Introduction

Saudi Arabia (SA) is facing many healthcare challenges related to what could be viewed as poor management over time. There is an urgent call to reform the current policies and strategies (Almalki et al., 2011-b; Khaliq, 2012). The policy makers have realised that providing free services in all public health reforms is an unsustainable and inefficient strategy. The accessibility to these services, their quality of care, and the outcomes have been questioned by literature due to the poor and mal-distributed healthcare infrastructure, work stress, dissatisfaction, and turnover among immigrant staff including nursing. Thus, finding alternative ways to meet health care costs would need to lead to changes in health providers’ and customers’ behaviours, particularly, with the oil depletion likely within a timeframe of 50 to 200 years.

Advancing and professionalising nursing practice is governed largely by contemporary social health care demands and needs, and its influencing factors, namely; population growth, increasing life expectancy, the absence of family planning programs, as well as health related behaviours; such as smoking (Khaliq, 2012), hypertension, type II diabetes, hypercholesterolemia (Al-Nuaim, Al-Rubeaan, Al-Mazrou & Al-Daghari, 1996; El-Hazmi & Waresy 2000; Osman & Al-Nozha 2000; Warsy & El-Hazmi 1999), obesity (WHO, 2010-b), and sedentary life style (Al-Hazzaa, 2004); advanced knowledge and technology, and increasing expectations of patients and professionals. It is important to address these factors and reduce the expenses associated through prevention or early intervention. (Almalki et al, 2011-b). To meet these challenges, nursing is re-inventing itself although not without debate.

However, nursing is still in its infancy in KSA and experiencing some difficulties, hence needs attention. Problems with meeting health needs have usually been done through bringing many nurses are brought from countries with poor nursing quality, who come to SA to gain experiences and skills then they leave to other developed countries, which affects the budgets of the MoH and the quality of the delivered healthcare services (Almalki et al., 2011-a). There are also cultural issues for nursing profession. Although women are segregated in
varying degrees everywhere in the Middle East, this practice is stricter in the Saudi communities. This has meant many women spend and fulfill their lives in private space and most of the working females prefer to be employed in all-female environment. Also, the family obligations including maternal and extended family roles have created difficulties to meet both the work customers’ and the family needs at the same time (Tumulty, 2001). This cultural sensitivity to women poses difficulty for female healthcare workers, including nurses, to achieve work-life balance (Tumulty, 2001). The lack of professional development, clear career pathway, nursing advocacy, and importantly the conflict between the family and personal life and the nursing profession made nursing not the most attractive future career for the graduating high school students and all play a vital part in hampering the flourishing of nursing in SA. Thus, this exploratory qualitative study will serve as an assessment tool and allow people in executive positions to understand the status of, and reasons for advancing nursing practice in SA (Vishnevsky & Beanlands, 2004) so as to optimise accessibility of health care services. The aim is to explore and explain the current advancing of nursing practice roles so as to articulate the problems, and investigate the expectations for these roles in the future.

**Method**

In general, I used grounded theory (GT) in general as a methodology in this research because it (with the use of symbolic interactionist lens) allows the researchers to document the changes inside social groups as well as to understand the fundamental processes key to that change. It assists in identifying and describing any phenomenon, its main attributes, the fundamental social or social psychological process, and its interaction in changing trajectories. It enables researchers to explain what is happening or has happened within a context or around a certain phenomenon (Morse et al., 2009, p. 14). Additionally, GT is a very powerful social science that provides researchers with the tools to synthesise these data, generate conceptualisations, and midrange theory that is still tied to data, yet is applicable to other cases and to future cases (Morse et al., 2009, p. 14). Importantly, GT can influence “the understanding of policymakers or their direct actions to confine actions or reform activities” with intention to improve the studied social group basically (Strauss & Corbin, 1994, p. 281). Higgs (2005) explains that personal experiential knowledge of the research participants influences their understanding of a phenomenon (p, 342). The meaning is “derived from, or arises out of, the social interaction that one has with one’s fellows” (Blumer, 1969, p. 2).

In particular, Clarke’s Situational Analysis (SitA) GT is used in this work, as the
chosen method for data collection analysis considering language or conversation where participants’ thoughts are the centre, and in SitA approach, discourse is similarly the centre to the methodological and method agenda. SitA can “deeply situate research projects individually, collectively, organizationally, institutionally, temporally, geographically, materially, discursively, culturally, symbolically, visually and historically” (Clarke, 2005, p. xxii). In addition, SitA can provide the tools to be able to understand the current complex situation of the nursing system in SA comprehensively, and then; others can improve this system based on the drawn map of the fully analysed in its socio-cultural aspects (Clarke 2005, p. xxii). SitA uses all discursive materials in research including “narrative, visual, and historical” (p. 147). It articulates the missing positions and explores silenced data explicitly and systematically (Clarke, 2005, p. 136). The data is analysed situationally derived from both the previously identified influential factors for the nursing system in SA from literature (our provisional assumption related to the situation) as well as the newly collected data from interviews or other needed key narrative materials, such as policy documents (unknown assumption) (Clarke 2005, p. 185), so it includes all human, non-human, and other factors that are named to shape the nursing system in SA.

Data was collected over six months in 2015 through semi-structured interviews from thirty-eight participants located in three main regions in SA. The key informants of this exploratory study included nursing regulators and government policy makers, healthcare nursing administrators, nursing education administrators, nursing educators, general and specialised nurses and physicians. The understanding and responding to the questions varied according to the participants’ workplace. It was also influenced by the role and position they held and their years of experience. Their diverse response is related to constructivism belief that people construct their social reality through their experiences and interactions with their world. That reality is “relative, multiple, socially constructed, and ungoverned by natural laws” (Costantino, 2008, p. 117). Berger and Luckman (1966, p. 79) explained that although people can exert their own choices and exercise agency, they also respond to their social contextual influences. According to Crotty (1998), “each one's way of making sense of the world is as valid and worthy of respect as any other, thereby tending to scotch any hint of a critical spirit” (p. 58).

**Barriers in situation: the nurse practitioner in the community**

Some participants were acquainted with the concept of advanced practice nursing (APN) roles. In particular, those who were either exposed to the global nursing movement
though higher education and international conferences, work in health organisations where nursing leaders are in process to or have already established the roles, or had worked previously as APNs overseas.

As an initiative for evolving the appropriate APN roles in the Saudi healthcare system, members from the Saudi Commission for Health Specialties (SCFHSs) announced that the family Nurse Practitioner (NP) role will be legitimate and practised in the governmental Primary Healthcare Centers (PHCs). They will work on regulating the level of family NP practice, its scope and the educational qualifications required. There is a plan to pilot the role of NP in selected primary health care centers. The desire for the role came as the high authority in the MoH convinced that nursing are able to take some of the traditional physicians’ responsibilities, the idea has succeeded internationally, and there is a severe shortage of specialised physicians and a need for more specialised healthcare providers. One said:

“the Saudis are spoiled. They want a particular specialty as they like...... why brother? we need this specialty, come and study it. We have now XXX they will send them right now [he means to take international board in particular speciality]” (AA, 2015, p. 6).

Despite the fact that introducing family NPs would not really increase the number of specialised healthcare providers and is like general advanced nursing practice, the initiatives of the role emphasised that changes need to be done gradually and slowly. People need first to recognise the role and its capabilities first before developing it in more critical health settings. Also according to them, family NPs would have a clear role to shape and regulate compared to other population based specialties. There are insufficient Saudi family medicine physicians in the PHCs. One participant said:

"The family physician if he saw a nurse practitioner in action, will cling to them with their hands and legs, because they [NPs] will help them” (AA,2015, p.10)

However, until 2016, no actions have been taken neither by the MoH nor the SCFHSs to introduce the roles. The pilot study has not been implemented. The problem is within nursing themselves. They are not in agreement and do not share the same plans and visions for nursing profession in the country. AA (2015) believed:

“the problem is in us, not in other people, the problem is in us, the weakness is in us”

(p. 8)

“The solution is to first change ourselves [nurses]. The problem is in us. I mean so many people in the healthcare, ministry, .... the problem is in us, here [he pointed to
his mind], the problem is here. The problem is that now I [he means another person in leadership position] come, I say: I did and I did and I did, and he did not do anything. I do not say what I did in my life, I do not say to people. But when it becomes an illness, this is a problem. I mean we [he as a leader and his team members in his organisation] actually I swear to Allah did and worked, you [the leaders without any obvious achievements] what have you done my brother to the profession? From devastation to ruin to ruin, from worse to worst, no allowance no bonuses, no career, no license, no specialised program...What you have done tell me? You have to do something; this is my concept. The illness is us. I’m telling you, I say it always, we start with ourselves. If the nurse practitioner ‘s and the nurse’s colleague make fun from her, and her brother [call her in a negative way] hey nurse practitioner, the defect is in us...... We must fix the brain. The matter is a matter of ideology” (p.11)

In the middle east, multiple cultural factors have reduced nurses’ empowerment and professional self-confidence. These factors also played a role in forming the belief that nurses are subordinates and servants to physicians (Adib Hagbaghery, Salsali & Ahmadi, 2004-2).
The healthcare system is controlled by physicians and most of the top-managers in the MoH and in the healthcare facilities are physicians. This has resulted in a physician-favoured and pro-physician structure. This physician-centered structure has affected the shape of nursing culturally and professionally (Adib Hajbaghery & Salsali, 2005, p. 6). May (1993, 1995) argued that despite the continuous changes in the healthcare systems’ operations and increasing the nursing professional responsibilities and authorities, physicians will always remain the ultimate controllers for patient care.

The other problem in not implementing the family NP pilot study might be the lack of the national prerequisite nursing legislation for the role. This is what happened exactly in the UAE. Although, there are new health professional qualification requirements that give opportunity to undertake the pilot study for NP, it was not implemented in the UAE due to the absence of national legislation for NP (Brownie, Hunter, Aqtash & Day, 2015, p. 46).
Brownie et al. stressed the need for nursing legislation development and endorsement of standards to complete the regulatory foundations required to establish APN roles in the UAE. According to Brownie, Lebago & Hag-Ali (2014) as cited in Brownie et al., 2015, “Once uniform laws are implemented, opportunities for the registration and licensing of advanced and speciality nursing and midwifery roles in the UAE will be facilitated, and the mechanism by which nurses and midwives could make significant contributions to the prevention and
management of preventable noncommunicable and chronic disease and the development of public health services across the UAE will be established” (p. 46).

**What has worked?**

On the other hand, for the two decentralised healthcare organisations that have the nurse-led clinics and other specialist nurses, they apply the principles of in-house nurse credentialing and privileging to ensure patient safety and professional development. The APN model followed there was constructed by expatriate nurses and it is not identified or classified nationally. There are various specialisations, namely; Wound, Ostomy and Continence, Tissue viability, Tracheostomy, Metabolic, Hematology, Pain management, and Palliative care. There is also a home healthcare nursing at the advanced level.

The patients’ needs are the main motivating factor for the advancement of nursing practice in this case in SA. With different patient populations, the organisations’ leaders conceded that they need more than general nurses to look after patients and provided specific nursing care. Physicians also found there was a substantial need for professionalising nursing profession to follow-up with patients before their next medical appointment to do specialised health education and promotion to prevent complications. Also, there was a need for nursing follow-up in the community for palliative patients in particular, who do not need hospitalisation. Thus, the provision of holistic non-surgical interventions for patients within a therapeutic context was the main goal of these clinics. One specialised nurse said:

"You can't go wrong if you look at a patient population and you look at what their needs are, and particularly the needs that are not met or not well-met. And so any position that you're gonna develop should come out of that." (DH, 2015, P. 4)

“I think that nurses are much better at judging patient population needs than physicians are.” (DH, 2015, P. 8).

The healthcare recipients have great expectations of nursing care in particular, thus, nursing leaders and decision-makers must show more resilience with regard to the change in their health needs. Burns (1978) emphasised that power is practiced to achieve “the collective goals of the relationally involved” (as cited in Paynton, 2009). Improving the nursing performance is counting on effective human resources strategies, which accordingly creates well-functioning systems (Al-Ahmadi, 2009, p. 51).

In addition, the organisations’ needs to develop specialised nurses in some Saudi healthcare organisation. There was a need to improve bed/patient flow and allow more patients to be admitted. So, nurse specialists are sent to the community to provide care for
stable patients, such as bedridden, geriatric, and dying patients. APNs have achieved the social recognition as cost-effective healthcare providers (Boss, 1996; Burl, Bonner, Rao, & Khan, 1998; Nichols, 1992; Safriet, 1992; Wynd, 2003). There has been a swift shifting of healthcare organisations’ motivation toward “business-oriented” nursing model. Thus, the need for nursing professionalism is at its height these days, yet; shaping and defining the nursing “professionalism” concept will need a careful adaptation to answer the rapidly changing (Davies, 1996a, 1996b; DeMoro, 1995; Mechanic, 2000; Rayman, Ellison, &Holmes, 1999; Scott, 1999; White & Begun, 1996, Wynd, 2003, p. 252).

In the study of Ghadirian, Salsali and Cheraghi (2014) to identify how nursing professionalism can be determined, they used Rodger’ (2000) evolutionary concept analysis process. They concluded that: “nursing professionalization as a multi-dimensional concept and it introduced cognitive, attitudinal, and psychomotor dimensions as the main features of nursing professionalization. In the review of studies, antecedents of the concept [that is, nursing professionalization] were demographic factors, factors related to experience, factors related to education, factors related to situation, and value-related factors.” Therefore, during the restructuring of the strategic direction of nursing service, the nursing executives and staff must also identify their own needs from the operational decision of any newly implemented role. Any dissatisfaction with the process related to the marginalisation and the lack of authority might lead to nursing low morale and motivation, burnout, and high turnover (Di Frances, 2002; Duffield, Kearin, Johnston & Leonard, 2007; Duffield & O’Brien-Pallas, 2002; Roan, Lafferty & Loudon, 2002).

Also, throughout the past years, the International Council of Nurses (ICN) identified that:" Disorderly development of specialties, with no central controls by the total profession, could lead to fragmentation of nursing care and the splintering of the profession ... Orderly development on the contrary, may well play a critical role in expanding the depth, breadth and rigor of nursing knowledge and expertise, strengthening the integrity of the profession, and enhancing the career opportunities and benefits available to nurses" (International Council of Nurses 1992, p.7). One western specialist nurse, who used to practice and teach her APN role in her home country before coming to SA, was asked whether or not she believes that the Saudi commission for health specialty will give a nurse practitioner or other APNs the appropriate responsibilities, authority, and autonomy, and she replied:

“They should do it. They have to do it, otherwise it's like, I don't know if you know mickey mouse? Otherwise it'll only be a mickey mouse and it'll only be a position by title but not by action, and that's no use. That's frustrating for everybody. They either
embrace the whole idea or they don't do any of it ............I would caution not to rush his whole process. To do it step by step, to get the best of all the other models and to make sure that the pieces of the puzzle are falling together, like:

1) That the Saudi Commission are fully on board for the full regulations.
2) That the education in the universities is at the top level of standard equal to any other world university.
3) That the correct candidates are chosen, and
4) That the clinical placement for supervision is in place.

If any piece of that is not right, like if the correct candidates are not chosen it would fall. If there's not sufficient clinical supervision it would fall. So I would caution time. I wouldn't say, in three years time we'll have the first advanced ... you know... We will if she comes from education abroad, but if you want them fully home-grown I would say 15 years minimum. Take your time. Do it properly because it would last and it will be something to be proud of” (VF, 2015, p. 21-22).

A few questions about the paper in a conclusion?

1. What factors can make nursing authority more interested and supportive to the APN roles and make other nurses accepting the roles without resistance?

2. What could be the influence of recruiting foreigner nurses to fill APN roles in the Saudi healthcare system from diverse cultural back grounds, with different nursing practice models, and have qualifications from worldwide universities that embrace different measures and criteria?

3. What legislations and regulations should be considered to grant and protect the APN title and to avoid any roles’ confusion or misapplication?

4. How can the policy and decision makers balance between the need to shape a powerful roles of a female dominant profession and the Saudi culture that is characterised by gender gap related to structural constraints faced by women, namely; social, religious, cultural and gender inequality.