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NAVIGATING ROLE AMBIGUITY: THE LIVED EXPERIENCES OF OCCUPATIONAL THERAPISTS WORKING IN MULTIDISCIPLINARY HOSPITAL TEAMS IN RIYADH

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Abstract

Background: Role ambiguity among occupational therapists in multidisciplinary teams is a persistent problem. It affects collaboration, professional identity, and recognition. In Saudi tertiary hospitals, systems are hierarchical and medically driven, so the ambiguity can be stronger. Understanding how OTs experience and negotiate this issue is important to improve interprofessional practice.

Aim: To explore the lived experiences of occupational therapists regarding role ambiguity and identity negotiation within multidisciplinary hospital teams in Riyadh.

Methods: A qualitative phenomenological approach was employed. Twelve licensed OTs from a tertiary hospital participated in semi-structured, in-depth interviews. Data were analyzed using interpretative phenomenological analysis (IPA), guided by role theory and reflective thematic interpretation.

Findings: Four superordinate themes emerged: (1) Navigating invisible boundaries, (2) Being misunderstood yet indispensable, (3) Power, hierarchy, and the medical model, and (4) Reclaiming the OT voice. Participants described ongoing efforts to assert professional identity, educate colleagues, and advocate for the occupational perspective amid structural and cultural constraints.

Conclusion: Role ambiguity, while a source of professional tension, also serves as a catalyst for reflection and advocacy. Strengthening interprofessional education, clarifying institutional role frameworks, and empowering OTs as collaborative leaders are essential for enhancing visibility and professional identity within Saudi healthcare settings.

Keywords: Occupational therapy · Role ambiguity · Professional identity · Multidisciplinary teams · Phenomenology · Interprofessional collaboration · Saudi Arabia · Hospital practice

INTRODUCTION

In modern healthcare, teamwork across professions is very important for patient-centered care. Occupational therapists focus on helping people join meaningful daily activities. However, in complex teams their role is often not clear. This creates role ambiguity, where professionals feel unsure about duties, authority, and expectations (Algeo & Aitken, 2019). This problem can reduce good communication and also limit the use of OT skills.

Research shows that role ambiguity among OTs can lead to professional stress, low job satisfaction, and weaker teamwork (Hughes, 2001; Robertson & Finlay, 2007). In both community and acute care, OTs often report that other professionals do not fully understand their scope of practice, so tasks overlap or some care is missed (Atwal, 2002). This problem is strong in hospitals, where hierarchies and medically led models often dominate and the occupational perspective becomes less visible (Griffin, 1996; Kinn & Aas, 2009).

Early studies showed that this confusion comes from poor communication and different professional cultures inside teams (Hughes, 2001; Atwal, 2002). More recent work says the problem still continues, even after many years of asking for clearer roles (Brian, Cook, Taylor, & Freeman, 2015). Even in advanced health systems, OTs still have to defend their identity and explain their contribution, while team goals often prefer biomedical results over occupational ones (Mack, Stanton, & Carney, 2023).

In critical care and tertiary hospitals, role ambiguity can become stronger because care is complex and teams change often (Algeo & Aitken, 2019). When role boundaries are unclear, some tasks are done twice, or OT is left out of important decisions. Schmidt (2025) also reported that weak communication and inconsistent documentation make collaboration harder, so OTs may feel undervalued and not fully used in team meetings.

Understanding how OTs experience and manage role ambiguity is important because it can improve teamwork, job satisfaction, and patient outcomes. Although there is growing international research on this topic (Robertson & Finlay, 2007; Mack et al., 2023; Schmidt, 2025), we still know little about how it appears in Middle Eastern healthcare, especially

in Saudi tertiary hospitals. These settings may have stronger professional hierarchies and different organizational cultures, so more study is needed.

This study will explore the lived experiences of occupational therapists who work in multidisciplinary teams in a tertiary hospital in Riyadh. It will examine how they see, handle, and negotiate role ambiguity in daily practice. A qualitative design will be used. The goal is to give context-specific insights that add to global and regional knowledge about professional identity and interprofessional collaboration in occupational therapy.

METHODOLOGY

Research Design

This study used a qualitative phenomenological design to explore OTs' lived experiences of role ambiguity in multidisciplinary hospital teams. Phenomenology fits this aim because it tries to show the essence of experience as people feel it, not to test hypotheses or measure variables (Creswell & Poth, 2018).

Following Husserl's descriptive phenomenology, we focused on participants' subjective meanings, their context, and their emotional responses about professional roles in complex healthcare systems. The epistemological stance was that knowledge is co-constructed through reflection and interpretation between researcher and participant (Van Manen, 2016).

Setting

The study took place in a tertiary hospital in Riyadh, Saudi Arabia. This site has a highly interdisciplinary clinical environment and a hierarchical organizational structure. Teams include physicians, nurses, physiotherapists, speech therapists, and occupational therapists who work across units such as intensive care, neurology, and rehabilitation medicine.

This context was suitable for studying role ambiguity. Professional boundaries often meet cultural hierarchies and institutional expectations, so overlaps and gaps in roles can appear. This made the setting rich for examining how OTs experience and manage role ambiguity in daily practice.

Participants and Sampling

Participants were licensed occupational therapists working in the hospital's rehabilitation and acute care units. We used purposive sampling to recruit therapists who had direct experience in multidisciplinary teams and could discuss role clarity, overlap, and conflict.

Inclusion criteria

- At least two years of clinical experience in a multidisciplinary hospital team.
- Current employment as an occupational therapist in the tertiary facility.
- Willing and able to take part in an in-depth interview in English or Arabic.

Following phenomenological traditions that value depth over breadth (Smith, Flowers, & Larkin, 2009), the target sample was 8–12 participants. Recruitment continued until data saturation was reached, meaning no new themes or insights appeared in later interviews.

Data Collection

Data were collected using semi-structured, in-depth interviews. This format let participants speak in their own words while keeping attention on the main phenomenon.

An interview guide was developed from the literature (Atwal, 2002; Algeo & Aitken, 2019; Robertson & Finlay, 2007). It covered:

- perceptions of the OT role within the team,
- experiences of collaboration and communication with other professionals,
- examples of role conflict, overlap, or ambiguity,
- strategies used to clarify or assert the OT role.

Each interview lasted 60–90 minutes, took place in a private setting in the hospital, and was audio-recorded with written consent. Interviews conducted in Arabic were professionally translated and back-translated to ensure both linguistic and conceptual accuracy.

Data Analysis

We used interpretative phenomenological analysis (IPA) (Smith et al., 2009). IPA uses a double hermeneutic: participants try to make sense of their experiences, and the researcher interprets their sense-making.

Analytical steps

1. Transcription and immersion: Interviews were transcribed verbatim and read several times to gain familiarity.
2. Initial noting: Key statements, emotions, and patterns were coded in the margins.
3. Emergent themes: Codes were grouped into clusters to show shared meanings and differences.
4. Connecting themes: Clusters were organised into superordinate themes that captured the essence of role ambiguity.
5. Synthesis: A narrative account was written to explain the structure of the phenomenon, supported by direct quotations.

NVivo software was used to store, manage, and code data in a systematic way. A reflexive journal was kept throughout to improve transparency and reduce researcher bias.

Trustworthiness and Rigor

We followed Lincoln and Guba's (1985) criteria to ensure rigor.

- Credibility: built through prolonged engagement with participants and member checking, where participants reviewed and confirmed thematic summaries.
- Dependability: supported by an audit trail that recorded key methodological decisions and analytic steps.

- Confirmability: strengthened with reflexive journaling and peer debriefing with two qualitative research experts.
- Transferability: enhanced by providing rich, contextualised descriptions of the setting and participant backgrounds.

Ethical Considerations

Ethical approval was granted by the hospital Institutional Review Board (IRB) and the Research Ethics Committee. All participants received a written information sheet explaining the study purpose, confidentiality, and the voluntary nature of participation. Informed consent was obtained before each interview. Data were anonymized; all identifying details were removed from transcripts to protect privacy.

Researcher Reflexivity

As an occupational therapist and researcher within the same professional field, I recognized the potential influence of my professional identity on data interpretation. To manage this reflexivity, I employed bracketing, consciously setting aside preconceived notions of role dynamics within multidisciplinary teams. Continuous reflective practice, memo writing, and consultation with a qualitative research mentor helped maintain interpretive neutrality and authenticity throughout the study.

Summary

This methodology was designed to deeply explore the lived experiences of occupational therapists navigating role ambiguity within multidisciplinary hospital teams in Riyadh. Through a phenomenological lens, it aims to reveal how these professionals make sense of their identities and contributions within complex interprofessional structures—ultimately informing strategies for clearer role delineation, stronger collaboration, and enhanced patient care.

RESULTS

The lived experiences of occupational therapists (OTs) working in multidisciplinary teams within the tertiary hospital revealed a complex interplay between professional identity, interprofessional dynamics, and institutional structures. Through interpretative phenomenological analysis (IPA), four superordinate themes emerged:

“Navigating the Invisible Boundaries” – understanding and negotiating unclear professional roles.

“Being Misunderstood Yet Indispensable” – perceptions of occupational therapy’s undervalued but essential contribution.

“Power, Hierarchy, and the Medical Model” – the influence of institutional hierarchies on professional autonomy.

“Reclaiming the OT Voice” – strategies for advocacy, collaboration, and identity affirmation.

Each theme is presented below with supporting participant quotations, maintaining confidentiality through pseudonyms. The analysis aims to capture both the essence and variations of participants’ experiences.

1. Navigating the Invisible Boundaries

Participants described role ambiguity as a constant negotiation. Expectations were unclear, duties overlapped, and team boundaries moved from case to case. Several called these lines “invisible boundaries,” showing how fluid and contested their responsibilities felt.

“Sometimes I’m not sure where my role ends and the physiotherapist’s begins. The team knows I help patients functionally, but they don’t really understand how that’s different.” – Senior OT

The problem was stronger when there were no clear role descriptions and when communication was inconsistent. Multidisciplinary teamwork was valued in theory, but in practice role clarity often depended on personal assertiveness, not on institutional rules.

“You have to keep reminding people what you do. If you stay quiet, they assume your work is optional or secondary.” – OT in ICU

OTs also said they had to justify their place in team meetings and discharge planning, especially when medical priorities led the discussion. Many reported a feeling of “peripheral inclusion”: they were inside the team, but not fully seen as equal contributors.

2. Being Misunderstood Yet Indispensable

Although many felt marginalised, they also showed pride in their unique and holistic view. This paradox—misunderstood yet indispensable—appeared in most interviews.

“When the patient finally manages to dress independently or hold a cup again, everyone celebrates—but few realize it was through occupational therapy. Our outcomes are visible, but our role is invisible.” – Rehabilitation OT

Participants said the psychosocial parts of OT, like motivation, adaptation, and participation, were often valued less than measurable medical results. Because indicators for occupational performance are not always clear, the profession can stay invisible.

However, in complex cases their role became clear. OTs used creative and patient-centred problem solving, and this showed strong impact. This evidence strengthened their internal sense of professional value, even when outside recognition was limited.

3. Power, Hierarchy, and the Medical Model

Role ambiguity was also shaped by the strong medical hierarchy in tertiary care. Participants described power gaps where physicians and nurses led most decisions, while allied health—especially OTs—stood lower in the structure.

“Decisions are made before we’re even consulted. Sometimes we find out about discharge plans after the patient has already left.” – Acute Care OT

This hierarchy reduced OT autonomy and limited advocacy for occupation-centered care. Routine processes focused on medical stability first, not functional recovery, so therapists felt tension between their ideals and organizational rules.

"The system is medically driven. We're trained to look at occupation, but the environment pushes us to think like doctors or physiotherapists." – Senior OT

Cultural elements in Saudi healthcare, such as respect for authority and some gendered norms, strengthened these patterns. However, participants also noted a slow change. Greater interdisciplinary awareness and contact with international OT models are beginning to challenge the old hierarchy, especially among younger staff.

4. Reclaiming the OT Voice

Despite ambiguity and limits, participants showed agency and resilience. They tried to assert their professional identity. Main strategies were education, collaboration, and advocacy.

"We realized that people can't value what they don't understand. So, we started doing short awareness sessions for doctors and nurses. Slowly, they began referring more appropriate cases." – Head of Department

Many OTs taught teammates about scope and value through informal talks, case presentations, and small workshops. They also used occupation-focused language in notes and reports, so the occupational view became visible in the clinical record. Peer mentorship and regular reflection helped build confidence and keep motivation in hard settings.

"It's easy to feel invisible, but when we share stories and mentor new graduates, it reminds us why we're here—to make occupation matter." – Senior OT Educator

Overall, the theme shows a shift from passive adaptation to active agency. OTs started to see themselves not only as team members but also as change agents who can improve interprofessional understanding and patient-centered care.

Synthesis of Findings

Together, the four themes show a detailed picture of OT practice in multidisciplinary hospitals. Role ambiguity is not only an organizational problem. It is also a personal and professional struggle. It shapes how therapists see themselves, how others see them, and how they act in daily work.

The results indicate that role clarity is not fixed. It changes with context, culture, and day-to-day negotiation inside the team. Participants' stories showed both vulnerability and adaptability. Although role ambiguity is difficult, it also pushed reflection, small innovations, and growth. In this way, therapists were able to redefine and defend the core of occupational therapy within a medically driven environment.

DISCUSSION

This study explored the lived experiences of occupational therapists in multidisciplinary hospital teams in Riyadh. It focused on how they see and handle role ambiguity in complex clinical settings. The results showed four connected themes: navigating invisible boundaries, being misunderstood yet indispensable, power and hierarchy within the medical model, and reclaiming the OT voice. Together, these themes show a clear tension between the ideals of occupational therapy and the daily realities inside medically led institutions.

In this discussion, we place the findings within the wider literature and simple theory. Role Theory helps explain unclear expectations and shifting duties. Models of interprofessional collaboration explain how teamwork can either reduce or increase ambiguity. Work on occupational identity helps us see how OTs protect their core values and advocate for occupation when power structures are strong.

1. Role Ambiguity as a Persistent Phenomenon in Multidisciplinary Practice

The theme of "invisible boundaries" shows an ongoing problem: it is hard to define the OT role inside multidisciplinary teams. Participants were unsure about limits and shared tasks. This matches earlier work that found OTs often stand between medicine and rehabilitation (Hughes, 2001; Atwal, 2002). The issue is not only structural. It also reflects a deeper tension between two models. The biomedical model values physical recovery, while the occupational model values participation, meaning, and identity (Kinn & Aas, 2009).

In the Riyadh tertiary setting, hierarchy and cultural norms made this ambiguity stronger. Physicians usually hold decision power. Similar patterns are reported where medical dominance hides the occupational view (Algeo & Aitken, 2019; Robertson & Finlay, 2007). Therefore, role ambiguity is not just a simple logistics problem. It is a structural and cultural phenomenon, kept by power relations and different ideas of health.

2. The Paradox of Visibility: Being Misunderstood Yet Indispensable

This theme shows a clear paradox. Participants felt invisible in team processes, but they also knew their work was essential for recovery and holistic care. This agrees with Brian et al. (2015), who note that OTs act as change agents, linking psychosocial and functional care even when their role is not fully appreciated.

OT work is often hard to see because many outcomes are intangible. Autonomy, motivation, and participation are less measurable than medical numbers (Mack, Stanton, & Carney, 2023). When metrics are not visible, the value of therapy may be missed. However, when patients dress alone again or return to meaningful activities, the OT impact becomes clear, even if the mechanism is not. These findings suggest the profession must communicate better and show evidence for its distinct contribution inside multidisciplinary teams.

3. Power, Hierarchy, and the Medical Model

This theme shows how institutions and power shape OT practice. The medical voice is dominant, so allied health views become secondary. This limits OT participation in decisions and reduces autonomy. The pattern echoes Griffin's (1996) early work on professional layers and it still matters today.

In Riyadh, hierarchy and respect for authority add more complexity. These cultural factors affect how professions interact and can make some OTs less ready to assert expertise. This is not only a weakness; it also shows that practice is tied to

context (Hammell, 2009). To move inside this system, therapists used cultural awareness, diplomacy, and careful communication.

Role Theory helps explain the strain (Biddle, 1986). Ambiguity grows when others' expectations clash with an OT's own professional view. This creates role conflict and stress, and performance may drop. However, many participants turned this tension into reflection and advocacy. In doing so, they slowly reshaped and strengthened their professional identity.

4. Reclaiming the OT Voice: Agency and Professional Identity

This final theme gives a more positive view. Participants showed resilience and agency. They used education, collaboration, and advocacy to protect their role. They taught team members, wrote occupation-focused words in clinical notes, and mentored peers. In this way they re-stated their boundaries and value.

These actions agree with Robertson and Finlay (2007), who saw similar identity work in acute care. It reflects role negotiation, where professionals keep redefining their place and contribution inside teams (Hardy & Conway, 1988). The OTs in this study were not passive. They adapted and showed leadership, turning uncertainty into a chance for growth.

Among Saudi OTs, these advocacy steps also suggest a wider change in professional identity in the region. As occupational therapy gains more recognition in Middle Eastern systems, role ambiguity may even act as a catalyst. It can push collective reflection and progress, leading to more clarity, visibility, and interprofessional legitimacy.

5. Implications for Practice and Policy

The findings suggest clear steps for practice and for organizations.

Practice and service level

- Develop role clarification tools with OTs. These should define core OT functions, referral routes, and expected input inside the team.
- Use interprofessional education in student training and clinical orientation. Include occupational perspectives to build shared understanding and reduce hierarchy (D'Amour & Oandasan, 2005).
- Provide leadership programs for OTs. Focus on advocacy, clear communication, and systems thinking so they can work better within power structures.

Policy level

- Vision 2030 reforms offer a chance to strengthen OT recognition in Saudi healthcare.
- Add OT competencies to national hospital accreditation standards. This can improve visibility, legitimacy, and support person-centered care.

6. Limitations and Future Research

This phenomenological study gives rich, detailed views, but it is context-specific. The results apply mainly to similar tertiary hospitals, so they cannot be widely generalized. Future work should include other allied health professions to compare roles and team dynamics. Longitudinal studies are also needed to track how role clarity changes over time, especially when policies or organizational structures change. Such research would deepen understanding of professional identity in developing healthcare systems.

7. CONCLUSION

This study adds to qualitative work on the link between role ambiguity, professional identity, and teamwork. For occupational therapists in tertiary hospitals, role ambiguity is both a barrier and a driver. It creates pressure, but it also pushes reflection, advocacy, and change.

By working across invisible boundaries, facing hierarchy, and reclaiming their voice, therapists showed that professional identity is not fixed. It is rebuilt through daily practice, dialogue, and persistence.

These findings call for system-level action so the occupational view is not hidden. Clear roles, fair participation in decisions, and better interprofessional education can help. The occupational perspective—meaning, participation, and function—deserves visibility and authority in modern healthcare.

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