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Reciprocal knowledge sharing: exploring professional–cultural knowledge sharing between expatriates and local nurses

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Reciprocal knowledge sharing:

Exploring Professional-Cultural Knowledge Sharing Between Expatriates and Local Nurses

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Abstract

Purpose – This study explores *how* professional-cultural knowledge is reciprocally shared between experienced expatriates and novice local nurses. To address this, the situated learning in practice lens is combined with social exchange lens.

Methodology approach – An interpretive case study methodology enabled an exploratory approach into the knowledge-sharing practices between experienced expatriates and novice local nurses in Saudi Arabia.

Findings – Insights gained in the fieldwork suggest that professional-cultural knowledge sharing often occurred through three primary practices. Developing a professional-cultural meaning, forming clinical competency development opportunities, and intervening in unfamiliar professional-cultural situations. In addition, two micro-level conditions shaped the reciprocity of professional-cultural knowledge sharing practices between expatriate and local nurses, which were individual differences and situational conditions.

Originality – This study advances and improves the understanding of two intertwined but rarely studied aspects of knowledge-sharing practices. The exploratory lens sought and gained rich insights into the knowledge-sharing practices between experienced and novice individuals and expatriate and local individuals.

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Introduction

Knowledge is one of the most valuable resources of organisations (Alavi and Leidner, 2001; Karamat et al., 2019). For organisations to capitalise on the knowledge, it needs to be shared (Ipe, 2003; Turulja *et al.,* 2020). Knowledge sharing (KS) is the exchanging of explicit and implicit forms of knowledge to co-construct new knowledge (Van Den Hooff, and De Ridder, 2004; Han, Yoon and Chae, 2020). Because KS is an activity that is partly articulable and largely grounded in actions (Gherardi and Nicolini, 2000), involving interactions of individuals with a focus on common goals, this study is informed by the practice-based lens (Gherardi, 2019; Nicolini, 2013; Schatzki et al., 2001). A practice-based lens is useful to study reciprocal KS as it enables a nuanced description of actions emerging from individuals jointly performing activities. It also helps to interrelate individuals' roles, intentions, organisational rules, institutional regulations, and outcomes of their actions (Gherardi, 2009; Marabelli, M. and Vaast, E., 2020). Several studies using different theoretical lenses have explored KS processes with a focus on one form of knowledge at an individual level (Balle *et al.*, 2019; Burmeister *et al.*, 2015; Cricelli and Grimaldi, 2010; Mueller, 2012; Stadler and Fullagar, 2016; Turulja *et al.,* 2020). Less attention has been paid to KS situations dealing with two types of knowledge. We examine this phenomenon considering a mutually reciprocal situation of KS: professional knowledge and cultural knowledge exchanged between expatriate experienced nurses and local novice nurses.

In cross-cultural KS research, culture has been defined through the essentialist lens, with influences of national culture on KS patterns (Hong *et al.,* 2006; Michailova and Hutchings, 2004; Peltokorpi, 2006). Alongside other forms of knowledge, there is a paucity of KS research that considers culture as a form of knowledge (Holden, 2002). In the context of expatriate-local interactions, cultural antecedents such as personal values (Cole and McNulty, 2011), cultural agility (Caligiuri and Tarique, 2016), and host country language proficiency (Zhang

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and Peltokorpi, 2016) influence expatriate-local interactions. The continued influence of the essentialist lens of culture on KS research has obscured the exploration of KS practices in which expatriates and locals reciprocally participate to enact new forms of knowledge. Calls have been made to extend research that addresses KS between expatriates and locals (van Bakel, 2019).

Expatriates are strategic conduits for developing the competencies of locals (Fee and Gray, 2020; Riusala and Suutari, 2004). In health care organisations, expatriate and local professionals depend heavily on professional knowledge (Amin and Roberts, 2008; Beach, 2002; Turulja *et al.*, 2020), alongside cultural knowledge (Campinha-Bacote, 2002; Suh, 2004). Professional knowledge can be thought of as knowledge that originates from academic education in combination with the experience in performing the job (Beach, 2002). Cultural knowledge is defined as understanding patients' worldviews and behaviour involving health-related belief practices and cultural values (Campinha-Bacote, 2002). KS between expatriates and locals requires traversing competency gaps and cultural challenges (Fee *et al.,* 2017; Massingham, 2014). Given the existing divergence in their professional and cultural knowledge, expatriates and locals are less likely to participate in KS automatically and unconditionally (Shao and Ariss, 2020). The social exchange lens (SEL) has the potential to improve understanding of the bi-directional, mutually contingent and beneficial KS of sequential exchanges (Emerson, 1976) between expatriates and locals. This study aims to explore professional-cultural KS between expatriate nurses and local nurses through the research questions:

1. How is professional-cultural knowledge sharing initiated, stabilised and sustained between expatriate nurses and local nurses?

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2. What micro-level conditions, if any, promote or restrain the reciprocity of professional-cultural KS between expatriate nurses and local nurses?

To address these questions, we combined the situated learning in practice (Lave and Wenger, 1991; Wenger, 2003) and SEL (Blau, 1964; Cropanzano and Mitchell, 2005), which fall within the umbrella of the practice-based perspective. While the situated learning view focusses on the processes of KS, the social exchange view emphasises the underlying reasons of why KS occurs. An interpretive case study provided the appropriate methodology to explore the unique conditions of the Saudi Arabian health care context and answer the research questions. With 46 interviews of a cross-section of expatriate and local nurses, the data collection and analysis were supported by observations and documents. The findings pointed to three key KS practices: the development of professional and cultural meaning, forming clinical competencies including development opportunities, and interventions due to the unfamiliar situation of professional and cultural differences. This paper contributes to the understanding of reciprocal forms of KS in cross-cultural contexts and is highly relevant as most research to date focuses on one form of knowledge only. The paper is structured as follows: Section 2 reviews the literature on situated learning in practice and social exchange to illuminate the understanding of reciprocal KS processes. Section 3 outlines the research method used. Drawing on collected data, section 4 discusses the findings on professional-cultural KS practices and influencing conditions. Sections 5 and 6 outline the theoretical contributions, managerial implications and highlight avenues for future research based on the research limitations.

Theoretical background

Professional-cultural knowledge sharing as situated learning in practice

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The lens of situated learning in practice is about the process of a novice becoming an expert through participation that takes place outside traditional settings like classrooms (Lave and Wenger, 1991). Through participation in situated practice, novices develop their new identities and know-how (Lave and Wenger, 1991; Handley *et al.,* 2007). The expert's role is to support the processes of identity formation and practice development of novices through instructions and feedback that encourages good behaviour or corrects wrong behaviour (Lave and Wenger, 1991). Knowledge is constructed in practice through social interactions in context (Corradi *et al.,* 2010; Gherardi, 2009; Handley *et al.,* 2007; Lave and Wenger, 1991; Orlikowski, 2002; Wenger, 1998, 2003).

Professional knowledge is a form of knowledge that requires the mastery of both tacit and codified/theoretical knowledge (Amin and Roberts, 2008; Beach, 2002). While most codified/theoretical knowledge can be learnt during academic studies, tacit dimensions of professional knowledge must be developed in situated practices through participation in learning by doing (Amin and Roberts, 2008).

Culture has often been defined through the essentialist lens as a relatively uniform and internally coherent system of distinctive assumptions, norms, and values (Heizmann, Fee, & Gray, 2018; Hong, Snell, & Easterby-Smith, 2006). This definition is based on the premise that members of the same culture have been raised and interacted in the same environment and hence share a set of common values. The notion of stability and homogeneity of cultures based on mutual values has been criticised for failing to capture the nuances and complexities of the landscape of contemporary organisations, where cultural differences of the members of the same organisations intersect in many ways (Heizmann, 2009, Holden, 2002). The frequent adoption of this static view of culture as something members of the same culture possess, have led emphasise KS research between groups of different nations (Heizmann, 2009). In

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comparison, little attention has been devoted to explaining how culture is reciprocally shared and developed.

Alternatively, the situated learning in practice lens recognises culture as a set of shared and negotiated practices through socialisation and interaction with others (Heizmann *et al*., 2018). The underlying assumption of this lens is viewing culture as social constructions formed and maintained by the participation of individuals to enact or realise new forms of knowledge (Fee and Michailova, 2021, Heizmann *et al*., 2018). The situated learning practice lens of culture is tied to understanding culture as knowledge. Holden (2002, p. 227) defines *cultural knowledge* as "infinitely overlapping and perpetually redistributable habitats of common knowledge and shared meaning". This means that cultural knowledge is at the intersection of shared meanings and common knowledge. Because cultural knowledge is mostly tacit (Holden, 2002), it can be developed through participation in situated practices only (Lenartowicz *et al.*, 2014). Thus, professional-cultural KS is seen as a set of interactions between local novices and skilled professional expatriates in situated practices, aiming at sharing two-fold forms of knowledge.

The lens of situated learning in practice is used to elaborate on a collaborative learning process ("thinking together") where members in health services utilise their understanding of health problems to jointly guide each other and share tacit knowledge (Pyrko *et al.,* 2017). Situated learning has also been used to explore the communicative processes of organisational knowledge through the elements of mutual engagement, negotiation of a joint enterprise, and shared repertoire (Iverson and McPhee, 2008). Situated learning is useful to explain reciprocal KS between novice and experienced individuals, however, there are limitations (Gherardi, 2009; Handley *et al*., 2006; Pyrko *et al.,* 2017). Minimal attention is paid to how two-fold forms of knowledge are bi-directionally shared in practice. This gap has resulted in a call to move beyond the ordinary tacit-explicit knowledge dichotomy grounded in the resource-based

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view to expand understanding on how the sharing of diverse forms of knowledge unfolds in practice (Barley, Treem, & Kuhn, 2018; Venkitachalam & Busch, 2012). In addition, the difficulties associated with operationalising 'participation' in a situated learning environment, suggests a degree of ambiguity (Handley *et al.,* 2006) that emerges as a lack of clarity regarding how learning progresses through participation (Pyrko *et al.,* 2017). Attention to cultural heterogeneity among members in situated learning in practice is needed (Handley *et al.,* 2006). How participation is initiated, stabilised and sustained between novices and expert instructors in cross-cultural settings is rarely addressed with empirical evidence. Informed by the situated learning and practice lenses, this study explores how professional-cultural KS transpires in a cross-cultural setting.

Professional-cultural knowledge sharing as social exchange

The lens of social exchange advocates that individuals who engage in mutual relationships of learning and support are based on both parties receiving an outcome of perceived value (Blau, 1964; Emerson, 1976). Whilst SEL emphasises the mutual dependence in relationships, it is also contingent on the values of each actor and what derives from the exchange in terms of tangible and or intangible resources (Blau, 1964). The mutual exchange is between actors and the initiation of constructive actions and interchanging responses (Cropanzano and Mitchell, 2005).

SEL has been applied to understand KS at macro-and micro levels in different contexts. For example, it was used to examine the impacts of online health community members (Yan *et al.*, 2016), the factors that affected the relationship between commitment and KS intention (Zhang and Liu, 2021) and, the roles of KS and knowledge helping in governing knowledge effectiveness (Singh *et al.*, 2019). In the context of expatriate-local interaction, the expertise of expatriates that takes the forms of knowledge, skills, and experiences is considered significant

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in developing the capacity of local employees (Fee and Gray, 2020; Riusala & Suutari, 2004). On the other hand, locals can offer expatriates valuable assistance in terms of provision of local cultural information, and language interpretation that supports the expatriate's adjustment to the host culture (Napier, 2006; Li & Scullion, 2010; Toh & DeNisi, 2007). This two-way exchange is often contingent on the value expatriates place on the locals' assistance and, vice-versa.

Culture, under social exchange lenses, is approached as mutual adjustment processes between host country and expatriate individuals. Host country nationals' cultural adjustment involves cognitive and behavioural changes as a result of continuous interactions with expatriates in professional work situations (Fee and Michailova, 2021). Expatriate cultural adjustment, on the other hand, encompasses accommodating expatriates' behavioural and communication patterns because of received information about host country, such as the appropriate norms, behaviours, and values (Napier, 2006; Li & Scullion, 2010). Thus, cultural knowledge, under social exchange lenses, is a two-way flow of information and tacit knowledge between host nationals and expatriates. Consistent with the situated learning lens, culture is reciprocally co-produced and negotiated in the exchange relationships between expatriates and locals. Viewed this way, professional-cultural KS between expatriates and locals is a reciprocal and joint relationship involving a sequence of exchanges (Blau, 1964; Emerson, 1976).

Although SEL is useful in unveiling ties between expatriates-locals and their intentions for mutual sharing behaviours, the explanatory power of it is not without limitations. SEL overlooks the motives of exchange that go beyond the motives of reciprocity and benefits (Mittal *et al.,* 2020; Zhang and Liu; 2021), such as altruistic motives (Serenko and Bontis; 2016). Little is known about the processes of exchange (Cropanzano and Mitchell, 2005; Göbel

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et al., 2013), particularly in the case of expatriates-locals' dyads (van Bakel, 2019). Likewise, situated learning (Lave and Wenger, 1991; Wenger, 2002) assumes spontaneous and voluntary activities, in which individuals unreservedly share their knowledge with third parties. This view, however, has been challenged since it underestimates the role of trust and neglects power relations attached to social interactions (Roberts, 2006).

To address some of these issues, Serenko and Bontis (2016) proposed four modes of social exchange that influence KS. Professional-cultural KS between expatriates and locals is shaped by different exchange modes: negotiated exchange, reciprocal exchange, generalised exchange and productive exchange. In the negotiated mode, a knowledge donor is based on exchange rules, and in return, a knowledge recipient explicitly commits to exchange in a pre-established form. In the case of the reciprocated mode, a knowledge donor believes that the knowledge recipient will share their knowledge in return. In the generalised exchange mode, a knowledge donor shares knowledge with a colleague under the assumption that other organisational members will share their knowledge with them in the future. In the productive mode, a knowledge donor shares their knowledge for altruistic causes because they believe that all colleagues work together toward a common goal and should, thus, unconditionally support one another, as the knowledge donor expects no direct or indirect reciprocation. Although the importance and the impact of different modes of knowledge exchange have been established (Serenko and Bontis; 2016), the practices and conditions that promote or restrain different modes of exchange in bidirectional KS processes remain largely unknown.

The Research Methodology

Research Design

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Given the relatively unexplored nature of professional-cultural KS through the combined theoretical lenses of situated learning in practice and social exchange, this study adopted a qualitative interpretive case study (Lincoln *et al.*, 2011; Yin, 2009; 2014). The interpretive approach is primarily concerned with gaining an understanding of human activity by interpreting its subjective meaning (Lincoln *et al.,* 2011). Subjective meaning is "socially constructed through language and interactions, and reality as connected and known through society's cultural and ideological categories" (Tracy, 2013, p. 41). Human activity is considered to exist in the form of multiple mental constructions that are socially and experientially based, locally and specifically reliant in their form and content on the humans who embrace them (Lincoln *et al.,* 2011). The interpretive inquiry affords the exploration of (i) human reasons for a particular social activity; (ii) the methods humans utilise to make sense of their world, and how they assign meaning to it; and (iii) the comprehension of the broader social structure or context of that social activity (Lincoln *et al.,* 2011).

This study adopts Yin's (2009; 2014) qualitative case study approach to address the "how" research question. Yin (2011; 2014) highlighted conditions to determine the suitability of the case study approach where the researcher has no control over actual behavioural events; and the research focus is on contemporary events, as opposed to entirely historical events. In this research, professional-cultural KS was explored from the perspectives of expatriate versus local as well as experienced versus novice nurses. The research question focussed on "how", patterns of KS took place in hospital wards/units. It would have been difficult for the researcher to determine a true picture of the professional-cultural KS without consideration of and immersion in the settings within which this KS occurred (see Siggelkow, 2007). Notably, whereas recognising the impossibility of generalisations from case study findings (Yin, 2014), this is a theory-building (Flyvbjerg, 2006; Eisenhardt, 1989), rather than a theory-testing case study, as it fulfills the requirements advanced by Eisenhardt and Graebner (2007) to justify

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new conceptual insights. Specifically, this study uses theoretical, rather than random sampling as the selected case was particularly suitable to investigate, simultaneously, sharing of two types of knowledge under diverse social exchange modes; obtained data via multiple instruments (observation, document analysis and interviews) with individuals playing diverse roles and hierarchy positions and; as a result, provides new insights about bi-directional KS processes.

Research Setting

Access to hospitals is challenging in most countries (Høyland et al., 2015). Saudi Arabia is no exception and has similar access challenges that include continuous negotiations of strong gatekeeping throughout the data collection process (Aldaheri, Guzman, & Stewart, 2019). The research setting is across two nursing hospitals in Saudi Arabia. Participants were sampled through personal networks and snowballing (see table 1). In Saudi Arabia, the majority of nurse training is in universities and public hospitals; therefore, the inclusion of each was appropriate. The health system in Saudi Arabia is primarily staffed by expatriate nurses from diverse cultural and linguistic backgrounds (Almutairi and McCarthy, 2012). Expatriate nurses with over five years of nursing experience were involved in the education of Saudi nursing intern students (herein local nurses). An experienced professional (herein expatriate instructor) is assigned to a local nurse for 3 to 12 months, depending on the degree of work readiness, progress made and educational goals. The expert instructor/novice relationship aims to bridge the theory-practice gap by offering an ideal learning environment that supports the skill development of novice nurses to autonomously provide care of the highest standard possible for patients (Billay and Myrick, 2008). Expatriate instructors bring different cultural values, beliefs, customs, behaviours, and attitudes with them that can differ greatly from those of their patients and their Saudi Arabian nursing counterparts (Almutairi and McCarthy, 2012;

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3 Almutairi *et al.,* 2015). Many expatriates are employed without basic Arabic language skills
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5 that might facilitate nurse-patient interactions (Almutairi *et al.,* 2015). The Saudi Arabian
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8 nurses voluntarily participate in a cultural-language education of their expatriate nurse
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10 counterparts.
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14 **Data Collection**
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17 Fieldwork began with data collected from a constant comparison of complementary sources:
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19 observations, formal and informal interviews and document reviewing (Corbin and Strauss,
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22 2008; Yin, 2014) over five months (February 2018-June 2018). Data collection was performed
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24 by the first author (NA), a Saudi Arabian national, who was able to understand both local
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26 culture and language. Observations took place in a male surgical ward, obstetrics ward, and
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29 gynaecological unit. The researcher accompanied expatriate and local nurses in the wards on
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31 each visit when they needed to perform a procedure or attend to a patient. The aim was to build
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33 an understanding of the dynamic nature of nurses' daily routines, practices, and language
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36 usage. Through liaising with the head nurses, the researcher obtained a copy of hospital
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38 policies, ward and unit routine clinical checklists, competencies, and assessment criteria to
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40 understand how clinical practices and tasks should be undertaken. During fieldwork, common
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43 practices in the three settings through which learning-teaching and social interactions occurred
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45 were observed, either in one-to-one relationships or in a team. Examples of observed practices
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47 include monitoring of vital signs, medication administrations, cannulations, shift-handovers,
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50 orientation, and training programmers.
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53 The primary source of data was semi-structured interviews which were supplemented by an
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55 interview guide and document analysis. As the researcher became familiar with the hospital
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57 settings, and the behaviours and attitudes of nurses, there was a shift to unstructured interviews
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60 for deeper engagement with emerging practical challenges (e.g., rescheduling of interviews

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3 due to unpredictable workloads). Clinical instructors and preceptors formed the expatriates' nurses pool, while Saudi nursing intern students and newly hired nursing staff formed the local nurses. The selection criteria for expatriates included: a minimum of five years of nursing experience gained outside the host country's health care system and a minimum of one-year of supervision experience. For local nurses, the selection criteria comprised intern students and newly graduated nurses with less than two years' nursing experience.

The participant selection went from purposive to snowballing with purposive participation reliant on relationships with the key gatekeepers to identify and recruit further potential participants (Saunders and Townsend, 2018). To reach a broad pool of participants outside the observed hospital settings, new participants were referred to the researcher by head nurses, nursing managers, or other participants. These recruitment methods provided 46 representatives from a broad group of nurses within two hospitals across eight different wards and units. All participants (see Table 1) were voluntary with a cross-section of qualified staff versus novices, age (25-50 years old), experience (<1 year to 25 years), and education (undergraduate to masters). The participant pool represented "a range of different perspectives" (Lee & Aslan, 2018 p.105) to optimise the exploratory semi-structured interviews (Lee & Aslan, 2018 p.105) and observations. Table 1 provides a summary of participants recruited for the interviews and it is noted that in Saudi Arabia nursing is a female-dominated profession however one male matched the participant selection criteria. Theoretical saturation (Saunders and Townsend, 2018) was reached at the 39th interview, and seven additional interviews were conducted to ensure no new themes emerged. Interviews ranged from approximately 20 to 90 minutes in length. All interview was audio-recorded and transcribed, except in response to a request made by one of the participants.

Table 1 Summary of 46 Participants

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First Hospital – University					
	Gender	**Age**	**Experience**	**Role**	**Education**
Host (HC)	F – 18	22-25: 15 25-34: 3	<1 year: 18	Nursing Staff: 5 Nursing intern: 13	Bachelor: 18
Expatriate (EXP)	F: 15 M: 1	25-34: 5 35-50: 11	6-10 years: 5 10-15 years: 3 16 – 20 years: 3 20+ years: 5	Clinical instructor: 3 Preceptor: 13	Diploma: 1 Masters: 1 Bachelor: 14
Second Hospital: Public					
Expatriate (EXP)	F: 12	25-34: 6 35-50: 6	6-10 years: 6 10-15 years: 6	Clinical instructor: 9 Preceptor: 3	Masters: 1 Bachelor: 11

The multi-method data collection that led the iterative and abductive analysis (Timmermans and Tavory, 2012) was focussed on answering the research questions based on the constant comparison method (Corbin and Strauss, 2008). While this method embeds triangulation of the data collected and the analysis, the constant comparison is deeper and allows the researcher to take a more immersive experience to explore findings.

Data Analysis

In keeping with the interpretive epistemology, the analysis was guided by three stages of (Miles *et al.,* 2014; Tracy, 2013), to enhance and add rigor to the coding processes (Corbin and Strauss, 2008) and thematic analysis (Braun and Clarke, 2006). The first stage included the entire data set, (interview transcripts, observational notes and summarised documents) that were

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3 iteratively reviewed to optimise the data immersion (Braun and Clarke, 2006). Initial coding
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5 began in parallel with data collection to determine the basics of pattern sharing and engaging
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8 in constant comparison (Braun and Clarke, 2006; Corbin and Strauss, 2008).
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11 The second stage reviewed the first-order development with a focused analysis that described
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14 the various shared patterns in the data (Corbin and Strauss, 2008). To transform general shared
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16 patterns, codes that captured the essence of sharing patterns were assigned (Tracy, 2013).
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18 Research questions, and theory concepts, were revisited against the developed first-order
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21 components to see how they overlapped, ensured relevancy, and determined whether any new
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23 directions could be considered (Tracy, 2013). This stage allowed possible second-order
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25 themes/sub-themes to emerge. Through constant comparison (Corbin and Strauss, 2008),
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28 similarities were examined and merged to form themes with unrelated themes eliminated. The
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30 assigned meanings were reconstructed employing the researcher's unique interpretations.
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33 The third stage was based on the developed dimensions in stage one and two to generate
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36 dimensions and variations to provide scope and range to themes (Corbin and Strauss, 2008).
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38 The second-order themes were synthesised into a smaller number of broad dimensions, to
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40 identify the sense-making of the professional-cultural KS phenomenon. The constant
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43 comparison continued as the researcher moved back and forth between the data, concepts,
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45 themes, and research questions.
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48 **Research Findings**
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52 **1. Professional-cultural knowledge sharing practices**
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55 Although none of the research participants directly described professional-cultural KS as
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57 incremental practice, the fieldwork suggests that professional-cultural KS is often initiated,
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60 stabilised and sustained through three practices: developing professional-cultural meaning,

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3 forming clinical competency development opportunities, and intervening in unfamiliar
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5 professional-cultural situations. (See Table 2).
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9 Table 2: Three key KS practices
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Dimension – Sharing Practices			
Theme	Second-Order Sub-Themes	First-Order Components	Evidence Source
Developing Professional-Cultural Meanings	Raising awareness of nursing hospital system	Delivering general nursing hospital orientations	Documents, Fieldnotes, Interviews
		Providing nursing area orientations	Documents, Fieldnotes, Interviews
		Promoting inclusivity	Interviews
	Raising awareness of common cultural-language praxis	Providing cultural information	Interviews
		Language assistance	Fieldnotes, Interviews
		Forming interpersonal bonds	Interviews
Forming Clinical	Displaying work readiness	Demonstrating clinical preparedness	Interviews
		Demonstrating interest in learning	Interviews

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Competency Development Opportunities	Facilitating clinical competency development	Assessing readiness status	Interviews
		Supporting learning by doing	Fieldnotes, Interviews
		Assessing performance progression	Interviews
Intervening In Unfamiliar Professional-Cultural Situations	Intervening to cope with uncommon and critical situations	Proactive actions	Interviews
		Reactive actions	Interviews
	Intervening to assist with cultural-language difficulties	Pursued assistance	Fieldnotes, Interviews
		Spontaneous assistance	Fieldnotes, Interviews

1.1 Developing Professional-Cultural Meaning

Developing a professional-cultural meaning involves a set of activities in which expatriate nurses and local nurses reciprocally form a shared understanding (Gherardi, 2009; Handley *et al.,* 2006) of the Saudi Arabia nursing-hospital system. Through shared understanding, expatriate and local nurses deliver nursing care that adheres to the nursing hospital policies while ensuring compatibility with the national culture of the largest patient populations. Expatriate nurses are typically responsible for raising awareness about nursing hospital policies while influencing local nurses' sense of belonging. In contrast, local nurses play vital roles in interpreting the various aspects of national culture, including the behavioural customs and norms, language, and dialects of their expatriate counterparts. Local nurses also form

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interpersonal relationships to access abundant KS opportunities. As Gherardi (2009) suggested, the common factor between the roles of expatriate nurses and local nurses in developing professional-cultural meaning was the joint development of abstract and contextually situated knowledge, from mutually convenient practices to both parties. Expatriates, who make up most of the nursing workforce in Saudi Arabian hospitals, are usually responsible for raising awareness of the nursing hospital system and nursing-area orientations.

Expatriate instructors used different sharing mechanisms to deliver the orientation to local nurses, including oral presentations and simulation sessions followed by basic nursing competencies exams. Upon passing the general nursing hospital orientations, local nurses were allocated to hospitals' units/wards to be accompanied by expatriate instructors. Local nurses were familiarised with the wards and units' physical features, general and area-specific policies, safety standards, and patient rights through repeated exposure to the clinical sites, verbal instructions and competencies checklists. An expatriate clinical instructor described what a nursing-area orientation involved:

> "When they are here, we are giving them a unit orientation. We are explaining to them everything in the unit. Where the things are kept, where the files and the protocols [are], what is our routine, how to record things and how to do the procedures if any." (EXP #N2)

When accompanied by expatriate clinical instructors, local nurses viewed the application of clinical competencies and performed nursing duties. Observing the behaviour and duties demonstrated by instructors while they perform practices was one of the most common sharing mechanisms used. Observation of expatriate nurses raised awareness of local nurses and how the clinical competencies are applied according to clinical policies as shared here by an expatriate clinical instructor:

> "Interns (local nurses) are always with the staff (expatriates) at the bedside. I am sure 50% of the things they observe and learn from the staff, so I think there is no need for the staff (expatriates) to stop and make them understand what they are doing." (EXP #N25)

Raising awareness of the nursing hospital system entailed inviting local nurses to be part of the nursing settings on equal terms. Inclusion was a key value as an expatriate nurse expressed:

> "We (expatriates) try to communicate in a friendly way; we give [them] our attention, and we ask in a friendly way. We do not wait for them to call for help. We try to work and do things together." (EXP#N18)

Another key aspect that influenced KS practices was the lack of cultural-language programmes for expatriate instructors. The orientation programme included a single cultural awareness session provided upon arrival. Expatriates sought further informal interactions with local nurses to raise their cultural-language awareness. Local nurses provided their expatriate counterparts with cultural information that enabled the continuity of delivering nursing care to domestic patients. For example, local nurses spoke about receiving queries about the usage of some traditional medicines as a local nurse described:

> "Once, a patient asked one of the nurses (expatriates); "Can I drink Myrrh?" Myrrh is the name of traditional medicine, and the nurse told her that she did not know; then she asked me; "What is Myrrh?" so, I searched on Google, showed her its pictures ,explained its uses and its benefits to her[...]" (HC#N10)

Expatriate nurses also underlined the role of local nurses in learning about the norms of communication during informal conversations. An expatriate nurse expressed:

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3 "Through socialisation with Saudi nurses, I came to know the customs and traditions
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5 of Saudi Arabia. I know many of their traditions. I chat with them about our life in
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8 general, after working hours or during the break. Thanks to them, I have benefited from
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10 them, now I know how to deal with patients, even in some situations and with particular
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12 people, I knew what I should say or do, what I should not say or do[...]" (EXP#N5)
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16 Local nurses formed interpersonal bonds with their expatriate counterparts to develop a sense
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18 of integration and to enrich their learning experiences. Local nurses perceived interpersonal
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21 bonds as essential to navigate existing culture-based differences in values, attitudes and
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23 competency gaps. A local nurse reflected on her experience:
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26 "In the beginning, the [nationality name] staff were all speaking with each other in their
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29 language and taking breaks with each other. So, I would ask them to call me when they
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31 take breaks, and I would go and sit with them during the breaks[...], so they noticed that
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34 I am trying to participate and talk with them, so they started to speak in English so I
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36 could understand them." (HC#N11)
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43 **1.2 Forming Clinical Competencies Development Opportunities**
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46 The data analysis suggested that developing professional-cultural meaning laid the foundations
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48 for the second practice, which involved both local and expatriate nurses forming more focused
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51 clinical competencies development opportunities. Clinical competencies in the nursing context
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53 encompass understanding abstract knowledge, mastery of area-specific skills, the ability to use
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55 sound judgment, adherence to nursing professional standards in practice, positive interpersonal
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58 relationships, situational application of skills and knowledge, and outcome evaluation by
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60 standards (Church, 2016). Local nurses and expatriate instructors applied diverse practices to

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support the development of clinical competencies. Local nurses displayed work readiness, which is comprised of demonstrating clinical preparedness, along with interest in learning and commitment to gain expatriate nurses' trust and subsequently entry to supported clinical learning in the nursing settings:

> "At the first ward, surgical ward, I was working with a nice and helpful nurse (expatriate), and when I moved to the Intensive Care Unit, there was not much help, but I proved myself in work. I proved that I knew how to work, and I just wanted them to give me a chance[...]. As soon as the nurses (expatriates) see that you know and understand the work, they allow you to handle the patients[...]" (HC#N6)

Expatriate nurses facilitated clinical competencies development by supporting "learning by doing" (Orlikowski, 2002). This support was demonstrated through identifying safe opportunities to practice different clinical competencies, allowing multiple repetitions and delaying corrective feedback and interventions. A piece of observational data illustrates this point:

> "Around 11:37 a.m. in (Unit), an expatriate preceptor called a nursing intern (local nurse) who was assigned to her to come with her to a patient's room that had two patient beds[...], the preceptor guided the intern by giving verbal explanations for each step of the device preparation while the intern was applying the steps[...]. When they finished, the preceptor told the intern: "You are going to do it by yourself on the next patient"[...].The intern applied the same steps while the preceptor attentively supervised each step as the intern was applying with little verbal guidance[...]" (Researcher Fieldnote)

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Expatriate nurses facilitated clinical competencies development through assessing local nurses' performance progression that helped to identify specific competencies where local nurses could improve. Expatriate instructors stressed the importance of partnering with unit-based nurses to assist in assessing progression and making assignments for local nurses. An expatriate clinical instructor explained:

> "We evaluate them (local nurses) by asking them questions, by looking at the performance, ask colleagues to report on the performance, how they are doing, the attitude, how they treated the colleagues and patients, how they responded." (EXP #N22)

The described practices are not straightforward. There is a fine line between local nurses and expatriate instructors that both parties needed to navigate to be able to form opportunities for clinical development. Here we can see the relevance of reciprocal relations.

Beyond displaying an interest in learning, local nurses started to perform undesirable basic nursing tasks. These actions helped manage expatriate nurses' negative behaviour, such as national stereotypes and withholding knowledge, therefore inhibiting the development of local nurses' clinical competencies. An expatriate instructor emphasised:

> "I believe the attitude of the interns (local nurses) can change the staff (expatriates). We have a few interns. They would often come and complain to me: "When I go to the bedside, the staff (expatriates) gives me a nasty kind of look, or when I ask them questions, they do not even act as if they heard me"[...]. I often tell them, "When you get comments like this, do not feel bad and just stay close to that same person who has given you this comment and imagine that you, as a person, who is the beneficiary here [...], just use your polite manner of talking and asking[...].These staff also don't like you

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> going behind them always asking questions, so instead of asking questions, you get involved in their work, and in between[...], they will teach you, for sure." I have seen so many changes like that" (EXP#N25)

1.3 Intervening in Unfamiliar Situations

The data analysis showed that developing professional-cultural meaning allowed for the formation of clinical competencies development opportunities and joint intervention efforts. Nursing care is provided in settings with complex interactions between many factors, including policies, procedures, standards, nurses, patient disease, and demands. When these factors interact, harmful and unanticipated outcomes might occur. Through reciprocal interventions, continuity of delivering safe and culturally compatible nursing care was sustained. Interventions in unfamiliar situations represented the reciprocity, synchronised and harmonised actions that expatriate and local nurses use to cope and minimise the negative consequences of uncommon situations. Interventions, however, are a two-way process.

Expatriate nurses took proactive and reactive actions to cope with uncommon situations faced by local nurses. Local nurses needed special guidance on how to carry out nursing procedures that do not occur very often. These difficulties were demonstrated in the inability to connect theoretical knowledge with the realities of nursing practice. To respond to uncommon situations, expatriate clinical instructors applied a close mentoring approach to detect early mistakes, prevent medical errors and provide feedback. As an expatriate instructor described:

> "One afternoon, I saw a new staff (local nurse) was preparing medication alone. I had to intervene and watch because they usually think about finishing the job, but safety is our concern. Maybe she is taking the wrong medication to the wrong patient[...]. I

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asked: "Why are you preparing alone"[...], i told her “Let me see the order." We both checked the order. The medication was the wrong one[...]” (EXP#N8)

Novice local nurses’ behaviours which are often rule-driven, lead to nurses feeling overwhelmed and anxious when faced with unfamiliar situations. An expatriate nurse described the following incident:

“[...]she (local nurse) gave that patient an antibiotic[...], but the patient went into shock because she has an allergy[...]. She (local nurse) came and told me, “come and see." [...]. When I went, the patient was a bit reddish, and her eyes were rolling up[...], i then told her to take care of the vital signs[...]. Immediately, I called the doctors; I stopped the timetable[...]. I called my staff; they all came. It was a peak time, 05:50 p.m, our endorsement timing, I assigned the staff[...]. The doctors came, and they managed the patient, giving all the medicine. When the patient became okay, [...] we had to sit with her to teach how to write the incident report[...], she was not familiar with these sorts of incidents. She was seeing it for the first time[...]” (EXP#N7)

Expatriates also experienced unfamiliar situations related to cultural-language difficulties when handling patients. Local nurses acted as language interpreters and mediators to cope with difficulties faced by expatriates. An expatriate instructor described a situation:

“A patient was already old, and he was dying. In these situations, we tend to involve family toward the end, but I heard that it is essential for the nurses to get all the priests (imam) from the mosque so that they can come and talk to them. The patient's family must have closure. So, this is something which my colleague (expatriate) was not aware of[...]. So, it was a Saudi nurse who intervened on behalf of the tenured staff and made sure the priest (imam) came and then got the cultural things done[...]” (EXP #N14).

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2. Conditions that influence the reciprocity of professional-cultural knowledge sharing

The insights drawn from the fieldwork suggested that two micro-level conditions shaped the reciprocity of professional-cultural KS practices between expatriate and local nurses: individual differences and situational conditions (Table 3).

Table 3: The two micro-level conditions that influence the reciprocity of KS practices

Dimension – Micro-level Conditions			
Theme	Second-Order Sub-Themes	First-Order Components	Evidence Source
Individual Conditions	Personality Attributes	Cultural empathy	Fieldnotes, Interviews
		Cultural curiosity	Fieldnotes, Interviews
		Commitment	Interviews
		Trust	Interviews
		Exploitation	Interviews
		Aggressive behaviour	Interviews
	Work Readiness	Knowledge-based clinical preparedness	Interviews
		Communication skills	Fieldnotes, Interviews
		Interpersonal skills	Fieldnotes, Interviews

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Situational Conditions	Workloads	Increased patient ratios	Fieldnotes, Interviews
		Overlap between procedures and tasks	Interviews
		Increased severity of patients' illnesses and demands	Interviews
	Case Criticality	Acute patients	Interviews
		Critical units	Interviews
	Staffing Adequacy and Roles	Chronic shortage of experienced nursing staff	Interviews
		Extended nursing roles	Interviews

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2.1. Individual Conditions

The individual conditions comprised of personality attributes of expatriate nurses and work readiness of local nurses. The data analysis pointed to the individual conditions that influenced the degree of reciprocity in professional-cultural KS. There is disparity among expatriates in the way they feel, think and behave in a cross-cultural setting (Shaffer *et al.,* 2006), which promotes or restrains the engagement in reciprocated KS with local counterparts plus their engagement in KS with expatriate counterparts.

Cultural curiosity and empathy manifested in the cultural KS practices with local nurses. The expatriates were likely to engage in the KS practices when they considered them practical and desirable to affirm one's own moral values. For example, expatriate nurses with a high interest

in building a rapport with domestic patients were likely to engage in professional-cultural KS with local nurses. As a local nurse said:

> "(expatriate's name) loves to learn Arabic, she always asks me: "What is the difference when talking between masculine and feminine?" She asks about the traditional expressions[...]" (HC#N11)

Expatriate nurses with genuine empathy toward domestic patients were prone to engage in professional-cultural KS with local nurses. Having a high sense of empathy was attributed to the core principles of the nursing profession and one's own values. An expatriate revealed:

> "If you are a nurse, you need to have a heart[...], you have to go along with them, not for them to go along with you, because you are not a local. You are a foreigner[...], you are the one who came here to work. You did not come here to be higher socialites than them, so you have to go with them. You have to be loved by them, not for you to love them[...], it has to do with your upbringing from what you are [sic] before[...]" (EXP#N7)

High levels of commitment and trust, which are associated with successful reciprocal exchanges (Molm, 2003) were manifested as expatriate nurses attributed and strengthened KS ties with local nurses. Even in the face of challenging situational conditions characterised by heavy workloads and time constraints, expatriates with a high sense of commitment were able to find a balance to support local nurses on the ground. Supporting local nurses during intense situations concurs with the motives of altruism and social exchange, whereby an actor seeks to benefit another person even at a cost to themselves (Meeker, 1971), as revealed by a local nurse:

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> "There are some nurses (expatriates) here (referring to the unit) who are dependable, committed to their work. They tell us "Teaching is our job", and they ask us if we need any support, they teach us everything, they call us when they do any new procedure that we have not seen, they offer opportunities and ask us if we want to try, for example, to pull blood, they are so cooperative[...]"(HC#N2)

Expatriates' high level of trust was acknowledged by local nurses to enhance participation in KS activities between local and expatriate nurses. Trust was demonstrated in the sense of working with local nurses as equal professional peers. In the words of a local nurse:

> "She (expatriate) always says that she and I are a good team, So, when I see her [become] tired, I tell her, "Sit, and I will do the work". Other expat nurses look at her in some way as to "How [can] you let her look after the patient alone", and she tells them; "Why do you look at me that way, she can manage the patient alone". She even reinforces me in front of others, saying; "(local nurse's name) is professional", she is such wonderful person[...]" (HC#N10).

In contrast, exploitation and aggressive behaviour were manifested as expatriates' negative behaviour repressed the bidirectional engagement in professional-cultural KS. The instructor role was used by some expatriate nurses to assign undesirable tasks or routine activities to local nurses, undermining opportunities to advance local nurses' clinical competencies. In the words of a local nurse:

> "Some nurses (expatriates) may exploit you[...], they ask us to do tasks for patients who are not assigned to our preceptors or tasks that should not be done by us….a nurse once asked me to go with a patient to the MRI... sometimes we (local nurses) do not

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> mind to help them, and they start to use us. The problem is that while we are doing these tasks, we may miss out on seeing a new procedure[...]"(HC#N5)

When the researcher asked expatriate nurses whether they learned, received help, or benefited from any of the suggestions offered by local nurses, numerous reactions and remarks were associated with expatriates' negative behaviours. For example, Expat #N16 responded, "I have no experience like that until now", and Expat#N18 chuckled to herself and then responded in a surprised tone, "They are not competent enough. We help them".

Work readiness, locals' knowledge base and clinical preparedness, communication skills, and interpersonal skills influenced reciprocal KS practices. Local nurses with adequate clinical exposure were perceived to have the required work readiness to be engaged in the clinical settings. An expatriate instructor expressed:

> "Nowadays, juniors (local nurses) are really good; they come with knowledge already. Maybe because nowadays, they are taught nicely in nursing colleges[...].We (expatriates) only have to refresh[...].We give them tasks; they do all the work[...]. We will just have to supervise them." (EXP#N11)

Competent English skills were seen as an enabler of reciprocal KS. Some of the most common communication problems were the unfamiliarity with medical terms, and with expatriates' socialisation patterns. N2, an expatriate instructor stated:

> "I feel like they are very innocent people (local nurses). They are very innocent, so they do not understand indirect messages[...], it is difficult for them (locals) to understand most of the things, but for the teaching and all those who are interested to learn they are very good. They learn very fast" (EXP#N2)

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2.2 Situational Conditions

Situational conditions entailed temporal and spatial aspects, which varied across nursing hospital units over time in predictable and unpredictable ways. The situational conditions comprised workloads, case criticality, and staffing adequacy and roles. A combination of these situational conditions contributes to feelings of time pressure and preoccupation that restrain the reciprocity of professional-cultural KS between expatriates and local nurses. The rapid and continuous flow of a large volume of patients created unstable situational conditions that influenced professional-cultural KS practices:

> "If we (expatriates) are given a fixed number of patients for the day, at least we get some time to sit with the juniors (locals), but when the patient ratio is increasing, we do not get enough time to teach them, Because we become so stressed and in a hurry to finish our work**.** So, when talking to these juniors, our concentrations are lost." (EXP#N12)

Several local nurses shared similar experiences about the challenges of engaging in learning and being supported by expatriates when patients' conditions were acute. For example, a local nurse pointed out:

> "Most of the nurses (expatriates) fear and do not allow interns (locals) to perform even the injections. They refuse when I ask them to do any procedure, they say that the patients are in critical conditions, so we cannot let the interns do any procedures." (HC#N9)

Other expatriate and local nurses spoke about the extended roles that they had to play to meet the demands of patients, which eventually constrained reciprocal KS. For example,

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> "Nowadays, the situation is worse. It is not easy to work smoothly here now. Even the doctors are not that much responsible, we have to run after the doctors for each and everything, and our time is wasted here following up with the doctors. We are calling them, telling them to do things like writing medication orders and completing patients' care plans. The people's mentalities are not that dedicated like before[...], the new generation is not that dedicated, they just want to finish their job." (EXP#N2)

Discussion: Theorising reciprocal knowledge sharing

While the literature has acknowledged the no-generalisation of case study research findings (Yin, 2014), it is still possible to inductively build theory from case studies (Eisenhardt, 1989; Eisenhardt and Graebner, 2007; Flyvbjerg, 2006). Drawing from our empirical evidence, we have synthetised new insights, about reciprocal knowledge sharing, into a framework (see Figure 1). We argue that the initiation, stabilisation and maintenance of reciprocal KS processes requires some sort of alignment between KS practices and reciprocity modes while attending micro-level conditions. Specifically, the framework indicates that reciprocal KS unfolds through interactions between three KS practices (developing professional-cultural meaning, forming clinical competencies development opportunities, and intervening in unfamiliar situations) and three social exchange modes (reciprocal, negotiated and productive) that are mediated by a set of individual-situational conditions.

Figure 1: Reciprocal knowledge sharing framework

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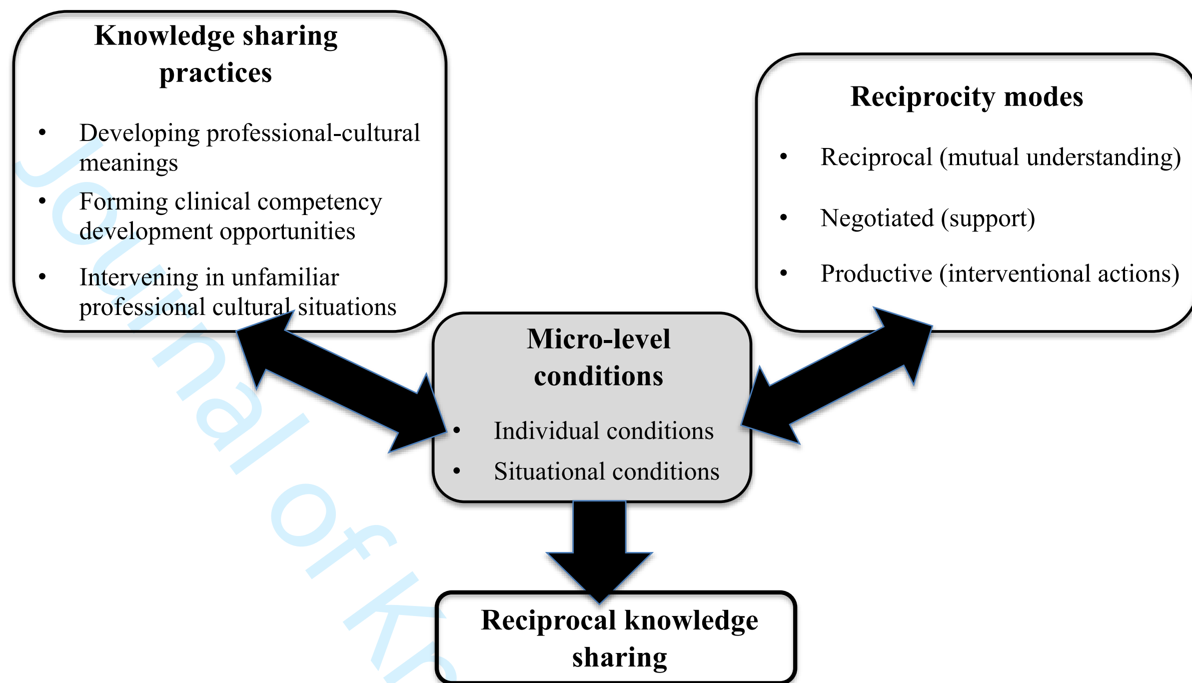

Developing professional-cultural meaning was predominantly shaped by the reciprocal mode. Motivated by mutual needs to improve their awareness of the professional-cultural context, expatriate and local nurses used multiple forms of participation to share their knowledge. The bi-directional KS is underpinned by the bi-directional KS in the relationships, and participation involving orientation programmes, socialisation, and peer-assisted learning to navigate existing competency gaps and culture-based differences. The findings support previous research on KS among health care professionals (Turulja *et al*., 2020), and junior-senior consultants (Handley *et al.,* 2007), which suggest that both formal (institutionalised) and informal social means are vital channels for KS of experiential know-how. Our findings however indicate that cultural knowledge is predominantly shared through informal means that confirm the tacit nature of a significant portion of KS (Holden, 2002).

Forming clinical competencies and developing opportunities were predominantly shaped by the negotiated mode of exchange (Lawler, 2001). Local nurses were prone to exchange their commitment, persistence and help for expatriate nurses' support in facilitating learning

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opportunities. Negotiated knowledge exchange promotes negative sharing attitudes that may inhibit KS between employees (Molm, 2003; Serenko and Bontis; 2016). The findings here indicate that in an expatriate-local interaction context, locals' exchange of commitment and persistence often assist in overcoming expatriates' negative behaviours such as national stereotypes and knowledge withholding that promote KS. Additionally, the findings add to the situated learning research (Gherardi,2009; Handley et al., 2007) by extending the roles of expatriate instructors in facilitating local nurses' competency development.

Intervening in unfamiliar situations was shaped by the productive mode of exchange (Blau, 1964). Motivated by the common goal of ensuring the continuity of delivering safe and culturally compatible nursing care, expatriate and local nurses worked collaboratively to cope with critical situations. The findings here are aligned with productive knowledge exchange to generate positive KS outcomes (Serenko and Bontis, 2016). Interestingly, the findings also suggest that the expatriate nurses' unconditional contributions to acting in situations are often triggered by the urgency and criticality of the situations rather than altruistic motivations. The contributions of local nurses in the interventional actions are in parallel with prior research that suggests local nurses act as socialising agents (Toh and DeNisi, 2007), or job coaches (Carraher *et al.,* 2008), to help expatriates adapt to the host-country culture (van Bakel *et al.,* 2015).

Individual-situational conditions mediated the reciprocity of professional-cultural KS between expatriates and locals. This insight contributes to the micro-foundations' perspective (Foss and Pedersen, 2019), highlighting the need to further explore micro-level conditions. Individual-situational conditions play a critical part in KS, explaining how participation in KS patterns differ between expatriates and locals who are bound by the same set of institutional factors and normative forces. In contrast to Lave and Wenger's (1991) assumption that only altruistic

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motivation drives individual learning or Blau's (1964) view that exchange is derived from the calculation of reciprocity and benefits, the participants' behaviour was predominantly related to individual-situational conditions.

This indicates that reciprocal KS processes involve two-way KS processes that unfold under mutually interdepended social relationships. On the one hand, reciprocal KS processes are likely to unfold when there is alignment between KS practices and social exchange modes. However, there is no direct univocal relationship between a knowledge practice and a social exchange mode since micro-level social conditions mediate relations between KS practices and social exchange modes. On the other hand, micro-level conditions can affect the viability of KS practices and reciprocity modes (see double arrows in Figure 1). While the reciprocal KS framework opens research opportunities (see conclusion section for details), it is necessary to acknowledge some caveats. First, micro-level conditions might change from one setting to another setting. For example, micro-level conditions in large mature organisations performing in stable markets (like hospitals, universities, government organisations) are likely to be different from new small and innovative organisations (like start-ups, non-for-profit organisations). In turn, these diverse micro-level conditions might affect the social exchange mode required for particular KS practice. This pinpoints the need for further empirical research to observe how KS practices and social exchange modes vary depending on micro-level conditions. Second, while KS practices highlighted in this study constitute reasonable guidelines for supporting reciprocal KS processes in hospitals, in settings other than hospitals, there is a need to customise KS practices to the specific situation.

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Conclusions

This study focussed on the phenomena of sharing two forms of knowledge, professional and cultural, in mutually interdepended social relationships. On the one hand, expatriate nurses were highly experienced in practicing professional knowledge but lacked local cultural knowledge. On the other hand, local novice nurses were highly experienced in practicing local cultural knowledge but had little professional knowledge in practice. The empirical focus on a healthcare organisation provided a unique opportunity to explore reciprocal KS processes as exposed to diverse actors and mechanisms in one setting (see Flyvbjerg, 2006). To this end, we combined situated learning in practice (Lave and Wenger, 1991; Wenger, 2003) and social exchange (Blau, 1964; Cropanzano and Mitchell, 2005) lenses to understand further professional-cultural knowledge sharing processes in reciprocal situations. The combination of these lenses, helped to extend the understanding of culture beyond being a barrier to KS (e.g., Mueller, 2012; Li, 2010; Peltokorpi, 2006) or being a unidirectional KS (e.g., Napier, 2006; Toh & DeNisi, 2007). Our findings show culture as knowledge that is reciprocally shared between expatriates and locals to accommodate and negotiate culture-based differences and competency gaps. The cultural adjustment of locals thus was evident by displaying work readiness characterised by imitating or taking on some of their expatriate peers' social and behavioural patterns. Likewise, cultural adjustment of expatriates was demonstrated by acknowledging local customs (e.g. end of life religious support) and adjusting their professional practices to the local situation.

Research findings indicate two micro-level conditions (individual and situational) that mediate relationships between three KS processes (developing professional-cultural meanings, forming clinical competency development opportunities, intervening in unfamiliar professional cultural situations) and three reciprocity modes (reciprocal, negotiated, productive).

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The reciprocal KS framework advanced in this study contributes to the evolving literature (e.g. Han et al., 2020; Holden, 2002; Lenartowicz et al., 2014; Michailova and Hutchings, 2004; Yan et al., 2016; Zhang and Liu, 2021) to understand of reciprocal KS processes. Our framework provides a conceptual instrument to explore mechanisms and relations, associated to the reciprocal sharing of professional and cultural knowledge. This is relevant since most research has usually focussed either in knowledge sharing processes and mechanisms overlooking social exchange modes (e.g. Bouncken and Aslam, 2019; Singh *et al.,* 2019), or in social exchange relationships neglecting KS processes (e.g. Fee and Michailova, 2021; Toh and DeNisi, 2007).

Our research findings extend KS research from the situated learning in practice lens (Handley *et al.,* 2006, Wenger, 2003) by elaborating on the practices of how bi-directional KS progresses through participation among culturally diverse novices and masters. The findings also add to the KS literature from the social exchange lens beyond the focus of either the impact of social exchange modes on KS (Serenko and Bontis; 2016) or the social exchange mechanisms (Singh *et al.,* 2019) and the roles of motivational factors in KS (Sedighi *et al.,* 2016). Through exploring professional-cultural KS in the context of expatriate-local interactions, the findings contribute to cross-cultural research that sheds light on the imbalance in the treatment of cultural relations that go beyond prescriptive and positivist cultural differences as either positive or negative (Stahl and Tung, 2015).

The practice-based view (Gherardi, 2019; Guzman, 2013; Schatzki et al., 2001) underscoring this study allows suggesting that reciprocal KS processes are relational, dynamic, emergent and personal. Reciprocal KS is relational since it connects practices to share diverse forms of knowledge in different social exchange situations; it is dynamic as both relations between KS practices and social exchange modes might change over time depending on micro-level

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conditions and; thereby, it can be emergent since changing micro-level conditions are likely to induce novel KS practices. Lastly, it is also personal. Because tacit knowledge and knowing are embodied, they can only be shared when individuals are embedded in the same social milieu (Collins, 2010). The latter raises questions about the limitations of reciprocal KS processes in virtual spaces. While explicit forms of professional knowledge are feasible to be virtually shared, most tacit/embodied knowledge (e.g., emotional, intuitive, human sensory capabilities) required to share cultural knowledge remains blocked from the virtual spaces (Dreyfus, 2009). The new insights about KS practices and reciprocal relationships bring managerial implications. Findings can guide human resources practitioners to frame individual behaviour and organisational policies, standards, and procedures to support reciprocal relationships to improve KS practices. Managers can purposefully establish an organisational setting that promotes close social relationships between team members, engagement, and support-to-nurture trust. This is truer in organisations where sharing tacit knowledge is critical for their operations, like in the case of healthcare, research and new product development organisations.

To conclude, it is necessary to highlight that the limitations of this study open new opportunities for future research. Since research findings were generated by data collected utilising a single case study, generalisations are not possible (Yin, 2014). However, conceptual insights crystallised in the reciprocal KS framework constitute a heuristics and helpful device to investigate further the reciprocal KS phenomenon (Eisenhardt and Graebner, 2007; Flyvbjerg, 2006).

New conceptual insights can be further tested in different industry settings (out of the health sector) and countries, involving other forms of professional and cultural knowledge and populations. For example, reciprocal KS processes are likely to work differently in large public sector hospitals than small private engineering firms. Similarly, longitudinal studies could

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result in richer insights into the incremental progression (stages) of reciprocal KS processes; the weight of diverse reciprocity modes to support/constraint KS practices; the explanatory power of individual and situational conditions to explain alignment between KS practices and particular reciprocity modes; how KS practices are organised and; how reciprocal KS processes are connected to organisational outcomes, including the development of capabilities and performance.

Based on the reciprocal knowledge sharing framework, the following research propositions may serve as guidelines to further refine the understanding of reciprocal KS processes in the different industry sectors and countries considering diverse combinations of expert-novice and expatriate-local individuals:

P1. Practices to develop professional cultural meanings are both associated with the reciprocal social exchange and mediated by micro-level conditions.

P2. Practices to form professional competency development opportunities are both associated with the negotiated social exchange and mediated by micro-level conditions.

P3. Processes for intervening in unfamiliar professional cultural situations are both associated with the productive social exchange and mediated by micro-level conditions.

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Table 1 Summary of 46 Participants

First Hospital – University					
	Gender	**Age**	**Experience**	**Role**	**Education**
Host (HC)	F – 18	22-25: 15 25-34: 3	<1 year: 18	Nursing Staff: 5 Nursing intern: 13	Bachelor: 18
Expatriate (EXP)	F: 15 M: 1	25-34: 5 35-50: 11	6-10 years: 5 10-15 years: 3 16 – 20 years: 3 20+ years: 5	Clinical instructor: 3 Preceptor: 13	Diploma: 1 Masters: 1 Bachelor: 14
Second Hospital: Public					
Expatriate (EXP)	F: 12	25-34: 6 35-50: 6	6-10 years: 6 10-15 years: 6	Clinical instructor: 9 Preceptor: 3	Masters: 1 Bachelor: 11

Table 2: Three key KS practices

Dimension – Sharing Practices			
Theme	Second-Order Sub-Themes	First-Order Components	Evidence Source
Developing Professional-Cultural Meanings	Raising awareness of nursing hospital system	Delivering general nursing hospital orientations	Documents, Fieldnotes, Interviews
		Providing nursing area orientations	Documents, Fieldnotes, Interviews
		Promoting inclusivity	Interviews
	Raising awareness of common cultural-language praxis	Providing cultural information	Interviews
		Language assistance	Fieldnotes, Interviews
		Forming interpersonal bonds	Interviews
Forming Clinical	Displaying work readiness	Demonstrating clinical preparedness	Interviews
		Demonstrating interest in learning	Interviews

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Competency Development Opportunities	Facilitating clinical competency development	Assessing readiness status	Interviews
		Supporting learning by doing	Fieldnotes, Interviews
		Assessing performance progression	Interviews
Intervening In Unfamiliar Professional-Cultural Situations	Intervening to cope with uncommon and critical situations	Proactive actions	Interviews
		Reactive actions	Interviews
	Intervening to assist with cultural-language difficulties	Pursued assistance	Fieldnotes, Interviews
		Spontaneous assistance	Fieldnotes, Interviews

Table 3: The two micro-level conditions that influence the reciprocity of KS practices

Dimension – Micro-level Conditions			
Theme	Second-Order Sub-Themes	First-Order Components	Evidence Source
Individual Conditions	Personality Attributes	Cultural empathy	Fieldnotes, Interviews
		Cultural curiosity	Fieldnotes, Interviews
		Commitment	Interviews
		Trust	Interviews
		Exploitation	Interviews
		Aggressive behaviour	Interviews
	Work Readiness	Knowledge-based clinical preparedness	Interviews
		Communication skills	Fieldnotes, Interviews
		Interpersonal skills	Fieldnotes, Interviews
	Workloads	Increased patient ratios	Fieldnotes, Interviews
		Overlap between procedures and tasks	Interviews

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Situational Conditions		Increased severity of patients' illnesses and demands	Interviews
	Case Criticality	Acute patients	Interviews
		Critical units	Interviews
	Staffing Adequacy and Roles	Chronic shortage of experienced nursing staff	Interviews
		Extended nursing roles	Interviews

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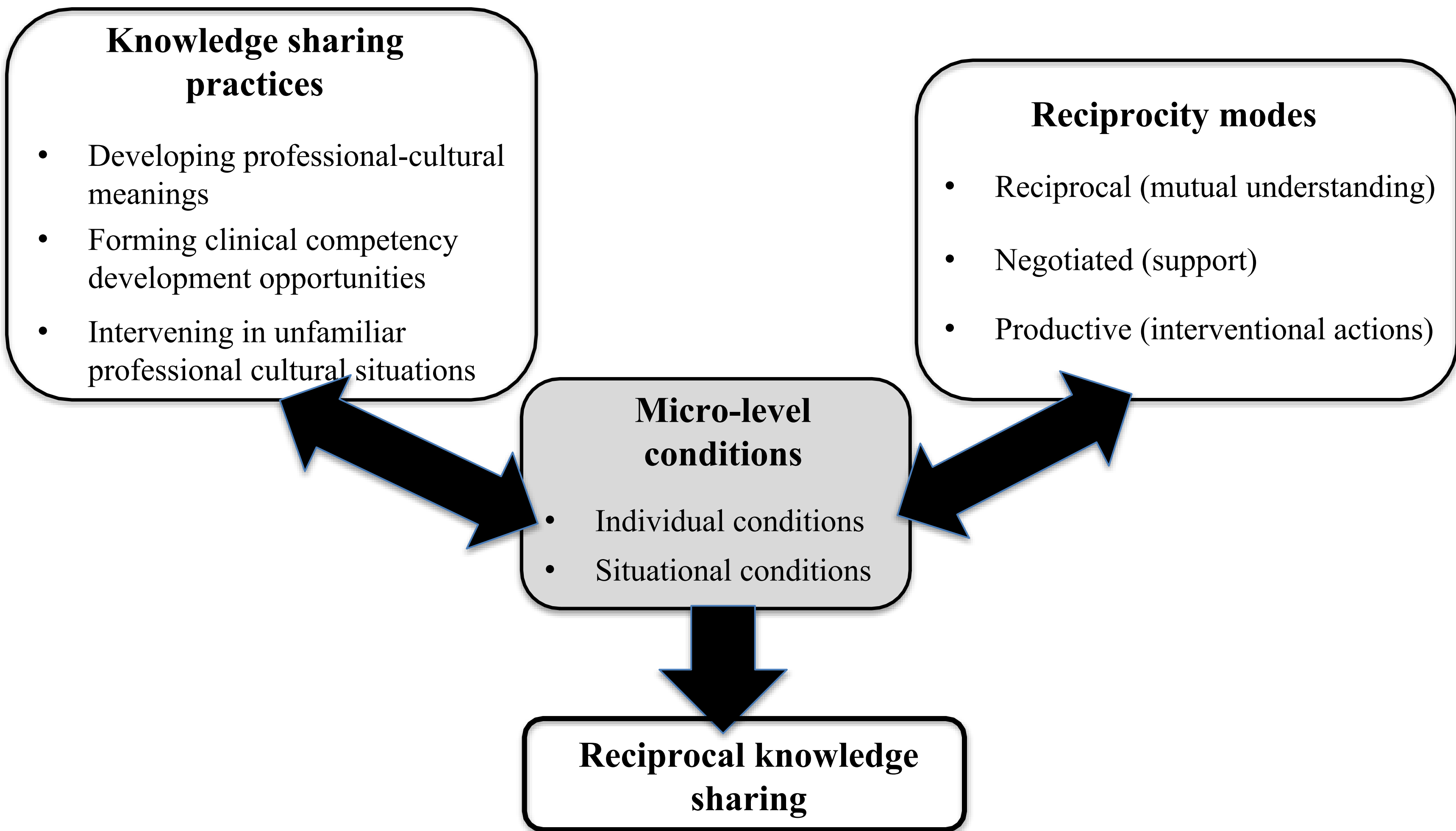

Figure 1: Reciprocal Knowledge Sharing framework