patient expectations, family involvement, cultural norms surrounding authority and hospitality, digital visibility, and *wasta* required continuous emotional regulation and shaped behaviour even before clinical work began. Recognising these pressures as part of the demand structure extends JD-R beyond organisational boundaries and highlights the need to account for socially embedded work environments.

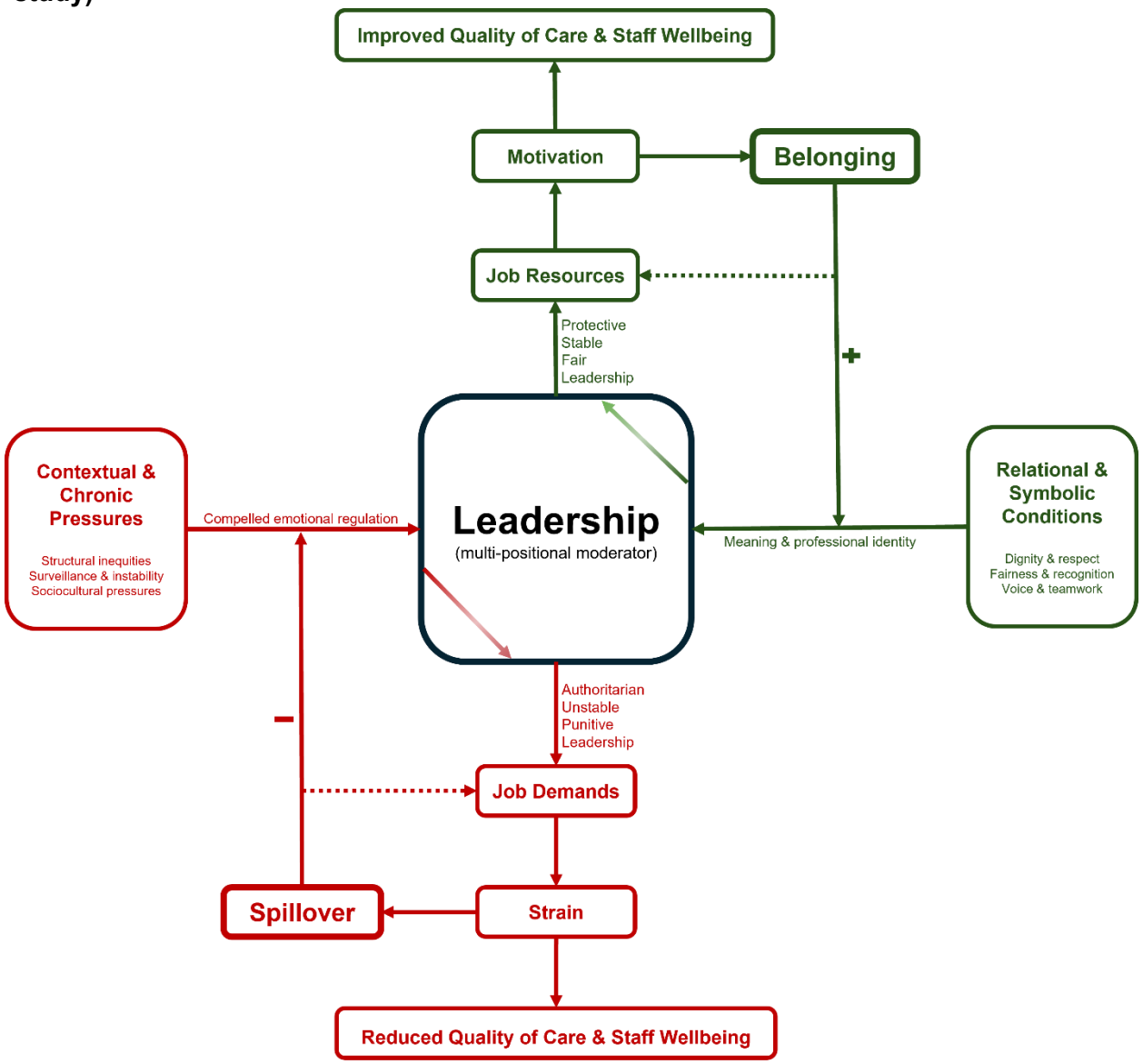
Spillover and emotional labour further refine the model by clarifying how demands accumulate over time. Spillover is conceptualised as an active transmission mechanism through which strain extends into non work domains, depletes regulatory capacity, and feeds forward into subsequent work experiences. Emotional labour functioned as a core regulatory process shaping how demands were appraised and why some pressures felt disproportionately taxing. Cultural interpretation mediated these processes, influencing vulnerability, moral discomfort, and the emotional weight of interactions. Incorporating meaning-making processes into JD-R helps explain why similar demands produce different outcomes across individuals and professional groups.

Finally, the study extends JD-R by showing that surveillance operated not only as an administrative demand but also as a symbolic one, shaping trust, autonomy, and professional dignity in ways not fully captured by existing formulations of the model.

Together, these refinements highlight the limitations of applying occupational models developed in Western contexts directly to stratified healthcare systems characterised by pronounced hierarchy and contractual differentiation. By incorporating leadership instability, symbolic resources, structural inequity, external sociocultural pressures, emotional labour, spillover, and cultural interpretation, this study advances JD-R as a more context responsive framework for understanding job satisfaction and wellbeing in public healthcare systems such as those found in the GCC.

Figure 12 brings together the findings of this study in a refined interpretation of the JD-R model. The figure highlights how leadership, contextual pressures, relational conditions, and workhome spillover interacted in participants' accounts, positioning leadership as a multi-positional influence shaping both demands and resources within the Kuwaiti public healthcare context.

Figure 12: A refined Job Demands-Resources model illustrating leadership as a multipositional moderator in a stratified public healthcare context (Developed for this study)



The purpose of this figure is to visually integrate the theoretical contributions outlined above and to clarify how the refined JD-R model should be interpreted within this study. This figure presents a contextual refinement of the JD-R model based on the findings of this study and represents an interpretive conceptual model developed from qualitative themes rather than a tested predictive or causal framework. Leadership is positioned as a multi-positional moderator that simultaneously operates as a source of job resources, a generator of job demands, and a higher-order mechanism shaping how contextual and chronic pressures are appraised and experienced by HCWs. Contextual pressures, including structural inequities, systemic

constraints, and external sociocultural forces, enter everyday work through compelled emotional regulation, thereby increasing emotional burden under conditions of limited control.

While this study did not explicitly adopt a eudaimonic framework in its analysis, the prominence of belonging, meaning, and professional identity in participants' accounts aligns closely with eudaimonic perspectives on wellbeing, which emphasise functioning, purpose, and selfrealisation over pleasure or satisfaction alone (Ryan and Deci, 2001). In this context, belonging operated less as an affective state and more as a form of institutional and professional legitimacy that enabled continued functioning, sustaining engagement and moral commitment under chronic demands. This alignment helps explain why these elements occupy a central position within the gain pathway of the refined model, without implying that they were theorised as eudaimonic constructs in advance.

Where leadership is experienced as protective, stable, and fair, it supports the availability of job resources, fostering motivation, belonging, and the development of meaning and professional identity. These processes form a gain pathway associated with improved quality of care and staff wellbeing. Conversely, authoritarian, unstable, or punitive leadership amplifies job demands, contributing to strain and subsequent spillover into non-work domains. Spillover is conceptualised not merely as an outcome, but as a temporal transmission mechanism through which strain accumulates across time, depletes regulatory capacity, and feeds forward into subsequent work experiences. Dotted arrows indicate indirect or cumulative processes, while plus and minus symbols denote reinforcing gain and loss dynamics rather than linear causal effects.

Implications for practice

The findings from this study offer several reflections that may inform how healthcare organisations, professional bodies, and system-level actors think about staff wellbeing within public healthcare settings. These reflections are grounded in participants' lived experiences and in the interpretive lens developed through the analysis. Given that the study draws on accounts from twenty participants within a single public hospital, the implications outlined here do not seek to prescribe system-wide reform. Rather, they highlight areas where existing practices and structures may shape everyday wellbeing, particularly in contexts characterised by relational, cultural, and structural pressures.

System-level considerations

Participants consistently described frequent changes in hospital leadership as a source of instability and uncertainty, contributing to emotional strain and disrupted working relationships.

Leadership rotation is embedded within Kuwait's wider civil service system and sits beyond the control of individual organisations. However, participants' accounts point to the importance of how these transitions are managed in practice. Clear communication, structured handovers, and visible continuity planning may help reduce the uncertainty that staff associated with leadership change. These reflections are not intended as critiques of national policy, but as observations about how system-level arrangements are experienced on the ground.

The dual-contract structure within Kuwait's public healthcare system also shaped participants' experiences of recognition, security, and access to professional development. While employment contracts themselves are determined at a national level, participants' accounts suggest that the internal allocation of opportunities such as training, courses, and development pathways plays an important role in shaping morale. Extending eligibility for certain forms of professional development or clarifying criteria for progression may help address perceptions of unfairness, even within fixed contractual frameworks.

Participants also described delays and bottlenecks within residency and postgraduate training pathways, which created prolonged periods of uncertainty about career progression. Although these systems are governed nationally, participants highlighted the value of transparency, predictable intake cycles, and interim development opportunities. Training related to communication, conflict management, and wellbeing was viewed as particularly meaningful. Ensuring that such forms of development remain accessible across professional groups may help buffer some of the emotional pressures associated with stalled progression.

Organisational considerations

At the organisational level, participants placed strong emphasis on the relational dimensions of leadership. Their accounts suggest that leadership development initiatives may benefit from prioritising listening skills, conflict management, emotional awareness, and inclusive decisionmaking alongside administrative competence. Approaches such as coaching, mentoring, or structured feedback were viewed as potentially supportive, depending on local norms and feasibility.

Recognition and acknowledgement emerged as powerful influences on everyday wellbeing. Participants described how small, visible forms of appreciation such as verbal thanks, written acknowledgement, or symbolic gestures carried significant emotional weight. These reflections highlight the importance of embedding recognition into routine organisational practice, based on what staff themselves described as meaningful rather than on formal reward systems alone.

Transparency around staffing and workload decisions was also identified as important. Participants reported that clear explanations about how tasks were allocated, and why certain

decisions were made, helped reduce frustration and foster a sense of shared understanding, even during periods of staff shortage. Attention to how such decisions are communicated may therefore support perceptions of fairness and collective responsibility.

Chronic staff shortages were a persistent source of strain. While recruitment levels are set nationally, participants' accounts suggest that organisations play a role in how these pressures are distributed and explained. Thoughtful workload balancing, shared responsibility, and honest communication about constraints were seen as ways of mitigating the day-to-day impact of shortages.

Several participants emphasised the importance of safe and accessible channels for raising concerns, particularly in contexts shaped by hierarchy or nationality-based power differences. Reviewing how these channels are communicated, and whether all professional groups feel protected when using them, may strengthen psychological safety within teams.

Long shifts, night duties, and irregular schedules were also described as contributing to cumulative fatigue, especially for those with caregiving responsibilities. Participants' experiences highlight the value of reflecting on how shift patterns influence recovery and whether small, locally feasible adjustments could help reduce sustained strain, without implying broader system reform.

The introduction of digital monitoring systems was another area of uncertainty. Participants described discomfort when such systems were implemented without clear explanation or alignment with clinical workflow. These accounts point to the importance of change management processes that emphasise transparency, gradual implementation, and sensitivity to how new technologies affect everyday practice, rather than focusing solely on the technical function of the systems themselves.

In addition, several participants expressed a desire for confidential and easily accessible wellbeing support within the hospital. They described the potential value of dedicated wellbeing services or confidential support lines that staff could access during periods of emotional strain. These reflections underscore the importance of considering how support can be made visible, trusted, and practically accessible within organisational settings.

Community-facing considerations

Participants described emotionally challenging encounters with patients and families, particularly where expectations around sick leave certification, service entitlement, or family involvement conflicted with hospital procedures. These situations were often intensified by the presence of personal connections, or *wasta*, which enabled some patients to bypass standard pathways. While such practices were often understood as culturally embedded and well intentioned, staff

described feeling conflicted and exposed when asked to make exceptions without clear managerial backing. Protecting staff who uphold clinical judgement and standard procedures, rather than leaving them to navigate these pressures alone, emerged as an important organisational concern.

Being recorded during clinical encounters and the circulation of videos on social media further contributed to feelings of vulnerability. Participants were often uncertain about how to respond in these situations and described anxiety about reputational and professional consequences. Clear organisational guidance, combined with visible managerial support during and after difficult encounters, was experienced as reassuring.

Participants' accounts suggest that brief, practical awareness sessions or guidance materials could be valuable. For staff, such support could clarify how to respond, de-escalate situations, and report incidents. For managers, it could reinforce the importance of timely and visible backing when staff face confrontation or public complaint. These reflections point to the value of shared understanding across staff and management regarding how such encounters are handled.

Integrated considerations

The findings indicate that HCW wellbeing is shaped through interactions between structural conditions, organisational practices, team relationships, and community expectations. Rather than being addressed through isolated interventions, participants' experiences suggest the importance of attending to how these pressures intersect. For example, leadership stability influenced everyday relationships, while access to training shaped perceptions of fairness and recognition. Although the modest scale of this study limits broader claims, the accounts presented here indicate that small, relationally informed shifts within existing structures can have meaningful effects on everyday wellbeing.

Strengths, limitations, and future research

Every research project has boundaries that shape what it can and cannot claim. For a qualitative, interpretivist study such as this, those boundaries are not flaws but context-setting conditions that clarify the contribution. This section reflects on the study's main strengths, acknowledges its limitations, and outlines directions for future research.

Strengths

A key strength of this study is its qualitative depth. Semi-structured interviews allowed participants to describe their experiences in detail, revealing not only what affected their

wellbeing but how and why it mattered to them. This depth enabled the analysis to move beyond surface-level descriptions toward interpretation of meaning.

A related strength is the diversity of participants. By including physicians, nurses, pharmacists, lab technicians, and administrative staff, the research captured perspectives across multiple professional groups rather than privileging one. This breadth made it possible to examine systemic themes such as leadership, inequity, and training alongside profession-specific concerns such as residency bottlenecks for physicians or blocked promotions for non-Kuwaiti HCWs.

Another strength lies in the methodological approach. Reflexive thematic analysis ensured that participants' lived experiences remained central, while the JD-R model provided a flexible framework for interpreting those experiences. This combination of bottom-up theme development and theoretical framing gave the study both authenticity and explanatory reach.

Furthermore, my position as a Kuwaiti physician provided an 'insider' perspective that facilitated cultural and professional fluency during data collection. This insider status likely fostered rapport and depth in participant responses, particularly with national staff.

The study also offers contextual originality. Research on HCW wellbeing in GCC is often quantitative and profession-specific. By using qualitative methods in Kuwait's main teaching hospital, this study provides nuanced insight into how structural features, civil service employment rules, nationality-based contracts, and cultural norms such as *wasta*, shaped wellbeing in this setting. In doing so, it contributes both a local account and a resource for broader national research, as well as for international comparative work.

Limitations

This study was conducted in a single site, Mubarak Al-Kabeer hospital, Kuwait's main teaching hospital. Although its diversity of staff made it a rich setting for qualitative enquiry, my findings cannot represent all public hospitals within Kuwait. Primary healthcare centres, specialised centres, or facilities in less central areas may differ in staffing patterns, resources, or organisational culture. The insights presented here may offer potential for transfer to similar settings, but this would need to be assessed in future research rather than assumed.

Although sampling included major clinical and administrative professions, some groups remain under-represented, particularly allied health professions such as physiotherapists, radiographers, and dieticians. Additionally, although I interviewed staff at different career stages, the sample included fewer senior managers and department heads than originally intended. The perspectives of those in higher leadership positions may therefore be less fully represented, potentially overlooking experiences unique to these roles.

Participants in this study volunteered to take part, which may have introduced self-selection bias. Those who came forward may have been more confident, more dissatisfied, or more reflective about their workplace experiences than colleagues who chose not to participate. The accounts presented here should therefore be understood as representing the views of those willing to share their experiences.

The use of the JD-R model as a conceptual lens strengthened the explanatory structure of the analysis but inevitably directed attention toward demands and resources. Other frameworks, such as effort reward imbalance, demand control support, or role theory, might have highlighted aspects such as identity, power, or organisational politics more explicitly. However, JD-R was selected because it provided the best fit for the data, particularly in capturing how structural pressures and relational dynamics interacted to shape wellbeing. While the refinements to JD-R developed here are a strength, they also define the analytical boundaries of the study.

My position as a Kuwaiti physician was both an asset and a limitation. Insider status facilitated rapport and cultural fluency, especially with national staff, but may also have constrained openness among some expatriate participants who perceived differences in contract type or status. Reflexive journal notes and supervisory discussions were used to mitigate these effects, yet positionality inevitably shaped data collection and interpretation.

Finally, the study reflects a specific moment in time. Data were collected in 2024, when staff were still navigating the longer-term effects of the COVID-19 period, managing chronic staffing shortages, and responding to new workplace developments such as biometric attendance monitoring. Organisational cultures are dynamic, and subsequent changes may have shifted the balance of demands and resources in ways not captured here. As with all interview-based qualitative research, these findings prioritize how HCWs construct meaning and interpret their workplace experiences, which may not always align with objective indicators of workload or wellbeing.

Reflexivity and researcher positionality

In interpreting these findings, it is important to reflect on how my positionality shaped both the analytic emphasis and the theoretical framing of the study. As a Kuwaiti physician working within the same public healthcare system, I approached the data with lived experience of the hierarchical, bureaucratic, and relational structures described by participants. This insider status enhanced cultural fluency and facilitated rapport, particularly with national staff, allowing interviews to unfold in a conversational and open manner. Several Kuwaiti participants explicitly expressed a desire for the study to reach senior leadership and contribute to meaningful change, positioning the research within shared professional and institutional concerns.

My clinical background in psychiatry further sensitised me to the moral and emotional dimensions of healthcare work. Psychiatric practice requires sustained emotional regulation in interactions with patients and families who may be navigating stigma, uncertainty, and social pressure. This professional experience heightened my attention to emotional labour, relational strain, and wellbeing as central features of participants' accounts, and likely contributed to the prominence of these themes in the analysis. At the same time, I remained mindful of the risk of over-identification, particularly when participants described frustrations closely aligned with my own experiences, such as exclusion from training opportunities or navigating unstable leadership structures. In these moments, I consciously maintained analytic distance, allowing participants to articulate their experiences without affirmation or comparison.

My academic training in public health also influenced how I interpreted participants' accounts throughout the study. Having previously explored HCWs' mental health during the COVID-19 pandemic, I entered this research with awareness that many workplace pressures affecting wellbeing were not entirely new but had become more visible during periods of heightened strain. This perspective increased my sensitivity to organisational dynamics, emotional exhaustion, and relational aspects of healthcare work during analysis, while also reinforcing the importance of reflexively questioning my own assumptions and remaining attentive to meanings grounded in participants' accounts rather than my own experiences.

My position as a HCW also shaped the interview dynamic. Many participants appeared to assume shared understanding of institutional pressures and used the interview space to articulate accumulated strain in depth. While this facilitated rich accounts, it may also have encouraged emphasis on emotional depletion over other forms of coping. Conversely, some expatriate participants appeared more cautious, describing their experiences carefully and, at times, requesting reassurance around confidentiality. These dynamics reflect broader hierarchies related to nationality, contract status, and perceived vulnerability, which may have constrained openness for some staff and influenced the range of perspectives represented.

The choice to use RTA and the JD-R Framework was similarly shaped by experiential knowledge of healthcare work. Having worked in contrasting environments characterised by both supportive and unsupportive leadership, I was particularly attuned to the role of relational and symbolic resources, such as recognition, fairness, and dignity, in sustaining motivation and professional confidence. This experiential lens informed the decision to treat JD-R as a flexible interpretive guide rather than a fixed categorisation system, enabling attention to culturally embedded demands such as *wasta*, family involvement, and bureaucratic constraint.

Throughout analysis, I made deliberate efforts to approach participants' accounts as if encountering these issues for the first time, even where experiences were familiar, recognising that similar situations may carry different meanings across roles, professions, and identities. This reflexive stance supports an interpretation that is situated and contextually grounded, while acknowledging that the findings are shaped by my positionality and should be understood as one perspective within a complex and stratified healthcare system.

Directions for future research

Several directions for future research follow from these limitations. First, further qualitative work across multiple sites in Kuwait, including general public hospitals, specialised centres, and private facilities, would help explore how organisational culture, resources, and community expectations vary across settings. Such studies could test the transferability of the present findings and deepen understanding of how staff across Kuwait's wider healthcare system experience their working conditions.

Second, comparative research across Gulf countries would help examine whether the refinements to JD-R identified here, such as leadership instability, nationality-based inequities, and the emotional meaning of bureaucratic controls, emerge in other health systems with similar structures. Cross-country work could also illuminate how cultural, policy, and workforce differences shape wellbeing. Beyond the Gulf, there is also potential to explore these findings in other international contexts. Some of the patterns highlighted in this study, such as the emotional impact of hierarchical leadership or the strain of balancing professional and domestic responsibilities, may have wider relevance. Comparative work could help distinguish which aspects of staff experience are culturally specific and which reflect broader patterns in healthcare work.

Third, profession-specific studies could address gaps in the present sample. Allied health professions such as physiotherapists, radiographers, and dieticians were under-represented, as were senior managers and department heads. Additionally, support staff such as porters, domestic workers, and unqualified administrative staff were not included. Exploring these groups qualitatively would help address gaps in regional research, which has traditionally centred on physicians and nurses, and provide a fuller picture of how different roles experience the healthcare workplace.

Fourth, quantitative and mixed-methods designs could complement this qualitative foundation by assessing the prevalence of key demands and resources across larger samples and linking them to outcomes such as burnout, engagement, and turnover. These approaches would not replace qualitative insight but could provide broader system-level patterns.

Fifth, intervention studies could evaluate how targeted practices, such as leadership development, communication training, or structured grievance pathways, affect staff wellbeing over time. Such work would help examine how specific organisational adjustments might buffer demands or strengthen resources.

Finally, longitudinal research could follow HCWs across different stages of their careers to explore how demands and resources accumulate or shift, and how gain or loss spirals unfold in the Gulf context.

Conclusion

The discussion in this chapter has interpreted HCWs' job satisfaction and wellbeing as experiences shaped through organisational structures, workplace relationships, sociocultural expectations, and broader institutional conditions. The findings suggest that wellbeing in Kuwait's public healthcare system is relational, contextual, and deeply embedded within the everyday realities of healthcare work, rather than being determined by isolated workplace factors alone. Emotional strain also appeared to accumulate over time through the interaction of workplace demands, inequities, organisational pressures, and limited opportunities for recovery. This makes spillover an important mechanism through which workplace experiences extend into HCWs' personal lives.

The chapter also shows that several aspects of HCWs' experiences within Kuwait's public healthcare system are not fully captured by existing applications of the JD-R framework alone. The discussion therefore extended the framework conceptually by highlighting the significance of leadership instability, symbolic and justice-related resources, nationality-based inequities, emotional labour, and wider sociocultural pressures in shaping workplace wellbeing and job satisfaction. This reinforces the importance of interpreting healthcare wellbeing within its organisational and cultural context, rather than viewing it solely through individual psychological outcomes.

The implications discussed throughout the chapter suggest that organisational approaches to HCW wellbeing require attention not only to workload and staffing pressures, but also to fairness, recognition, communication, leadership continuity, and the relational conditions through which professional value and emotional support are experienced. The discussion also highlighted the need for future qualitative, longitudinal, and cross-context research capable of examining how demands, resources, and workplace inequalities evolve over time across different healthcare environments.

Overall, this chapter concludes that HCWs' wellbeing is closely connected to the wider functioning, sustainability, and relational culture of Kuwait's public healthcare system. These

conclusions provide the foundation for the final chapter, which synthesises the overall contributions of the thesis and reflects on its conceptual, methodological, and practical significance.

Chapter 8: Conclusion

Introduction

This thesis set out to explore how healthcare workers (HCWs) in Kuwait's public healthcare system experience job satisfaction and mental wellbeing. Through the systematic review presented in Chapter 2 and the conceptual grounding in Chapter 3, a significant gap was identified in the existing evidence base. While international research has examined these concepts extensively, studies from Kuwait and the wider Gulf Cooperation Council (GCC) region have largely relied on cross-sectional quantitative designs, often focused on single professional groups and prioritising negative indicators such as burnout. As a result, existing research has offered limited insight into how HCWs themselves interpret and make sense of their experiences within the specific organisational, cultural, and institutional conditions of public healthcare in Kuwait.

The study was motivated by a set of interrelated concerns. First, despite the central role of HCWs in sustaining Kuwait's public healthcare system, little was known about their lived experiences of work, satisfaction, and wellbeing. Second, job satisfaction and mental wellbeing have frequently been examined as separate outcomes, with limited exploration of how they intersect and are shaped through everyday organisational realities. Third, research in the region has tended to focus primarily on physicians and nurses, with minimal attention to the diverse professional groups that comprise the healthcare workforce and limited consideration of how nationality, gender, and professional role shape these experiences differently.

To address these gaps, this thesis adopted a qualitative, interpretivist approach to explore how HCWs working at Mubarak Al-Kabeer Hospital, Kuwait's main public teaching hospital, understood and experienced the factors shaping their job satisfaction and mental wellbeing. Drawing on semi-structured interviews with 20 HCWs from diverse professional backgrounds, nationalities, and genders, and analysed using reflexive thematic analysis (RTA), the study examined job satisfaction and wellbeing as lived, contextually embedded experiences rather than fixed or easily measurable states.

This concluding chapter brings the thesis together as a whole. It reflects on the journey from identifying knowledge gaps through methodological and theoretical decisions to the study's central findings and contributions. It synthesises the key findings, articulates the study's empirical, theoretical, and methodological contributions, summarises strengths and limitations,

outlines implications for practice and future research, and concludes with a reflection on the research ethics process and its significance within the study context.

Research focus and aims

This thesis examined how participating HCWs understood and experienced the factors shaping their job satisfaction and mental wellbeing within their everyday work contexts. In doing so, it responded to concerns identified early in the thesis regarding the limited contextual insight offered by existing research, which has largely focused on quantifying distress and dissatisfaction rather than exploring how such experiences are understood and negotiated in practice.

The thesis contributes to existing knowledge by integrating organisational, relational, and sociocultural influences to show how job satisfaction and mental wellbeing are experienced differently across professional roles, nationality, and gender. While participants worked within a shared organisational environment, their accounts revealed differing exposures to demands, resources, and constraints, shaping distinct experiences of satisfaction, strain, and support.

Overall, the findings demonstrate that job satisfaction and mental wellbeing were experienced as dynamic and context-dependent, shaped through ongoing interactions within institutional and social conditions. Rather than focusing solely on whether participants were satisfied or distressed, the thesis examined how job satisfaction and mental wellbeing were produced and negotiated through everyday interactions, expectations, and organisational arrangements.

Key findings

The findings indicate that participants' experiences of job satisfaction and mental wellbeing were shaped through an interconnected set of organisational, relational, and sociocultural conditions rather than by any single factor. Participants consistently described job satisfaction and wellbeing as fluctuating over time, responding to leadership practices, workplace relationships, work demands, and pressures that extended beyond the hospital environment. The detailed presentation and analysis of these findings are provided in Chapters 5 and 7.

Leadership and management emerged as a central organising influence on how participants experienced both job satisfaction and strain. Leadership was not perceived as operating in a singular or stable manner but functioned simultaneously as a source of support, a source of demand, and a moderating influence on how other workplace pressures were interpreted. Supportive leadership was associated with trust, stability, and emotional buffering, whereas authoritarian or inconsistent leadership intensified uncertainty and strain. Frequent leadership rotation, linked to Kuwait's civil service governance structure, was experienced as a structural

demand that disrupted continuity and weakened confidence in organisational processes, amplifying the impact of other workplace stressors.

Participants' day-to-day emotional experiences of work were closely tied to workplace relationships. Collegial support, teamwork, professional respect, and effective communication functioned as important resources that helped participants manage heavy workloads. In contrast, poor communication, lack of recognition, and interpersonal conflict contributed to frustration, emotional exhaustion, and disengagement. Recognition and voice were particularly salient within hierarchical contexts, shaping whether participants felt valued, respected, and included within the organisation.

Participants also described environmental and organisational demands that affected both emotional wellbeing and professional identity. These included challenging patient behaviour, heightened visibility through social media, chronic understaffing, and equipment shortage. Such pressures were often experienced as cumulative, contributing to moral strain when participants felt unable to deliver the standard of care, they believed patients deserved.

Structural inequities further shaped participants' experiences of job satisfaction and wellbeing. Nationality-based differences influenced access to training, job security, and perceived protection from complaint, with expatriate participants frequently describing heightened vulnerability and caution in workplace interactions. Gendered expectations also shaped wellbeing, particularly for female participants with caring responsibilities, who described additional pressures that constrained opportunities for rest and recovery. These inequities functioned as ongoing background conditions that shaped how other demands were experienced rather than operating as discrete stressors.

Work-related strain frequently extended beyond the workplace through work-home spillover. Participants described difficulty disengaging from work, persistent mental preoccupation, disrupted rest, and physical health consequences. This spillover contributed to cycles of cumulative strain that affected both personal wellbeing and work performance over time.

Although participants shared an organisational context, experiences varied across professional roles. Nurses often described absorbing emotional labour from patients and families, physicians highlighted pressures associated with authority and responsibility, and laboratory technicians reported experiences of professional invisibility that limited recognition and opportunities for progression. These findings demonstrate that job satisfaction and mental wellbeing were understood as embedded within everyday organisational realities rather than as individual or static states.

Contributions to knowledge

This study makes specific contributions to understanding job satisfaction and mental wellbeing among HCWs within Kuwait's public healthcare system. Empirically, it is one of the first qualitative studies to provide an in-depth account of healthcare workers' experiences within a major public teaching hospital, extending a regional literature that has been largely dominated by survey-based studies focused on physicians and nurses. By including HCWs from multiple professional groups and both Kuwaiti and expatriate backgrounds, the study offers nuanced insight into how organisational structures, employment arrangements, and everyday working conditions are experienced in practice.

The findings contribute contextual insight to understandings of job satisfaction and wellbeing by demonstrating how sociocultural forces beyond the immediate workplace shape participants' experiences of work and wellbeing. The study illustrates how cultural context influences both the meaning and experience of job satisfaction and mental wellbeing. Patient expectations, family involvement, social media exposure, and informal influence networks such as *wasta* were shown to shape emotional labour, professional judgement, and perceptions of vulnerability and protection. These dimensions are not routinely captured within dominant quantitative approaches in the regional healthcare literature and add depth to existing evidence on healthcare work.

The study also contributes theoretically by refining the JD-R framework to better reflect participants' lived experiences within a hierarchical, culturally embedded, and labour-stratified healthcare system. Rather than applying the model prescriptively, the analysis adapted it to account for contextual and relational dynamics evident in participants' accounts, particularly the role of leadership, structural inequities, and sociocultural pressures in shaping how demands and resources were experienced and interpreted in practice.

Beyond the Kuwaiti and GCC context, this study contributes to the wider international literature on HCW wellbeing by showing how job satisfaction and mental wellbeing are shaped through culturally embedded organisational realities rather than through universal workplace factors alone. Much of the international literature applying models such as the JD-R framework has focused primarily on workload, burnout, staffing pressures, and individual coping resources. The findings of this study suggest that symbolic and relational dimensions of work, including dignity, recognition, fairness, professional visibility, and perceptions of protection, may function as equally important resources influencing wellbeing within hierarchical and culturally stratified healthcare systems.

The findings also raise broader questions about how internationally established organisational frameworks are applied across different cultural and institutional contexts. Although the JD-R

model has previously been adapted across professions and national settings, these adaptations have often remained focused on occupational demands and resources within relatively stable organisational systems. In contrast, the present study demonstrates that demands and resources may also be shaped by wider sociocultural pressures, labour stratification, nationalitybased hierarchies, and forms of relational vulnerability that extend beyond the immediate workplace itself. Rather than rejecting the JD-R framework, the study suggests the importance of applying it flexibly and contextually, particularly within healthcare systems characterised by multicultural workforces, hierarchical governance structures, and strong sociocultural influences on professional life.

The thesis further contributes theoretically by demonstrating how the JD-R framework can be extended to better account for leadership instability, structural inequities, symbolic resources, and sociocultural pressures within healthcare settings characterised by hierarchical governance and multicultural workforces. In doing so, the study highlights the importance of interpreting demands and resources not only as organisational conditions, but also as relational and culturally mediated experiences shaped by broader institutional and social contexts.

Strengths and limitations

The study's primary strengths lie in its qualitative depth, purposive sampling across professional roles, nationalities, and genders, and the rigorous application of reflexive thematic analysis. Conducting the research within Kuwait's main public teaching hospital enabled access to a wide range of participant experiences within a single organisational context, supporting detailed and contextually grounded analysis.

Several limitations should be acknowledged. The single-site design limits transferability to other healthcare settings, such as primary care or private hospitals. Some professional groups were less represented, and fewer senior managers participated than originally intended. As participation was voluntary, the findings may reflect the perspectives of those more willing or able to engage. The interpretive nature of the analysis means the findings represent a situated account shaped through participants' narratives and analytic engagement rather than objective or generalisable truths. Data collection occurred during a period characterised by postpandemic pressures and organisational change, which may also have shaped participants' experiences.

Implications for practice and policy

The findings highlight several implications for practice within Kuwait's public healthcare system. At the system level, frequent leadership rotation was experienced as disruptive, suggesting a need for clearer communication during transitions and greater continuity in managerial priorities. Nationality-based differences in access to training, career progression, and procedural

protection point to the importance of addressing perceptions of fairness and security within organisational structures.

At the organisational level, participants emphasised leadership practices that prioritise relational competence, transparency, and ethical conduct. Recognition and appreciation, even when symbolic, were described as meaningful resources for sustaining morale. Participants also highlighted the value of accessible and confidential wellbeing support within hospital settings. Experiences of surveillance practices suggest that how such systems are implemented and communicated can influence trust and perceptions of professional autonomy.

At the interface with the public, participants described the emotional impact of patient expectations, social media exposure, and informal influence pressures. Clear communication around professional boundaries and visible managerial support during challenging encounters were viewed as important in supporting staff dignity and confidence.

Directions for future research

Future research could build on this study through multi-site qualitative research across different healthcare facilities in Kuwait to further examine how organisational context shapes HCWs' experiences. Comparative research across GCC countries could explore whether the refinements to the JD-R framework identified here are evident in other healthcare systems with similar governance and labour structures.

Profession-specific qualitative research focusing on groups such as physiotherapists, nutritionists, and senior leadership would allow deeper exploration of role-specific experiences. Longitudinal research designs could examine how job satisfaction and wellbeing evolve over time in response to organisational change and leadership transitions. Mixed methods research integrating qualitative insights with quantitative assessment may further strengthen understanding of how demands and resources interact across professional groups.

In addition to substantive research directions, the study also highlighted structural considerations that shape the feasibility and sustainability of future qualitative research in public hospital settings. Securing ethical approval involved multiple administrative layers and prolonged delays, with approvals extending from late December until June, followed by a comparatively rapid university approval period. While I did not commence data collection prior to receiving formal approval and participant protection was not compromised, the extended and uncertain timelines shaped the research process in significant ways. The delays generated ongoing uncertainty and emotional strain, alongside the physical and financial burden associated with travelling between Kuwait and the UK in order to progress approvals.

Reflecting on this experience showed that ethics processes, while essential for protecting participants, can negatively affect researcher wellbeing and study progress when timelines and procedures are unclear. Based on this experience, I suggest that future research within major teaching hospitals could be better supported through clearer approval timelines, more streamlined and digitalised application systems, and improved communication mechanisms, including email-based correspondence and application-tracking processes. Increased awareness among healthcare workers and managers of the value of research participation, supported through training or educational activities, may also help foster a more researchsupportive hospital culture. Together, such developments could strengthen ethical governance while enabling timely, sustainable, and ethically robust research within complex healthcare settings.

Final reflection

In this thesis, I have shown that, for the HCWs who participated in this study, job satisfaction and mental wellbeing were not experienced as individual psychological states, but were shaped through the interaction of organisational structures, workplace relationships, cultural expectations, and wider social forces. Through close attention to participants' accounts, I have illustrated how wellbeing was constructed, challenged, and negotiated within everyday professional practice.

My findings suggest that supporting HCWs wellbeing requires attention to the conditions under which care is delivered, rather than a narrow focus on individual resilience alone. Within the study context, this points towards the importance of organisational environments that recognise dignity, fairness, and professional contribution. In highlighting these dynamics, I hope the research contributes to more humane and sustainable approaches to supporting healthcare workers within Kuwait's public healthcare system.

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Appendices

Appendix A: Extracted studies' quality assessment table

Study	Year	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Al Sabei et al.	2020								
Al Sabei et al.	2022								
Albashayreh et al.	2019								
Alblihed and Alzghaibi	2022								
Alboughami et al.	2020								
Alenezi et al.	2022								
Alenezi et al.	2022								
AlHamdan et al.	2021								
Alharbi et al.	2020								
Alonazi et al.	2023								
Al-Wotayan et al.	2019								
Anzar et al.	2022								
Aruta et al.	2022								
Baghdadi et al.	2020								
Bahari et al.	2022								

Batran	2019								
Falatah and Alhalal	2022								
Inocian et al.	2021								
Jradi et al.	2020								
Kader et al.	2021								
Salem et al.	2018								
Saquib et al.	2019								
Shdaifat et al.	2023								
Yehya et al.	2018								

Q1	Was the target population clearly defined?
Q2	Does the response rate raise concerns?
Q3	Is the sampling approach rigorous?
Q4	Were measures taken to categorize and account for non-respondents?
Q5	Was reliability test performed?
Q6	Was validity assessment performed?
Q7	Were the limitations discussed?
Q8	Is ethics management described?

	Passed
	Not Passed
	Unclear

Appendix B: Ethical approval forms

Figure 13: Kuwait MOH ethical approval letter

دولة الكويت
وزارة الصحة
الوكيل المساعد لشئون الخدمات الطبية الاهلية

كويت جديدة NEWKUWAIT

تاريخ: ٢٠٢٤/٤/٧٥ المرجع: ٩٢٧

السيد الفاضل / د. وكيل الوزارة المحترم

تحية طيبة وبعد،،،

الموضوع / تسهيل مهمة
الباحثة / د. أنفال الطالب
(رقم البحث 2555 - 2024)

يرجي التفضل بالإحاطة بأن اللجنة الدائمة لتنسيق البحوث الطبية والصحية المشكلة بموجب القرار الوزاري رقم 232 لسنة 2023 قد أوصت بإجتماعها 104 (2024/4) يوم الأثنين الموافق 13-5-2024 بالموافقة على إجراء البحث المقدم من الباحثين بتاريخ 2024/1/31.

وذلك بعد أن قامت اللجنة باستطلاع آراء الجهات ذات العلاقة بموضوع البحث حيث **وافق السيد / أ. مدير إدارة الشئون القانونية والتحقيقات بالكتاب 545 بتاريخ 2024/4/1 ووافق السيد / مدير إدارة الصحة العامة بالكتاب 369 بتاريخ 2024/2/29 (مع إبلاغ الإدارة بالنتائج بعد الانتهاء من البحث) ووافقت السيدة / مدير إدارة الصحة المهنية بالكتاب 457 بتاريخ 2024/3/14 ووافقت السيدة / مدير مركز الكويت للصحة النفسية بالكتاب 595 بتاريخ 2024/4/15.**

ويتم البحث من خلال استخدام نموذج لجمع البيانات عن المؤشرات المستهدفة بالدراسة حسب بروتوكول البحث **(مرفق ملخص الدراسة).**

التاريخ: ٢٠٢٤/٦/٥ المرجع: ٩٤٧

برجاء التفضل بالاطلاع والتوجيه بما ترونه مناسباً نحو اعتماد توصية اللجنة والموافقة على مخاطبة الجهات ذات الصلة بموضوع البحث ***(السادة / مدير منطقة حولي الصحية - مدير مستشفى مبارك الكبير)*** بهذا الشأن للعمل على تسهيل مهمة الباحثين لإجراء البحث ***(مدة مشروع البحث 6 شهور) .***

مع مراعاة التزام الباحثين بالمحافظة على حقوق المشاركين بالبحث بالخصوصية وسرية المعلومات وعدم تداولها خارج إطار البحث وتقديم تقارير متابعة دورية ***Progress Reports (تقرير عند انتهاء مدة المشروع)*** للجنة الدائمة لتنسيق البحوث الطبية والصحية عن مدي التقدم المحرز في سير الدراسة ومدي تحقيقها للأهداف المرجوة من إجرائها والتنسيق مع رؤساء الأقسام التي ستجري بها الدراسة وفقا للضوابط المنظمة لذلك.

،،،،،،،،وتفضلوا بقبول فائق الاحترام،،،،،،،،

الوكيل المساعد لشئون الخدمات الطبية الاهلية
رئيس اللجنة الدائمة لتنسيق البحوث الطبية والصحية

[redacted]

يعتمد،،
حسب النظم
وكيل وزارة الصحة

[redacted]

Figure 14: University of Sheffield ethical approval letter

Approved: 19/07/2024

Anfal Al-Taleb
Registration number: 220233965
Population Health [Archived]
Programme: PhD of Public Health

Dear Anfal

PROJECT TITLE: Exploring Factors Influencing Job Satisfaction and Mental Health of Healthcare Professionals in Kuwait: A Qualitative Exploration of Constructs, Their Antecedents and Outcomes
APPLICATION: Reference Number 058305

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 19/07/2024 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 058305 (form submission date: 17/07/2024); (expected project end date: 13/11/2025).
- Participant information sheet 1136305 version 3 (16/07/2024).
- Participant consent form 1136306 version 2 (07/07/2024).

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Your responsibilities in delivering this research project are set out at the end of this letter.

Yours sincerely

Email Scharr Rec
Ethics Admin
School of Medicine and Population Health

Please note the following responsibilities of the researcher in delivering the research project:

- The project must abide by the University's Research Ethics Policy: https://www.sheffield.ac.uk/research-services/ethics-integrity/policy
- The project must abide by the University's Good Research & Innovation Practices Policy: https://www.sheffield.ac.uk/polopoly_fs/1.671066!/file/GRIPPolicy.pdf
- The researcher must inform their supervisor (in the case of a student) or Ethics Admin (in the case of a member of staff) of any significant changes to the project or the approved documentation.
- The researcher must comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- The researcher is responsible for effectively managing the data collected both during and after the end of the project in line with best practice, and any relevant legislative, regulatory or contractual requirements.

Appendix C: Invitation letter

Invitation letter

Exploring Factors Influencing Job Satisfaction and Wellbeing of Healthcare Professionals in Kuwait.

You are invited to take part in a study about job satisfaction and factors affecting job satisfaction and wellbeing of healthcare professionals in Mubarak AlKabeer hospital.

I am a Kuwaiti researcher doing my PhD study at The University of Sheffield- United Kingdom-. I will conduct a research interview that will take the form of a conversation and will last about an hour, it can be face to face or online according to your preference. The hospital administration will not be informed of your participation and your personal data will be secured and not identifiable (including name, job, and any other personal data). Further information will be provided in the attached information sheet.

Please, contact me on:

email address: aal-taleb1@sheffield.uk.ac

or

mobile number:

if you would like to participate or have any questions.

Best wishes,

Dr. Anfal AlTaleb

Appendix D: Information sheet

Exploring Factors Influencing Job Satisfaction and Mental Wellbeing of Healthcare Professionals in Kuwait

1. What is the project's purpose?

The purpose of this study is to identify the factors related to job satisfaction and well-being of healthcare workers in Kuwait from the point of view of the staff themselves. The study aims to determine what the most important components of job satisfaction are and how it affects the well-being of healthcare workers. The results of the study will be used to inform specific policies to improve job satisfaction and well-being of healthcare workers in Kuwait.

2. Why have I been chosen?

You have been chosen for this study because you are a healthcare professional currently working in Kuwait. Your unique experiences and insights will be invaluable to our understanding of the factors influencing job satisfaction and mental well-being among healthcare professionals in this context. Your participation will help us gain a deeper understanding of the challenges and opportunities faced by healthcare workers in Kuwait, which will inform strategies to improve their well-being and hopefully enhance the quality of healthcare services provided to the public.

3. Do I have to take part?

Participation in this study is voluntary. You are under no obligation to participate, and you may decline to participate or withdraw from the study without giving a reason but any data collected will be kept. .
Your decision will not affect your current job or any other professional or personal relationships.

4. What will happen to me if I take part? What do I have to do?

If you decide to take part in this study, you will be invited to participate in an interview. This interview will be conducted face-to-face or online depending on your preference and will typically last for approximately one hour. The interviews will be conducted in a confidential and secure setting, either at your workplace e.g. vacant clinic room or another suitable safe location. You will need a computer and private room for an online interview.
During the interview, you will be asked questions about your experiences as a healthcare professional in Kuwait. The questions will be based on the themes such as your job satisfaction, and factors affecting job satisfaction. The interview is structured in a way allowing you to share your thoughts and experiences in your own words.
Your participation in the study will involve:

- Completing a brief demographic questionnaire to gather information about your background and work experience.
- Participating in an individual interview, lasting approximately 60 minutes.
- The interview will be audio recorded for the purposes of making an anonymised transcription of the words spoken. After this the recording will be destroyed.

5. What are the possible disadvantages of taking part?

As with any research study, there are some potential disadvantages associated with participating in this study. In this study the main disadvantage is recalling some sensitive topics or events that may be emotional to you. However, the purpose of the interview is not to discuss anything that you are uncomfortable with and, you can ask the researcher for a break or to not answer such questions.

6. What are the possible benefits of taking part?

Your participation in the study is voluntary, which means that no tangible personal benefits will be provided. However, your participation will make a contribution to our understanding of the factors influencing job satisfaction among healthcare professionals in Kuwait. Adding more,Some participants may find it helpful to talk about their experiences in a confidential setting.

7. Will my taking part in this project be kept confidential?

We take confidentiality very seriously.

- Your personal data in this study will be kept confidential.
- Audio recordings will be confidential by using encrypted audio recording device and will be deleted after transcription .
- Transcription will be anonymous, personally identifying information will be removed from interview transcripts before the data is analysed or presented in writing.
- Transcriptions will be stored securely in password-protected electronic files. Only authorised personnel will have access to the data, and all data access will be logged.
- You will not be identifiable in any reports or publications. Your words will be used as quotations as part of the data used.
- All participants involved in the study will be given code numbers so no one will be identified by his/her name.
- We will not tell the hospital administration that you have participated in the research, although if you wish to take time out of your working day to participate, you may have to tell your manager. Still, given the data anonymization, it will be impossible for the administration to tell which responses you personally provided.
- This research will not ask you to divulge details about patients or colleagues unless there is a patient's harm or risk of harm. As there is an ethical obligation to report the harm to the appropriate department or person in charge to take appropriate action to prevent any further harm or similar harm to other patients.

8. How will we use information about you?

The information you provide will be used for the following purposes:

- **Conducting the study:** the anonymised interview transcripts and demographic data will be used to analyse the factors influencing job satisfaction and mental well-being among healthcare professionals in Kuwait. This information will be used to identify patterns, themes, and potential areas for improvement and the study will be written for submission as part of my PhD

9. What is the legal basis for processing my personal data?

According to UK data protection legislation, we are required to inform you that the legal basis we are applying in order to process your personal data is that 'processing is necessary for the performance of a task carried out in the public interest' (Article 6(1)(e)). Further

information can be found in the University's Privacy Notice https://www.sheffield.ac.uk/govern/data-protection/privacy/general.

10. Who is organising and funding the research?

This research is funded by the Civil Service Commission (CSC) in Kuwait and the Ministry of Health in Kuwait.

11. Who is the Data Controller?

The University of Sheffield (School of Medicine and Population Health) will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

12. Who has ethically reviewed the project?

This project has been ethically approved via the University of Sheffield's Ethics Review Procedure, as administered by theSchool of Medicine and Population Health and approved by Kuwait Ministry of Health ethics committee.

13. For further information, if you are happy to participate or have any complaint contact:

Research Team:

- aal-taleb@sheffield.ac.uk
- j.a.burr@sheffield.ac.uk, e.f.wood@sheffield.ac.uk and jaqui.long@sheffield.ac.uk

Thank you for considering participating in the project!

Appendix E: Participant consent form

Exploring Factors Influencing Job Satisfaction and Mental Health of Healthcare Professionals in Kuwait

Consent Form

Please tick the appropriate boxes	**Yes**	**No**
Taking Part in the Project		
I have read and understood the project information sheet dated DD/MM/YYYY or the project has been fully explained to me.	☐	☐
I have been given the opportunity to ask questions about the project.	☐	☐
I agree to take part in the project. I understand that taking part in the project will include face to face interview or online interview that will take approximately one hour and will be audio recorded	☐	☐
I understand that by choosing to participate as a volunteer in this research, this does not create a legally binding agreement nor is it intended to create an employment relationship with the University of Sheffield.	☐	☐
understand that my taking part is voluntary and that I can withdraw from the study (maximum time to withdraw two weeks after the interview) and any data collected will be kept.	☐	☐
How my information will be used during and after the project		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	☐	☐
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs.	☐	☐
So that the information you provide can be used legally by the researchers		
I agree to take part in this research	☐	☐

Name of participant [printed] Signature Date

Name of Researcher [printed] Signature Date

ANFAL ALTALEB

Project contact details for further information:

Researcher contact details:
Email: aal-taleb1@sheffield.ac.uk
phone number

Supervisor contact details
Email: j.a.burr@sheffield.ac.uk

Appendix F: Interview protocol

The questions presented below form a basis of our interview. Please note, that these questions are not set: they can be changed and modified as the interview progresses. Likewise, additional questions may emerge to explore some topics and themes further. Please note, there are no

right and wrong answers. The purpose of the interview is to examine your perceptions on the given topics given your past and present working experiences at the hospital.

Theme one: environment

Please describe your working environment. You can address some of the following: your work title, department, responsibilities, work hours, co-workers, supervisors etc.

What do you particularly like or dislike about your working environment? Why?

Theme two: job satisfaction

Are you generally satisfied with your job? What are the key components that make you satisfied with the job? Anything that makes you dissatisfied with your job? Why so?

What factors do you see as contributory to your job satisfaction? In what ways? What factors make you dissatisfied with your job? Why?

What do you think the administration can do to make you more satisfied with your job?

Theme three: mental wellbeing

How would you describe you current mental wellbeing? Do you ever have signs of anxiety, depression, or burnout? What would you relate them to? To what extent does your job contribute to this? Can you name other factors that you see influential to your mental well-being at work?

Do you think administration can help employees like you in preserving mental well- being? How?

Theme four: job satisfaction and mental wellbeing

How would you describe yourself at present (explain your answer):

Satisfied with the job and in good mental wellbeing

Satisfied with the job and not in good mental wellbeing

Dissatisfied with the job but in good mental wellbeing

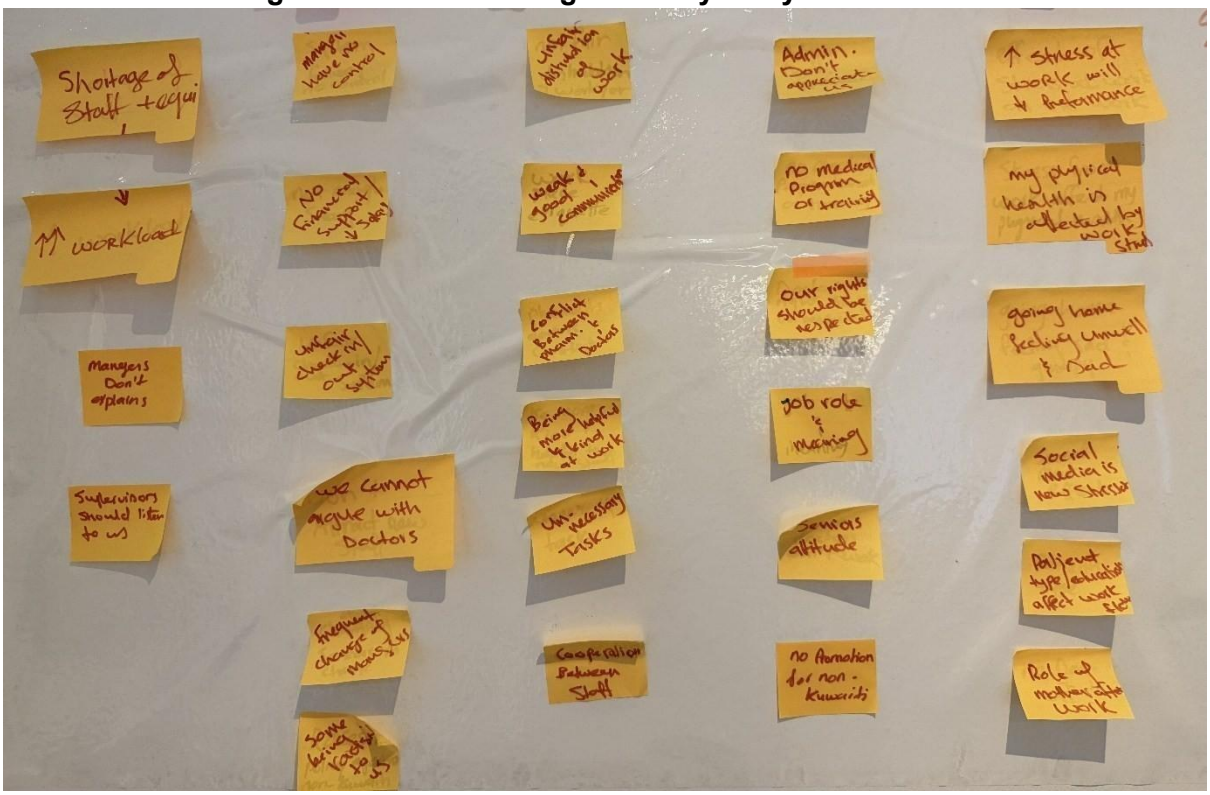
Dissatisfied with the job and not in good mental wellbeing

How do you think job satisfaction and mental wellbeing related? Consider yourself. What precedes what? Can one exist without another? Why so?

Imagine you have an opportunity to make everyone at the hospital like their jobs or make everyone in good mental wellbeing. Which one would you choose and why?

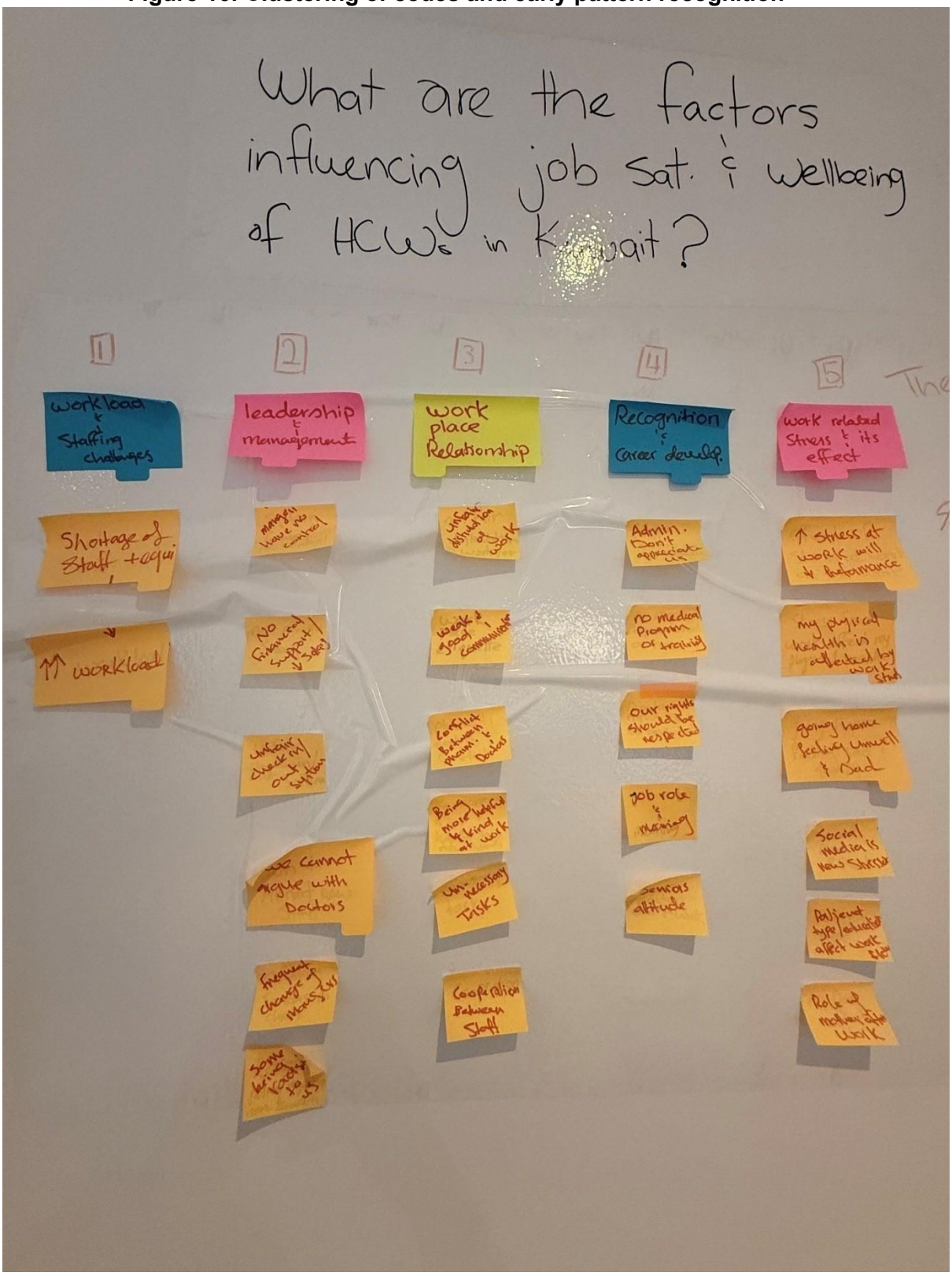
Appendix G: Visual documentation of the thematic analysis process

Figure 15: Initial coding and early analytic notes



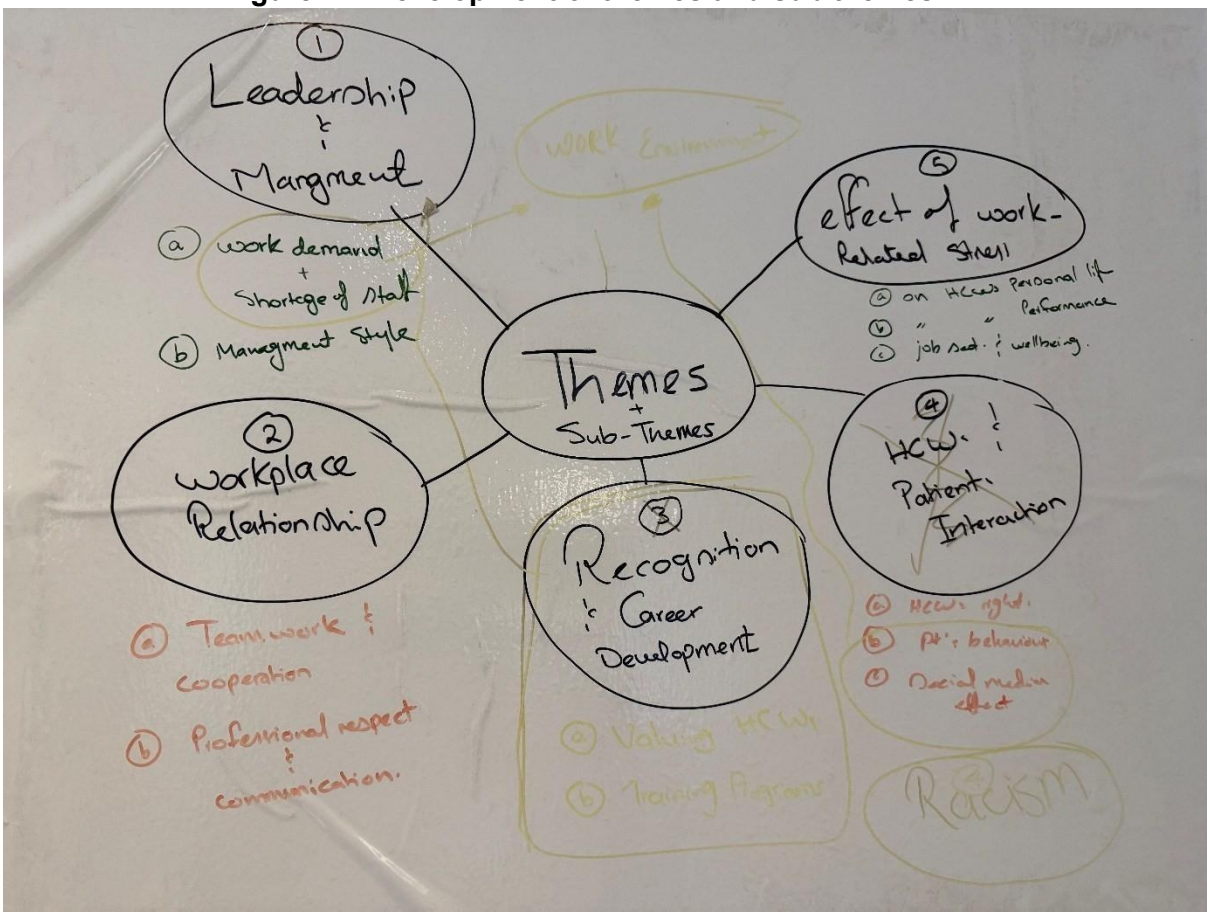
An example of early-stage manual coding using handwritten notes and sticky notes to capture initial codes and analytic observations during familiarisation with the interview data. This stage focused on identifying recurrent issues, pressures, and experiences described by participants across interviews.

Figure 16: Clustering of codes and early pattern recognition



Visual clustering of initial codes using sticky notes to explore relationships between codes and identify emerging patterns across the dataset. This process supported the movement from individual codes toward provisional sub themes.

Figure 17: Development of themes and sub themes

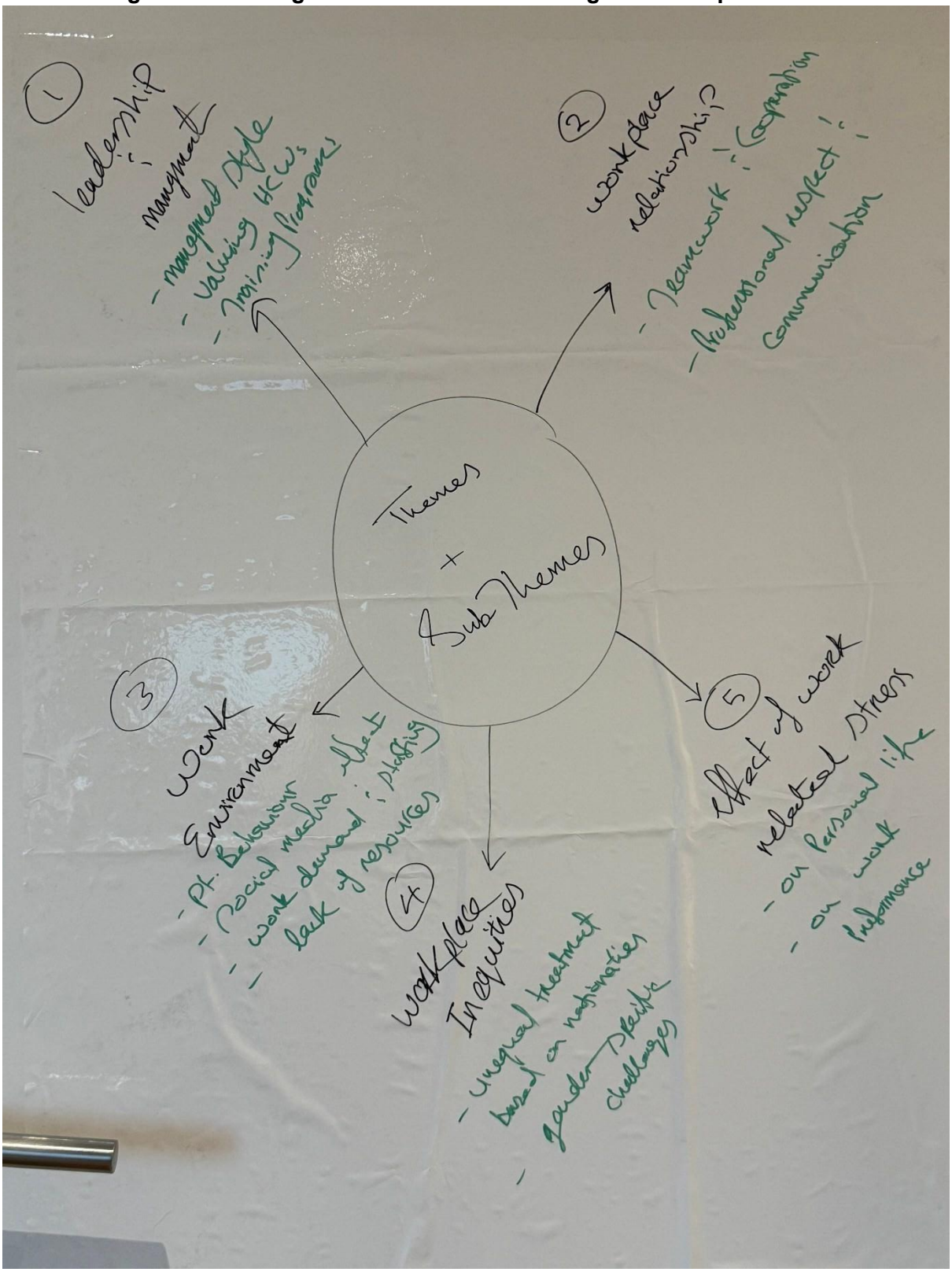


Iterative mapping of themes and sub themes using hand drawn diagrams to examine relationships between domains such as leadership, workplace relationships, work environment, recognition, and the effects of work-related stress. This visual process was used to refine theme boundaries and ensure internal coherence.

Figure 18: Refinement and re organisation of the thematic structure

Further refinement of the thematic structure through re organisation and comparison of themes and sub themes. This stage involved collapsing overlapping concepts, clarifying analytic focus, and testing the fit of themes against the full dataset.

Figure 19: Linking themes to the overarching research question



Final stage visual mapping showing how the developed themes and sub themes addressed the overarching research question concerning factors influencing job satisfaction and wellbeing among healthcare workers in Kuwait.