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Workforce Diversity, Managerial Effectiveness, and Knowledge Management as Drivers of Organisational Resilience in Saudi Healthcare: A Conceptual Framework

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Abstract

This conceptual paper develops an integrated framework linking workforce diversity, managerial effectiveness, and knowledge management to organisational resilience in Saudi healthcare. The framework addresses a research gap: most studies examine these antecedents separately, and it is situated at King Faisal Medical Complex (KFMC) in Taif. Drawing on Dynamic Capabilities Theory (DCT) and the Knowledge-Based View (KBV), the model proposes that workforce diversity and managerial effectiveness positively contribute to organisational resilience, while knowledge management mediates both relationships. Workforce diversity is conceptualised through demographic, professional, and cognitive differences; managerial effectiveness emphasises relational leadership and adaptive management; knowledge management comprises acquisition, sharing, storage, and utilisation; and organisational resilience reflects the capacity to prevent, respond to, adapt to, recover from, and learn from disruptions. The conceptualisation is informed by a systematic literature review undertaken during construct operationalisation, which highlighted the multicultural nature of Saudi healthcare and the importance of diversity climate, psychological safety, knowledge sharing, and knowledge utilisation. This study proposes a quantitative, cross-sectional explanatory survey using proportionate stratified sampling, with PLS-SEM planned for empirical testing. The paper contributes a context-sensitive framework aligned with Saudi Vision 2030 and provides practical directions for hospital leaders seeking to strengthen resilience through coordinated diversity, leadership, and knowledge-management strategies.

Keywords: Workforce Diversity, Managerial Effectiveness, Knowledge Management, Organisational Resilience, Saudi Healthcare, Saudi Vision 2030

Introduction

Healthcare organisations operate in environments characterised by public-health emergencies, workforce shortages, technological change, regulatory reform, and changing patient expectations. Organisational resilience has therefore become a strategic requirement, as hospitals must maintain essential services during disruption while learning and adapting afterwards. In Saudi Arabia, this challenge is intensified by the transformation agenda associated with Saudi Vision 2030, including healthcare reform, service-quality improvement, and movement toward more responsive and efficient models of care (Sheerah et al., 2026; Al-Sadoun et al., 2025).

Organisational resilience refers to the capacity to prevent, respond to, adapt to, recover from, and learn from disruptions (Qassim & Abedelrahim, 2024). This definition goes beyond immediate crisis response by emphasising organisational learning and renewal. Hospitals therefore require resources and capabilities that allow them to sense emerging problems, coordinate responses, mobilise knowledge, and redesign routines.

Workforce diversity is one potentially important antecedent. Saudi hospitals contain highly multicultural workforces as well as substantial professional and cognitive diversity. Heterogeneity can broaden the range of knowledge and perspectives available to teams, but it can also create communication difficulties and conflict when inclusion is weak (Almuqati et al., 2026; Knippenberg et al., 2013).

Managerial effectiveness represents a second antecedent. In the Saudi healthcare transformation context, effective management can be framed through relational leadership and adaptive management. Managers who cultivate psychological safety, inclusion, open communication, and flexible responses to changing circumstances can help teams coordinate across professional boundaries and cope with disruption (Alhosani & Ahmad, 2024; Aouad et al., 2024). However, managerial effectiveness may not automatically produce resilience; its effects can depend on processes that convert managerial actions into collective learning.

Knowledge management provides a plausible mechanism. Hospitals continuously generate and depend on knowledge concerning clinical protocols, patient information, operational procedures, safety events, and lessons from crises. Knowledge acquisition, sharing, storage, and use enable organisations to mobilise distributed expertise for problem-solving and adaptation (Ismael et al., 2021; Basiony & Ghonem, 2023). From the Knowledge-Based View, knowledge is a strategic resource, and the capacity to combine and apply it determines whether that resource generates organisational value (Grant, 1996; Kogut & Zander, 2008).

The central problem is the limited integration of diversity, managerial effectiveness, and knowledge management in Saudi healthcare research. Existing studies have often considered diversity, leadership or management, and knowledge processes as separate explanatory variables. Less is therefore known about how workforce diversity and managerial effectiveness may influence resilience through knowledge processes. This gap is particularly relevant to Vision 2030, where hospitals must coordinate diverse human resources while adapting to institutional and technological change.

Problem Statement and Research Gap

Although diversity may provide a broader knowledge base, its benefits are not guaranteed. Diverse teams may experience communication barriers, subgroup formation, or status differences that reduce knowledge exchange (Ellwart et al., 2013; Knippenberg et al., 2013). Similarly, managerial effectiveness may foster resilience, but managers need systems that facilitate knowledge flows and learning (Araei & Mehr, 2022). The unresolved issue, therefore, is how these resources and capabilities translate into resilience.

The gap is threefold: limited integrated examination of the three antecedents; insufficient attention to knowledge management as a mediating mechanism; and limited contextualization of these relationships within Saudi healthcare. The proposed framework addresses these gaps while remaining explicitly conceptual and subject to future empirical testing.

Literature Review

Workforce Diversity and Organisational Resilience

Workforce diversity encompasses demographic, professional, and cognitive differences. Diversity can increase the variety of perspectives available for problem-solving and decision-making, strengthening an organisation's ability to recognise alternative interpretations of disruption (Nyamboga, 2026; Wallrich et al., 2024). Cognitive diversity is particularly relevant because teams facing uncertainty can benefit from different knowledge structures and problem-solving approaches.

However, diversity is double-edged. Without supportive conditions, demographic and professional differences may generate communication breakdowns, interpersonal tension, or reduced coordination (Knippenberg et al., 2013). Diversity climate matters because perceptions of inclusion, equity, and psychological safety influence whether differences become a collective value (IV et al., 2021). In multicultural Saudi hospitals, this issue is particularly salient (Almuqati et al., 2026).

H1: Workforce diversity is positively associated with organisational resilience.

Managerial Effectiveness and Organisational Resilience

Managerial effectiveness concerns managers' ability to coordinate people and resources, respond to changing conditions, and create environments conducive to collective performance. Relational leadership emphasises trust, participation, and psychological safety, while adaptive management emphasises adjusting to changing circumstances (Alhosani & Ahmad, 2024; Su, 2024).

These behaviours support resilience because disruption requires rapid coordination and a willingness to revise routines. Healthcare literature links leadership practices to resilience-building, and supportive, flexible management can help preserve service continuity and staff well-being during crises (Istiqaroh et al., 2022; Qassim & Abedelrahim, 2024).

H2: Managerial effectiveness is positively associated with organisational resilience.

Workforce Diversity and Knowledge Management

Diverse employees contribute different experiences, information, professional knowledge, and perspectives. These differences can enrich knowledge acquisition and creation, particularly where employees are encouraged to exchange ideas (Barley et al., 2018; Mitchell et al., 2009). However, trust deficits and status differences can impede sharing (Ellwart et al., 2013).

H3: Workforce diversity is positively associated with knowledge management.

Literature Review (continued)

Managerial Effectiveness and Knowledge Management

Managers establish social conditions under which knowledge can circulate. Relational behaviours such as active listening, empowerment, recognition, and inclusive communication can reduce barriers to knowledge sharing (Pellegrini et al., 2020). Adaptive management can facilitate knowledge utilisation when decisions must be made under changing conditions (Su, 2024). Conversely, authoritarian practices may restrict knowledge flows because employees fear blame or treat knowledge as a source of power (Chen et al., 2018).

H4: Managerial effectiveness is positively associated with knowledge management.

Knowledge Management and Organisational Resilience

Knowledge management is conceptualised as a multi-process capability involving acquisition, sharing, storage, and utilisation. In healthcare, knowledge sharing is essential for coordination because staff must access current protocols, patient information, safety updates, and operational lessons. Knowledge utilisation is equally important because stored knowledge has limited resilience value unless it can be applied to novel problems (Schmutz et al., 2015; Oborn et al., 2013).

Research connects knowledge management with resilience and agility. Organisations that learn from disruptions and mobilise knowledge quickly adapt more effectively (Ismael et al., 2021; Oo & Rakthin, 2022).

H5: Knowledge management is positively associated with organisational resilience.

Knowledge Management as a Mediator

The central proposition is that knowledge management mediates the relationships between workforce diversity and resilience and between managerial effectiveness and resilience. Mediation is appropriate because knowledge management is conceptualised as the mechanism through which antecedent resources and capabilities are converted into adaptive outcomes.

Workforce diversity enlarges the knowledge pool, but its resilience benefit depends on the ability to acquire, exchange, store, and use that knowledge. Managerial effectiveness establishes trust, psychological safety, and coordination for knowledge flows, after which knowledge processes support learning and adaptive responses (Duchek et al., 2020; Yao & Wang, 2024). This logic is consistent with KBV (Spender & Grant, 1996).

H6: Knowledge management mediates the relationship between workforce diversity and organisational resilience.

H7: Knowledge management mediates the relationship between managerial effectiveness and organisational resilience.

Diversity Climate

The review identifies diversity climate as an important contextual condition. A climate characterised by inclusion, equity, and psychological safety may determine whether diversity supports or hinders knowledge sharing (IV et al., 2021; Asfahani, 2024). Although it is not a formal moderator in the core model, it represents an important extension for future empirical research.

Theoretical Foundation and Conceptual Framework

Dynamic Capabilities Theory

Dynamic Capabilities Theory explains how organisations build, integrate, and reconfigure competencies in response to changing environments (Teece et al., 1997). Wang and Ahmed (2007) emphasise that dynamic capabilities support organisational adaptation. This perspective is relevant to Saudi healthcare because Vision 2030 has created a context of reform, changing regulations, evolving patient expectations, and new organisational arrangements.

Within the proposed model, workforce diversity contributes to sensing by widening the perspectives through which potential disruptions can be detected. Managerial effectiveness supports seizing by facilitating decisions, coordination, and adaptive responses. Knowledge management supports transformation by enabling organisational learning, routine reconfiguration, and application of lessons from disruptions.

Knowledge-Based View

The Knowledge-Based View positions knowledge as a strategically important organisational resource (Grant, 1996). Kogut and Zander (2008) emphasise combinative capabilities through which organisations integrate dispersed knowledge, while Cohen and Levinthal (1990) highlight the importance of absorptive capacity in acquiring, assimilating, transforming, and exploiting knowledge.

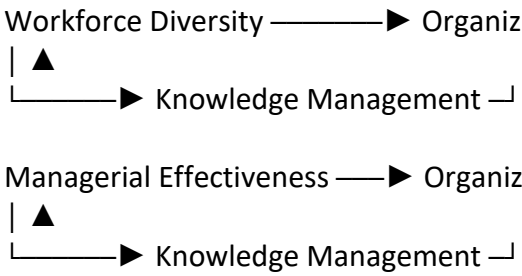
In this framework, workforce diversity creates heterogeneous knowledge resources, managerial effectiveness creates the social conditions for integration, and knowledge management operationalises the processes through which dispersed knowledge becomes an organisational capability.

Integration of DCT and KBV

DCT explains the dynamic process through which organisations sense, seize, and transform in response to disruption, whereas KBV explains why knowledge and knowledge integration are central to adaptive capability. Together they provide a coherent explanation for the proposed mediation model.

Hypothesis	Relationship	Theoretical logic
H1	Diversity → Resilience	DCT: broader sensing; KBV: heterogeneous knowledge
H2	Management → Resilience	DCT: adaptive seizing; KBV: enabling climate
H3	Diversity → KM	KBV: richer knowledge pool; DCT: combinative capability
H4	Management → KM	KBV: integration; DCT: adaptive utilisation
H5	KM → Resilience	DCT: learning/transformation; KBV: application
H6	Diversity → KM → Resilience	KM converts diversity into adaptive capacity
H7	Management → KM → Resilience	KM converts managerial action into adaptation

Figure 1. Proposed Conceptual Framework



Proposed Research Methodology

Research Design

The proposed study adopts a quantitative, cross-sectional, explanatory survey design. The design is appropriate for examining relationships among latent constructs and testing the proposed mediation model at a defined point in time. Because cross-sectional data cannot establish temporal precedence, interpret future findings as associations rather than definitive causation.

Population and Sampling

The target population comprises clinical and non-clinical employees at King Faisal Medical Complex (KFMC) in Taif who have completed at least six months of service. The population includes physicians, nurses, allied-health professionals, administrators, supervisors, and managers, reflecting the professional heterogeneity central to the framework.

If a complete staff list is available, proportionate stratified random sampling by department and professional category is proposed. If access is not feasible, convenience sampling may be used, with explicit acknowledgement of selection bias and limited representativeness.

The source methodology proposes an a priori G*Power calculation using $f^2 = .15$, $\alpha = .05$, and power = .80, producing a minimum of approximately 119 respondents. An oversampling target of approximately 417 usable responses is proposed to accommodate non-response and missing data. These 417 figures are a planning benchmark, not the number of responses to be collected.

Instrument Development

Construct	Proposed measure/source	Items
Workforce Diversity	Mor Barak et al. (2016) Diversity Scale	12
Managerial Effectiveness	Carless et al. (2000); Yukl et al. (2002)	10
Knowledge Management	Gold et al. (2001) KM Capability Scale	16
Organizational Resilience	Lee et al. (2013) Resilience Scale	15
Diversity Climate	McKay et al. (2007) Diversity Climate Scale	9

The measures will be adapted to the Saudi hospital context while retaining their conceptual meaning. Workforce diversity covers demographic, professional, and cognitive dimensions; managerial effectiveness covers relational leadership and adaptive management; knowledge management covers acquisition, sharing, storage, and utilisation; and resilience covers prevention, response, adaptation, recovery, and learning.

Translation and Cultural Adaptation

The questionnaire will be translated from English into Arabic using Brislin's forward-and-back-translation procedure. An independent translator will translate the Arabic version back into English, after which the translators and research team will review discrepancies. This procedure is intended to improve linguistic and conceptual equivalence.

Ethical Considerations

The researchers will obtain ethical approval from the relevant institutional review bodies before data collection. Participants will receive information about the study's purpose, voluntary participation, confidentiality, and their right to withdraw without penalty. Personally identifiable information should not be collected unless necessary and approved. Data should be stored securely and reported in aggregate form.

Data Analysis Strategy

PLS-SEM using SmartPLS 4 is proposed for model estimation because the framework contains multiple latent constructs and mediation paths and has a predictive orientation. Analysis will proceed through data screening, measurement-model assessment, structural-model assessment, and mediation testing.

Data screening will examine missing values, outliers, and distributional issues. The source methodology proposes mean substitution when missingness is below 5% and multiple imputation when it reaches or exceeds 5%. Common method bias will be evaluated using Harman's single-factor approach and VIF; a VIF below 3.3 indicates that severe common method bias is less likely (Kock, 2015).

Measurement Model Criteria

Criterion	Measure	Benchmark	Source
Indicator reliability	Outer loading	> .70	Hair et al. (2019)
Internal consistency	Cronbach's alpha	> .70	Nunnally & Bernstein (1994)
Internal consistency	rho_A	> .70	Dijkstra & Henseler (2015)
Internal consistency	Composite reliability	> .70	Hair et al. (2019)
Convergent validity	AVE	> .50	Fornell & Larcker (1981)
Discriminant validity	HTMT	< .85	Henseler et al. (2015)
Collinearity	VIF	< 3.3	Kock (2015)

Structural Model and Mediation

The structural model will assess the direct paths (H1–H5) and indirect paths (H6–H7). We propose bootstrapping with 10,000 resamples to generate confidence intervals. R^2 will indicate explained variance, f^2 will assess effect contribution, and Q^2 will assess predictive relevance. PLSpredict will be used to examine out-of-sample prediction (Stone, 1974; Geisser, 1974; Shmueli et al., 2019).

Expected Contributions and Implications

Theoretical Contribution

The primary contribution integrates workforce diversity, managerial effectiveness, and knowledge management into a single explanation of organisational resilience. Rather than assuming that diversity or management automatically produces resilience, the framework specifies knowledge management as the mechanism that translates heterogeneous resources and managerial conditions into adaptive capacity.

Together, DCT and KBV provide a coherent explanation of healthcare resilience. DCT explains how organisations sense, seize, and transform in response to disruption, while KBV clarifies how knowledge is acquired, combined, and applied (Teece et al., 1997; Grant, 1996).

Workforce Diversity Contribution

The framework addresses mixed findings on diversity by emphasising the processes through which diversity creates value. Diversity may broaden organisational knowledge but may also create friction. Knowledge management is therefore proposed as a mechanism through which heterogeneous expertise becomes useful for resilience (Duchek et al., 2020; Wallrich et al., 2024).

Knowledge Management Contribution

The study conceptualises knowledge management as a multidimensional capability involving acquisition, sharing, storage, and utilisation. This is important because resilience may depend particularly on rapid knowledge sharing and application during disruption (Ismael et al., 2021; Oborn et al., 2013).

Practical Implications

Hospital administrators should treat diversity as a strategic resource rather than merely a demographic feature. Diversity management should promote equity, belonging, and

psychological safety. Mentoring across professional and cultural groups, inclusive promotion practices, and diversity-climate assessments can support knowledge exchange (IV et al., 2021; Asfahani, 2024).

Leadership development should emphasise relational and adaptive capabilities. Managers should encourage open dialogue, recognise employee contributions, respond flexibly to changing conditions, and create psychologically safe environments. Crisis simulations may strengthen adaptive decision-making (Aouad et al., 2024; Su, 2024).

Hospitals should invest in knowledge-sharing infrastructure, including electronic repositories, cross-departmental forums, after-action reviews, and decision-support mechanisms. Embed knowledge management in routine operations rather than activating it only during crises.

Emergency Preparedness

Build resilience before disruption occurs. Hospitals can integrate diversity, leadership, and knowledge-management capabilities into preparedness plans so staff know how to communicate, access current knowledge, coordinate across departments, and learn from critical incidents.

Discussion of the Conceptual Model

The proposed model coherently explains how hospitals can build resilience through people, management, and knowledge. Workforce diversity provides a broader set of perspectives; managerial effectiveness creates conditions for coordination and adaptive action; and knowledge management converts these resources into organisational learning and usable knowledge. Organisational resilience is consequently treated as an outcome of interacting capabilities.

The framework is particularly relevant to Saudi healthcare because Vision 2030 has created a changing institutional environment. Healthcare organisations must respond to reform, evolving quality expectations, technological developments, and changes in workforce composition (Sheerah et al., 2026; Al-Sadoun et al., 2025).

Diversity Climate as a Potential Extension

Although diversity climate is not included in the core hypotheses, the literature indicates that it may determine whether diversity supports or impedes knowledge exchange. Employees are more likely to contribute knowledge when they perceive inclusion, fairness, and psychological safety. Future research should therefore test diversity climate as a moderator of diversity-related relationships (IV et al., 2021; Asfahani, 2024).

Methodological and Contextual Limitations

The cross-sectional design limits temporal inference. It cannot determine whether diversity and managerial effectiveness precede resilience or whether resilient organisations subsequently attract diverse employees and develop stronger knowledge systems. Longitudinal research is therefore needed.

The single-institution setting also limits generalizability. KFMC may differ from primary care centres, specialised hospitals, or private providers in workforce composition, hierarchy,

resources, and knowledge-management practices. Multi-hospital studies across Saudi regions would provide stronger evidence.

Perception-based measures may introduce common method variance and social desirability bias. Future research should triangulate employee perceptions with objective indicators such as service continuity, patient throughput during disruptions, staffing stability, accreditation performance, and incident-learning records. The source manuscript reports that attempts to obtain granular Ministry of Health and accreditation data were largely unsuccessful because the data were inaccessible.

Institutional and Environmental Factors

The model does not explicitly include regulatory pressure, market competition, government funding, or workforce policies. These factors may alter the strength of the proposed relationships as Saudi healthcare continues to transform. Comparative research across hospitals and stages of transformation could clarify how resilience antecedents evolve.

Future Research

Conduct longitudinal studies across disruption and recovery cycles. Replicate the model across multiple public and private hospitals and Saudi regions. Test diversity climate as a formal moderator. Examine psychological safety, organisational learning, and absorptive capacity as additional mechanisms. Develop healthcare-specific measures of cognitive diversity and knowledge utilisation. Combine surveys with interviews and objective hospital performance indicators.

Conclusion

This conceptual paper proposes an integrated framework in which workforce diversity and managerial effectiveness precede organisational resilience, while knowledge management mediates both relationships. The framework is grounded in Dynamic Capabilities Theory and the Knowledge-Based View and is situated within the Saudi healthcare transformation context. It addresses a literature gap by integrating organisational resources and capabilities that have often been studied separately.

The framework argues that diversity can strengthen resilience by broadening organisational knowledge and perspectives, but its potential depends on effective knowledge processes and an inclusive climate. Managerial effectiveness can strengthen resilience by creating psychological safety, supporting coordination, and enabling adaptive action; it is also expected to operate partly through knowledge acquisition, sharing, storage, and utilisation.

The proposed methodology provides a practical route for empirical testing at King Faisal Medical Complex in Taif using a structured survey and PLS-SEM. At this conceptual stage, sample size, measurement thresholds, and analytical procedures are proposed benchmarks rather than empirical results. Do not report reliability, validity, path coefficients, or mediation results until you have collected and analysed the data.

The study suggests that Saudi hospitals should not manage diversity, leadership, and knowledge management as isolated initiatives. Instead, they should develop them as

mutually reinforcing capabilities that help organisations anticipate disruption, coordinate responses, learn from experience, and sustain service continuity.

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