# The Role of Nurse Educators in Student Clinical Education in Saudi Arabia

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***Abstract*— Background: Clinical education is considered a significant part of the learning process for nursing students. There is, however, no research that has explored this area of learning in Saudi Arabia. Theoretical Framework: Informed by a symbolic interactionist framework, this research explored the role of nurse educators in student clinical education in Saudi Arabia. Method: Using Glaserian grounded theory methods the data were derived from 14 face-to-face interviews with nurse educators from both hospital and faculty settings in King Abdu-Aziz University (KAU) and King Abdu-Aziz University Hospital (KAUH). Findings: The findings of the research are represented in the core category *Redefining Identity Work* and its two constituent categories *Questioning the Situation* and *Creating Role Identity.* The core and sub- categories were generated through a theoretical exploration of the identity work of nurse educators in Saudi Arabia. Conclusion: The social identity of the nurse educators was mediated culturally and socially within the hospital and university contexts and Saudi Arabian culture. In light of an increased understanding of the identity and role of nurse educators in clinical education in Saudi Arabia, the research presents implications and recommendations that may contribute to the development of nursing education as a coherent health care profession that is perceived as a desirable career option for Saudi women and men.**

***Index Terms*— Clinical education, Identity, Nursing Education, Role of nurse educator, Role theory, Symbolic interactionism, and Grounded theory.**

## I. Introduction

### *A. Research Background*

Saudi Arabian culture is embedded within a framework of Islamic religious beliefs and this extends to nursing practice in general and to clinical nursing education. The Holy Quran, the Islamic holy book, Hadith, Saying of Prophet Mohammad (PBUH), and religious groups constitute the governing code for the Islamic religion in Saudi Arabia [1], [2].

Where health care is concerned, most Muslims hold the belief that health, sickness and death emanate from God. Thus, illness is perceived as a way of atonement for one's sins rather than a form of punishment [3], [4].

It is also important to recognize that Saudi Arabia is a nation with only eighty years of history [5], and nursing education has been a relatively recent phenomenon in this country. Nursing started with volunteers with no formal skills to care for ill people. However, with rapidly expanding oil-production in Saudi Arabia from the 1960s on, the government looked to industrialization by investing in infrastructure including education. Nursing education was one area that received considerable investment in response to an increase in the demand for nurses in this country [5], [6].

The first Health Institute Program for nurses was initiated in 1958 through the collaboration of the Ministry of Health and the World Health Organization (WHO) [6], [7]. Subsequently, two further Health Institutes were established for Saudi women with the same entry standards [6], [7]. In 1990, the total number of Health Institutes for females was 17 and 16 were in place for males.

By 1992, nursing colleges were instituted and all those recruited were high school students. A Bachelor of Science in Nursing had been initiated by the Ministry of Higher Education at three universities by 1987 to be followed by a Master of Science degree. In 1996, a PhD scholarship program was established. Government collaboration with international universities was also developed to enable Saudi nurses to undertake Master and PhD degrees while remaining at home [6]-[8].

### *B. Purpose of the study*

The purpose of this research was to explore the role of nurse educators in student clinical education in Saudi Arabia.

## II. Theoretical Framework

The theoretical framework underpinning this research draws on the concepts of identity and role as they have evolved within the broad tradition of symbolic interactionism. Symbolic interactionism focuses on individuals in reciprocal social connections that create their environment through a process of self-reflective communication [9], [10]. The primary focus of symbolic interactionist research is the social processes whereby people come to shared meanings to achieve outcomes [9], [10].

Identity theory, which turns the focus to the internalised interaction within the individual's self, is argued to be essential to the construction of individual personal, social and structural identities [9], [10]. As Stryker [11] explained, a person's self has different identities that interact with others'

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identities dependent upon the situation. In other words, the overall self is organized into multiple parts whereby identities are tied to different social contexts [12]. Understanding the concept of identity and connection to self provided insight into the ways in which nurse educators defined themselves as persons and thus their identities in the Saudi Arabian social and structural contexts. The associated concept of role is relevant to an exploration of perceptions of individuals within a community of nurse educators as they interact within health care organisations in educating nurses and students. Roles are perceived as relationships between what a person does and what others do around them. Communication is central to this process and achieved through the use of verbal and non-verbal symbolic acts such as speech, gestures and body language. Thus, the concepts of identity and role in this research provided the lens through which to explain the multiple and complex dimensions of the work of nurse educators in Saudi Arabia.

## III. Method

### A. Glaserian Grounded Theory

The documentation of the history of nurse educators in Saudi Arabia is limited and to some extent because the evolution of the nurse educator role in Saudi Arabia is a recent phenomenon. The grounded theory method, because of its interpretive function, provides an appropriate process for exploring phenomena that have been largely unresearched. Grounded theory facilitates the study of human phenomena and does so by developing and validating theory grounded in data about the phenomena under study [13]-[15]. This study has adopted the key premises of Glaser's work the central one of which is a coding process that allows for theory generation [16]-[20].

### B. Research Site:

The research was undertaken at two locations; King Abdul-Aziz University (KAUH) and University Hospital (KAUH).

### C. Sampling

Grounded theory sampling is not pre-determined and is both purposeful and theoretical [13], [14], [21], [22].

#### 1) Purposeful sampling

The first author initially and purposefully recruited 10 participants with the experience and knowledge directly relevant to the research focus. An invitation letter was distributed to potential participants including a summary of the research and a consent form with the researcher contact information attached. As the analysis proceeded, theoretical sampling was employed based on emerging theoretical development.

#### 2) Theoretical sampling

The researcher applied theoretical sampling to recruit a further four participants with the experience and characteristics to meet specific gaps identified through data analysis and relevant to the theory development. The researcher sought further clarification from two nurse educators who were members of the student clinical education committee.

### D. Data Collection Strategies

#### 1) In-depth interviews

The initial interview questions were broadly designed to encourage conversation. The questions posed included for example: *tell me about your experience in student clinical education and describe for me your day with students during clinical placement*. Probing questions, such as *can you give me examples and could you say more*, were used when necessary to facilitate elaboration and explanation.

#### 2) Other sources of data

There were additional sources of data generation. First, literature was used as a data source during analysis to expand on understandings of the concepts and to fill conceptual gaps. Second, field notes taken after each interview to record information based on researcher observation and initial analytical ideas sensitized the analysis process. The research followed Glaser's [19] recommendation that data collection concentrate not just on what is being told but rather on the underpinning conditions within the research context.

### E. Data Analysis

Data analysis commenced following transcription of the first interview. Constant comparison as a core tenet of the grounded theory method [18], [19] required movement back and forth between data generation and data analysis to ensure conceptual growth [14]. This meant that data were constantly compared with previous data as categories appeared and also with sub-categories that had emerged from previous data. The objective was to verify the development of sub-categories by constantly redesigning theoretical concepts as new data emerged [14]. The process of constant comparison continued throughout the research process through three coding steps: open, selective and theoretical coding.

#### 1) Memos

Glaser [13] explains that "memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding" (p. 83). Indeed, Glaser [13] is of the view that if a researcher is not writing memos then she/he is not doing grounded theory. Memos in this research were integral to the ongoing analysis.

#### 2) Open coding

Open coding involved the fragmentation of data to allow for conceptualisation beyond the obvious [23]. This phase involved the identification of codes and the situating of like codes within sub-categories [13].

TABLE I. CODING THE DATA (OPEN CODING)

| Transcript | Open codes |
|---|---|
| Our role is defined by the course coordinator. Every course coordinator has a slightly different way based on what she needs. Some ask us to write exams and others say your role is with students in laboratories and in hospitals and not exams. So we follow the course coordinator's instructions | ➢ Our role is defined by the course coordinator<br>➢ Every course coordinator has a slightly different way to define our role<br>➢ We follow their instructions |

*3) Selective coding*

The analysis then shifted to selective coding where the most theoretically significant sub-categories were identified. A significant sub-category was one where codes were more directed, selective and conceptual. The data were then analysed categorically with each category containing sub-categories related to each other and holding similar meaning as can be seen in the table below.

TABLE II. OPEN CODES FIT INTO CATEGORY (EXAMPLE)

| Categories | Sub-Category | Open codes |
|---|---|---|
| Category 1 Questioning the Situation | Culture and Clinical Education | communication between males and females in their society is restricted because it is controlled by norms<br>They should understand that this is acceptable.<br>They should have male patients and deal with male patients. |
| | Language and Clinical Education | They really have a difficult time speaking English.<br>They cannot understand English, and they were afraid to ask.<br>Some of them avoid talking or interacting |

*4) Theoretical coding*

In the third phase the data were theoretically coded in order to conceptualize possible links between categories and to move data analysis beyond the descriptive level. Theoretical coding, as argued by Glaser [13], is a process of using theoretical codes to "conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into a theory" (p. 72).

One core category *redefining identity work* emerged from the two categories *questioning the situation* and *creating a role identity*. The core category represents a theoretical understanding of the assumptions that shape the role of nurse educators in clinical education in Saudi Arabia. The following explores, in turn, the two categories and core category.

## IV. QUESTIONING THE SITUATION

Clinical education in Saudi Arabia is characterized by situations and issues that give rise to questions in relation to nursing clinical education. Three key dimensions of the category "*Questioning the Situation*" are culture*; language* and *the hospital faculty divide*. The focus of the first category is the social context of clinical education in Saudi Arabia as demonstrated in Figure 1.

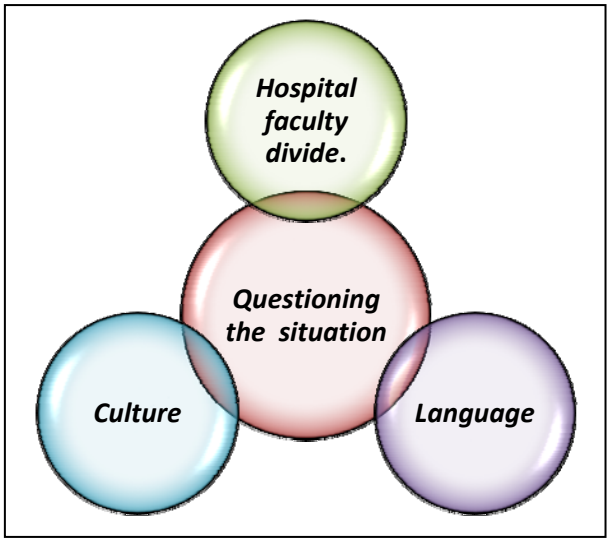


Figure 1: Questioning the situation in student clinical education

*Culture and Clinical Education*

Saudi Arabia's cultural environment significantly shaped the student experience and particularly during the first clinical placement. Issues around male and female communication manifested in different ways. The students were overwhelmed by the prospect of participating in a mixed gender situation on clinical placement as seen below:

> *The students ask me a lot of questions Can I touch the patient? How can I? And because of their customs and culture they asked how can I work? No, I want only to work with females!! I don't want males!! I don't want to touch those, I don't want to do a physical examination. … these situations happen a lot (interview 14) (Hospital Nurse Educator HNE)*

> *We should force them to work with both genders because when she graduates she will work in a hospital and she can't say no I just want female patients. We can't make a female hospital for her (Interview 11) (Faculty Nurse Educator FNE)*

Gender separation is characteristic of Saudi Arabian culture where, for example, gendered schooling is mandatory. Hence there was some inevitability in an initial culture shock where the self identity of female nursing students on clinical placement was challenged by the experience of a mixed-gender working situation. The conflict between traditional values and the demands of the workplace deems it difficult where the identity of students does not readily accommodate the presence of the opposite gender. Yet, identity did change

within a process of interaction and negotiation between the student's expectations of self and the expectations of others within the new situation.

The concept of situational identity theory [9], [10] is relevant here in pointing to the ways in which context shaped the role definition of the student on clinical placement. As Stryker [11] argued, role identity is founded on the combined role expectations of the self and others within a social context. Thus, student role identity was defined by self-perception and the perceptions of supervisors, hospital employees and faculty. Nonetheless, the process gave rise to tension between identities and associated expectations of student nurse and daughter, sister, wife and mother.

*A. Language and clinical education*

In addition to the issue of gender communication there was a further crucial factor in clinical education; the language barrier. In Saudi Arabia, Arabic is the first language and although nursing schools teach the English language in the first year to all nursing students many have limited English proficiency as illustrated below.

> *You know that there are some students who can hardly understand and speak English. And we, as foreigners, we don't have this. We cannot explain more in Arabic. We cannot discuss more, even if they know theory. But putting it into practice is different, because they have the communication gap (Interview 2) (HNE)*

> *They really have a difficult time speaking English. They cannot understand English, and they are afraid to ask. Some avoid talking or interacting (because) they feel inferior (Interview 5) (HNE)*

The language barrier was most apparent during clinical placement where students struggled to read and understand hospital documentation including patient files which were in English. Furthermore, some had difficulty in communicating in English with hospital employees and in particular nurses and nurse educators the majority of whom are from abroad.

This issue resonates with the relationship between identity and self-esteem [24]-[26]. Self-esteem is generally viewed as an affect attached to the self and as an emotional outcome in the identity process. James [27] described self-esteem as the balance between goals and successes and argued that successful identity usually builds and maintains self-esteem while failure to verify individual identity weakens self-esteem [27]. Cast and Burke [24] built on James' work in arguing that self-esteem can be considered as a goal that motivates individual behavior.

The nursing students experienced communication problems which may have directly impacted on their self-esteem. As such, some students developed and sustained self-esteem while others failed to verify their identity thus undermining self-esteem. Here there was a clear perception from the participants that most students experienced low self-esteem as a result of lack of communication proficiency. It may be the case, therefore, that student self-esteem and confidence is associated with an ability to communicate within, and understand, the clinical community and that English language proficiency is a key factor in successful interaction in this context.

*B. The hospital/ faculty divide:*

The hospital nurse educators were nurses appointed as either ward based clinical instructors or educators for hospital nurses. Facilitation of student nurses enters into their role description but is not the first priority. Yet they also assumed a role in educating students during clinical placement. By contrast, the role of faculty based educators ranged from undertaking lectures to teaching in laboratories and writing exams. Clinical education in clinical labs and on clinical placement was the primary occupation of the university educators There appeared to be limited communication between hospital and faculty educators and where this did occur it was via memos, faxes and official letters. As two participants noted:

> *Actually, we don't have a formal meeting day. We just meet them when they come to our unit. They introduce themselves to us, or sometimes not even that, with no words. The students just say that is our clinical instructor. If they have anything to say, they inform us through memos (Interview 5) (HNE)*

> *We have no relationship at all even with the clinical instructors. We have no relations with them at all. It will not only affect the student, especially when I have experience as a university staff member. I think there are certain areas where they can be of benefit to me and I can be of benefit to them. We need to have a collaborative relationship (Interview 10) (FNE)*

Social identity theory explains how people categorise themselves and others. This occurs through a social comparison process where categorising is based on similarities and differences among groups of people [28], [29]. Through this process people label others as in-groups and out-groups; persons who are similar to the self are categorized with the self and labeled as the in-group and those who differ are categorized and labeled as belonging to the out-group [28].

In this research, the social structural context was based on recognizing the self and others in the sense of occupants of the roles of either hospital or faculty nurse educator. The categorizations were based on expectations associated with each role and its performance. These expectations were the reference point for and thus guided behavior.

Members in organizations subscribe to a common set of values through both organizational identity and management style [28-31]. Where the faculty and hospital educators are concerned, group-based identity was based on work groups, work relationships, level of education and religious and cultural backgrounds. The limited face to face communication between faculty and hospital educators was the obvious divide for where communication occurred it was formal and through official documentation. The divide may then extend to cultural, academic and professional levels.

## V. Constructing Role Identity

The meanings attached to the role of the nurse educator are both self-ascribed and assigned by others. Identity in this sense is continually being shaped and reshaped as a result of the interplay between the nurse educator and the environment in which clinical nursing education in Saudi Arabia takes place. This category analyses those issues that emerged in relation to the respective roles of hospital and faculty nurse educators (see Figure 2). The overriding focus here is the organizational context of clinical education in Saudi Arabia.

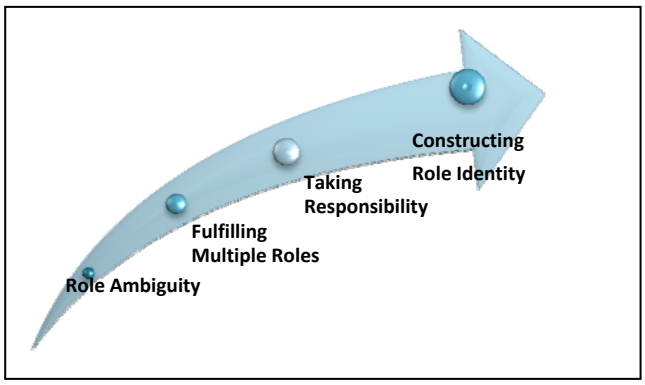


Figure 2: Constructing the role identity of nurse educators

### A. *Role ambiguity:*

The role of faculty based clinical nursing educators as depicted in this research, is at first glance unambiguous. Yet although the role is seemingly well understood, there are no documented role descriptions. It appears that university educators have a tacit understanding of their role even though it is not explicitly stated.

> *Every one of us knows what to do with students even if it's not written (Interview 13) (FNE)*

Despite the superficial recognition and basic understanding of faculty nurse educators (university educators ), he ambiguity became more apparent when hospital educators were asked to define *their* role in student clinical education.

> *It is frameless, there is no frame. There is no plan, and there are no measurement tools for the outcomes of student clinical education (Interview 6) (HNE)*

Role ambiguity as a concept refers to the expectations surrounding a role and whether a measure of clarity, necessary for adequate performance, exists in those expectations [32], [33]. Role ambiguity, however, is also integral to the mediated relationship between individual identity and role expectations [32], [33]. Mead [34] argued that the individual is more than just an occupant of a position or role for which there is a set of rules. In this research, both faculty and hospital nurse educators experienced role ambiguity; however, the ambiguity was more apparent for hospital nurse educators While faculty nurse educators relied on course coordinators to define and set limits to their role in clinical education, the hospital nurse educators did not have this support. The self-identity of hospital nurse educators was formed through interaction, or absence of interaction, with others including managers and other educators.

The frameless role, as referred to by one participant, may allow some autonomy for the nurse educators to create a role. Yet where that role fails to be acknowledged by others and is not congruent with other roles, the outcome can be poor student education. As Stryker and Burke [35] point out, role identity is the internal role expectations of self which develop in the social context of roles and counter roles. Thus a nurse educator must know what activities will fulfill the responsibilities of a position and how those activities are to be performed. For both faculty and hospital nurse educators' uncertainty was compounded and this has the potential to engender less effective workplaces [36], [37]. Hence, the role ambiguities of the nurse educators in both faculty and hospital settings give particular cause for concern.

### B. *Fulfilling multiple roles:*

In addition to role ambiguity, the respective roles of both faculty and hospital nurse educators were expanding and encompassed a range of responsibilities. Saudi Arabia has a young nursing profession which is struggling to meet the health care needs of a growing population and this is considered a critical challenge [40], [41]. Underpinning this tension is a shortage of permanent staff and an increase in students and in-patient numbers. As indicated below, both hospital and faculty educators are required to assume multiple roles.

> *I am working as a course coordinator. I usually take the students to the hospital because of staff shortages. Sometimes, I have over 60 students. Sometimes I have a demonstrator but one demonstrator is not enough to supervise the students. It is a lot to do. (Interview 8) (FNE)*

> *Like now, we are handling paramedics, we have the interns, and we have the nursing students and new nurses. They are known here in the Kingdom and are assigned to us as a preceptor for 3 months. They are our priority. For other nurses also, we have to do yearly competency evaluation and a staffing profile. (Interview 4) (HNE)*

A blurring of roles was evident for these educators and the changing nature of responsibility had increased workloads which they perceived affected their performance. As Hardy and Conway [39] pointed out, role strain exists when the demands of a particular position exceeds an individual's capacity to undertake a given role. The issue, in this research, is not that nurse educators are unable to comprehend the nature of what is required, but rather that they lack the capacity due to limitations of time, skill level and education.

The outcome of role strain may ultimately lead to burnout. It has been argued that role conflict and role ambiguity can lead to lower productivity, tension, anxiety, dissatisfaction and withdrawal from the group [43]-[45]. In addition, where role strain is prevalent, dissatisfied nurse educators may be drained

of energy and commitment to both the organization and their professional values [46]-[48]. The current environment wherein the educator must accommodate the demands of the workforce and management leaves less room for nurse educators to realise the self [38] and more space for questioning the self as competent.

### *C. Taking Responsibility:*

Despite the ambiguity and multiple role expectations the analysis indicated that hospital nurse educators assumed active roles and responsibilities in student clinical education. In other words the educators were not passive actors but engaged in the construction of their role as they negotiated a rapidly evolving health care sector.

Hospital nurse educators took on student education based on both the expectation of others and as they saw themselves. s As such hospital nurse educators developed the educator role for all who needed support whether in the nursing field or not. This may resonate with Mead's [34] view that role taking is one of the keys of social control where actors take the roles of others to fit their actions into a social interaction [34]. They do this by viewing themselves as objects on the stand points of others [34]. Although the nurse educators perceived pressure from management the act of assuming additional responsibilities was not passive.

In the terms of Cooley [49] and Blumer [50], in the Saudi Arabian context the shaping of 'self' for nurse educators was a complex process of creating an identity through mediation of organizational, social and cultural factors. In the current nursing environment this process of mediation was made more complex by lack of management support and an incongruency between the roles of different nurse educator positions.

## VI. Core Category: Redefining Identity Work

As has been argued, identity theory is grounded in the view that identity is not a substitute for self but rather a component of the self [9], [10]. Understanding the self and thus identity as part of the self is to understand the society in which the self is acting and where other selves exist [12]. The theoretical concept of identity, importantly therefore, assumes an interrelationship between the self and society.

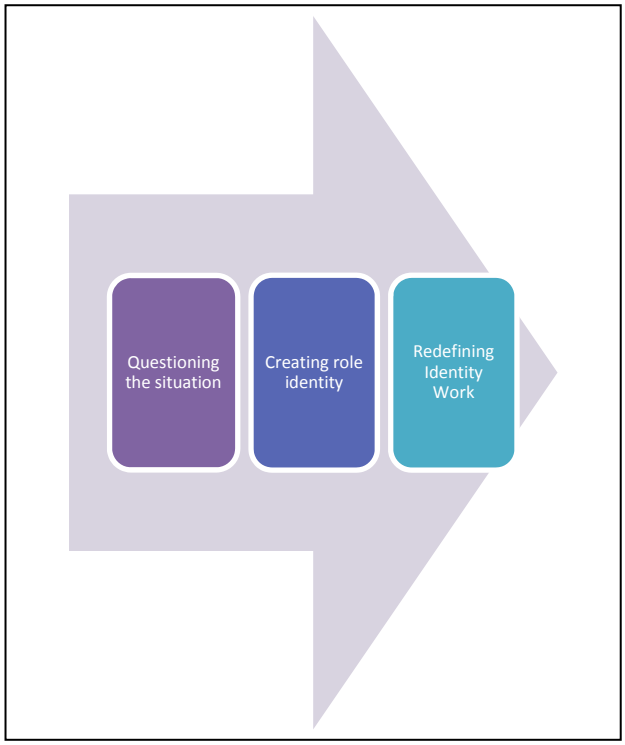


Figure 3: Core Category Formation

### *The concept of identity work*

Identity work is anything people do to give meaning to themselves or others within a social context [51]. It refers therefore to labeling and defining the self and others by creating codes that help in self-signifying and interpreting others [51]. In identity work, people apply labels to themselves which are the result of both social and internal responses. As Stone [52] wrote, identity work is changeable based on the responses of others to the self in a social context as a meaning making activity [52].

Further to this, identity work means that people actively engage to construct and assert their identities whereby they are congruent with both a self identity and a social identity. While Snow and Anderson [53] used the concept of "identity work" to mean the work of individuals to build self-identity, Snow [54] extended the concept to mean sustaining collective identities. It is the case then that identity work is not static but rather a dynamic force that is shaped by people interactions [55].

### *A. The concept of reforming identity*

Stryker [11], [57] emphasised the ways in which relationships between social structures and the self provide the basis for identity and thus for behaviour. Furthermore, as Stryker [11], [57] argued, the salient aspect of an individual's identity has the most influence over a person's behaviour within a social network. In this research, the identity as a nurse educator prevailed within the context where the participants were

employed. But as we have seen, while this identity may have dominated it was not static but continuously in the making.

Burke focuses on the "internal dynamics within the self" which creates a person's identity and influences behavior [58]-[60]. Burke's dissection of this concept depicts the relationship between the perceived meaning of the self in a social situation and the standard meaning of identity. By framing the interpretation of nurse educators' (internal) actions and reactions, this research examined identity construction among nurse educators with particular attention to the potential implications for student clinical education. However, social identities, which are socially constructed and imputed by others, also contribute to the reforming of the nurse educator identity.

McCall and Simmons [61] share the view that identity performances are outcomes from actors who seek to inter-relate their identities with others in social contexts. In returning to our research, the identity of a nurse educator is played out in relation to the identities of students and of other educators. In the case where conflict emerged between two identities, such as hospital and faculty educators, consultation and negotiation strategies were employed to allow interactions to proceed smoothly [61].

Thus the central analytical point is that nurse educators give meaning to their experiences through the lenses of both personal and social identities and they continuously reform their identity. A nurse educator's self emerges as a result of social interaction between individuals within the Saudi Arabian social and cultural context and identity is continuously renegotiated, redefined and reformed in the course of daily interaction. The focus here is on the spaces in which the identities of the nurse educators were negotiated and/or contested.

### *B. Redefining Identity Work*

*Redefining identity work* depicts the connection between self-identity, social identity and identity work and as can be seen in Figure 4) both self identity and social identity are constraints on and shape identity work.

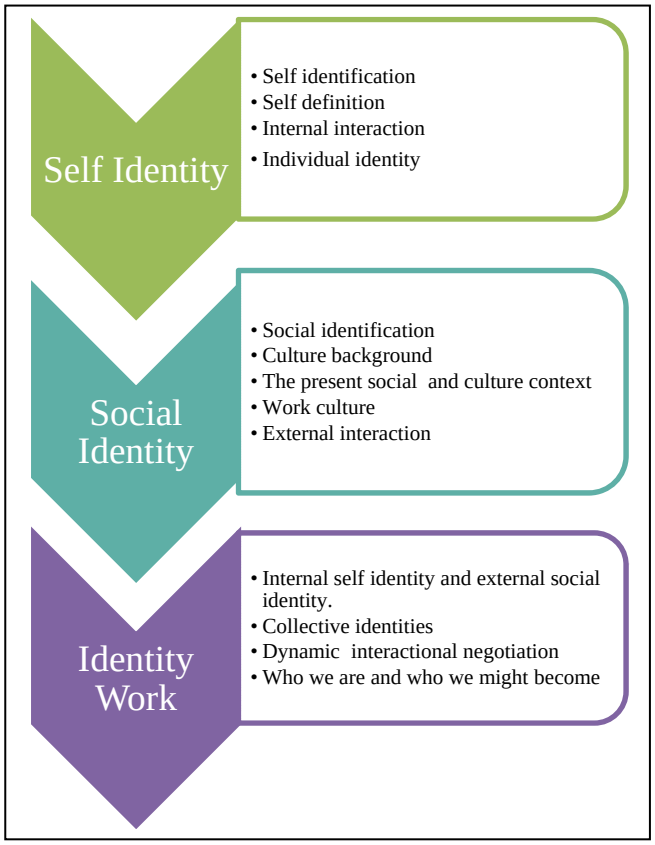


Figure 4: Redefining identity work

Nurse educator work was but one role in the life of the study participants. In different contexts, at different times, a participant was an educator, wife mother. Thus the two perspectives which contribute to an understanding of the self and in this case of the nurse educator are "agency and social structure" [12, p.135].

In terms of agency the participants were actively engaged in the construction of their role in student clinical education. .Although individuals took on responsibilities as described for them and performed roles given to them [12] as nurse educators, they brought their own meanings to work organization and thus their work orientation changed over time [55].

Where social structure was concerned each nurse educator assumed an identity definition based on the salient individual and social identities. In terms of redefinition of role, both faculty and hospital, nurse educators appeared to interact with nursing students in different ways. Where nurse educators perceived student clinical education as a primary responsibility interaction with students was given priority. On the contrary, where educators were positioned within the hospital, student clinical education was a lesser concern. Stone [52] argued that where individuals have different aims, the process of self-definition or behaviors will be individually constructed. It might also be assumed that where occupational groups have shared aims then work actives will be shared.

Thus, identity work is a social activity which serves the particular needs of an individual(s) within a social group or/and a common needs of the group [53].

More broadly and of significance is that, within a globalising world, Saudi Arabia retains a distinctive social and cultural structure. Historically, Saudi women have been constructed as subservient to men and dependent on the protection of men [63], [64]. Although women's paid work in Islam is not forbidden, Saudi women traditionally have worked in positions perceived as women's work such as in gendered schools and other institutions. The introduction of women into the health care field, including nursing, has taken place incrementally [65]. A contributing factor is that males have governance over all major decisions and females are subjects of those decisions.

As such and in the research context, a male may insist that wife or daughter, as a nurse, not work on weekends or at night and not work with males. Women usually acquiesce to such wishes or demands in order to ensure good relationships within the home. The strictly gendered role in Saudi Arabia also influences non-Saudi nurse educators. Working in Saudi Arabia may produce conflict, prejudice, and misunderstanding between non- Saudi nurse educators and others including patients, Saudi students, Saudi staff and management. Restrictive customs in Saudi Arabia such as practicing only Islam may also exacerbate tensions.

In addition to social and cultural aspects there are additional political issues in Saudi Arabia which contribute to the redefining of identity work for both national and non-national nurse educators. One factor is the Saudisation of the nursing workforce policy designed to relieve the dependency on foreign workers which, to be successful, would require a transformation in social perceptions of the nursing role. In addition it may increase the insecurity for non-nationals as nationals are recruited into tenure-track and the non-nationals employed on annual renewable contracts [66]. Identity work is thus complex and unpredictable [54] for both national and non-national nurse educators where experiences are mediated through cultural, social and political experiences.

## VII. IMPLICATIONS AND RECOMMENDATIONS

### *Implications and recommendations for practice*

An implication of this study is that the role of nurse educator in student clinical education is flexible, arbitrary and as such largely undefined. A lack of clarity combined with role ambiguity leads to frustration and confusion. It is desirable that both faculty and hospital nurse educators have access to role descriptions in student clinical education. In addition, effective communication on student clinical education between hospital and facility educators is essential to effective student learning processes and outcomes. This communication should exceed memos and official documentation as is current practice.

The findings of this study also have implications for policy making in Saudi Arabia in regard to student clinical education. It is recommended that hospital and university leaders should clearly define the objectives of student clinical education. This will allow hospital and faculty nurse educators to better collaborate and to avoid unnecessary confusion and conflict. Defined roles for nurse educators will enhance the learning process and outcomes for the students and ensure a quality of education.

### *Implications and recommendations for future research*

The sample in this study was limited to two research sites, a university and a hospital, in Jeddah city. It would be interesting to expand the research to other cities in Saudi Arabia. In addition, exploring the role of the nurse educators in student clinical education in private universities and hospitals within Saudi Arabia would contribute to the general understanding in this field.

## References


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

[2] Littlewood, J., & Yousuf, S. (2001). Primary health care in Saudi Arabia: applying global aspects of health for all, locally. *Journal of Advanced Nursing, 32*(3), 675-681.

[3] Halligan, P. (2006). Caring for patients of Islamic denomination: critical care nurses' experiences in Saudi Arabia. *Journal of clinical nursing, 15*(12), 1565-1573.

[4] Luna, L. (1998). Culturally competent health care: a challenge for nurses in Saudi Arabia. *Journal of Transcultural Nursing, 9*(2), 8.

[5] Al-Osaimi, M. (1994). *Nursing in Saudi Arabia*. Jeddah: King Fahd National Library.

[6] Tumulty, G. (2004). Professional development of nursing in Saudi Arabia. *Journal of Nursing Scholarship, 33*(3), 285-290.

[7] Miller-Rosser, K., Chapman, Y., & Francis, K. Historical. (2006). Cultural, and contemporary influences on the status of women in nursing in Saudi Arabia. *OJIN: The Online Journal of Issues in Nursing, 11*(3).

[8] Abu-Zinadah, S. (2006). *Nursing situation in Saudi Arabia*. Riyadh, Saudi Arabia: Saudi Council for Health Specialties. Retrieved June 4, 2010, from Nursing Symposium.

[9] Reynolds, L. T., & Herman-Kinney, N. J. (2003). *Handbook of symbolic interactionism.* Walnut Creek, CA: AltaMira Press.

[10] Stryker, S., Owens, T. J., & White, R. W. (2000). *Self, identity, and social movements* Minneapolis ; London University of Minnesota Press.

[11] Stryker, S. (1980). *Symbolic interactionism: A social structural version*. Menlo park: Benjamin / Cummings.

[12] Stets, J. E., & Burke, P. J. (2003). A sociological approach to self and identity. In M. Leary & J. Tangney (Eds.), *Handbook of Self and Identity*. Forthcoming: Guilford Press.

[13] Glaser, B. (1978). *Theoretical Sensitivity*. Mill Valley, CA: The Sociology Press.

[14] Glaser, B., & Strauss, A. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago, CA: Aldine.

[15] Strauss, A., & Corbin, J. (1990). Basics of qualitative research: grounded theory procedures and techniques. Newbury Park, Calif Sage.

[16] Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing,* 31(6), 1476-1484. Retrieved March 10, 2009 from Current Contents Connect.

[17] Cutcliffe, J. R. (2005). Adapt or adopt: developing and transgressing the methodological boundaries of grounded theory. *Journal of Advanced Nursing,* 51(4), 421-428.

[18] Glaser, B. G. (1992). Emergence vs forcing: basics of grounded theory analysis, Calif Sociology Press.

[19] Glaser, B. G. (2001). The grounded theory perspective: conceptualization contrasted with description, Mill Valley Sociology Press.

[20] Wilson, H. S., & Hutchinson, S. A. (1996). Methodological Mistakes in Grounded Theory: is there a difference? Journal of Advanced Nursing, 31(6), 1485-1492.

[21] Strauss, A. (1991). *Qualitative Analysis for Social Scientists*. Cambridge: Cambridge University Press.

[22] Strauss, A. a. Corbin, J. (1994). Grounded theory methodology: an overview. In N. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research*. Thousand Oaks, Calif: Sage Publications.

[23] Charmaz K. (2000) Grounded theory. Objectivist and constructivist methods. In: *Handbook in Qualitative Research*, 2nd edn (eds N.K. Denzin & Y.S. Lincoln), pp. 509–535. Sage, Thousand Oaks, London, New Delhi.

[24] Cast, A. D., & Burke, P. J. (2002). A theory of self-esteem. *Social Forces, 80*(3), 1041-1068.

[25] Ervin, L. H. & Stryker, S. (2001). Theorizing the relationship between self-esteem and identity. In T. J. Owens, S. Stryker, & N. Goodman (Eds.), *Extending self-esteem theory and research* (pp. 29–55). Cambridge: Cambridge University Press.

[26] Owens, T. J. & Serpe, R. T. (2003). The role of self-evaluation in identity salience and commitment. In P. J. Burke, T. J. Owens, R. T. Serpe, and P. A. Thoits (Eds.), *Advances in identity theory and research* (pp. 85–104). New York: Kluwer Academic/Plenum.

[27] James, W. (1890). *The Principles of Psychology*. Boston: Duxbury Press.

[28] Hogg, M. A., & Terry, D. J. (2000). Social identity and self-categorization processes in organizational contexts. *Academy of Management Review, 25*(1), 121-140.

[29] Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup conflict. In *Psychology of intergroup relations*, (pp. 7–24). *Nelson-Hall, Chicago*.

[30] Bergami, M., & Bagozzi, R. P. (2000). Self-categorization, affective commitment and group self-esteem as distinct aspects of social identity in the organization. *British Journal of Social Psychology, 39*(4), 555-577.

[31] Cornelissen, J. P., Haslam, S. A., & Balmer, J. M. (2007). Social identity, organizational identity and corporate identity: Towards an integrated understanding of processes, patternings and products. *British Journal of Management, 18*, 1.

[32] Ahmad, Z., & Taylor, D. (2009). Commitment to independence by internal auditors: the effects of role ambiguity and role conflict. *Managerial Auditing Journal, 24*(9), 899-925.

[33] Tubre, T. C., & Collins, J. M. (2000). Jackson and Schuler (1985) revisited: A meta-analysis of the relationships between role ambiguity, role conflict, and job performance. *Journal of Management, 26*(1), 155.

[34] Mead, G. H. (1934). Mind, self, and society from the standpoint of a social behaviorist. Chicago: University of Chicago.

[35] Stryker, S., & Burke, P. J. (2000). The past, present, and future of an identity theory. *Social Psychology Quarterly, 63*(4), 284-297.

[36] Burke, R. J., & Belcourt, M. L. (1974). Managerial role stress. *Journal of Business Administration, 5*, 55}68.

[37] Schwab, R. L., & Iwanicki, E. F. (1982). Perceived role conflicts, role ambiguity and teacher burnout. *Educational Administration Quarterly, 18*, 263-269.

[38] Ramage C. (2004) Negotiating multiple role: link teachers in clinical nursing practice. Journal of Advanced Nursing 45(3), 287–296.

[39] Hardy, M. & Conway, M. (Eds) .(1988). *Role Theory: Perspectives for Health Professionals* (2nd edn) Appleton and Lange, California.

[40] Bozionelos, N. (2009). Expatriation outside the boundaries of the multinational corporation: A study with expatriate nurses in Saudi Arabia. *Human Resource Management, 48*(1), 111-134.

[41] Tumulty, G. (2001). Professional development of nursing in Saudi Arabia. *Journal of Nursing Scholarship, 33*(3), 285-290

[42] Turner, R. H. (1978). The role and the person. *American Journal of Sociology, 84*(1), 1-23.

[43] Chang. E. & Hancock. K. (2003). Role stress and role ambiguity in new nursing graduates in Australia, *Nursing & Health Sciences* 5(2): 155–63.

[44] Lambert. V. & Lambert. C. (2001). Literature review of role stress/strain on nurses: An international perspective, *Nursing & Health Sciences* 3(3): 161–72.

[45] Majomi. P, Brown. B.E. & Crawford. P. (2003). Sacrificing the personal to the professional: Community mental health nurses, *Journal of Advanced Nursing* 42(5): 527–38.

[46] Henning, J., & Weidner, T. (2008). Role strain in collegiate athletic training approved clinical instructors. *Journal Information, 43*(3).

[47] Lois, J. (2006). Role Strain, Emotion Management, and Burnout: Homeschooling Mothers' Adjustment to the Teacher Role. *Symbolic Interaction, 29*(4), 507-530.

[48] Schuler, R., Aldag, R. & Brief, A. (1977). Role conflict and ambiguity: A scale analysis, *Organisational Behaviour and Human Performance* 20: 111–28.

[49] Cooley, C. H. (1902). Looking-glass self. *Human Nature and the Social Order*, 179-185.

[50] Blumer, H. (1986). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, N.J.: Prentice-Hall.

[51] Schwalbe, M., & Mason-Schrock, D. (1996). Identity work as group process. *Advances in group processes, 13*, 113-147.

[52] Stone, L. (1981). *The past and the present*: Routledge; Thoemms Press.

[53] Snow, D. A., & Anderson, L. (1987). Identity work among the homeless: The verbal construction and avowal of personal identities. *American Journal of Sociology, 92*(6), 1336-1371.

[54] Snow, D. (2001). Collective identity and expressive forms. In *international Encycloedia of the Social and Behavioral Sciences*,ed.Neil, J. Smelser and Paul, B. Baltes, 2212-19. Oxford: Pergamon Press.

[55] Einwohner, R.L. & Myers, D.J. (2008). Identity work in social movements. University of Minnesota Press: Minneapolis.

[56] Stryker, S. (2007). Identity theory and personality theory: Mutual relevance. *Journal of personality, 75*(6), 1083.

[57] Stryker, S. (2004). Integrating emotion into identity theory. *Advances in group Processes, 21*, 1-23.

[58] Burke, P. J. (1980). The self: Measurement requirements from an interactionist perspective. *Social Psychology Quarterly, 43*(1), 18-29.

[59] Burke, P. J. (1991). Identity processes and social stress. *American Sociological Review*, 836-849.

[60] Burke, P. J., & Tully, J. C. (1977). The measurement of role identity. *Social Forces, 55*(4), 881-897.

[61] McCall, G. J., & Simmons, J. L. (1978). *Identities and interactions: An examination of human associations in everyday life*: Free Press London: Collier Macmillan, New York.

[62] Goffman, E. (1983). Felicity's condition. *American Journal of Sociology, 89*(1), 1-53.

[63] Ochsenwald, W. (2009). Saudi Arabia and the Islamic revival. *International Journal of Middle East Studies, 13*(03), 271-286.

[64] Vidyasagar, G., & Rea, D. M. (2004). Saudi women doctors: gender and careers within Wahhabic Islam and a [`]westernised' work culture. *Women's Studies International Forum, 27*(3), 261-280.

[65] Mitchell, J. (2009). Job satisfaction and burnout among foreign-trained nurses in Saudi Arabia: A mixed-method study. Ed.D. dissertation, University of Phoenix, United States -- Arizona.

[66] Mazawi, A. (2005). The Academic Profession in a Rentier State: The Professoriate In Saudi Arabia. *Minerva, 43*(3), 221-244.

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