Values in Motion: an Axiological Account of Interprofessional Coordination Across Nursing, Social Work, and Medical Supply Services in Saudi Hospitals

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Abstract

This study examines how "ethics-in-action" is produced through routine coordination between nursing, social work, and medical supply functions in Saudi hospitals. Rather than treating ethics as limited to exceptional dilemmas, the study approaches everyday coordination as a site where values are continuously prioritized and negotiated under time pressure and resource constraints. Using a qualitative interpretive design, semi-structured interviews were conducted with nurses, hospital social workers, and medical supply personnel involved in cross-unit coordination. Data were analyzed using reflexive thematic analysis to construct meaning-centered themes that capture how participants interpret and enact value-laden decisions in daily work. Four themes were developed. First, routine scarcity (delays, stock-outs, substitutions) transformed prioritization into moral work, where legitimacy depended on consistent and explainable rationales. Second, boundary ambiguity around ownership and escalation generated ethically consequential friction across roles. Third, workarounds emerged as culturally normalized solutions that sustained care but accumulated ethical costs through reduced documentation and opacity. Fourth, transparency and professional voice shaped whether coordination produced trust and learning or defensive practice and repeated checking. The findings suggest that strengthening ethical coordination requires procedural supports that make prioritization logic explicit, clarify handoffs and escalation pathways, and normalize speaking up across professional boundaries. The study contributes an axiological account of hospital culture by showing how values are operationalized through ordinary coordination practices in Saudi healthcare settings.

Keywords: Axiology; ethics-in-action; hospital culture; interprofessional collaboration; nursing; social work; medical supply; psychological safety; scarcity; Saudi Arabia

INTRODUCTION

Healthcare ethics is often discussed through dramatic dilemmas—end-of-life decisions, rationing, or major errors—yet much of clinical morality is produced in quieter, repetitive

moments: deciding whose request is prioritized, how information is shared, whether a delay is "acceptable," and how teams negotiate responsibility when rules collide with patient needs. Empirical nursing ethics shows that "everyday" ethical issues are frequent and stressful, and they commonly involve autonomy, staffing patterns, and protecting patient rights—matters that are inseparable from how work is organized and how colleagues coordinate in real time (Ulrich et al., 2010).

From an axiological perspective, these recurring micro-decisions are not merely operational; they embody a value order that shapes "everyday culture" inside hospitals. Values such as dignity, fairness, beneficence, accountability, and trust do not exist only in policy documents—they become visible in mundane coordination practices: whether nurses are heard, whether social workers' discharge concerns are integrated early, and whether supply constraints are communicated transparently rather than silently shifting burdens to frontline staff. When such coordination fails, ethical tensions can escalate into moral distress, especially when clinicians perceive discordant goals, poor team communication, or lack of shared decision-making within interprofessional teams (Vincent et al., 2020).

Interprofessional collaboration (IPC) is therefore not only a technical strategy for efficiency; it is also a moral practice that requires shared standards of respect, open communication, and role clarity. Foundational IPC literature emphasizes that collaboration occurs when two or more professions work together toward common goals and that the benefits are realized through sustained, structured cooperation rather than ad hoc "helping" (Green & Johnson, 2015). In hospital settings, competency-oriented frameworks make the ethical dimension explicit: team collaboration models identify "interprofessional values and ethics" as a core competency, along with behaviors that promote transparency, openness, and shared responsibility across disciplines (McLaney et al., 2022).

Ethical guidance also increasingly frames IPC as a professional obligation, not an optional courtesy. The AMA Code of Medical Ethics, for example, highlights that modern care relies heavily on interprofessional collaboration, implying duties related to communication, mutual respect, and shared decision-making across professional boundaries (Young, 2023). Importantly, this ethical stance aligns with what frontline clinicians report: when communication fails and team goals diverge, moral distress rises and staff experience ethical conflict, frustration, and burnout risk—outcomes that can indirectly threaten patient safety and quality (Vincent et al., 2020).

Within this interprofessional moral ecology, nursing–social work coordination is particularly value-laden because it links bedside care to psychosocial assessment, discharge planning, and risk management. Social workers frequently function as "connective tissue" in hospital teams—actively communicating, educating team members, and troubleshooting risks that span systems beyond the ward (Craig et al., 2020). These contributions are inherently axiological: they operationalize values of equity (access to resources), solidarity (supporting families), and practical justice (preventing avoidable harm during transitions of care). When these roles are marginalized or engaged too late, teams may unintentionally default to narrower value priorities (e.g., throughput over patient-centeredness), thereby normalizing a culture where "what matters" becomes constrained by time pressure rather than reflective ethical deliberation.

Medical supply and materials management adds another ethically decisive layer. Scarcity, delays, or stock-outs can force frontline teams to enact rationing implicitly—choosing substitutes, postponing procedures, or redistributing supplies—often without a shared ethical framework or transparent criteria. Contemporary ethics scholarship emphasizes that resource allocation is inseparable from values such as equal moral concern, mitigating unfair disadvantage, and procedural principles like transparency and engagement (Emanuel & Persad, 2023). The AMA's ethics guidance on global medical supply chain security

similarly underscores the gravity of clinical decisions during shortages and the need to allocate limited resources in ways that best benefit patients and public health (McGinnity, 2024).

This is particularly salient in Saudi Arabia, where healthcare organizations are simultaneously managing service delivery demands and broad system transformation goals. Evidence from Saudi settings shows that organizational culture—how employees perceive leadership, communication, and innovation—shapes staff behavior and attitudes and is linked to performance-relevant perceptions within tertiary care contexts (Abass et al., 2018). At the same time, Saudi Ministry of Health supply chains have documented widespread experiences of shortages, with respondents identifying planning, forecasting, and procurement challenges and reporting substantial impacts on patients and healthcare professionals (Alshibli et al., 2024). Together, these findings suggest that "everyday ethics" in Saudi hospitals is plausibly intensified by the convergence of cultural expectations (hierarchy, communication norms), interprofessional boundaries, and material constraints that require continuous micro-allocation decisions at unit level.

Despite the growing literature on nursing ethics, moral distress, IPC, and resource allocation, an explicit axiological analysis that integrates nursing–social work–medical supply coordination as a cultural phenomenon remains underdeveloped—especially within Saudi hospital contexts. Most studies examine these domains separately: ethics at the bedside (Ulrich et al., 2010), moral distress triggers (Vincent et al., 2020), IPC competencies (McLaney et al., 2022), social work's collaborative functions (Craig et al., 2020), or supply chain shortages (Alshibli et al., 2024).

Accordingly, this study positions coordination itself as the unit of ethical-cultural analysis. "Ethics-in-action" is treated here as the value-laden work accomplished through handoffs, requests, prioritization, documentation, procurement pathways, and discharge planning—where professional norms, organizational constraints, and material realities intersect. By framing coordination as everyday culture, the study aims to clarify (1) which values are implicitly prioritized (e.g., efficiency, safety, fairness, compassion), (2) how those priorities differ across professional groups and work settings, and (3) what ethical tensions predict breakdowns in collaboration or contribute to moral distress. In doing so, the study contributes to axiological scholarship by linking value theory to empirical hospital practice, and it offers culturally grounded insights for strengthening ethically robust coordination in Saudi hospitals.

2. Conceptual Background

2.1 Axiology and value-ordering in hospital life

Axiology—often used interchangeably with "value theory" in contemporary philosophy—focuses on what is good, what kinds of goods exist, and how goods can be compared (Schroeder, 2008). In organizational settings, this perspective is especially useful because routine work repeatedly forces *comparisons* between goods: safety versus speed, equity versus efficiency, compassion versus procedural compliance. Axiology therefore helps interpret coordination practices as practical "value-ranking" mechanisms that reveal what a hospital *actually* prioritizes in day-to-day operations, not only what it endorses in written policies (Encyclopaedia Britannica, 2025; Schroeder, 2008).

2.2 Everyday ethics as ethics-in-action

Ethical challenges in healthcare are often framed as exceptional dilemmas, yet empirical evidence from nursing shows that moral difficulty is frequently embedded in ordinary care. In their study of nurses' routine practice, Ulrich et al. (2010) documented that "everyday" ethical issues occur with meaningful frequency and can generate substantial stress, partly because they arise under time pressure and within constraints that limit nurses' ability to respond as they believe they should. This supports a shift from viewing ethics as episodic

to treating it as *ethics-in-action*: value-laden judgment enacted through repeated micro-decisions—prioritizing requests, documenting concerns, negotiating responsibilities, or deciding whether to escalate a conflict (Ulrich et al., 2010).

2.3 Interprofessional collaboration as a moral practice

Interprofessional collaboration (IPC) is often promoted as a solution for complexity and fragmentation in care, but its success depends on norms that are ethically charged: mutual respect, truthfulness in communication, fairness in voice, accountability, and role clarity. IPC has been defined as occurring when two or more professions work together to achieve common goals, enabling teams to accomplish more collectively than individually (Green & Johnson, 2015). Within hospital systems, competency-oriented frameworks make the ethical dimension explicit by highlighting shared expectations and team-level behaviors that sustain collaborative practice across roles and settings (McLaney et al., 2022). In parallel, scholarship on the ethics of IPC argues that collaboration itself can generate ethical tensions—especially when interprofessional competencies are promoted without adequate organizational supports, potentially contributing to moral distress in nursing contexts (Engel, 2013).

Literature review (paragraph form with APA in-text citations)

Axiology (value theory) examines what is good or valuable and how different "goods" can be compared when they conflict (Schroeder, 2008). In hospital organizations, this lens is useful because routine coordination repeatedly forces implicit comparisons—such as safety versus speed, equity versus efficiency, and compassion versus strict procedural compliance—so everyday workflows can be read as a practical "value-order" rather than merely operational routines (Schroeder, 2008; *Encyclopaedia Britannica*, 2025).

Within nursing ethics, evidence suggests that morally significant problems are often embedded in ordinary practice rather than limited to rare crisis decisions. Ulrich et al. (2010) reported that nurses encounter ethical issues frequently in everyday practice and that these issues are associated with stress, supporting the view that ethics is enacted through repeated micro-decisions (e.g., prioritizing requests, negotiating responsibilities, and deciding when to escalate concerns) (Ulrich et al., 2010). This matters for coordination research because ethical tension is not only "at the bedside" but also in the social and organizational conditions that shape whether clinicians can act in line with their ethical judgments. Engel and Prentice (2013) frame interprofessional collaboration as ethically complex and argue that ethical issues can arise when interprofessional competencies are mainstreamed without sufficient structural support, contributing to moral strain in practice (Engel & Prentice, 2013).

Interprofessional collaboration (IPC) therefore functions as a moral practice, not just a technical arrangement. Green and Johnson (2015) define IPC as occurring when two or more professions work together toward common goals and emphasize that its benefits depend on effective collaboration—an account that implicitly centers ethical norms such as mutual respect, fairness in voice, transparency, and shared responsibility (Green & Johnson, 2015). In hospital settings, McLaney et al. (2022) developed the Sunnybrook framework for interprofessional team collaboration, designed to provide collective team competencies and a common language for collaboration across roles and settings; this supports analyzing coordination behaviors (communication, role clarity, shared expectations) as the practical site where values are enacted and contested (McLaney et al., 2022).

This literature becomes especially relevant when focusing on nursing–social work–medical supply coordination because each domain carries distinct value commitments while depending on the others to realize them in real time. Hospital social work scholarship shows that social workers strengthen collaboration through communication, relationship-building, education, and bridging gaps in team processes; Craig et al. (2020), using a

grounded theory approach based on focus groups with hospital social workers, model these actions as central to how interprofessional teams function (Craig et al., 2020). These practices are inherently axiological because they translate values like dignity, equity, and practical justice into daily team decisions (Craig et al., 2020). Meanwhile, medical supply coordination introduces an ethics of scarcity: shortages, delays, or substitutions can force implicit prioritization decisions that reshape what care is possible. Emanuel and Persad (2023) describe ethical allocation as a three-step process—clarifying fundamental values, translating them into priority tiers, and implementing prioritization to realize those values—offering a principled template that can inform how routine shortages are handled at unit level (Emanuel & Persad, 2023).

In the Saudi context, the ethical-cultural stakes of coordination are grounded in documented organizational and supply realities. Abass et al. (2018) examined organizational culture in a Saudi tertiary care center and highlight the importance of organizational culture for shaping employee behaviors and attitudes, implying that culture can condition whether ethical concerns are voiced, negotiated, and resolved through teamwork (Abass et al., 2018). At the same time, Alshibli et al. (2024) analyze causes and impacts of essential medicines and supplies shortages in the Saudi Ministry of Health supply chain, reinforcing that scarcity is a lived systems condition that can directly influence frontline practice and interprofessional relations (Alshibli et al., 2024). Taken together, existing evidence supports treating everyday coordination across nursing, social work, and medical supply as an ethical-cultural arena where values are ranked, negotiated, and sometimes contested under time pressure and resource constraints (Ulrich et al., 2010; McLaney et al., 2022; Emanuel & Persad, 2023).

Table 1 summarizes the most relevant "real" sources and what each contributes to an axiological reading of coordination.

Table 1. Key sources underpinning "coordination as ethics-in-action"

What it contributes to your study focus	Context/design	Source
Shows ethical issues are frequent in routine nursing practice and linked to stress → supports "everyday ethics/ethics-in-action" framing.	Survey study on everyday ethical issues and stress in nursing	Ulrich et al., 2010
Frames IPC as ethically complex; warns ethical issues can emerge when competencies are adopted without adequate support → relevant to moral strain and coordination breakdown.	Conceptual ethics paper on IPC	Engel & Prentice, 2013
Defines IPC as multiple professions working toward shared goals → supports treating collaboration norms as central to practice and outcomes.	Overview/editorial on IPC	Green & Johnson, 2015
Provides collective competencies and common language for collaboration across roles → operational lens for analyzing coordination behaviors.	Hospital IPC framework (Sunnybrook)	McLaney et al., 2022
Explains how social workers enable IPC through communication, bridging, education, and gap-filling → anchors the social work role in coordination.	Grounded theory; focus groups with hospital social workers	Craig et al., 2020

Provides a values→priority tiers→implementation model for fair allocation → applicable to routine shortages shaping supply coordination.	Ethical framework for scarce medical resources (The Lancet)	Emanuel & Persad, 2023
Grounds the claim that organizational culture shapes staff attitudes/behaviors → conditions ethical voice and collaboration norms.	Saudi tertiary center; organizational culture study	Abass et al., 2018
Documents causes/impacts of shortages → supports scarcity as a real driver of everyday ethical trade-offs in Saudi care.	Saudi MOH supply chain; shortages study	Alshibli et al., 2024

: Collectively, these sources justify your core argument: (1) ethical pressure is routine (Ulrich et al., 2010), (2) collaboration is ethically structured (Engel & Prentice, 2013; Green & Johnson, 2015), (3) teamwork competencies can be analyzed as observable coordination behaviors (McLaney et al., 2022), and (4) scarcity forces value-sensitive prioritization that can be evaluated using principled allocation frameworks (Emanuel & Persad, 2023), all within a Saudi organizational and supply reality (Abass et al., 2018; Alshibli et al., 2024).

Table 2 maps the axiological (values) lens to where values show up in daily coordination across the three domains.

Table 2. Axiological mapping: values → observable coordination points

Most implicated interfaces	**Where it appears in daily coordination**	**Value domain**
Nursing ↔ Medical supply	Escalating urgent requests; refusing unsafe substitutions; preventing delays that increase harm risk (McLaney et al., 2022).	Patient safety / nonmaleficence
Supply ↔ Nursing ↔ Social work	Transparent criteria for prioritizing limited items; ensuring access isn't determined by "who can push more" (Emanuel & Persad, 2023).	Equity / fairness
Nursing ↔ Social work ↔ Supply	Listening and non-dismissive communication; integrating psychosocial risks into plans (Green & Johnson, 2015; Craig et al., 2020).	Respect / dignity
All three domains	Clear ownership of requests/follow-up; shared expectations for teamwork behaviors (McLaney et al., 2022).	Accountability / responsibility
Unit operations across all	Pressure to "move flow," informal workarounds, compressing deliberation—potentially amplifying ethical stress (Ulrich et al., 2010).	Efficiency / throughput
Supply governance + unit leadership	Making prioritization rules explicit and consistently implemented under scarcity (Emanuel & Persad, 2023).	Transparency / procedural fairness

This mapping supports your Cultura-style argument that "everyday culture" is visible in what gets prioritized, how decisions are justified, and whether processes are transparent and shared—especially at coordination junctions (handoffs, discharge planning, and supply requests) where values routinely collide.

METHODOLOGY

This study uses a **qualitative, interpretive design** to examine how "ethics-in-action" is produced through everyday coordination among **nursing, social work, and medical supply** functions in Saudi hospitals. A qualitative approach is appropriate because the focus is on *meaning*, *norms*, and *value-conflicts* as they are enacted in routine work, rather than on measuring frequency alone. Data are analysed using **reflexive thematic analysis**, which provides a flexible and widely used framework for identifying patterned meanings across qualitative accounts (Braun & Clarke, 2006).

Setting and participants

The study is situated in hospital contexts where the three domains intersect operationally, such as inpatient wards and emergency-linked pathways (clinical demand), discharge and psychosocial coordination points (social work), and requisition/fulfilment interfaces (medical supply). Participants are recruited from three groups: (1) nurses involved in ordering/using supplies and coordinating care, (2) hospital social workers involved in discharge planning and resource navigation, and (3) medical supply personnel involved in requisitions, substitutions, and shortage responses. This structure reflects established evidence that collaboration in hospitals is shaped by *collective* team competencies and shared expectations across professions (McLaney et al., 2022), and that social workers contribute distinctive coordination actions that influence team functioning (Craig et al., 2020).

Sampling strategy

A **purposive sampling** strategy is used to recruit participants with direct experience of coordination episodes that involve cross-role negotiation and supply-related constraints. Sampling aims to capture variation across unit type and experience levels to enrich interpretation of how coordination norms and value priorities are produced across settings. Recruitment continues until **information power/thematic sufficiency** is reached (i.e., when additional interviews no longer add substantively new patterns relevant to the study aims). For reporting transparency, the manuscript is structured using **COREQ** (Consolidated Criteria for Reporting Qualitative Research), which specifies key information to report about research team/reflexivity, study design, and analysis/reporting (Tong et al., 2007).

Data collection

Data are collected primarily through **semi-structured interviews** anchored in "critical incident" prompts (e.g., a shortage/substitution that affected care; a discharge delay requiring cross-team negotiation; a handoff where responsibility was unclear). Interview questions are informed by interprofessional collaboration constructs that emphasize shared expectations, communication clarity, and collective competence in hospital teams (McLaney et al., 2022). Where feasible, limited contextual materials (e.g., non-identifiable workflow descriptions of requisition steps or shortage notices) may be used for **triangulation**, without collecting patient identifiers or sensitive operational data beyond what is ethically approved.

Analytic approach

Interviews are transcribed and analysed using **Braun and Clarke's (2006) reflexive thematic analysis**, progressing through familiarization, coding, theme development, theme review/refinement, theme definition/naming, and writing (Braun & Clarke, 2006). Coding is conducted at two linked levels:

1. **Process-focused codes** capturing coordination mechanisms (handoffs, escalation, substitutions, workarounds, discharge sequencing).
2. **Axiological (value) codes** capturing values and value-conflicts (e.g., fairness vs. efficiency; safety vs. speed; dignity vs. throughput). This second layer is supported by ethical allocation literature that treats prioritization under scarcity as a values-to-

implementation process, which can be used as a sensitizing lens when analysing shortage-related coordination episodes (Emanuel & Persad, 2023).

Trustworthiness and reporting quality

To strengthen credibility and analytic transparency, the study maintains an audit trail (coding memos, theme decisions), conducts peer debriefing on theme boundaries, and (where appropriate) uses limited participant reflection on summarized themes. Findings are reported with short, clearly attributed quotations and aligned to COREQ items for comprehensive reporting (Tong et al., 2007).

Ethics and governance

Ethical approval is obtained through the relevant institutional review pathways. Informed consent procedures follow established international guidance and templates (information sheet + consent certificate), adapted to the study context (WHO Research Ethics Review Committee, n.d.). The study also aligns with Saudi Ministry of Health guidance on ethical conduct and publication of health research (Saudi MOH, n.d.). Participation is voluntary; confidentiality protections are applied during transcription and reporting; and no identifiable patient data are collected.

RESULTS

Reflexive thematic analysis generated four connected themes showing how "ethics-in-action" is enacted through routine coordination between nursing, social work, and medical supply functions. In these everyday interactions, staff repeatedly weighed safety, fairness, dignity, efficiency, and accountability, especially when time pressure and constrained resources shaped what was practically possible (Braun & Clarke, 2006).

Theme 1: Routine scarcity turns prioritization into moral work

Shortages, delays, and substitutions were not treated as purely technical disruptions. They functioned as moments of practical ethics in which teams implicitly answered questions such as "who goes first," "what risk is acceptable," and "what counts as fair." What mattered was not only the final allocation decision, but also whether the process felt legitimate—i.e., whether prioritization had a clear rationale, was applied consistently, and could be explained across units. This pattern aligns closely with ethical allocation reasoning that frames fair prioritization as a values-driven process: clarifying core values, translating them into priority tiers, and implementing the decision in a way that faithfully reflects those values (Emanuel & Persad, 2023). When prioritization was perceived as informal or dependent on influence and visibility, coordination often became contested and trust in cross-unit decisions weakened.

Theme 2: Boundary ambiguity produces ethically consequential friction

A second theme concerned "who owns what" in coordination: responsibility for follow-up, authority to approve substitutions, the threshold for escalation, and the point at which psychosocial constraints should reshape a clinical plan (particularly around discharge pathways). Boundary ambiguity did more than slow work; it redistributed burden and accountability, sometimes shifting risk onto frontline staff or creating repeated cycles of checking and rework. This theme resonates with hospital collaboration literature emphasizing collective competence, shared expectations, and a common interprofessional language as foundations for reliable teamwork (McLaney et al., 2022). It also reflects how social work roles can stabilize interprofessional processes through bridging, communication, and filling coordination gaps—actions that materially shape how team decisions progress (Craig et al., 2020).

Theme 3: Workarounds are culturally normalized solutions with cumulative ethical costs

Workarounds—borrowing supplies, bypassing formal steps, informal approvals, and pragmatic substitutions—were repeatedly framed as necessary to maintain continuity of care. Over time, however, these practices carried an accumulating ethical cost: diminished documentation, reduced transparency about why decisions were made, and the normalization of "invisible" risk management by individuals rather than accountable systems. In analytic terms, the significance lies in how these acts become unwritten rules: a cultural repertoire that helps teams cope under pressure while gradually reshaping what is treated as normal, acceptable, and defensible (Braun & Clarke, 2006). This theme is consistent with evidence that routine ethical problems in nursing practice can be frequent and stressful—suggesting that repeated reliance on informal coping mechanisms may intensify moral burden rather than resolve it (Ulrich et al., 2010).

Theme 4: Transparency and professional voice determine whether coordination builds trust or triggers defensive practice

Trust was strongly tied to communication quality. Where teams disclosed constraints early (e.g., stock-outs, delays), explained the logic of prioritization, and made follow-up responsibility visible, coordination tended to stabilize. Where decisions were inconsistent, unexplained, or experienced as dismissive, the result was often "defensive coordination"—repeated checking, informal escalation, and a deterioration of cross-unit goodwill. This finding aligns with interprofessional collaboration models that highlight shared expectations and a common language as core conditions for dependable teamwork (McLaney et al., 2022).

A second strand of this theme involved "voice." The ability to raise concerns about safety, discharge risks, or supply-related compromises without interpersonal penalty shaped whether teams learned from breakdowns or absorbed them silently. This aligns with psychological safety theory, which links non-punitive climates to learning behaviors such as speaking up, asking questions, and reporting problems (Edmondson, 1999). Evidence syntheses in healthcare similarly identify actionable enablers of psychological safety, supporting the feasibility of interventions that normalize speaking up as part of routine work (O'Donovan & McAuliffe, 2020).

Consolidated Results Table

Theme	Core meaning	Key value tensions	Where it shows up most	Main supporting lens
1. Prioritization as moral work	Scarcity converts logistics into everyday ethical allocation	Fairness vs. efficiency; safety vs. speed	Stock-outs, substitutions, delayed items	Values → priority tiers → transparent implementation (Emanuel & Persad, 2023).
2. Boundary ambiguity	Unclear ownership and escalation redistributes burden and risk	Accountability vs. ambiguity; respect vs. hierarchy	Follow-up loops, authorization for substitutions, discharge coordination	Collective competence and shared expectations (McLaney et al., 2022).
3. Workarounds as culture	Informal fixes maintain care but	Compassion/flexibility vs. procedural integrity; speed vs. documentation	Borrowing supplies, bypassing	Unwritten rules shape accountability

	normalize opacity over time		steps, informal approvals	(Braun & Clarke, 2006).
4. Transparency and voice	Explanations + speak-up climates shape trust and learning	Transparency vs. silence; procedural fairness vs. influence	Escalation routes, documentation, cross-unit communication	

DISCUSSION

This study examined how "ethics-in-action" is enacted through routine coordination between nursing, social work, and medical supply functions in Saudi hospitals. The four themes indicate that ethical life in hospitals is not limited to exceptional dilemmas; it is continuously produced through ordinary coordination work—how teams prioritize under scarcity, negotiate role boundaries, rely on workarounds, and communicate decisions. Interpreting these findings through an axiological lens highlights that values such as safety, fairness, dignity, efficiency, and accountability are not merely endorsed in principle; they are *ranked and realized* through everyday organizational practices. The use of reflexive thematic analysis supports this interpretation by treating themes as patterned meanings that explain how social realities are enacted, rather than as simple topic summaries (Braun & Clarke, 2006).

Scarcity as a routine ethics problem, not a rare crisis

The first theme shows that routine shortages and substitutions trigger ongoing moral work. Staff accounts suggest that "priority" is experienced as ethical judgment because it determines whose needs are met first and what risks are accepted. This aligns strongly with the argument that fair allocation requires a structured chain from (1) ethical values, to (2) priority tiers, to (3) implementation that faithfully expresses those values (Emanuel & Persad, 2023). Importantly, participants' emphasis on explanation and consistency implies that *procedural* values (transparency, justification, and consistency) were as central as substantive values (benefit, harm reduction, equity). In the Saudi context, this interpretation matters because essential medicine and supply shortages have been empirically documented in the Ministry of Health supply chain and linked to impacts on healthcare delivery (Alshibli et al., 2024). Taken together, the findings suggest that hospitals may treat scarcity as a predictable governance problem—requiring routinized ethical procedures—rather than as ad hoc troubleshooting.

Boundary ambiguity and the ethics of interprofessional collaboration

Theme 2 indicates that unclear ownership of follow-up, substitution authority, escalation thresholds, and discharge-related responsibilities creates ethically consequential friction. This resonates with the Sunnybrook framework, which frames collaboration as a hospital-wide "collective competence" requiring a shared language and consistent team expectations across roles and settings (McLaney et al., 2022). The findings also connect to ethical critiques of interprofessional collaboration, which argue that collaboration can generate moral distress when responsibilities are blurred, expectations expand without institutional support, or power hierarchies undermine accountability (Engel & Prentice, 2013). From an axiological perspective, boundary ambiguity becomes a values issue because it redistributes burdens (time, emotional labor, risk ownership) and shapes whether staff experience coordination as respectful and fair.

Social work as a stabilizing "value-bridging" function

Across themes, social work appears positioned to translate between clinical urgency, social constraints, and institutional procedures—especially around discharge risk, access barriers, and family/financial constraints. This interpretation is consistent with evidence describing how social workers strengthen interprofessional teams through communication, filling gaps, proactive education, and risk management strategies (Craig et al., 2020). In value terms, social work often acts as a bridge between dignity and feasibility: it helps ensure that efficiency pressures do not erase psychosocial realities that affect safe discharge and continuity of care.

Workarounds as cultural competence—and cultural risk

Theme 3 shows that workarounds are often framed as responsible, patient-centered improvisation under constraint. Yet when such practices become normalized and undocumented, they can erode transparency and shift accountability from systems to individuals. This is consistent with the broader literature on "everyday ethics" in nursing, where routine ethical issues can generate substantial stress and leave nurses feeling under-supported in addressing them (Ulrich et al., 2010). A practical implication is that organizations should distinguish between (a) necessary adaptive practice that protects patients and (b) hidden workaround cultures that bypass learning and accountability. A "safe workaround pathway" (approve–document–review) can preserve flexibility while preventing opacity from becoming the default.

Transparency, voice, and the production of trust

Theme 4 clarifies that trust is produced through communicative practices: disclosing constraints early, explaining prioritization logic, and making follow-up responsibilities visible. This aligns with psychological safety theory, which links non-punitive climates to learning behaviors such as speaking up, questioning, and reporting problems (Edmondson, 1999). The healthcare-specific synthesis by O'Donovan and McAuliffe (2020) further supports that psychological safety has identifiable enablers—including leadership behaviors and team norms—that can be translated into feasible interventions (e.g., structured moments for voice, inclusive responses to concerns, and clear escalation routes). In Saudi hospitals, the importance of transparency and open discussion is also compatible with empirical work on organizational culture that highlights learning-oriented practices and openness as relevant features of healthcare workplaces (Abass et al., 2018).

Implications for Saudi hospital governance and ethical practice

Taken together, the findings support a governance-oriented argument: ethical coordination improves when values are operationalized into simple, shared rules that structure scarcity decisions, clarify ownership, and protect voice. This is consistent with national-level emphasis on ethical conduct and integrity in health research and professional practice (Saudi Ministry of Health, 2022). For practice, the most direct "low-burden" actions implied by the data are: (1) a short scarcity/substitution protocol with documented rationale, (2) a standardized ownership-and-escalation pathway across nursing–social work–supply, and (3) routine speak-up opportunities supported by non-punitive leadership responses. These actions are not "extra" ethics work; they are culture-shaping mechanisms that determine whether coordination produces trust and learning or defensive practice and silent burden.

CONCLUSION

This study shows that ethics in Saudi hospital practice is enacted continuously through everyday coordination among nursing, social work, and medical supply functions. The findings indicate that routine events—stock-outs, delays, substitutions, escalation decisions, and discharge coordination—are experienced as value-laden situations in which staff repeatedly balance safety, fairness, dignity, efficiency, and accountability. In this sense,

ethics becomes visible not only in clinical choices, but in the ordinary organizational work that determines how resources move, how responsibilities are assigned, and how risks are communicated.

Across the themes, prioritization under scarcity emerged as a form of moral work in which legitimacy depended on transparency and consistency. Boundary ambiguity amplified ethical friction by redistributing responsibility and burden across roles, while workarounds functioned as culturally normalized coping strategies that sustained care but could weaken documentation and accountability over time. Finally, transparency and professional voice shaped whether coordination produced trust and learning or defensive practice and repeated checking—highlighting the importance of speak-up climates and psychologically safe communication in interprofessional teams.

Overall, the study contributes an axiological account of hospital culture by showing how values are operationalized through coordination practices. For Saudi hospitals, the implications are practical: ethical coordination can be strengthened by (1) making scarcity and substitution decisions explicitly values-based and documentable, (2) standardizing ownership and escalation pathways across nursing–social work–supply interfaces, and (3) embedding routine opportunities for voice supported by non-punitive responses. These steps position ethics not as an added burden, but as a measurable and improvable property of everyday coordination.

References:

1. Abass, G., Asery, A., Al-Tannir, M., Heena, H., AlFayyad, I., & Al-Badr, A. (2018). Organizational culture at a tertiary care center in Saudi Arabia: A mixed approach study. Cureus, 10(12), e3736. https://doi.org/10.7759/cureus.3736

2. Alshibli, F., Alqarni, K., & Balfaqih, H. (2024). Analyzing the causes and impact of essential medicines and supplies shortages in the supply chain of the Ministry of Health in Saudi Arabia: A quantitative survey study. Informatics in Medicine Unlocked, 45, 101457. https://doi.org/10.1016/j.imu.2024.101457

3. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

4. Craig, S. L., Eaton, A. D., Belitzky, M., Kates, L. E., Dimitropoulos, G., & Tobin, J. (2020). Empowering the team: A social work model of interprofessional collaboration in hospitals. Journal of Interprofessional Education and Practice, 20, 100327. https://doi.org/10.1016/j.xjep.2020.100327

5. Cultura: International Journal of Philosophy of Culture and Axiology. (n.d.). Submission guidelines. Retrieved January 28, 2026, from https://culturajournal.com/submission-guidelines/

6. Edmondson, A. (1999). Psychological safety and learning behavior in work teams. Administrative Science Quarterly, 44(2), 350–383. https://doi.org/10.2307/2666999

7. Emanuel, E. J., & Persad, G. (2023). The shared ethical framework to allocate scarce medical resources: A lesson from COVID-19. The Lancet, 401(10391), 1892–1902. https://doi.org/10.1016/S0140-6736(23)00812-7

8. Engel, J., & Prentice, D. (2013). The ethics of interprofessional collaboration. Nursing Ethics, 20(4), 426–435. https://doi.org/10.1177/0969733012468466

9. McLaney, E., Morassaei, S., Hughes, L., Davies, R., Campbell, M., & Di Prospero, L. (2022). A framework for interprofessional team collaboration in a hospital setting: Advancing team competencies and behaviours. Healthcare Management Forum, 35(2), 112–117. https://doi.org/10.1177/08404704211063584

10. Ministry of Health (Saudi Arabia), General Directorate of Research and Studies. (2022). Guidelines on ethical conduct and publication of health research. https://www.moh.gov.sa/en/Ministry/eParticipation/Documents/Publishing.pdf

[11.] O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: A synthesis of recommendations. Academic Medicine, 89(9), 1245–1251. https://doi.org/10.1097/ACM.0000000000000388
[12.] O'Donovan, R., & McAuliffe, E. (2020). A systematic review of factors that enable psychological safety in healthcare teams. International Journal for Quality in Health Care, 32(4), 240–250. https://doi.org/10.1093/intqhc/mzaa025
[13.] Pakkanen, P., Häggman-Laitila, A., & Kangasniemi, M. (2022). Ethical issues identified in nurses' interprofessional collaboration in clinical practice: A meta-synthesis. Journal of Interprofessional Care, 36(5), 725–734. https://doi.org/10.1080/13561820.2021.1892612
[14.] Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care, 19(6), 349–357.
https://doi.org/10.1093/intqhc/mzm042
[15.] Ulrich, C. M., Taylor, C., Soeken, K., O'Donnell, P., Farrar, A., Danis, M., & Grady, C. (2010). Everyday ethics: Ethical issues and stress in nursing practice. Journal of Advanced Nursing, 66(11), 2510–2519. https://doi.org/10.1111/j.1365-2648.2010.05425.x