Chapter 1: Introduction

The Kingdom of Saudi Arabia (KSA) has given the country's healthcare system a high priority, leading to relatively notable improvements in the delivery of healthcare in terms of quality as well as quantity across the country (AlMalki, FitzGerald & Clark, 2011). Gallagher (2002) further points out that:

> Although many nations have seen sizeable growth in their healthcare systems, probably no other Nations (other than Saudi Arabia) of large geographic expanse and population has, in comparable time, achieved so much on a broad national scale, with a relatively high level of care made available to virtually all segments of the population (p. 182).

Of great influence to the healthcare delivery in KSA are the demographic and economic patterns of Saudi Arabia (AlMalki, et al, 2011). KSA's population has grown from 22.6 million in 2004 to 27.1 million in 2010 (AlMalki et al., 2011). The United Nations approximates that the KSA will have about 39.8 million people by 2025 and nearly 54.7 million by the year 2050 (Ministry of Economy and Planning, 2009). These projections assume continued improvements of the existing levels of healthcare and social services delivery in addition to low child mortality rates. These assumptions are based on the government's initiative in the implementation of an obligatory childhood vaccinations programme which was operational since 1980. The projected population increase should have a positive impact on the economy because of the increased availability of human resources.

The Ministry of Health (MOH) in Saudi Arabia was established in 1950 (Walston, Al-Harbi, & Al-Omar, 2008). Currently the Saudi government, through the MOH, finances the country's

healthcare system. The KSA has approximately 415 hospital facilities with approximately 55,932 patient beds and MOH facilities, making up a cumulative 58.7 per cent of the total healthcare services in the KSA, with the remaining 41.3 per cent delivered by other government and private sector organisations (MOH, 2011, p. 232).

Governmental healthcare facilities include: referral hospitals such as the King Faisal Specialists Hospital and Research Centre; medical services for security forces; medical services for armed forces; Ministry of Higher Education hospitals, also known as the teaching hospitals in Saudi Arabia; and the National Guard Health Affairs. Private healthcare facilities, such as the Red Crescent Society, are not included as government healthcare facilities because they offer medical services to a specified group of individuals, including their employees and the dependents of these employees. Although this group has a component of Saudi employees it is largely non-Saudi (expatriates - an uncomplementary term for those from other countries brought into Saudi as a means of complimenting the work force), although they usually provide healthcare services to others in emergency cases that require immediate medical attention.

1.1 Background of the study

In KSA hospitals, patient care has historically been delivered to the population by Overseas Qualified Nurses (OQN) because nursing as a profession in Saudi Arabia is both in its infancy and yet to be wholly accepted by Saudi society (Miller-Rosser, 2009). Of the nearly 14,500 doctors employed by the government of Saudi Arabia to provide healthcare services to the Saudis, only 12 per cent are Saudi citizens (Younge, Moreau, Ezzat, & Gray, 1997). Almost all of the 33,000 nurses employed by the government of Saudi Arabia are non-nationals

(Younge, et al.1997). The percentage of the nursing workforce could not be obtained. Nursing is perceived as an inferior profession in the KSA (Gallagher, 2002). According to Abu-Zinada (2006, cited in Aldossary, While & Barriball, 2008, p. 127), "[an estimated] 25 years will be needed to train enough Saudi nurses" to meet the country's nursing needs effectively. Brown (2005, p. 86) argues that Saudi Arabia is perceived as having the best medical facilities amongst the Middle Eastern countries. The same cannot, unfortunately, be said about the Saudi Arabian nursing profession.

The ability to pay overseas medical personnel well has attracted many medical staff to Saudi Arabia. Van Rooyen, Telford-Smith and Strümpher (2010) maintain that nurses migrate to improve their learning experiences, to improve their living conditions, and, sometimes, to improve their personal safety by leaving dangerous situations in their homeland. However, these personnel, in particular the nurses, face challenges that are caused by social as well as religious factors.

Communication proves to be a major barrier for non-national nurses (referred in this study as OQN), potentially affecting not only culturally sensitive aspects of nursing care to Saudi patients, but also safe and holistic nursing care. Efficient nursing care for patients from different cultural affiliations calls for efficient inter-cultural communication to enable the two parties to understand each other. Equally, personal values as well as lifestyles should be considered in the process of planning for nursing care because different individuals have different world-views (Laird, De Marrais, & Barnes, 2007).

Baker (2007, p. 304) urges international nurses to consider cultural safety as well as cultural practices when delivering healthcare services to patients from different cultural origins. Baker notes that "globalisation does not necessarily blur the distinction between culturally safe and culturally unsafe individuals" and globalisation has the capability of exposing the local minority cultural groups to cultural risks. Torsvik and Hedlund (2008) hold the opinion that the forces of globalisation have led to the establishment of reflective practice with the aim of facilitating the delivery of efficient healthcare to patients with different cultural origins with the health practitioner.

Maier-Lorentz (2008) argues that nurses are required to know the importance of cultural differences during client care delivery and are obliged to demonstrate skills regarding cultural knowledge and competence. Nurses should have knowledge of the values of nursing care and the way of life and ethnicity of the patients they are caring for. Culture defines what is acceptable versus what is not acceptable in a society, it defines the way of life of a people. Culturally competent nurses will use their knowledge to meet the client's needs (Maier-Lorentz, 2008). Leininger (1999) noted that the nurses can no longer remain ignorant nor be prejudiced towards their patient's culture. This statement by Leininger holds a degree of strength, especially when discussing the multinational/multicultural nursing workforces that are becoming apparent worldwide.

Leininger and McFarland (2002, p. 46) point out that nursing "is a learned, humanistic and scientific profession/discipline that focuses on human care and caring activities to assist, support or facilitate individuals or groups to maintain/regain their health/wellbeing." In this definition, nursing is seen as encompassing the ideology of caring for others as the heart of

nursing practice regardless of the cultural background of the patients. In another sense nursing comes from the heart of individual nurses who are committed to the caring practice of nursing.

Addressing the challenges faced by nurses operating in an international arena might begin by encouraging nurses to engage in advancing their education, especially in areas of intercultural communication, which prioritizes the cultural aspects of the communities they intend to be working in. Nurse instructors should take on this challenge in addition to instilling in nurses the virtues of support and compassion as well as patience, the three virtues which are the hallmarks of professional growth and development in the nursing profession (Doughlas & Lipson, 2008). Such intercultural training is in line with the views of Leininger (1990), who introduced the element of transcultural nursing in the nursing curriculum with the intention of equipping nurses with highly sought-after skills of providing healthcare services to patients from different cultural backgrounds. Campesino (2006) suggests that the nursing curriculum should incorporate approaches focusing on trans-cultural relations to enable the nurses to effectively respond to the medical needs of patients regardless of their cultural backgrounds. Deeper and more meaningful explanations of: health and sickness, societal norms, spirituality, and mental illness, among other issues, would go a long way towards ensuring efficient delivery of healthcare to patients from diverse cultural backgrounds.

This study will determine the issues and concerns of OQNs when caring for the Saudi Arabian population. Trans-cultural aspects are included because it is perceived that, within such a multinational workplace, aspects of cultural sensitivity, holistic care and patient's values and believes are central to a high standard nursing care. Along with aspects of trans-cultural

nursing, a description of the Saudi Arabian culture, lifestyle and unique nursing profession will be offered.

1.1.1 Significance and purpose of the study

The purpose of this study is to establish the lived experience of OQNs who are delivering nursing care to Saudi patients within Saudi hospitals. The study will describe the challenges perceived by this group of nurses experienced in the process of delivering care to Saudi patients. The outcome of the study will inform health policy, nursing practice and the development of curricula.

1.2 Study aim and objectives.

Baker (2006) and others (El-Amouri & O'Neill, 2011) note that communication barriers have been identified as one of the main challenges faced by the OQNs working in foreign countries. Baker (2006), in her paper titled: "Globalization and the cultural safety of an immigrant Muslim Community" further states that good communication can only be achieved by ensuring that the challenges of cultural differences are addressed to ensure that the patients are able to communicate efficiently with the foreign healthcare professionals.

This research study aims to explore the experiences of a group of OQNs working in King Fahad Medical City. Twenty-three international nurses who had been officially qualified to work in Saudi Arabia were recruited to participate in this research. These OQN nurses were from 11 countries and had at least two years experience working in KSA. They were asked the following questions (see Chapter 3).

- Can you tell me about your experiences of providing care for patients in a Saudi Arabian hospital?
- What were the problems and challenges facing you in providing nursing care for Saudi patients?

1.3 Organisation of thesis

- Chapter 1 provides an introduction and background to thesis, states the research aims and objectives and provides an explanation of the motivation for the research.
- Chapter 2 is a review of the relevant literature on the provision of cross-cultural hospital/healthcare. Cross-cultural communications as well as transcultural nursing theories are also explored.
- Chapter 3 explains the methodology used for the study, and details the methods used in the collection and analysis of the data.
- Chapter 4 discusses the background to the study. This background is written partly as a reflexive approach in order to give substance to the enquiry and assist the reader to understand the circumstances of the participants.
- Chapter 5 presents the findings of the study in relation to the Saudi Islamic Culture and how it affected the experiences of the group of OQNs.
- Chapter 6 presents the finding of the communication difficulties that faced the research group of OQNs.
- Chapter 7 discusses the problems which the research group faced in their professional practice.
- Chapter 8 gives the conclusion and recommendations.

- Chapter 9 is an epilogue which focuses on the reflexive nature of the phenomenological approach to the study.

1.4 Conclusion

This chapter concludes with the researcher's perspective. The journey from a goat herd to being a student in a foreign country to study at a higher level has been a long one. The concept of reflection was new to me but in one of the nursing units I studied we had to 'reflect'. It was a new and strange thing for me to do. One of the earlier exercises in my career was to reflect on why I had made the decision to undertake nursing as a career. It was one of the easier tasks. The memory that I have written here was already part of me. It was easy to write and the lecturer told me to keep it. I did. Years later it formed the nucleus of this research.

1.5 Researcher's perspective

This thesis is part of a personal nursing journey which began when I was NINE YEARS old when I was with my father during his sickness – he suffered for 33 years from lung failure. Once I went with him to the hospital and one of the western nurses came and a translator was not available at that time. My father and I did not know a word of English, but the nurse was so great and smart and able to give us instructions about how my father should take his medication. She used her experience of having worked in the Kingdom of Saudi Arabia by communicating with us in nonverbal ways. Thereafter, I have increasingly been intrigued by the question: "How did she manage to communicate with us without knowing our language, without any help from any one?" I also believed: "Human sense was the highest believe. She did care with her heart". I believe a nurses' care comes from their hearts and senses. I found that respect is one of the major aspects that would help in understanding others. On the other

hand, most of us have grown up in different environments, which have unique impacts on us throughout our life journeys, but we may get a chance to learn from each other if we give ourselves a space. Nowadays, nurses are in need and demands are higher than before, which will lead to opportunities to work with people from different cultural backgrounds and languages, requiring nurses to have increased awareness of cultural norms. The care that nurses provide is, in my belief, not a job; it is a professional field that needs from us to learn the needs of patients and how to meet challenges that will elevate our image of the level of other health care team members. However, respect for the nursing profession in Saudi Arabia needs more time to develop. There is an urgent need to develop strategies that will help to attract and develop Saudi nurses to the field of heath care. This may need strong support from healthcare leaders in Saudi who have the authority or the people to develop such strategies. Finally, I am proud to be a nurse and I look forward to being part of the Saudi team to lead and worship Rufaidah Al-Aslsamyia, may Allah bless her. I consider nursing care is part of our worship of Allah, as we have been instructed by Allah to take care of and be responsible for the care of our parents.

Chapter 2: Literature review

2.1 Introduction

This chapter explores the literature on intercultural nursing, particularly the available literature on nursing in the KSA. The literature review will be used to guide the study by revealing issues influencing care delivery to Saudi Arabian patients by nurses of varying cultures, backgrounds and languages. Areas explored will include nursing in the KSA, culturally competent care, as interpreted by the expatriate nursing workforce and communication variables that affect the nurse-patient relationship. In addition, the chapter will explore, albeit briefly, the history of the Saudi Arabian Nursing profession and the Islamic believes relating to health and health care. This is important because aspects of KSA cannot be extricated from Islamic believes concerning health. In a similar way the concepts of cross-cultural nursing and cultural safety are inextricably intertwined. The interconnectedness of these two concepts is not explored in this thesis. It is also assumed that fundamentally, safe nursing practice is required at all times and is inherent in all nursing registration bodies throughout the world irrespective of the dominant culture.

2.2 Health care in the Kingdom of Saudi Arabia

Until the beginning of the twentieth century the Saudi people were desert nomads leading an impoverished life. The discovery of oil and the resultant wealth in the country changed this scenario into one in which the majority of Saudi citizens have assured incomes and, increasingly, live in growing cities (El-Sanabary, 1993, p. 138).

As a result of modernisation and the recent increase of migration into cities, KSA has been faced with the need to develop a health care system that meets the demands of a more contemporary population. The country's health care system has developed quickly, resulting in a marked positive impact on the health of the Nations (Tumulty, 2001). Diseases that in the past were once considered incurable, such as Tuberculosis, Poliomyelitis and Malaria have now become curable or treatable, adding to the longevity of the population (Al-Yousuf, Akerele & Al-Mazrou, 2002). This longevity has increased the strain on health care services. In addition the increase of disabilities in the young due to road accidents and consanguineous marriages is also putting a strain on the Health Care System (El-Sanabary, 2003, p. 273).

The health care system in the KSA is huge and does not have the history of gradual growth for the development and education of local people to effectively manage it. By 2011, the KSA had 415 hospital facilities with 55,932 patient beds (MOH, 2011, p. 232). In addition, the private sector plays a significant role in the provision of health care services to urban areas (large towns and cities) comprising 130 hospitals with approximately 13,298 patient beds (MOH, 2011, p. 186).

The *Constitution* of the KSA mandates the government to provide free access to public health care to all individuals working in the public sector. The MOH is responsible for establishing, implementing and monitoring health policies and programmes in both the private and public heath sectors, advising both sectors on ways to achieve set aims and objectives, both for the short-term and long-term (Aldossary et al., 2008). The MOH is responsible for regional directorates-general of health affairs in the Kingdom and currently supervises 20 directorates, each with a number of hospital facilities and health sectors. The MOH further monitors the

performance of primary health care centres. The MOH offers services to its citizens at three distinct levels: the primary level consists of health care centres that offer curative and preventive care to members of the public and refers advanced cases to the public facilities that fall into the secondary level. Complex cases that require advanced medical attention are referred by the secondary facilities to the specialised care facilities (MOH, 2009).

The ever-expanding health care system required the services of health care personnel which could not be found from among the Saudi population. However, the country's new wealth enabled access to healthcare personnel from overseas. Healthcare expatriates were paid well, stayed for a contract period and left again. However, there are significant problems associated with the employment of non-Saudi nurses, doctors and related healthcare personnel because they often do not understand how to deliver care to peoples with a culture worlds away from their own. This is the case even with healthcare professionals who come from other Muslim countries where the interpretations of Islam differ; they believe they have a good command of the Saudi culture but, unfortunately, they do not (Ministry of Islamic Affairs, Endowments, Da`wah, and Guidance in KSA).

The KSA is governed by Shariah, which is the law based on the Holy *Qur'an* as well as the Sayings of the Prophet Mohammed PBUH (Peace be Unto Him). Shariah Law and the Sayings are written in the book known as the *Sunnah*. All or most Saudi patients and families closely follow the guidelines ordered by Allah (in the Holy *Qur'an*) and the interpretation of the Prophet (in the *Sunnah*). The basic Islamic believes of the Saudi population remain the same as they have been for centuries. The place of women remains firmly in the home.

Muslims consult the Holy *Qur'an* to ensure that they make health care decisions that are in line with the teachings of Allah (Al-Rowais, Mohammad, Al-Rukban, & Abdulghani, 2010). There are many common believes, practices, and perceptions that govern their way of life, including how they perceive and seek health care services; believes in the "meaning of illness" and the Saudi Islamic culture may be misinterpreted by others. For example, Saudi patients believe in the concept of "insahalla" (God willing) meaning that, if they are meant to be well, Allah will surely cure them. This is sometimes confused with the concept of "alhamedlillah," which means that they are content with what Allah has given them whether it is a good or bad situation. Both the Holy *Qur'an* and the *Sunnah* teach that all Muslims should have peace and contentment with whatever Allah has given them. This peace with all situations in life is not expected of the very young or inexperienced Muslim or from Muslim who has not sought forgiveness from Allah for the sins they have committed.

Islamic culture is intimately tied up with the teachings of Prophet Mohammed PBUH and believes that a women's place is within the home. This school of thought has been ingrained within the KSA culture for centuries. While it has been argued that women, in the time of the Prophet Mohammed PBUH, were reputedly curing and treating the sick and injured (Miller-Rosser, 2009), the same cannot be said in the more contemporary lives of the Saudi Arabian women. In a more modern Saudi Arabia, the thought of a female Saudi Arabian nurse, for some, sends ripples through a very conservative society. The majority of today's population still believe that a woman's place is in the home. Therefore, with the non-existence of locally trained nurses, the country has relied heavily on an expatriate workforce.

The daily lives of those in the Saudi Islamic culture are ruled by numerous details, which cover all aspects of life from diet to sexual practice and cleanliness. These details are all given in the Holy *Qur'an*. These details not only influence the daily lives of individuals but also the way healthcare is practiced. In addition, Saudi patients practice spiritual healing as advised by the Holy *Qur'an* and the sayings of the Prophet Mohammed PBUH; Saudis believe that such spiritual healing improves a person's wellbeing and health (Al-Shahri, 2002). The practices also impose a number of regulations that make nursing in a public hospital difficult; for example, the left hand is considered unclean and cannot be used by a healthcare professional to feed or administer any other form of care to a Muslim patient. The problems associated with this when an overseas nurse who has been left handed all her life can only be imagined.

In spite of the availability of modern medicine, Al-Rowais et al. (2010), in their study of traditional healers in Riyadh, established that Saudi society adopts, what to Western eyes are, unorthodox means of medicine, usually categorised as Complementary and Alternative Medicine (CAM). The study of 462 families, sampled through a multistage random cluster sampling technique, established that the most common traditional healing techniques adopted among Saudi's include recitation of the Holy *Qur'an*, use of herbs, honey and cupping when it is absolutely needed (Al-Rowais et al., 2010, p. 201; Deuraseh, 2006). Common problems for which Saudis seek traditional healing include lower back pain, abdominal pain, sadness, headache and flatulence. Saudis seek traditional healing for various reasons, including an embedded believe in traditional medicine, a preference for natural materials, dissatisfaction with a physician's diagnosis, non-response to medical treatment and failure of medical treatment. The researcher has had the experience of working in the delivery of healthcare

services to KSA patients and, as such, clearly understands that the Saudi Arabian cultural and religious way of life promotes the application of a traditional healthcare system. An example of this is that Saudis believe in the evil eye whereby jealous individuals are believed to be responsible for the illnesses of children born through consanguinity.

Failing to accept these traditional practices may sometimes cause discomfort to patients as well as the visitors of patients with the result that patients and visitors do not always adhere to medical instructions given by nurses. A phenomenological study by Van Rooyen, Telford-Smith and Strümpher (2010) investigated the reflections of South African nurses working in Saudi Arabia. They found that the nurses experienced cultural diversity in both work and daily life. They especially noted differences in religious practices, in particular the practice of Ramadan. During this time non-Muslim are not allowed to eat or drink in public places; the nurses experienced feelings of discriminations and unfairness at this prohibition. They also pointed out that during prayer times, their workload increased as they became responsible for the patients of their Muslim colleagues. There was also dissatisfaction with the dress code imposed on women: the "abaya", which they were required to wear, increased discomfort during hot weather (Van Rooyen et al., 2010).

In relation to healthcare delivery, the influence of the Holy *Qur'an* and the *Sunnah* are important. The simplest example is found in the concept of modesty and gender laws of the Muslim culture. Unless it is an emergency, female nurses should provide health care services to female patients, and male nurses to male patients. The increase of male nurses in health care delivery today makes this facet of Islamic custom easier and more efficient in providing acceptable services to male patients. Services to female Muslim patients are heavily

influenced by concepts of modesty and privacy: at times a close relative of the same sex as the patient is delegated duties that are considered private, such as cleaning the sick person.

2.3 Nursing in the Kingdom of Saudi Arabia

The progress of nursing in the KSA has been extraordinarily slow. This is due to two factors. The first is the Islamic believe regarding the role of women, and the second is the new-found wealth in the KSA discussed above.

According to Porter (1997), the primary factor causing a lack of Saudi women in nursing is related to the role expected of the Saudi Arabian woman. Saudi Arabia is a very paternalistic society. The Holy *Qur'an* clearly articulates gender roles: men being the head of the homes, while women are considered home keepers. Men are responsible for matters outside the home, protecting and supporting their family, while women raise and educate the children, look after and comfort their families (Royal College of Nursing, 2012).

"Nursing" in the Islamic culture is intimately tied up with the teachings of Prophet Mohammed PBUH and the belief that a woman's place is within the home. Historically, religious leaders have had the responsibility for curing and treating the sick and injured. The influence of Islamic teaching in the use of honey and cupping and the limited use of surgery (cautery only) in trauma is contained in the hadith/book of Sahih Al-Bukhari (Deuraseh, 2006). This is related to the role of the traditional religious leaders when there was a clear distinction between trauma and disease and disease was thought to be essentially a spiritual condition.

> "During Prophet's time, there were people who they think that it is the cauterization itself which cures the affliction. In other words, they believed that if cautery had not been used, then the patient would have perished. This kind of cauterization practiced, according to Ibn Hajar, is prohibited. On the other hand, cautery is permitted when it is perceived as being the appropriate means to affect a cure, but not the essential cause of the cure because Allah (s.w.t) alone cures and grants good health and not cauterization" (Deuraseh, 2006, pp. 11-12).

The first recorded mention of nursing activity within the Muslim society is believed to have originated in the time of the Prophet Mohammed PBUH; which came about as a consequence of the Holy Wars in 625-630 A.D (Miller-Rosser, 2009). Muslim women treated the sick and wounded, provided water, tended injuries, gave medicine, provided comfort and transported the dead back to Medina (Bryant, 2003). One of these women, Rufaidah Al Aslsamyia, became a leader in health care. Rufaidah is reported to have established clinics in mosques and founded the first school of nursing for women (Miller-Rosser, 2009). She is further credited with developing a code of conduct and ethics (AlMalki et al., 2011). Implicit, if not always explicit, cultural sensitivity and passion were embedded in Islamic nursing practice long before the advent of multicultural health as a discrete discipline. Women also apparently practised nursing within their homes during the time of peace and also worked as midwives. Such women were given names such as "Al-Asiyah*"* From the verb *"*aasa*"* meaning "curing the wound" or "Al Qawam*"*, and nowadays called "maumarridah" (Miller-Rosser, 2009; Al-Osimy, 1994; Tumulty, 2001, p. 285).

It was centuries later in 1941 that Lutfiyyah al-Khateed, trained as a nurse in Cairo and returned to Saudi Arabia to become a staunch supporter of, not only women in nursing, but also the nursing profession (Miller-Rosser, 2009). She further advocated for the improvement of the general health and wellbeing of women in Saudi Arabia (El-Sanabary, 1993). Almost two decades later, in the 1960s, the first school for girls opened (El-Sanabary, 1993) and then, after another 16 years, the first college course of nursing was established. In 1990 there were 467 Saudi Arabian women in nursing courses in Kingdom of Saudi Arabia, a miniscule number (El-Sanabary, 1993) in a Saudi Arabian population of 16,259 million (United Nations, 2007, p. 3). In spite of important steps forward, the image of nursing has changed little in Saudi Arabia. As noted above, the growth of nursing in KSA has been 'extraordinarily slow'.

Saudi Arabia has also been slow in implementing systems for the registration of nurses, and for developing standards for nursing curricula and practice. These functions are often carried out by an appointed board, such as the Nursing and Midwifery Board of Australia, which is similar to those existing in other countries. Such boards implement standards meant to protect the public as well as guide and continually develop standards to continually improve the nursing profession. The boards also are responsible for assessing whether nurses qualified in other countries are up to a required standard to practice in the board's country. In the Kingdom of Saudi Arabia there are only standards of practice for doctors and dentists. The Nursing Board in the Saudi Commission of Health Specialties has not yet formalized many of the standards for nursing that are evident in other countries such as Australia. Aldossary (2013), in a study on "The role legitimacy of nurses in Saudi Arabia", notes that expatriate nurses who come to the Kingdom of Saudi Arabia "while they are required to speak English, they have

varied cultural, training, and experiential backgrounds, suggesting different levels of skills." In terms of patient safety this is an area that will need to be addressed in the near future.

Another factor in the slow progress of nursing is related to aspects of the country's changing focus on education, particularly for women, resulting from the KSA's increasing wealth. Until the 20th Century, and the discovery and utilization of oil, KSA was considered to be a third world country (El-Sanabary, 1993). Traditionally, before the discovery of oil, the KSA population were nomadic in nature (Miller-Rosser, 2009). As a consequence of the nomadic lifestyle, schooling took second place while the role of the women was keeping the home and nursing the sick members of the family (El-Sanabary, 2003, p. 257). Education, according to Metz (1993) was to ensure that the believer (Muslim) would understand God's law and live accordingly. While males were encouraged to undertake schooling, females were not. Although the first school for girls was established in 1960 (El-Sanabary, 1993), it was not till the mid-1970s that most Saudi Arabian girls began to actually attend school (Al-Farsy, 2000), providing Saudi Arabian women with the ability to integrate into various programs, such as nursing, and potentially replace the substantial number of OQN nurses within the country (Miller-Rosser, 2009). It should be noted that the education system is fully segregated with no integration of sexes at primary and secondary level of schooling.

In the 1970s the then KSA delivered a royal declaration for the Saudization of the nursing workforce to replace the largely expatriate workforce (Miller-Rosser, 2009). Consequently, the MOH is committed to increasing the number of Nationals in the total workforce as well as in health care – referring to this commitment as "Saudization" of the workforce. El-Sanabary (1993) notes that the concept of Saudization is an important one because the health problems

of the Saudi people cannot be effectively solved by foreigners (p. 1339). It is important that the KSA has professionals who are Saudi and who understand the language, culture and the requirements of the local people. El-Sanabary (1993) further stated that:

> The goal of Saudisation, or achievement of some balance between the numbers of Saudi and foreign health care providers, is not just a matter of National pride, but also of practical necessity (p. 1339)

The desperate lack of locally trained practitioners creates a dependence on foreign physicians and nurses, requiring the recruitment of an international workforce that ideally would settle in the country permanently to contribute to the consistent provision of medical services (Walston, Al-Harbi & Al-Omar, 2008).

A report prepared for the World Health Organisation (WHO, 2006, p. 21) by the MOH of Saudi Arabia included 2003 statistics regarding the human resources in health care in the KSA. The report notes that "61 % are expatriate workers" and that the instability that it brings means that the government needs to address this problem. The report goes on to state that the "Government now has ambitious plans to increase the level of Saudi Nationals providing health services. Targets for this have been developed (WHO, 2006, Table 4, p. 21), and support from WHO has been requested." It further stated that the "Ministry of Health will need to be reviewed more closely by WHO to clarify how it can best provide support." This indicates, to some extent, that WHO was of the opinion that the MOH needed help to achieve its targets. The figures for nursing were predicted to be 31 per cent Saudi nurses by years 2005-2010 and increase to 38 per cent in the years 2010-2015 WHO (2006, p. 21). The MOH statistical annual report of 2010 stated that there were a total of 129,792 nurses and Saudi

nurses were about 31.8 per cent of the total (MOH, 2010, p. 237). This means that the projected percentage in the MOH plan was achieved. The numbers of Saudi nurses increased in the following year to 33.6 per cent (MOH, 2011 p. 232) which means that, if that increase is maintained for each year the total of Saudi nurses would eventually reach the target as planned. The figures for 2012/3 are not yet available. The 10th MOH plan (2015–2020) predicts that the percentage of Saudi nurses will be 44 per cent by 2020 in (WHO, 2006, p. 21).

While an increase in the number of Saudi nurses is looking promising, the KSA's health care system continues to experience problems caused by the unexpected growth of the urban population and other changes in the Nations demography. Many of the problems are centred on the cultural dissonance between patients and nurses. The Saudi public perception is that nursing is less socially and professionally prestigious than other professions. Medicine enjoys much greater public acceptability in KSA than nursing, which remains a low-status occupation avoided by both men and women (Aldossary et al., 2008; AlMalki et al., 2011). Even though, historically, Islamic believes encourages and upholds the status of nursing, contemporary culture discourages young people from joining the profession (Miller-Rosser, 2009). This contemporary culture is something which has gradually evolved out of the Muslim faith, and become part of the multifactorial reasons why nursing has now become a job which is equated with being the same as a servant/maid. Multiple factors, have influenced the denigration of the image of nursing in KSA, including low societal prestige, concerns about mixing with the opposite gender, and the nature of the work and overall workplace conditions, particularly shift work (Al-Omar, 2004; Brown & Busman, 2003; Lovering, 2008).

Al-Omar (2004) studied the attitudes and intentions of high school students towards nursing. He showed that if there was more knowledge about and a more positive perception of nursing, more students would be attracted to the profession.

It is clear from the above that the influence of the Saudi culture on nursing as a profession is profound. Islam also has a powerful control on the everyday lives of those who are Muslim. This is seen in many ways in the area of healthy living and health care delivery itself. In conclusion it must be noted that AlMutairi, Moradi and Idrus (2011), in their study and literature review of the reasons why Saudi nurses do not remain in nursing note: "Apart from its cost, high turnover level will force health sector in Saudi Arabia to depend solely on foreign nurses", and that the government would have to have a 'strategic plan' to solve the problem (AlMutairi et al., 2011, p. 11).

Globalisation and increased diversity has made it crucial for nurses to learn to provide holistic and culturally appropriate services (Ryan, Carlton & Ali, 2000). For OQNs in KSA, this begins with being aware and culturally sensitive to the country's religious and cultural norms. While there is always some cultural orientation for OQNs, this is often not enough. What is necessary is what has been identified by a variety of terms such as "cross cultural care", "multi-cultural nursing and transcultural nursing, usually as part of the undergraduate curricula in Western nursing universities and colleges.

2.4 Transcultural nursing – theoretical models of competent cultural care

Leininger's (1990, 1997) transcultural model of nursing have been used to structure nursing curricula and is used as one of the foundations of practical nursing. Other transcultural models

of nursing have also been formulated. The question, however, remains. Are these models of nursing, practiced in the hospitals and healthcare centres? Leininger (1997) provides her definition of transcultural care:

> [a] formal area of study and practice focused on comparative holistic cultural care, health, and illness patterns of people with respect to differences and similarities in their cultural values, believes, and lifeway's with the goal to provide culturally congruent, competent, and compassionate care (p. 342).

Leininger discusses the need to focus on the nursing aspects of care and not totally on the theoretical aspects of research (Leininger, 1997, p. 342). In the past 30 years, her concept of transcultural nursing has gained widespread acceptance. This shift in thinking has been aided by an increased demand for the provision of competent service to patients from divergent backgrounds, and to the desire of individuals to retain their cultural heritage regardless of their geographical location. OQN nurses may instinctively cling to their own cultural norms, making it more difficult to communicate appropriately with their patients. Leininger (2002) felt the need to introduce transcultural nursing into the nursing curriculum with the realisation that a research-based knowledge of different cultures would equip nurses with the skills to deliver health care in multi-cultural environments, suggesting also that "care" is a universally recognised activity that extends beyond cultural boundaries. Given that Leininger's model has gained widespread acceptance and is the foundation of other models subsequently developed, it is used in this study to provide a theoretical context to the research and findings.

Globalisation and high population growth rates in different countries require cultural competence in the health care professions to ensure that the needs of the world's population are addressed efficiently (Kashima, 2007; Williamson & Harrison, 2010). Health care

professionals must be pro-active in developing world cultural skills by appreciating the personal and cultural viewpoints of others. This would promote the realisation of culturally competent care. Nurses and other health care professionals should understand their own cultural believes and practices before trying to understand the cultural perceptions of their patients, in order to avoid generalising (Maier-Lorentz, 2008). Modern healthcare settings provide an environment in which nurses can or should provide healthcare services and conduct related research activities in culturally diverse settings (Pinikahana, Manias & Happell, 2003).

Numerous transcultural nurse researchers have emerged through the influence of Leininger, with the aim of promoting transcultural nursing. According to Baker (2006), this new breed of transcultural scholars pose a myriad of challenges to nurses, encouraging them to incorporate holistic nursing approaches that address the health care needs of patients regardless of cultural background. The scholars have also developed theoretical and cultural frameworks to guide nurses in the process of providing culturally competent health care. Transcultural scholars stress the importance of not only identifying different cultural factors but also recognising their impacts on the behaviour of individuals.

Boyle (2000) notes that apart from Leininger's research and model, other models add new dimensions to guide the delivery of nursing care, including the Giger and Davidhizar Transcultural Assessment model, (2005) the Purnell model for cultural competence (2002), and the Campinha-Bacote (2008) model of cultural competence. The heart of being culturally competent is an "ongoing journey of unremitting cultural encounters", indicating that being culturally competent is not a skill that is learned quickly but is a "journey" (Campinha-Bacote, 2008, p. 147). Giger and Davidhizar (2002a) define six cultural traits that differ from one

culture to another, and that affect the provision of health care: biological variations, environmental control, the understanding of time, communication, space, and social organisation. Each cultural trait contains myriad variations and diversity between and among cultural groups.

One element that transcultural scholars emphasise is the ethical aspect of patient-nurse encounters. This requires that nurses develop a range of knowledge transcending the mere understanding of different cultures (Baker, 2006). Nursing schedules can incorporate elements that enable them to provide culturally competent services, such as communication modes, awareness of gender issues, interpersonal relationships, and the patient's environment.

The models emphasise the need to understand the adopted culture within the nursing environment in order to provide culturally competent nursing care. The transcultural nursing models provide an organisational framework for nursing care provision within a diverse cultural environment. The models view acquisition of cultural competence as both an endpoint and a process. All these models reflect the importance of communication. Communication is the foundation of social living and the need to communicate is fundamental to effective nursing care. Nurses working within a culturally diverse nursing environment should, therefore, strive to achieve cultural competence by observing communication rules and cultural norms associated with communication.

Narayanasamy (2003) defines trans-cultural nursing as "a formal area of study and practice focused on comparative holistic cultural care, health and illness patterns of people with respect to differences and similarities in their culture, values, believes and life ways" (p. 185). In his

study of trans-cultural nursing in the United Kingdom, Narayanasamy (2003) notes that a gap exists in the evidence explaining how nurses meet patients' cultural needs, arguing that trans-cultural care requires cultural negotiations and compromises that are not effectively carried out by some nurses. His study of 126 qualified nurses in regions with multicultural populations, found that 80 per cent of the participating nurses agreed that their patients had religious, dietary and other culturally specific needs, and that the patients' cultural needs were important in providing professional health care (pp. 187-188). In particular, language difficulties were seen as barriers to care: it would be difficult indeed for nurses to recognise patients' cultural needs if they cannot communicate with their patients, even if they are aware of the importance of these needs. Even though most nurses who participated in the study felt that the patients' cultural needs should be considered and that nurses should be qualified to meet them, Narayanasamy (2003, p. 189) found that 33 per cent of the participants also noted that it had been six months or longer since they had recognised a cultural feature of a patient's needs.

It would seem that experiences in cross-cultural nursing are similar. The transition to working in another culture is not easy. In a study of foreign nurses in the United States, where nurses from the Philippines, India and Nigeria were studied on their transition to nursing in a new country, it was found that the transition to a new culture was "challenging". The foreign nurses found that nursing expectations and standards were not as universal as they thought they might be. They felt incompetent, particularly in the areas of language and communication. These two factors were significant in their "difficult journey" and it was found that they were "major stresses" (Jose, 2008, p. 77; Jose, 2011). Other studies have found

similar results (Magnusdottir, 2005; Omeri & Atkins, 2002; De Veer, Ouden & Francke, 2004)

Magnusdottir (2005) affirms the importance of language in both personal and professional communication, and emphasises culture and communication as inseparable entities. Her study established differences in gender and social class as major communication barriers between patients and nurses. A study in Korea by Park and Song (2005) found that accent or differences in dialect were barriers to both effective communication and therapeutic relationships between nurses and patients.

Other necessary skills have been identified by a number of researchers. These have been classified as being religious understanding, communication and cultural sensitivity, as well as the finding that the experiences of bilingual nurses would be valuable in considering experiences of culturally diverse practice. In the Jose study (2008) knowledge of the language was a significant factor in addition to these skills. Only in circumstances in which healthcare providers can understand cultural norms and practices can true cross cultural care be given in a culturally appropriate ways (Tumulty, 2001; Cioffi, 2005; Narayanasamy, 2003).

Cultural competence and knowledge assessment in health care delivery have been studied in Australia, the United States, and Canada (Williamson & Harrison, 2010). It is significant to note that even when they share a cultural background with the patient, nurses are positioned as outsiders who are invading the beliefs and ideologies of another person. Application of cultural knowledge applies not only to patients from different cultures, but to those with the

same cultural values as the health care providers; for even within a common culture, people hold different personal views and ideologies (AlMalki et al., 2011).

Culturally competent care is taken for granted when nurses and patients share the same cultural values (Mebrouk, 2008). For instance, the role of communication in the Saudi nurse–patient relationship is similar to that in western nursing but is complicated by the cultural impact of gender behaviour. Islamic culture prohibits physical contact (touch) or even eye contact between different sexes, and this has significant impact on communication between patients and nurses that non-nationals have difficulty understanding or accepting. Lack of attention to the nursing role characterised by lack of cross-cultural training further aggravates the situation (El-Amouri & O'Neill, 2011).

To overcome the challenges faced by the OQN providing healthcare in the KSA, it is of great significance to promote learning of the Saudi culture, including language and other perceptions, by the OQN before they embark on the delivery of healthcare services. Daar and Khitamy (2001), point out that cultural knowledge defines a process through which an individual learns the perceptions as well as worldviews of other cultures different from his/her own. In the delivery of healthcare, understanding the culture of the patients can go a long way in enabling the healthcare professionals to provide their patients with highly competent healthcare services due to their cultural competence.

According to Giger and Davidhizar (2008, p. 15), cultural competence is a "complex integration of knowledge, attitude and skills" that enable an individual to understand a certain culture and, as such, be in a better position of working and relating with different individuals

from that culture more efficiently at the individual level, family level or the community level. On this note, Baker (2006) is of the opinion that in order to effectively provide healthcare services to individuals of a different culture, the healthcare provider must efficiently take into account the cultural as well as the religious contexts within which illness and healing occur.

Cultural and educational knowledge influence the cultural skills of nurses. The knowledge of existing cultural concepts in different cultures promotes confidence in the provision of services to patients in culturally diverse environments (Turgut, Yalta, & Tandogan, 2010). Educational interventions positively affect the knowledge of health care professionals, but it is still to be established whether knowledge achieved in this way improves healthcare delivery (Tumulty, 2001).

The goal of overseas healthcare providers should be to provide services that are sensitive to the worldviews as well as the perceptions of the patients, regardless of their cultural backgrounds (AlMalki et al., 2011). Saudi patients value special diets, both non-verbal and verbal communication, prayer time, and their religious and other cultural practices. A health care professional who respects these needs will enhance patient satisfaction and promote a favourable environment for the delivery of care. Healthcare providers need to enhance communication with their patients as a means of promoting the exchange of ideas and understanding ideologies from the patient's culture (Watson, 2007).

According to Tumulty (2001), healthcare providers at times lack knowledge of the cultural values and practices of their patients, leading to miscommunication and misunderstandings and negatively impacting on the delivery of health care. There is a need for healthcare

providers to focus on activities that enhance their cultural understanding (Williamson & Harrison, 2010), although Watson (2007) cautions against gaining "instant cultural competence" which oversimplifies the process of gaining cultural competency and can lead to inefficiency. Attaining cultural competency is a systematic process that is improved by day-to-day encounters, and is neither simple nor quick.

Healthcare professionals should understand that there exists a close relationship between the health of individuals and their cultural values and believes (Williamson & Harrison, 2010). Healthcare professionals with vast cultural knowledge have better chances of interacting effectively with patients from different cultures, and of being more effective in responding to their needs. Baker (2006) suggests that midwives are the most effective promoters of female healthcare since they particularly focus on the wellbeing and the health education of both mother and child. Others could follow this example and pay close attention to patients' cultural values in order to understand their health needs (Tumulty, 2001). This can be achieved through the development of healthcare plans/strategies based on the cultural values and healthcare needs of the patients, and delivering culturally competent services. It also enhances nurses' satisfaction. Cultural knowledge reduces the possibility that they will inadvertently cause distress by performing culturally offensive acts (Aldossary et al., 2008).

Culture is dynamic; some cultural practices lose their meaning and become subject to change as individuals embrace change and realities in the world. Biculturalism entails interaction between two different cultures and occurs when individuals from two different cultures interact. For the purpose of this study, biculturalism is used to describe the interaction between OQNs and Saudi Arabian patients (Tumulty, 2001). Healthcare practitioners must not blindly

uphold the cultural values and perspectives of their patients, especially when they are destructive to the patients and to others.

Cultural competence involves having vast knowledge about other cultures and exhibiting sensitivity when relating to individuals from those cultures. It is a continuous process whereby individuals sharpen their intercultural skills through the daily process of interacting with people from other cultures (Cowan & Norman, 2006; Tumulty, 2001). Issues of cultural competence incorporate the elements of gender as well as of sexual orientation, religion, superstition and family structures; in healthcare delivery, professionals need to acquire efficient cultural skills that enable them to provide services acceptable to individual patients regardless of their cultural background.

Gulati et al. (2012) provides guidelines to enhance the provision of culturally competent health care, citing such elements as accepting information from members of other cultural groups, understanding communicative restrictions, understanding and tolerating traditional health believes, understanding patient's cultural dietary needs, observing patient modesty, sharing news with patients' families, and cultural tolerance. These are all relevant in the case of Saudi Arabia.

Cultural competence is dynamic, giving nurse professionals the chance to learn and become culturally sensitive and as such expanding their abilities when providing health care services to patients from diverse cultural backgrounds (Al-Shahri, 2002). Technological advancement and westernisation have led many health care providers to neglect cultural considerations. Culturally competent care adapts itself to each patient's cultural needs and preferences,

beginning with a cultural assessment that forms the foundation of the care plan (Narayanasamy, 2003). OQN, like other professionals, face adaptation challenges before settling into new environments where an understanding of patients' cultural believes and perceptions is required (Bozionelos, 2009). Often, however, there is little time for them to learn and incorporate these qualities in their practice. They need to be equipped with sufficient cultural knowledge to enable them to adapt to a new culture quickly, and be able to provide culturally competent care with greater ease.

2.5 Caring and culturally competent care

Effective nursing practices are combinations of both caring and technical skills that are performed efficiently and ethically. Nursing is a comprehensive process that entails attending to all the needs of patients: not merely medical ones, but physical, spiritual, emotional, psychological, and cultural ones as well (Aldossary et al, 2008). In research on cross-cultural communication, El-Amouri and O'Neill (2011) use the term "intercultural literacy". It is an important way of describing the capacity or ability of nurses who are able to deliver culturally competent care.

Effective caring calls for a holistic understanding of many different factors at play, including both the patient's condition and the nurse's view of the patient as a complex whole. The nurses and other professionals must put into practice their social skills to facilitate the establishment of a nurse–patient healing relationship that enables the patient to have a feeling of love and care. Cultural stereotypes and prejudices interfere with effective service to patients and lead to biased medical decisions and culturally incompetent care. Cultural knowledge and

patient-centred health care restores the necessary cooperative relationship between healthcare professionals, patients, and patients' families.

In a recent qualitative study in Sweden using nursing students the researchers explored the student's experiences of communication in cross-cultural care. It was found that difficulties encountered in cross-cultural communication hampered the caring experience. This was said by the student nurses but it is probably an indication that the caring experience of the patients was the same – unsatisfactory (Jirwe, Gerrish &Emami, 2010).

Cynthia (2001) argues that customer satisfaction is an important aspect of health, and that this is affected by a nurse's attitude. Health care providers should understand the doubts, fears and apprehensions of their patients and achieve empathy through proper, efficient and effective communication. Treatment procedures such as surgery and physical examinations can become routine to nurses, making them blind to a patient's doubts and concerns. Experienced and devoted nurses remain sensitive to patients' other needs. They take time to alleviate fears and doubts and to ensure that patients are comfortable in all situations (Cynthia, 2001).

Caring entails activities that are geared towards providing support for patients to help them regain health (Leininger & McFarland, 2002). Culturally competent care involves aligning nursing care with the patient's cultural believes through cultural sensitivity and application of knowledge of the patient's culture (Cowan & Norman, 2006). Such an efficient therapeutic relationship calls for a series of encounters between the two parties, and relies on the ability of the nurse to understand the conditions of the patient and responding appropriately (Boyle, 2000).

Al-Shahri (2002) notes that cultural competency can be viewed from different perspectives; in health care, it is defined by understanding one's personal culture, possessing vast knowledge of other cultures, interacting, appreciating and tolerating other cultures, promoting cultural inclusion, and promoting day-to-day learning processes to promote knowledge of other cultures.

A study by Suliman, Welmann, Omer and Thomas (2009) applied Watson's nursing theory in assessing patient perceptions of being cared for in a multicultural environment, and in particular Saudi Arabia. Watson's theory champions the establishment of caring relationships between nurses and patients, unconditional acceptance, treatment of patients with positive regard, promotion of health though knowledge and intervention, and spending caring moments with patients. Nurses are encouraged to develop effective nurse–patient relationships central to each patient's experience and a nurse's identity considering physical, intellectual, cultural and emotional aspects. Unconditional acceptance of patients involves accepting their cultural and religious beliefs and providing care within the realm of those believes and practices.

Suliman et al. (2009) established that Saudi patients highly appreciate nurses who treat them with respect, listens to them and respects their modesty. Although the scales of importance are different, Saudi patients recognize and appreciate all levels of caring behaviours, such as boosting their esteem when they are stressed, anxious and frightened. Nurses are appreciated when they communicate to patients and shape their experience in terms of respect and dignity, offer more practical assistance by providing basic information about their progress, and convey compassion. Nurse–patient communication is clearly valuable, and it is important for nurses to understand and cater for patients' needs in accordance to Watson's trans-caring

model. Ineffective communication leads to anxiety and results in serious repercussions in cases where treatment is sensitive.

During the delivery of health care services, Giger and Davidhizar (2008) note, the relationship between nurse and patient is negatively affected if the nurse interprets the patient's messages incorrectly. They propose that a nurse evaluates his or her cultural believe system, judging the communication process from the patient's cultural perspective and modifying communicative approaches to meet the patient's cultural needs and healthcare delivery, and respecting patient health needs to ensure an efficient nurse–patient healing relationship. Healthcare professionals must eliminate possible cultural blinkers that may hinder their effective use of necessary cultural information (Canfield, Low, & Hovestadt, 2009).

Bozionelos (2009), discussing the global shortage of nursing professionals, argues that countries whose domestic supply is limited are faced with a dual challenge: they are forced to recruit OQNs, and seek the means to retain them for a reasonable amount of time. The dependency on OQNs puts countries such as Saudi Arabia at a high operational and financial disadvantage: not only must they attract enough nurses to staff their hospitals and health centres, but they must replace those who decide not to remain for long. This is particularly troubling because OQNs, as already noted, far outnumber local Saudi nurses.

2.6 Communication in cultural competent care

Communication is integral to nursing care as it facilitates understanding between nurses and patients, patients' family members, and even among nurses themselves (Munoz & Luckmann, 2005). Communication creates a sense of commonality with individuals from other cultures

and enables information sharing and transmission of signals, messages and feelings. Communication also provides a means of sharing and preserving culture. Communication facilitates acceptance of treatment regimens by patients. Giger and Dhavidhizar (2002a) propose judging the communication process from the patient's cultural perspective in order to ensure it is effective: the patient's personal cultural believes and perspectives must be evaluated. In addition, they note that communication across cultural barriers is often the most "significant problem" (Giger & Dhavidhizar, 2002a, p. 185).

Communication is also conveyed to nurses through a patient's expression. In a study by Cynthia (2001) in India where there is a sizable Muslim population, as well as with patients who were sight impaired, the following was emphasised: it is important for nurses to read expressions accurately and reassure the patient by explaining the procedure. Nurses should attentively listen and sympathetically respond to patients' concerns and questions. Nurses are required to talk in an understanding tone to patients who show anxiety but do not voice their concerns. Some of the admirable qualities in nurses are good communication involving more listening than talking, proper oral communication, friendly gestures, and a compassionate outlook depicting sensitivity to fear and pain (Cynthia, 2001). As most nurses interact with numbers of patients in different context and for different reason every day, their ability to effectively communicate with and relate to other people determines the level of comfort, trust and success of their interactions. Stein-Parbury (2005) suggests that listening skills "are fundamental and crucial to patient-nurse relationships and that that nurses' possession of sufficient listening skills could lead to effective patient-nurse relationships" (p. 87).

Communication is an important aspect in cultural preservation. Culture is transmitted and preserved from one individual to the other or from one generation to the next through communication. The elements of verbal and oral communication vary from one culture to the other and are learned by an individual's exposure to a certain culture. Nurses should understand the communication rules stipulated by the patient's culture in order to facilitate the patient's acceptance of the treatment regimen (Liljeroos, Snellman, & Ekstedt, 2011; Sidumo, Ehlers & Hattingh, 2010), as failure to understand and abide by the rules prevents efficient diagnosis. Nurses caught up in miscommunication utilise nonverbal communication and may end up sending or receiving wrong information. Culture engulfs the factors of appropriateness which influence the elements of communication (Bechtel, 2004). Efficient evaluation of cultural communication takes into account kinesics, communication volume, dialect, communication style, context of speech, and the element of touch. Giger and Davidhizar (2002b) note that some Saudis are expressive and warm while others are cold and shy. Male-to-male communication is widely accepted, while female to male conversation is strictly limited unless a female is communicating with her father, son, other male relative, or any other male as long as other females are included in the exchange. Direct eye contact between a male and a female is regarded as sexual seduction, and is highly regulated.

Transcultural communication refers to communication between individuals from different cultures. Burnard and Gill (2009) define four different communication parameters that differ across cultures: proximity – the distance maintained between individuals during conversations; touch; eye contact; speech volume and gestures. Eye contact and touch are restricted in Saudi culture although there are grey areas where they are allowed.

Liljeroos et al. (2011) take a different view and classify verbal elements of communication into word choice, emotion expressiveness, directness in speech, silence and inflection. Liljeroos et al. (2011) emphasise that effective interpersonal communication between health care providers and patients is one of the crucial elements for enhancing client satisfaction, compliance and therefore health outcomes. Patient satisfaction and their opinions of the quality of service received are an important aspect of health care service (Yazdi et al., 2008), to the extent that patient satisfaction is considered an important indicator of quality in many health care systems. Liu, So and Quan, (2007) noted that health care complaints are likely to relate to communication problems rather than medical skills.

Patient involvement through communication is associated with higher trust and satisfaction. Nurses and other health care providers are encouraged to adapt their explanations to patients' needs, to enhance the patients' understanding of the nature of their illnesses and create the impression that their health care providers are concerned about their well-being; this leads to greater satisfaction with the care being provided and increases compliance with proposed treatment regimes. Such effective communication had been identified as the most important factor for patient satisfaction and compliance with treatment (Aldona, Piechulek, & Alsabir, 2001; Hughes, 2003). Effective communication may disclose critical information enabling more accurate diagnosis and facilitating healthcare education or counselling, again leading to better medical treatment and enhanced patient compliance (Royal College of Nursing, 2012).

Effective communication benefits the entire health care system by improving its efficiency. Communication facilitates process behaviours such as information giving, closed and open questions, persuasive counselling, emotional handling/empathy, facilitation of patient input

and solicitation of patient concerns and agenda. Such process behaviours result in patient satisfaction, recall, comprehension and agreement on problems or recommendations, and reduce anxiety, which further results in compliance, confidence and proper utilisation of health care resources. The long-term effects of effective communication between nurses and patients are a resolution of symptom, physiological and function statuses, improved quality of life, reduced care and societal costs and reduced morbidity and mortality. Among the communication skills required for creating a caring atmosphere are being attentive, making eye contact – which is not practiced in Saudi Arabia, listening, asking questions, indicating understanding and empathy; that is, making patients feel significant and valuable. Effective interpersonal communication bridges the sociocultural distance between patient and nurse. Effective interpersonal communication facilitates the provision of information to the patient's family members and friends (Liljeroos et al., 2011), who will influence the patient's decision to understand and comply with healthcare advice. Family members further serve a crucial role in enforcing healthcare instructions. Communication in healthcare assists in establishing of relationships and demonstrating a caring and therapeutic approach (Obermeyer, 2006). Nurses should increase patients' knowledge of the conditions they suffer from and the various means by which they can assist in promoting their own health. Important behaviours in nursing care include appreciating patients as human beings, respecting them, showing sensitivity, treating patient information with confidentiality, talking with patients, treating them as individuals and attentively listening to them (Bruton & Beaman, 2000).

AlMalki et al., (2011), using a cross-sectional study, of the quality of working life among primary health nurses in the Jazan region of Saudi Arabia, established that work context was a

crucial aspect affecting the quality of working life among nurses. The nurses involved in the study highlighted communication as a component of the nursing profession, illustrating this with experiences of good relationships and friendships with co-workers and physicians, achieved through effective communication. A minority of the participants noted that they did not feel respected by physicians, but almost two-thirds of the nurses surveyed spoke favourably of team efforts with them. The participating nurses did highlight the poor perception of nurses within Saudi society.

Communication between nurses and patients is challenged by differences in language; but non-verbal communication using such techniques as touch, space, and silence has been identified as highly effective in overcoming part of the language barrier (Maier-Lorentz, 2008). Achieving competence in intercultural relations takes time and calls for patience and perseverance (Sidumo et al., 2010). Some aspects of non-verbal communication differ between Islamic and western cultures. Some gestures commonly used in western cultures are considered rude in the Asian culture. Touch is considered appropriate in the western cultures, but Islamic culture prohibits touch between unrelated males and females. The left hand is reserved for bodily hygiene in the Middle East and is not used to touch other individuals or pass objects. Touching infants on the heads is taboo in the Islamic culture as the head is considered sacred; western cultures do not share these restrictions or adopt different sets of restrictions.

Patient-oriented approaches emphasise nurse–patient communication as part of the treatment process (Anoosheh, Zarkhah, Faghihzadeh, & Vaismoradi, 2009), but interactions and communication in the healthcare team are also important.

2.6.1 Cross-cultural nurse-nurse communication

Teamwork is a key component of many professions. Teamwork makes employees feel that they are an integral part of a unit working towards relevant outcomes. Healthcare or nursing care calls for a coordinated effort by all those involved. Every care discipline is an integral aspect of patient care, offering something different to the team. Nurses involved in day-to-day care in a hospital environment as part of a coordinated effort report enhanced job satisfaction and a more efficient meeting of patient care outcomes than when they operate in isolation. Nursing, thus, demands teamwork and effective communication among the team (Ward, 2012). Teamwork reinforces the ability of all health care providers to offer higher quality and more efficient care. Effective communication is, therefore, paramount. It is driven by the need to share a patient's condition with team members and to develop collegial relationships.

Teamwork between nurses is underpinned by various nursing models, among them the collaborative care model. The relationship between collaboration and teamwork is the most essential facet of team care. Collaboration generates a synthesis of different perspectives necessary for delivering complete care. The collaborative model calls for individual understanding and appreciation of diversity among the team. Among the attributes associated with collaborative nursing care are the sharing of plans, joint decision-making, goal setting, assuming responsibility, communication and coordination's (Gardner, 2005). Other concepts include cooperation, joint practice and collegiality. Collaborative nursing care adopts communication methods, such as inquisition and dialogue, to achieve greater team effort. It requires the establishment of rapport, clarification of expectations, and requesting and providing feedback to establish and sustain itself. Under the model, nurses are provided with

patient information and collectively facilitate the development of a balanced and commonly understood care plan. Communication optimises teamwork as healthcare providers collectively engage with each other, share patient information, delegate tasks and develop strong working relationships that improve their efficiency and the quality of care provided to their patients (Gardner, 2005).

Van Rooyen et al. (2010) established that the multinational nature of Saudi hospitals creates a unique environment that leads to communication challenges with patients, non-English speaking family members, colleagues, multidisciplinary teams and even friends. The study identifies language differences and accents as the main communication barriers in the Saudi context, and notes that although expatriate nurses adapt and learn a little Arabic, it is usually not enough to achieve effective communication. Even English-speaking nurses in Saudi hospitals do not all speak the same English, and accents are a major barrier to nurse–nurse communication. Poor and ineffective communication results in frustration and feelings of helplessness and stupidity among OQN (van Rooyen et al., 2010). In a transcultural context, communication barriers emanating from differences in accents, especially in individuals who adopt English as the second language, can be overcome through accent reduction training. However, such training rarely occurs as nurses are overburdened with other work-related tasks, such as learning the Arabic language and taking culture-sensitivity classes (Queensland Health, 2010). Clegg (2003) acknowledges that patient aspirations for positive interaction with nursing care providers are undermined by both non-verbal and language barriers, and notes that healthcare providers spend less time with non-English-speaking patients because of the

difficulties in communicating with them. This leads to the creation of superficial relationships between healthcare professionals and patients.

2.7 Conclusion

This chapter reviewed the existing scholarly literature with the intention of providing a background to the lived experience of OQNs caring for patients in Saudi hospitals. It establishes that cultural competence is a continuous process by which individuals sharpen their intercultural skills in the daily process of interacting with people from other cultures. Cultural competence requires particular sensitivity in such matters as gender and sexual orientation. Health care professionals should apply culturally efficient skills that enable them to provide services that are acceptable to an individual with particular regard for his or her cultural background.

The forces of globalisation combined with high population growth in different countries have created an urgent need for professionals who can meet the healthcare needs of the world's population efficiently. In the provision of culturally competent healthcare, it is important that nurses and other professionals understand their own cultural believes and practices before trying to understand those of their patients, in order to avoid generalisations. Communication between nurses and their patients can be made difficult by differences in language, but non-verbal communication can be highly effective in overcoming some communication barriers.

Transcultural nursing refers to the delivery of healthcare in a Nations with different cultural perspectives from the nurse's. While providing healthcare services to patients in a foreign country, nurses often face adaptation challenges before settling down to understand the

cultural believes and perceptions of their patients; but this necessary task is hampered by the relatively limited time available to learn and adapt to the values of the host country.

The development of transcultural nursing is a response to the increased demand for culturally sensitive health care from patients from many different cultural backgrounds; it is fuelled by the forces of globalisation, which throws individuals from different cultures together. It is necessitated by the desire of individuals to retain their cultural heritage regardless of their geographical location. Transcultural nursing facilitates the provision of health care that transcends cultural boundaries. This requires new means of providing culturally specific health care. Theories of cultural diversity and universality in the mid-1950s, and Leininger's theory of transcultural nursing, has aided the development of a curriculum that equips nursing students with the skills needed to deliver culturally competent care (Leininger, 1997).

With a vast growth of Saudi population who are Muslim, Saudi Arabia requires a health service made up of people with effective communication and intercultural skills. Whether large matters like observing religious ceremonial requirements or small matters such as shaking hands, cultural differences need to be understood and accommodated. Consequently, these multinational nurses – most of whom are non-Arabic speaking – are responsible for meeting the healthcare needs of patients from a different culture. As such, nurses in Saudi Arabia face challenges in terms of communicating as well as providing culturally sensitive nursing care to Saudi patients.

Chapter 3: Methodology

3.1 Introduction

This chapter explains the methodology as well as the methods used in this research. Since these methods are grounded in phenomenology, the first part of this chapter discusses phenomenology in nursing and some of the theory behind the phenomenological movement. This will be followed by an explanations of the method used in this research.

The study aimed to establish the lived experiences of OQN providing health care services in Saudi Arabia. Specifically, the study aimed to establish the challenges experienced by OQN due to different cultural and language backgrounds. Further, the study sought to understand the influence of Saudi culture on care for Saudi patients, the experiences of OQN with the Saudi culture and its influence on their care delivery. The purpose of the study and the study objectives informed the choice of research design and research strategy.

3.2 Methodological theory

The researcher adopted phenomenology as the methodological theory. Phenomenology is founded in European philosophy and the assumption about the existence of a significant perceived reality among common features. Heidegger is known as one of the most influential thinkers and contributors to the field of phenomenology. In his foundational treatise, *Being in Time* Heidegger claimed that all research is about the central question of being (Sein) and the possibility of human existence (Dasein) (1962, p. 45). According to Korab-Karpowicz (2014) in a discussion on Heidegger he noted that "the Phenomenology for him is not a descriptive, detached analysis of consciousness. It is a method of access to this question of being." By

using this method Heidegger felt that he would be able to answer the philosophical question of what human existence was.

The aim of phenomenology is to provide detailed descriptions of the lived experiences of a research phenomenon (Starks & Trinidad, 2007). The term "phenomenology" is derived from two Greek words for "appearance" and "meaning". Phenomenology as a philosophy is founded on the Cartesian tradition which emphasises that the ability of humans to know objects is founded on knowledge. The aim of phenomenology is to acquire profound understanding of a phenomenon as opposed to solving a problem. Corben (1999, p. 52) views phenomenology as a "philosophical approach to research" but emphasises the significance of comprehending the changes within the philosophy from its Husserlian beginnings to the more current interpretations of Heidegger and Colaizzi. According to Crotty (1996) and Golding (2011) contemporary phenomenology is normally associated with hermeneutics, establishing a philosophical basis that covers the social interactional nature of experience in the comprehension of human meanings and reality. A "Phenomenologist" tries to provide an understanding of the meaning or the essence of the internal experience of people living in the world through a detailed description of that experience, and seeks to understand the experience rather than provide any sort of causal explanations (van der Zalm & Bergum 2000, p. 212).

Phenomenologists try to see the world through other people's eyes, and the goal is to understand peoples' experiences and the meaning that they give them in their own feelings, thoughts, interpretations and meanings (Andrews, Sullivan, & Minichiello, 2004). The research questions in phenomenology are structured around the lived experiences of the research phenomenon and data collected from a sample of individuals with similar experiences

of the research phenomenon. Data collection is achieved through observation of the participants within the context of the research phenomenon or through an interview strategy where participants describe their experiences in detail (Starks & Trinidad, 2007). Data analysis is done through clustering of the participants' experiences of the research phenomenon into discrete categories or themes and description of the significance of the experiences.

3.2.1 Phenomenology in nursing

Nursing is an interpersonal practice, therefore the experiences that are embraced by this profession aim to recognize the emotions and experiences that occur in the everyday context enabling translation into meaningful text by using the grounding of phenomenology (Spence, 2001). The use of the phenomenological method grounded in the philosophy of Heidegger to underpin nursing research leads to the capacity of researchers to generate a wealth of data that can ultimately benefit the profession. As commented by Johnson (2000):

> Hermeneutic phenomenology can remind us that both the problems we are trying to solve and our understanding of these problems are grounded in situational, cultural and historical contexts that can be brought to the fore. Although this background can never be made completely explicit, an increased understanding of these situational, cultural and historical contexts could potentially lend new insight into the solution of problems that plague nursing. (p. 140)

Yegdich (2000) explored the issue of the phenomenological method and how it related to nursing research. One of the conclusions of the article was that phenomenology was well-suited to nursing because the methodology focuses on the problem of inter subjectivity and not subjects or objects. Therefore, it affords insights into the nurse-patient relationship. Further

comment on the nature of the method of research well-suited to nursing is that by Graham (2001):

> The purpose of the phenomenological enquiry and its importance in clarifying nursing practice, is the opportunity to interpret the meaning of a patient's first-person experience of illness and care and the nurse's first-person experience of the practice of caring. (p. 337)

Schneider, Elliott, LoBiondo-Wood and Haber (2003) note that the approach is commonly used in nursing research because it reflects values and believes that are coherent with nursing, and allow experiences to be explored. The focused question that nurses often pose concerns understanding the experiences of phenomena including health and illness, treatment and care from the perspective of those cared for and those who provide care (Schneider et al., 2003). It is significant that frameworks for qualitative research exhibit coherence between the research question and problem statement, such as the sample/participant, data collection/interview and data analysis/transcription (Schneider et al., 2003).

Al-Busaidi (2008) emphasised the increased application of qualitative phenomenological research in nursing and healthcare research with social and cultural dimensions. Al-Busaidi, argued that nursing researchers prefer qualitative phenomenological research over quantitative research as it aids in establishing the meaning of a phenomenon through description with the objective of developing concepts that assist in enhancing the comprehension of the research phenomenon with an emphasis on the underlying connotations. Phenomenology assists nursing researchers to imaginatively and intuitively approach a research phenomenon with an open mind by laying down previous experiences and pre-conceptions. Wojnar and Swanson (2007) posited that phenomenology has been applied to comprehend experiences of human

healing, caring and wholeness. Balls (2009) views the application of phenomenology in nursing research as grounded in the nurses' view that phenomenology facilitates the sharing of nursing values. Mackey (2005) emphasised the increased adoption of phenomenological approach in nursing research. However, Mackey (2005) accentuated the need to lay the philosophical and methodological foundations for phenomenological research. The author calls for justification of phenomenological research with regards to the philosophical tone, nature of the study and research questions.

3.2.2 The philosophy of phenomenology

The philosophical origin of phenomenology is the ancient Platonic allegory of the cave (Converse, 2012). The allegory postulated the idea that human understanding of reality is a shade of the phenomena of the accurate reality (Starks & Trinidad, 2007). Phenomenology started to gain ascendancy as a philosophy in the 18th century. Immanuel Kant viewed phenomena as an appearance in the human mind and separate from the reality perceived through human senses (Converse, 2012). In the 19th century, Hegel (1997) posited phenomenology as a suitable approach to investigating the path to human consciousness and real knowledge based on exploration and reflection. Franz Brentano's, Principal of Intentionality, integrated thought in phenomenology by associating human mental processes with objective reality, implying that human perceptions are meaningful (Dowling, 2007). This became the central concept in phenomenology as furthered by other researchers such as Edmund Husserl (Converse, 2012).

3.2.3 The phenomenological movement

Husserl, a German philosopher, is credited with initiating the phenomenology movement in 1913 with the publication of the book "General introduction to pure phenomenology" (Converse, 2012, p. 28). This opened up the field to other emergent philosophers who re-theorised the approach to the study of phenomenology. Husserl (1970) as cited in Wojnar and Swanson (2007, p. 173) noted that phenomenology is "the science of essence of consciousness" emphasizing the concept of intentionality and the meaning of human lived experiences. Husserl accentuated philosophical reduction involving stripping off the researcher's preconceptions regarding the research phenomenon (Converse, 2012). This is called experiential epistemology or descriptive phenomenology and is achieved through bracketing, which involves separation of the research phenomenon from the world and dissection of the phenomenon away from held preconceptions (Wojnar & Swanson, 2007).

Husserl was succeeded by Heidegger who opposed the foundation of phenomenology on experiential epistemology grounds and argued that phenomenology should establish the meaning of being. As such Heidegger argued that phenomenology should be concerned with investigating the 'being' of a phenomenon as opposed to the meaning of a phenomenon (Converse, 2012). "Heidegger (1962) also said that the nature of being is a never-ending, circular process so that the meaning of being in the world is also circular" (Converse, 2012, p. 29).

Heidegger (1962) emphasised that before engaging in phenomenology research, researchers must establish their preconceptions in order to enhance understanding and interpretation of the research phenomena. The phenomenology movement was further developed by other

philosophers such as Hans-Georg Gadamer (1900). He viewed researchers as entrenched in social, cultural and historical world and emphasised the need for considering the 'situatedness' in assimilating research findings. Gadamer argued that the hermeneutic circle involved the movement between the study findings and the interpreter. As such, the interpretation process moves from the researcher's preconceptions to novel understandings (Wojnar & Swanson, 2007).

3.2.4 Heideggerian phenomenology

Heideggerian phenomenology is also referred to as hermeneutic phenomenology. Hermeneutic phenomenology is concerned with life as experienced. The aim is to illuminate the minor details and aspects within human experiences with the aim of developing meaning and a sense of comprehension of the illuminated experiences (Laverty, 2003). The approaches of Husserl and Heidegger to phenomenology disagreed in that Husserlian phenomenology emphasised a focus on comprehension of humans or phenomena while hermeneutic phenomenology focuses on the aspect of being human or "the situated meaning of a human in the word" (Wojnar & Swanson, 2007, p. 174). Moreover, while Husserl viewed knowledge as embedded in humans and was interested in their recall, perceptions and thoughts about the world, Heidegger viewed humans as concerned about their fate in the world (Laverty, 2003). Nevertheless, there exists a two-way exchange of influence between the world and humans. As such, human pre-understanding of the world is essential and forms part of human history of background (Laverty, 2003). This background influences the understanding and interpretations made from the lived experiences as the hermeneutic circle moves from past experiences (Converse, 2012).

3.3 Method

The study adopted a hermeneutic phenomenology approach as detailed in the following subsection. The approach assisted the researcher to elicit the lived experiences of OQNs providing services to Saudi patients.

3.3.1 Phenomenology and its use in this research

Hermeneutic phenomenology design was used to examine the OQNs' lived experiences and the meaning of the OQNs' experiences in the Saudi Arabia hospitals. Again, this was consistent with hermeneutic phenomenology as a methodology because human capacity understands and interprets a situation that is linked to background, experiences and culture (Mackey, 2005). A Heideggerian hermeneutic approach was followed in this interpretive inquiry because it recognises the role of the researcher in the research and because it offers a useful approach to asking questions, conducting interviews, analysing texts for themes and patterns, and writing interpretations (Ironside, 2005). The Heideggerian hermeneutic approach acknowledges that all understanding is linked to a given set of fore-structures, such as an individual's history, that cannot be eliminated. The hermeneutic circle, therefore, moves from past experiences in order to increase the depth of understanding of human experiences (Ryan, Coughlan, & Cronin, 2007). This fits well with this study because its sole purpose was to examine the past lived experiences of OQN who provided care to Saudi patients at KFMC.

Koch (1995) as cited in Laverty (2003) compared hermeneutics to earlier types of phenomenology and described Heidegger's conviction that withholding one's own believes was counterproductive to gaining understanding of a phenomenon. This is based on the assumption that researchers should examine their personal experiences before engaging in

phenomenological research as it enhances understanding of the participants' experiences and facilitates clearer interpretation of the experiences (Wojnar & Swanson, 2007). Finlay (2009) describes a phenomenological study as one which seeks to 'elicit descriptions of a subjective nature' by asking broad-based questions about thoughts, perceptions, views, opinions, concerns or feelings regarding the study topic; a methodology very appropriate for this research which operated through the interpretation of interviews and their transcription into text. Interpretation of the text constitutes a movement from understanding to explanations and from explanations to comprehension (Charalambous, Papadopoulos, & Beadsmoore, 2008). This research uncovered the subjective experiences of the participants; it was person-centred as it aimed to gain the OQNs' personal lived experiences in providing nursing care in Saudi Arabia (Bassett, 2004). An experience cannot be transferred to another person, but what can be transferred is the meaning of the experience.

The researcher works within the Saudi healthcare system and, as such, has witnessed the challenges experienced by the OQNs. Therefore, the researcher already had pre-conceptions of the issues experienced by OQNs providing care in Saudi hospitals. This preconception was further informed by the detailed literature review on nursing care in Saudi Arabia. The researcher believes that adopting a Heideggerian hermeneutic phenomenological approach assisted in unearthing and facilitated the interpretation of the necessary themes where the themes may not explicitly manifest (Giorgi, 2007).

3.3.2 Hermeneutics in research

Hermeneutic or interpretive phenomenology emphasises that humans cannot abstract themselves from the contexts that provide meaning to their lived experiences. The assumption

of hermeneutic phenomenology shapes the foundation of pre-understanding. Heidegger (1962) as cited in Wojnar and Swanson (2007) viewed familiarity with a research situation as facilitating easier understanding of the research phenomenon and making interpretation possible. Hermeneutic phenomenologists encourage reflection on researchers' personal experiences before engaging in research into the phenomenon, such as caring for patients. This facilitates easier understanding of the fore structure held by the participants during the interpretive process (Wojnar & Swanson, 2007). In hermeneutic phenomenology, researchers' preconceptions play a significant part in the derived interpretations because the interpretation takes place within the understanding of the researcher because the researcher is viewed as an integral aspect of the historical, social and political world (Converse, 2012). This is emphasised by the assumption in hermeneutic phenomenology that humans live in a social system in which they can experience and interpret; thus shifting the focus from establishing the meaning of a phenomenon to understanding of the phenomenon (Converse, 2012).

3.4 Research design

The study adopted a qualitative design which enables researchers to gain a deeper understanding of human experiences, perceptions and feelings towards the research phenomenon. Qualitative research also aids researchers in unearthing the underlying meanings and attitudes towards the study phenomenon (Mertens, 2010). A qualitative design enabled the researcher to gain the participants' understanding and perceptions of the influence of the Saudi culture on care delivery and the challenges of working in a multi-cultural and language work environment (Kothari, 2004). The study purpose and objectives also informed the adoption of a phenomenological research approach which assisted the researcher to acquire the lived

experiences of OQNs and the challenges they experience in providing nursing care to Saudi patients. Application of a phenomenological approach in the study was justified as the study aimed to gain understanding of the lived experiences of OQNs with regards to the challenges imposed by the Saudi culture on care delivery.

3.4.1 Research process

Two pilot interviews were conducted in 2010 to test the potential of a larger study and to ensure that interpretations of questions were appropriate and consistent (Schneider et al., 2003), to identify problems, and add to reliability through pre-testing (Silverman, 2001). The participants were two female nurses and were introduced to the researcher. The interviews were conducted in person and recorded using a portable digital voice recorder. The pilot interviews tested the interview schedule; that is, they determined the appropriateness of the semi-structured questions and gave an opportunity for the researcher to refine his interview skills.

The digital recordings were downloaded to the researcher's computer as sound files and backed up on a separate laptop computer as well as on a separate external hard drive to ensure the safety and security of the data. A copy of the written interview was given to each participant who requested it. The material was transcribed by the researcher and copies of the typed transcripts were forwarded to the participants and feedback requested. The nature of the feedback was editorial, and there were no requests for major changes or disagreement about the content. After the pilot study, the interview schedule was revised accordingly. The changes involved modifying some of the interview questions to make them more clear, specific and understandable.

A personal journal is a record of the researcher's impressions of the data collection phase; it allows the researcher to learn from the research process (Fink, 2000). Reflection on planned actions leads to a growing understanding and intelligent action (Fink, 2000). A researcher's diary or journal was used to ensure that the researcher was critically reflective of his performance. The keeping of a diary or personal logbook provides the researcher with a record of substantive or methodological issues which arise while collecting data. This record allows the researcher to consider the issues and make decisions about subsequent interviews.

In this study, the researcher used a journal to aid in reflecting on the management of each interview and to identify situations where the interview progressed as expected (Stokes, 2001). According to Shuster (2012), in phenomenological studies, each participant interprets questions differently and sometimes gives answers that are unexpected; the interviewer needs to develop the ability to guide the participant gently back to the topic of interest. The personal journal allowed the researcher to note down thoughts and impressions following each interview, and these proved useful when reflecting on how the interview could be improved. Highlights of what was learned from these journal notes are interwoven throughout this study, and are provided to give the reader insight into how the researcher reflected on and responded to thoughts and comments during the data collection stage.

The researcher noted, in the journal, the necessity to further develop the skills to guide participants and keep them on track discussing the topic of interest. After the first interview, more open-ended questions were developed to encourage the participants to discuss, in their own words, the topic of clinical assessment and to provide direction for the researcher. These strategies helped the interviews to flow and prevented the researcher and the participant from

becoming side-tracked (Fink, 2000). At the commencement of each interview, the participants were encouraged to ask questions after reading the information sheet, and prior to signing the consent form.

Permission was sought from each participant to record the interview, and each interview was transcribed by the researcher immediately afterwards. During transcription, each participant was allocated an identification code used to de-identify the participant in the transcription from the original digital sound file.

Each interview opened with a broad, open-ended question; and depending on the response, the researcher either asked further open-ended questions or prompted the respondent to continue. This process followed recommendations by Shuster (2012) who points out that phenomenological data collection requires the interview to yield a conversation, not to establish a question-and-answer session.

As previously mentioned, the interview schedule was amended following the pilot interview and the first interview as the researcher identified more effective prompts that encouraged the participants to present their experiences and perceptions as a narrative without putting words into their mouths (Fink, 2000). The questions were broad, designed to introduce the topic of interest and encourage a conversation between the participant and the researcher, rather than to gain specific responses to focused questions (Fink, 2000).

3.4.2 Ethical considerations

Following the rules and regulations of the University of New England (UNE) and the National Standards for the Conduct of Research with regard to the consideration of ethical aspects of

research, this study was put before the UNE Human Ethics Committee and the Saudi Arabia MOH and King Fahd Medical City (KFMC) Management for approval prior to commencing the study. According to Fraser and Alexander (2006), before conducting any research, the researchers must appropriately consult the relevant human research ethics bodies and carefully evaluate all possible advantages to be gained from the research as well as risks and discomfort to participants.

The researcher in this study emphasised that the nurses involved were all volunteers. The following points were noted:

- The researcher was a part of the data collection and was also the interviewer.
- Participants were involved in individual interviews.
- Participants responses remained anonymous at all times and they could withdraw from the study without repercussions.
- Participants were encouraged to ask questions about the study even before they started the interview; the researcher ensured that the nurses understood the research and their involvement in the study (Fraser & Alexander, 2006).

Participations were on a voluntary basis, following a detailed explanation of the rationale for the study (see Appendix 1). A signed consent form was required from each participant (See Appendix 2) and confidentiality was maintained by allocating a number to each study participant. Once the interview was completed, the recorded portable digital voice recorder were collected by the researcher and locked in a safe place; the researcher did not materially influence subject matter or content, or reveal private information about participants. During data analysis, identification codes and the transcribed hard copies of the interviews were kept

separately in a locked filing cabinet at the researcher's office in UNE. The portable digital voice recorder files were kept on a secured personal computer with a secure password access; only the researcher had access to the data files. According to the National Health and Medical Research Council guidelines, the portable digital voice recorder files and transcripts will be retained for five years from the date of publication the thesis in which this data set was used and will then be destroyed. In case the results presented to UNE or to academic journals for publication purposes, absolute anonymity of participants will be maintained. Only the researcher and his supervision panel had access to this data.

3.4.3 Methodological issues and limitations

Phenomenology is an inductive, interpretive form of research that allows participants to provide their personal experiences. The adopted interview schedule contained open-ended questions creating a leeway for the participants to drift from the questions. Further, the participants may have exaggerated their experiences thus providing misleading information. However, the researcher encouraged the participants to provide honest accounts of their experiences in providing nursing care within the Saudi culture. The data analysis may have been limited by the researcher's understanding of the experiences of OQN. However, the researcher attentively placed the OQNs' experiences into the identified themes. The adopted qualitative design and one-on-one interviews as the method of data collection inhibits the transferability or generalisability of the research findings.

3.4.4 Methodological rigor

The researcher enhanced procedural rigor by adopting interviews as the appropriate and precise data collection technique. The data analysis incorporated a reflective and critical

analysis of the OQNs' experiences in order to reduce bias and misinterpretations. A qualitative study is credible when it presents accurate descriptions of human experiences in a manner that individuals who share the same experiences would recognize. Credibility was enhanced by interviewing OQNs with more than two years of experience in the Saudi healthcare system. To enhance dependability of the collected data, the transcribed data were sent to the participants in order to verify authenticity and accuracy. The supervision panel of this study verified the data analysis procedure and the subsequent themes and patterns. The adopted data analysis characterised by the researcher's interpretation of the OQNs' experiences, followed by an account of the nurses' experiences, enhances conformability of the conclusions and the interpretations made by the researcher (Ryan et al., 2007). A final critical reflection which Lindseth and Norberg (2004) note is necessary was used in order to "revise, broaden and deepen our awareness" (p. 150). This critical reflection also called reflexivity by (Denzin & Lincoln, 2000, p. 183). "It is a conscious experiencing of the self as both inquirer and respondent, as teacher and learner, as the one coming to know the self within the processes of research itself" which this researcher called a re-ordering of his thinking. This final reflection is contained in Chapter 9.

3.5 Data collection

Data collection was done through face-to-face interviews. The semi-structured interviews were in English and were conducted using an interview guide (Appendix 1) by the researcher. As the researcher and the respondents all worked at the same medical facility, KFMC, it was possible to arrange for the interviews to be conducted face-to-face. Each interview lasted between 45 and 90 minutes. A semi-structured interview schedule, together with a recursive

conversational style of interviewing, was adopted as the major source of data collection. All the interviews were audiotaped electronically with the participant's permission and later transcribed verbatim. It has been argued that data collection should be undertaken in a rigorous and systematic manner, and that the topic area and research questions should always be kept in focus by the researcher (Sweeny, 2005). Throughout the interview, the researcher encouraged participants to relate their lived experience by listening conscientiously and acknowledging what they are saying. To facilitate the interviewing process, probing questions were used. Paraphrasing is also incorporated to gain a more comprehensive understanding of the participants' experience.

3.5.1 Recruitment strategy

A snowball sampling technique was used to recruit OQNs for the study. LoBiondo-Wood and Haber (2002) define the snowball effect as a strategy used to track participants who are difficult to locate. It utilises a social network to find those who have similar characteristics. Participants who meet the eligibility criteria asked others with the same criteria to contact the researcher. Crookes and Davies (2004) explain snowballing as a convenient way of obtaining a sample. The sampling approach assists where participants might hold back if they feel afraid of losing their jobs, or where marginalised or stigmatised groups may be reluctant to participate (Polit, Beck, & Hungler, 2001).This research was conducted in a hospital with a large nursing population which would have made it difficult to contact each OQNs. Moreover, the researcher had, in the past, served as a nursing manager and it was therefore probable that most or some of the OQNs knew the researcher. The snowball sampling technique was thus appropriate for the study.

The researcher, in order to gain the attention of OQNs, placed banners on different notice boards within the hospital inviting OQNs with more than two years of nursing experience in Saudi Arabia to participate in the study. The banners informed the nurses of the purpose of the study and asked OQNs to inform their colleagues about the study. The banners also contained the researcher's contact information through which interested OQNs could register their interest to participate in the study.

Through the snowballing technique, the researcher recruited a sample of 23 OQNs for the study. The small sample size is justified for phenomenological studies, which involve intensive data collection and analyses. According to Polit et al. (2001, p. 248) the number of participants in a phenomenological investigation can be ten or fewer.

3.5.2 The research participants

The study population was a group of OQNs providing nursing care in KFMC. Participants were recruited through their colleagues using a snowballing technique. In order to be included in the study, the nurses had to be non-Saudi's, either male or female nurses, who had worked at KFMC for a minimum of two years. The nurses also had to have the capability to fluently articulate their experiences in English. It must be noted that for some of the participants English was their second language. This is sometimes obvious in the quotations used in later chapters.

From this population, the researcher contacted 23 OQNs drawn from 11 countries: Australia, Canada, US, Ireland, UK, Germany, India, Philippines, South Africa, Portugal and New Zealand (Table 1).

Table 1: Participants' demography

Participant Pseudonym	Nationality
001 Kay	Australian
002 Joan	Canadian
003 Linda	South African
004 Alma	Filipino
005 Jill	Australian
006 David	Filipino
007 Joe	Filipino
008 Tanya	South African
009 Mavis	Indian
010 Betty	Filipino
011 Dot	Canadian
012 Louise	Indian
013 George	Canadian
014 Liz	American
015 Sue	Portuguese
016 Shirley	German
017 Bill	UK-British
018 Val	Filipino
019 Steve	UK-British
020 Sarah	New Zealand
021 Jean	New Zealand
022 Georgia	UK-Irish
023 May	Australian

The majority of nurses were female. The participants' ages ranged from 25 to 65 years old and both genders were interviewed (Table 2).

Table 2: Age of participants

Age range	Female	Male
20–25	0	0
26–30	2	1
31–35	1	1
36–40	3	0
41–45	3	2
46–50	6	1
51–55	2	0
51-55	0	0
61–65	1	0
66–70	0	0
Total (23)	**18**	**5**

Most of the nurses who participated in the study had over five years experience working in Saudi Arabia (Table 3).

Table 3: Length of experience in Saudi Arabia

Years	Male	Female	Total Participants
2–3	2	4	6
3–4	0	0	0
4–5	0	0	0
More than 5	3	14	17
Total	5	18	23

The majority of OQNs had acquired their bachelor degree while working as it is part of the permission requirements in most of the hospitals. Table 4 illustrates the level of nurses' qualification, starting from the level of nursing diploma up to PhD.

Table 4: Level of nurses' qualifications

Qualification	Years
Nursing certificate(s)	2
Nursing diploma	3
Bachelor degree	12
Postgraduate certificate	4
Graduate diploma	0
Master degree	1
Other (please specify) PhD	1
Total	**23**

3.5.3 The interviews

Three iterations of the interview schedule helped ensure the appropriate collection of "detailed and richly textured person-centred information" that gave "access to subjective perceptions, meaning and understandings" (Andrews, Sullivan, & Minichiello, 2004, p. 412).The first iteration of the interview schedule focused on the issues and challenges facing overseas nurses, and what nurses do: that is, the functions of nurse–patient communication in the trans-cultural setting; all issues that were raised were derived from contemporary nursing literature. This iteration was trialled in the two interviews of the pilot study. It was considered by the researcher to produce significant, often confirmatory, data about what nurses experienced, but not to elicit what they thought and perceived to be the reality of their role and what they saw as the issues and challenges of that experience. A second iteration was prepared but not used or trialled because of the drafted questions, when reviewed with the researcher's supervisors, were considered too directional. A refined third iteration was applied in the study properly to improve the effectiveness of the interview questions because they were broad and did not limit

the participants' capacity to respond, more accurately reflecting the research purpose and aims, and the design of the study. This staged approach to the development of the interview schedule and the inclusion of pilot interviews helped to develop the rigour data for further qualitative analysis. It is consistent with a hermeneutic – phenomenological approach (Shuster, 2012).

The final iteration is listed in Appendix 2. This version includes prompts and amplifications that were used to stimulate discussion. Semi-structured interviews to be the most effective way of eliciting valuable data because of the freedom and flexibility to obtain a better understanding of what the interviewee was giving. For example, the first opening question, which was broad, evolved from a review of the literature and the pilot interview. This is consistent with the tendency in phenomenological research to make opening questions deliberately broad; subsequent prompts or questions are only employed to keep the conversation flowing (Burns & Grove, 2007; Shuster, 2012). Following the opening question, the interviewer moved to more specific questions regarding the participant's perceptions of competence and related issues. The interview schedules also contained questions seeking the participants' demographics as the researcher believed that participants' demographics have an influence on how they perceive issues (Kothari, 2004) and on the perceived differences between the participants' culture and the Saudi culture.

3.6 Data analysis

Thematic analysis was used to analyse the data since the study involved interpretive and inductive processes. Qualitative data can be organised manually or by using NVivo computer software. The software facilitates interrogation of data and also enhances the accuracy and

transparency in data analyses (Welsh, 2002). Despite the advantages of NVivo, data analysis for the study was done manually since manual analyses facilitated adoption of the interpretive steps in data analyses. The data were subjected to the phenomenological process of analysis developed by nurse phenomenologists Diekelmann, Allen, and Tanner (1989) and Benner (1994). This framework allowed analysis to be considered as a time efficient process as to occur simultaneously with data collection (Halligan, 2006), its stages are flexible and it allows participants to validate their transcripts, thereby enhancing the rigour of the study.

The philosophical stance of Heidegger guided the interpretive approach taken. Analysis of the narrative text of interviews involved the following seven steps as outlined by Diekelmann, Allen and Tanner (1989). They are:

1. Reading the interviews to obtain an overall understanding;

2. Writing interpretive summaries and coding for emerging themes;

3. Analysing selected transcripts as a group to identify themes;

4. Returning to the text or to the participants to clarify disagreements in interpretation then writing a composite analysis for each text;

5. Comparing and contrasting texts to identify and describe shared practices and common meanings;

6. Identifying patterns that link the themes; and

7. Eliciting responses and suggestions on a final draft from the interpretive team and from others who are familiar with the content or the methods of study (Wojnar & Swanson, 2007, p. 177).

Consistent with this analytical approach, the researcher also embraced the suggestions of Benner (1994), which included: isolation of paradigm cases (cases that capture all themes), and examinations of repetitious themes within and between cases. Therefore, paradigm cases will be presented in the findings and be used to draw out and illustrate the various themes of the participants' experiences. The themes will be presented as exemplary quotes.

In this light, the researcher read the significant participants' descriptions and findings with the aim of gaining a better understanding of the participants' lived experiences. In the extraction phase, significant responses, terms and statements relating to the nursing care within the Saudi culture, influence of Saudi culture on nursing care, influence of trans-cultural setting on communication were extracted. The significant extracts and terms informed formulation of meanings. The researcher then reviewed the participants' responses, organizing the formulated meanings into themes. In order to ensure authenticity and consistency, the researcher referred to the original statements. The researcher then integrated the themes into exhaustive descriptions and formulated the significant structure of the research phenomenon. The final step involved validation of the analysed data through evaluation by the study participants (Mehrabi, Ghazavi, & Malbousizadeh, 2010).

The analysis proceeded as follows: First the researcher read each transcript thoroughly several times to gain an overall sense of the interviews. Major concepts or themes were identified and

listed. A code was used for each concept by a process called open coding (Liamputtong & Ezzy, 2005); the criterion for assigning a code was the code relation to the aim of the study. Axial coding was used to develop and re-organise the themes, sub-themes and sub-sub-themes, based on the connections between them that emerged from the data and the aim of the study (Halligan, 2006). The findings presented in chapters Five, Six, Seven and Nine offers paradigm cases followed by the themes and sub-themes of the phenomenon.

3.7 Summary

This chapter discusses the methodology adopted by the researcher in establishing the lived experiences of OQNs who deliver nursing care to Saudi patients KFMC. The study adopted a qualitative design and a hermeneutic phenomenological approach. The chapter reviews various phenomenological schools of thought and proceeds to justify the adopted hermeneutic approach. The use of snowball sampling to identify study participants was explained, as was the development and conduct of interview questions and techniques, and analysis of data. The chapter also details the ethical considerations that were followed in carrying out the study.

In the next chapter, the researcher will present the background to the study as reflective approach in order to give and assist the reader to understand the challenges that faced the participants while delivering their nursing care in a different country and culture. The researcher will identify themes and patterns in the transcribed data after which the participants' responses will be classified under the appropriate themes using exemplary quotes.

Chapter 4: Contextual practice in a foreign land

4.1 Introduction

This Chapter provides a background to the study, written partly as a reflexive approach in order to give substance to the enquiry and assist the reader to understand the circumstances of the participants.

In hermeneutic phenomenology, researchers' preconceptions play a significant part in the derived interpretations because the interpretations take place within the understanding of the researcher; the researcher is viewed as an integral aspect of the historical, social and political world (Converse, 2012). In addition this chapter is part of the process of understanding the environment of the hospital in which the research takes place. It was also considered important that, as part of a reflexive process, the milieu or context into which all the OQNs are working is be considered. The researcher also needed to ask himself if his experience in coming to Australia had affected his understanding of the overseas nurse as the researcher had become an 'expat' in Australia in order to upgrade his qualifications. He will be returning to Saudi Arabia. This was possibly a good place to begin. Why did the OQNs come to KSA?

Although the practice of nursing, caring for the sick, is the same the world over, the limitations imposed by the culture in which the nurse is working is significant. In Saudi Arabia the practice of nursing probably has more differences and limitations than found in many other cultures.

A necessary part of any phenomenological research process is to position the researcher to the time and place of the research and make an attempt to orient the reader to the results because

of some knowledge they have of the setting/mood/tone of the background/setting where the research was done. This can be difficult when the reader is not familiar with the place where the research is being carried out. In order to understand the complexities of this research it is considered important to orient the reader to the time and place of the destinations the new OQN will find themselves in.

Phenomenology seeks to find the lived experience of a particular group in a particular place often not a place which the researcher is not familiar with. In this case the setting is one in which this researcher is intimately involved in.

As a widely travelled person and now a student researcher in a foreign country, the researcher understood that the concept of reflexivity is important. The researcher asked himself: what would they need to know and what were the challenges? The researcher needed to try and place himself in the position of the OQNs and ask himself what sorts of problems might be encountered.

The researcher had worked with these OQNs for nearly 25 years and needed to understand the role of the OQNs and what his attitudes were toward this significant and essential group working in the hospitals of the KSA. He asked himself if he had, over time, come to regard and treat them as other Saudi Arabian qualified nurses did. An assumption that he treated them differently was indeed dangerous. Nurses are expected to observe such socio-religious practices such as greeting patients in a particular way after Ramadan. Failure to do so is culturally incompetent. Did the OQNs always conform to such cultural standards? The

research was about the challenges faced by this important group and first he needed to examine his own understanding of the group.

He gave some thought, again, to what the status of nursing would be in the countries that the OQNs came from. The KSA has a very different view of nursing than that of Western Nations where nurses are viewed as independent practitioners working with other members of an interdisciplinary health care team. He reflected again on the Saudi culture that considers nursing as an inferior profession, a perception that is reinforced by its long working hours and relatively poor remuneration. The pay for nurses is not competitive when compared to other professions within the Kingdom. As a male, the researcher's pay is far below the pay of other males in the KSA. However, the pay is made lucrative for OQNs who move from their parent countries to provide services within the KSA. The poor image within Saudi Arabia is worsened by the erroneous view that hospitals facilitate gender intermixing and parents are extremely protective of their daughters, so nursing is not encouraged as a profession. Traditionally under Saudi culture, roles are divided across gender lines. Although this perception is changing, and males and females are increasingly working in similar places, especially hospitals, the image of the nursing profession is yet to improve.

The researcher reflected on the friction between Saudi Nationals and the OQNs that he had been involved in mediating. On the one side Saudi National RNs (Registered Nurse) or medical staffs were adamant that cultural more and religious observances needed to be kept, and on the other side the leaders of nursing units insisted that some local standards have to be brushed aside to ensure that patients are provided with the best of care. Surely this would be a challenge.

There were many aspects of moving to a new country that would have an effect and affect the new OQNs. The physical realities would be problematical enough. The hot dry desert climate, single quarters called compounds and qualifications from a variety of different countries would all be bound to make it difficult to settle. The researcher reflected on his own move to Australia and the impact of the winter with cold wet days and freezing mornings having to get out of bed to go to the library, again. Over the years the researcher has come to a general understanding that the OQNs came for the money and the excitement of travel. Sometimes they came for the experience and a means of promotion when they returned to their home country.

Not only is there a lure of excitement about visiting a foreign country, there is also the promise of having an excellent tax-free salary and the ability to save for a new home in their own country or having extra money to travel further. Usually the story begins with a qualified nurse hearing about the exciting time that one can have in one of the Middle Eastern Countries and then exploring the internet for details. In reflecting, the researcher did the same. It served to quickly change his understanding of the OQNs. The hospitals usually have a photograph on the home page. Almost all the hospitals are new and, with the money from oil exports, are imposing. The KFMC is magnificent and the researcher himself was impressed (see Figure 4.1).

The hospitals in the Middle East are described as having the latest equipment and providing the ability to gain excellent experience and so gaining the advantage of being able to use this valuable experience to climb the professional ladder in their home country. There is the added

attraction of being able to work in an environment that has the latest state of the art medical technology; will be the pioneer tertiary care centre providing third and fourth levels of specialized medical care. Commissioning will also include inauguration of specialized centres of excellence in every major medical specialty to serve as a hub for excellence in medical care.

Figure 4.1: The King Fahad Medical City

The whole concept of being able to work in a new exciting hospital that is so well portrayed as well as having a good salary must be an excellent attraction. It occurred to the researcher that he had no idea that it was so alluring to come to his home country. He was proud that his understanding of the motivation of the OQNs deepened.

The researcher took some time to further explore the website of the City. He was sure that the OQNs would take the time and trouble to explore the website of the hospital they have elected to work in. The web page for the KFMC explains the facilities for staff – seven swimming pools, tennis courts and so on. For many of the OQNs it would be awe inspiring. Some of the text from the KFMC site has been used to give an idea of the surroundings that the OQNs would be working in:

> In this prosperous era of the reigning Custodian of Two Holy Mosques King Abdullah bin Abdulaziz; Ministry of Health is extremely proud of one of his greatest and most exceptional medical achievement.
>
> Enjoying the strategic location in the heart of Riyadh City – the capital of Kingdom of Saudi Arabia, King Fahad Medical City is considered the largest and most advanced medical complex in the Middle East with a total capacity of 1095 beds. This colossal medical facility built at a cost of 2.3 billion Saudi Riyals comprises of four hospitals expected to treat annually more than 50,000 in-patients and over 600,000 out-patients.
>
> KFMC is staffed with visionary management and highly qualified professionals sharing a common goal in making King Fahad Medical City a leading tertiary care referral centre throughout the Region. At all levels of treatment, Specialists from many disciplines are brought together to help patients.
>
> Environment at KFMC skilfully blends zealous people, exemplary care and a commitment to overall quality of life, while offering programs and services through its advocacy and community outreach efforts to improve the quality of life of patients. Extending knowledge and resources into the community is KFMC's top priority.
>
> The main and overriding object of the very existence of King Fahad Medical City is to provide every citizen of the Kingdom of Saudi Arabia with the best health care service and to become a bridge between the East and West for information channelling.

The researcher reflected that, although he is proud of his city this depiction seemed to be a little exaggerated. Maybe the researcher was so familiar with the city he was being negative. The new OQNs in their new environment would be challenged in some way by a new nursing world that would probably be different from anything that they could identify. How different and what were the challenges was the focus of this research. Aside from the foreign language the gender practice which dominates the whole of Saudi Arabia would possibly come as a shock.

Saudi women in public are almost an insignificant black presence and almost unrecognisable. Often in hospital, women are dressed in long nighties and wear special facial covering. The concept of modesty is fundamental to the Saudi Arabian society.

The researcher reflected that this may be on the issue of modesty that the OQNs would find the most significant of problems. The OQNs would also be dressed modestly. It was not talked about in the interviews but they might feel uncomfortable because the uniform they wear is so different to what most of them have been wearing. The KFMC nurses wear navy blue loose cotton pants and a long (mid-thigh) loose cotton tunic with long sleeves.

The researcher wondered about the weekly column in the *Arab News* by Benlafquih (2012) 'Modesty – Inner and Outer' in which she includes such behaviour as not gazing at someone, avoiding touching and details such as not wearing perfume, as being important. She further notes that Muslim should also strive to be 'truthful, sincere, humble, patient, forgiving, charitable, moderate, kind, and considerate' indicating the importance of both the inner and outer life. When details such as not wearing perfume are written in the National news, it gives

an idea of its importance in Islamic practices in Saudi Arabia. The researcher was sure that, in view of this important emphasis on modesty, the issue of patient privacy would not be a problem.

4.2 "Haya" – modesty

The concept of "haya" is pervasive in Saudi Arabia and there is no real translation of the word into English. "Modesty" in the Oxford Thesaurus for Australia, provides, as a first alternative, "self-effacement" or humility or unpretentiousness. However, this is not part of the Islamic interpretation. The closest that one could interpret modesty to be is that in order to bring honour to Allah, one must be humble and not "show off" or "be a bragger" or "boast".

The clarification of modesty's meaning and value comes from the Holy *Qur'an* and the Hadith of Prophet Mohammed PBUH. Modesty in the *Qur'an* is dealt with in detail. Modesty in Islam is known as "haya", a word which describes both shyness and a deeper modesty that is based on faith. A sense of haya should affect a Muslim's conduct before Allah (God) before others and even when one is alone. In the Holy *Qur'an*, Allah says: "O children of Adam, we have provided you with garments to cover your bodies, as well as for luxury. But the best garment is the garment of righteousness. These are some of God's signs, that they may take heed." (Al-Araf 7:26; Al-Hilali & Khan, 2009).

> Bk. 2:1.8: Narrated Abu Huraira: The Prophet said, "Faith (Believe) consists of more than sixty branches (i.e. parts). And Hay' (This word "Haya'" covers a large number of concepts which are to be taken together; amongst them are self-respect, modesty, bashfulness, and scruple, etc. Its predominant meaning is: pious shyness from committing religious indiscretions) is a part of faith" (Sahih Al-Bukhari) (Khan, 1997).

The researcher looked again at the mix of OQNs and National nursing staff. Administration is favoured by the Saudi Arabian health care team (including nurses) with the critical care areas being staffed heavily by OQNs. As a result, the patient care settings are staffed by multinationalities and the patients are predominantly Saudi. The researcher wondered whether Haya would be a problem.

The researcher thought about the fact that in spite of the Saudi Arabian close family ties, at times, family members overlook hospital guidelines, especially during visitation times, putting the health of their sick members at risk of deteriorating and making the work of nurses more complex. The researcher wondered about the practice of some Saudis who prefer to hire "watchers" or "sitters" to take care of their sick family members. I knew that, in some countries, family members take turns in staying at the hospital to give extra care to their family.

The researcher reflected on the problem of communication and his understanding of the concept was that it was an area that he was not concerned about. The official language of the hospital is English and all the documentation, policies and procedure books are in English. Further, the city has a good interpreter service. His understanding of the problems of Islam that might be generated or a challenge to the OQNs gave him some anxiety. Islam is part of who he is.

KSA been built on the "Shariah", which means the law based upon the *Holy Qur'an* and Prophet Mohammed PBUH *Sunnah*. Therefore all or most the Saudi patients and families closely follow the guidelines ordered by Allah and the interpretation of the prophet *Sunnah*.

Many of the OQNs especially those who come from the Western countries come from regions where culture and religion are fairly separated, and religion is not an aspect of everyday life practices. The researcher found himself thinking about the impact that this could have on patient compliance? Would this be a challenge to giving patients education about self-care in, for instance, diabetes? How would this reflect on the care or challenge the care that his research group gave to patients.

In the light of this the researcher continued to reflect on some of the religious aspects which he though was fundamental to the care of patients and their families. There were three inter-related concepts that every good Muslim knows: the fact that Allah sends disease; Allah is able to cure the disease, and here there is an aspect of what is sometimes in the West called "folk medicine"; and the pervasive believe that everything that happens to a good Muslim is *InshAllah* – literally, this means, "God willing", and denotes an acceptance of whatever happens – good or bad – is from Allah. It is part of the unconscious approach to illness that patients have when admitted to hospital.

The Islamic religion is deeply embedded into people's life. Religious practices such as fasting, praying five times a day, and observing religious holidays are deeply entrenched in the community. These religious observances are to be kept by everyone, including those who are sick, whether they are at home or patients in hospital. These religious observances are daily happenings, and nurses and other practitioners are charged with the role of advising their patients whether they are exempt from such practices as fasting, and advise when they are well enough to recommence. Surely these observances happened often enough for the OQN to rapidly become acquainted with them?

The researcher realised that the nurses probably did not have the background that they should have when he found an article written in the hope that patients would receive good cross-cultural care from the non-Saudi heath care professionals. It is significant that the writer was Al-Shahri, a Saudi physician who works in one of the biggest hospitals in KSA, the King Faisal Specialist Hospital. Islam is the driving force that is in effect a culture in itself that predominates the Health Care System in KSA. In writing about giving culture sensitive care to patients in Saudi, Al-Shahri made the statement that "Islam is undoubtedly the main factor responsible for shaping the Saudi Culture" (Al-Shahri, 2002, p. 133). The researcher was surprised that the vast Islamic religion could be condensed into such a short article. He realised as well that he should present some of the Islamic foundations in this thesis to orient the reader to some of the basic believes, giving a context to the research. Al-Shahri (2002) presented the basis of Islam in directing how Saudi patients should be cared for in a culturally sensitive way. In order to simplify this complex religion for expatriates working in Saudi, in a concise manner Al-Shahri, (2002, p134), summarises the five pillars on which Islam is based:

1. There is only one Allah and Prophet Mohammed PBUH is the messenger of Allah.
2. Prayer is the basis of the worship of Allah and is a daily activity which must be carried out five times a day.
3. Az'zakah, which is charity, should be payed to the Muslim community at the rate of 2.5 per cent of the wealth of each trader annually.
4. Fasting (Ramadan), which mean not eating, drinking and engaging in sexual intercourse during daytime (early morning until the sunset).

5. Al Hajj, which means that people need to go to Makkah once in their lifetime if they are in good health and have enough money.

Although these pillars of the behaviour of the followers of Islam are fundamental, there are a number of concepts in the Law that are expanded upon and detailed as to the way in which the behaviour should be carried out in daily life. Modesty and shaving are, to the non-Islamic mind, of minor importance, but are fundamental issues that affect nursing care.

Three of the five pillars of Islam impact on nursing care. The first and possibly the most significant is the first pillar, that Allah is the only God. The second pillar, prayer, which must be carried out five times a day, and the fourth pillar, that of fasting, impact on the delivery of nursing care as well as on the patients' perception of how they are obliged or required to carry out the fundamentals of their faith.

4.2.1 The first Pillar – there is one God, Allah

In the first place when a person says "La ellah ela Allah" (there is only one God) it means he/she believes and acknowledges there is no other God except Allah. Secondly Mohammed PBUH is the messenger of Allah. The *Qur'an* is the noble book of Islam and it is the Word of Allah and all Muslim worshipers must accept it and perform and believe what has been ordered by Allah and noted in the book. The people of KSA are fervent in their beliefs and are very careful that they carry out all that is required of them by the laws of Allah.

4.2.2 The second and fourth pillars: Prayer and fasting

Prayer is the second pillar of Islam and fasting is the fourth. Although these are separated at times, they are closely linked. The posture which should be used in praying as well as

requirement that prayer be performed five times a day will sometimes be a problem for patients.

Prayer is so important to those of the Muslim faith that there is a web site which deals with ways in which a patient can say prayers without the customary kneeling and bowing down and still be within the correct dictates of the faith.

All Saudis patients acknowledge that the Salah (Prayer) is an essential part of their daily lives however they are aware that when they are sick there is a way to perform Salah because of the statement in the noble *Qur'an* that the person who is sick has other ways to perform the Salah:

> Whoever has some excuse due to illness and cannot stand during the obligatory Prayer is allowed to pray sitting. If he cannot pray in a sitting posture, he may pray while on his side by making gestures. In such a case, his gestures forsujud (prostration) should be lower than those for his/her ruku` (bowing). This principal is based on Allah's words (And celebrates Allah's praises, standing, sitting, and lying on your sides). (Surah An-Nisaa Part 4 verse (Ayah) 103; Al-Hilali and Khan, 2009)

It is in this kind of instruction that the detail in which daily life is spelt out and which the OQNs have no way of being able to incorporate in detail into the care of the Muslim patient. There is a call to prayer five times a day and these times of prayer are an essential part of the daily life of all Saudi citizens.

The fourth pillar is that the true Muslim is expected to fast at specific times. The issue of fasting was not always associated with prayer but with the religious festival, particularly that of Ramadan. Ramadan is the holy month in which people must fast from the early morning of the day until the sunset in the evening. Ramadan is a time of spiritual reflection, improvement

and increased devotion and worship during which Muslim are expected to put more effort into following the teachings of Islam. The fast (sayam) begins at dawn and ends at sunset. In addition to abstaining from eating and drinking, Muslim also increase restraint, such as abstaining from sexual relations and generally sinful speech and behaviour. The act of fasting is said to redirect the heart away from worldly activities. Its purpose is to cleanse the soul by freeing it from harmful impurities. Ramadan also teaches Muslim how to better practice self-discipline, self-control (Yosef, 2008), sacrifice and empathy for those who are less fortunate; thus encouraging actions of generosity and compulsory charity (zakat) (Saadati, 2008)

It becomes compulsory for Muslim to start fasting when they reach puberty, so long as they are healthy and sane, and have no disabilities or illnesses. Many children endeavour to complete as many fasts as possible as practice for later life. Exemptions to fasting are travel, menstruation, severe illness, pregnancy and breast-feeding. The exceptions from fasting are detailed in the holy book *Qur'an*.

4.2.3 The third pillar - charity

The third pillar of Islam is charity. Az'zakah, often translated as "the poor-rate," is obligatory as part of the third pillar and is a fixed percentage of the person's savings that is required to be given to the poor. Charity is very important in Islam, and even more so during Ramadan. Sadaqah is a voluntary charity when giving above and beyond what is required from the obligation of zakat. In Islam, all good deeds are more handsomely rewarded in Ramadan than in any other month of the year. Consequently, many will choose this time to give a larger portion, if not all, of the Az'zakah which they are obligated to give. In addition, many will

also use this time to give a larger portion of Sadaqah in order to maximize the reward that will await them at the Last Judgment.

Ramadan is a lesson to Muslim to experience the same feelings of the poor as well as helping those in poverty. Ramadan is a time to learn the meaning of patience. Further, it is a time which encourages Muslim to treat others with respect while they are fasting, quarrels are stopped if the person responds with 'I am fasting' which means he or she should not or does not want to be involved with any arguments.

For many of the OQNs, it may mean coming to terms with a community of deeply religious practices. In the first instance the details of the religious effects on the daily lives of Saudi Arabians are complex. The complexity is increased when a person is ill and the impact on nursing care is profound.

Nevertheless, with time, OQNs adapt to Saudi cultural norms, religion and language. They begin to adopt Saudi ways of caring for patients. This created a workable bicultural approach. Over time, they became more adept at aligning their nursing activities with the expectations of their patients. In tandem, their facility in communicating and, specifically, their increased fluency in Arabic, overcame some of the barriers in communication between them and their patients, further facilitating the development of an effective therapeutic relationship that enhanced the care they could provide**.** The OQN comes to learn to observe and respect the religious mores of their patients. Doing so constitutes culturally competent health care on their part.

4.3 Summary

This chapter discusses the cultural and demographic context of the study hospital. The next three chapters will explore the findings of the study results that have been gained through the interviews. Chapters 5 and 6 will explore the challenges and problems that have faced the OQNs during their caring for the Saudi patients and families, while Chapter 7 will present the factors that affected their holistic care delivery. Chapter 8 will discusses the conclusions and recommendations about the experience that have faced OQNs while delivering their nursing care in the KSA and Chapter 9 will give specific case studies that illustrate some of the OQNs experiences that have partially effected their care delivery.

Chapter 5: Accommodating to the Saudi Islamic Culture

Something I found difficult … that it is a culture and religious thing.... (OQN, Shirley)

… the biggest thing, realizing that Islam is not just a religion it's like a way of life. (OQN Jean)

5.1 Introduction

The issue of culture dominated the discussions with OQNs in relation to how it shaped the nursing care and communication in all aspects of their daily work in KFMC. Some of the OQNs found accommodating the culture easy while others struggled to accept the effect that it had on both themselves and their patients. As already explained the Islamic religion is deeply embedded in the culture of KSA to the extent the words in the title of this chapter – Saudi Islamic Culture – must be interpreted as describing an integrated concept of daily living and believe.

This chapter will discuss the Islamic issues that impact on a Saudi's daily life and, therefore, directly affect the OQNs group and their nursing care under the headings of the Five Pillars of Islam described in Chapter 4. Other standards or regulations, such as haya, and dress codes, which are closely adhered to in good Saudi Islamic practice will also be discussed.

5.2 Difficulties with Saudi Islamic culture

OQN Shirley's comment, noted above, is typical of that made by OQNs in the interviews. For example:

> It took me a while, to get used to the **different culture** norms … and I found that very frustrating. *(OQN, Kay)*

> The other issue is the restriction that the culture place in my job. *(OQN, Alma)*

These few straightforward comments from three of the OQNs summarize the feelings of the research group. The comments about their feelings ranged from "fear" to a real appreciation of the values the population holds. The notion of culture and religion was an important part of the experiences of the OQNs. The responses to the questions in the research were interesting in that the word "culture" was mentioned 385 times, indicating the importance of culture and the way that it defined the nursing practice. References to Islam and religion were made over a 100 times. The only other most-frequently mentioned theme was "language", which was mentioned 221 times and affected communication practices; this will be discussed in Chapter 6.

> … not understanding the culture will give you a problem, not understanding the language will give you a problem. *(OQN, George)*

For OQN 6 it was something that influenced the entire healthcare system.

> I think that cultural point influenced the healthcare system, *(OQN, David)*

A brief introduction to the Islamic religion would have provided a background for understanding the practices of Saudis and help the OQNs to have an idea of how to meet requirements when they deliver their care to the Saudi patients. A powerful example of the depth of the patient's believe system was given by one of the participants when they told of a patient who refused to have his beard removed in preparation for surgery. Rather than have his beard off he said,

> "I will not go, I will not go" *(OQN, Joe)*

This aspect of the sincere believe of their patients was reiterated by many of the OQNs. This loyalty, as founded on the first pillar or main tenet of the Islamic faith, seemed to be pervasive in the transcripts. It is this concept of acceptance of ill health or even death that many of the OQNs could not come to terms with. They found it difficult to understand.

> Problem is, with the manner of thought in the Arab patient, he does not want to hear the factual negatives, and this is where the "inshAllah" (God willing) phrase becomes a predicament. Thus, one has had to learn the art of using 'inshAllah' (God willing) to convince an otherwise difficult patient. *(OQN, Linda)*

> They are often very hopeful because the doctor tells them InshAllah, everything will be better, InshAllah, yes, yes, InshAllah, he will be good again. It was interesting; I actually don't know "InshAllah". *(OQN, Shirley)*

> You ask a patient: how are you today … he tells you "inshAllah". Now, this to me is an inappropriate response. I need a direct answer: something like: "I still feel terrible, I tossed and turned the whole night, I have terrible nausea". This may be treatment related, and we need to change a tablet. I want to know if I am helping you so that I know whether to do something else. It takes me an extra hour to try probing the patient for an idea of their condition. *(OQN, Linda)*

Moreover, the way all Saudis believe that they completely depend on Allah's will on the way of their life journey and, especially, during their sickness, upon their strong believes of what been stated on the holy book *Qur'an*. Qur'an is Noble book of Islam and the word of Allah (God) and all Muslim believe that all who worship Allah have to accept it and follow what is on it.

> Some people would say they don't want to know – they would say "InshAllah" and they would really mean it. They would just say, "God willing". They will go with that, it's just an excuse but the more I got to know people well I realized that they really believe it. They really believe that Allah will get them through this and what

> they need. That is really interesting because I guess the biggest thing was realizing that Islam is not just a religion it's like a way of life. It affects everything that they do in their lives. *(OQN, Jean)*

One frustrating aspect in providing care was delivering bad news. If someone was dying, the doctor may say:

> "InshaAllah he will get better and everything will be fine" which really frustrates me as a Westerner. Tell the truth to the patient if they are dying. *(OQN, George)*

The experience for these OQNs were dominated by the fact that they found themselves in a culture that was totally different to what they had experienced in their home country.

Every issue of everyday life, and this includes the health of the people, is considered according to the *Qur'an* and the message of the Prophet Mohammed PBUH. The culture is welded to the religion so tightly that people accepts no intervention in their lives but apply and perform the rules of the *Qur'an* in every aspect of their lives. Saudi's firmly believe in the will of Allah, whereby life's occurrences and events are attributed solely to Allah's will.

OQN Shirley highlighted easier acceptance of bad news among the locals as surprising – an aspect which is tied to religious belief and acceptance of Allah's will. The patient that is described would appear to have been in a terminal state.

> … even though you know the patient who's really sick and probably won't survive within a week. Saudi's are often very hopeful because the doctor tells them InshAllah, everything will be better, InshAllah, yes, yes, InshAllah, he will be good again. It was interesting; I actually don't know "InshAllah". You know, you probably know the patient may not get better, but it is not my place to inform the family that ... So that's something I found difficult and it is something very

> different to deal with. I have been told at several occasions that it is a culture and religious thing. *(OQN, Shirley)*

> I learned it affects each and every aspect and then I put it into practice while giving care to patient – like you cannot just simply go and say: "oh, your child is handsome", you cannot just simply say it, you need to add, "praise the Lord" and then you put that word in so you really adopt it and change the approach. The staff that work under me I really train them how to deliver the patient care to best of their ability. *(OQN, Mavis)*

This was further emphasised by OQN, Georgia and Dot who articulated a difference in the acceptance of "bad" news and death in KSA where individuals readily accept life's occurrences as compared to the grief expressed in the West where individuals question God's will.

> Also religion has huge effect on how people accept their disease and sometimes I find it little difficult when something happens that shouldn't happen if they prevent it, but they accept things very easily. I find that not very easy to accept, they believe whatever will be, will be. *(OQN, Georgia)*

> KSA is a country where someone could have 16 pregnancies or no live births or eleven pregnancies with no live births and their acceptance of God's will and the strength in their faith. What I kind of looked at was, do they go through all those stages of grief, but it's culturally unacceptable for them to show them because that would mean they weren't believing in their faith and believing that it was God's will, or is that faith so strong, that there is no "why me?", "why did it have to happen?", or any questioning – it's just God's will and they move on. I'm sure they still have the pain of the loss, but for me that was a really interesting thing. Because in the West, we are very much about, "why me" and "why did this happen to me?" *(OQN, Dot)*

Certainly the Saudi patients and families have grown up and lived with Islam, and most of the OQNs would find it as new challenge, as they have not been working with such a way. Saudi's

believe in the power of prayer as one of the approaches for gaining healing, they further believe in various religious customs, such as drinking holy water in times of illness.

Because prayer means a lot to Saudi patients an awareness of that aspect would help OQNs to establish relationships with the patients.

Patients will, at times, insist on postponing taking medication and praying first. This is challenging to the nurses who would want to follow the doctor's prescribed time for giving the medication to patients but also have to respect the patient/s wish and religious practices. This calls for understanding and patience, as highlighted by OQN Joan:

> … if you want to give somebody their medication and it's prayer time, if that medication can wait then just wait, it's okay ... but you have to come back when they're done with their prayer. So I think, patience, was something that I learn a lot being here ... but I think you just need to learn to compromise with your patients more than you do at home. *(OQN, Joan)*

Performing prayer is part of the patients' duty and they often increase their prayers or prayer time when they become ill; they believe prayer will help them to get over their sickness and will gain blessings from Allah. However, for some of the OQNs, the experiences of patients praying were, unfortunately, often a major challenge from one day to the next. OQN Sarah tells of an experience that indicates how an awareness of some issues such as when the patients perform their prayers should be part of their orientation to the hospital.

> Another time … my patient was … really sick… We thought he has to go to ICU. Anyway we stabilized him after a couple of hours. I came out of the room and I came back to the room and he was on the floor praying. I thought, "Oh my God, he can't do this he shouldn't be in the floor. Luckily, I didn't go and stop him. I told the ward clerk to tell him he has to be stopped, go to his bed and he can't practice it.

> The ward clerk said, "we cannot interrupt anybody in the middle of praying". "Stopped what you are doing", but you were not taught these things. You find this things by accident, those kind of things are really important to know and also not walking in front of a person when they're praying – nobody tell you this things or they tell you "By the way you shouldn't have do this". *(OQN, Sarah)*

OQN Sarah felt that some of the information or guidance that they could be given was fairly straightforward and could help both themselves and their patients.

> … you just find out by accident when you get told off by a relative causes you've just walked in front of the father or whatever. No one ever told you and those simple things like that which are easy you know to deal with. *(OQN, Sarah)*

The experience of OQNs have built up different challenges that should need more attention during their orientation to the hospital; such as the meaning of prayer for Saudi patients, and the Saudi patient's practice during their daily lives of fasting – and the fast has to be for about one month.

The way in which Ramadan is observed is much stricter in KSA than in other Muslin countries. This is commented on by OQN Bill who came from England.

> … and these was the biggest changes – like I was not used to Ramadan, back in the UK Ramadan timings, Ramadan breaks, Ramadan shifts is a totally different life goes upside down, the day becomes the night, the night becomes the day for the locals here as well, I'm not used to that. *(OQN, Bill)*

Awareness of patient's religion and culture gives the OQNs a chance to deliver culturally safe practices, but the availability of information availability is one of the issues facing them:

> … understand that in the hospital many patients sleep during the daytime as the night time becomes the daytime. For the 30 days of Ramadan, once sundown

> occurs, the fasting is broken and special foods/drinks are taken, families gather together and stay late into the early morning hours. After the early morning prayer is the time when many patients will sleep until the next prayer at noon. It is important that during the fasting month each ward/unit checks on a daily routine the patients and sitters who are fasting and those who are non-fasting. This is essential information and needs to be accurate for the Dietary Department. They will only deliver meals for those identified as non-fasting patients. Those patients who have a medical diagnosis [Diabetes Mellitus] may still request to fast. It is important that the patient/family discuss the issue with the physician who will propose the final outcome, to fast or not to fast at this time. *(OQN, Sarah)*

OQN Sarah further added that part of the role and care of OQNs is to be aware in advance who is fasting or not, while there is a permission to the patients to break their fast when they are sick or travelling. However, those who can tolerate fasting should fast.

Children in Saudi Arabia start to practice fasting with their family from the age of seven but they do not have to fast till the end of the day. This is a challenge to the OQNs' experience with paediatric patients, such as OQN Kay's experienced as she told this story:

> You know when I am trying to get my little six-year old boy to eat his dinner, he tells me "no I am fasting", then I am saying that "you are diabetic" and he said "no I am fasting", to me I find that very worrying. I think he is too young to fast, but I admire him for doing that, but I think, "my gosh he is diabetic". In circumstances like that I think he needs to eat, so is he following his culture or is he following what is his parents want him to do – I do not know. I look at that he is following his culture. So that are the things that comes into the cultural care that I have to be aware of. It is not up to me to say you have to eat. I can only recommend to the parents he eats, you know. I like to see him eating, because I know he is a diabetic and I do not want him to get worse. *(OQN, Kay)*

Haya is other challenge raised by the OQN while caring for Saudi patients and their families, and surly it has been explained earlier, but to be sure that the meaning of "Haya" again:

Modesty in Islam is known as "**haya**", a word which describes both shyness and a deeper modesty that is based on faith. A sense of haya should affect a Muslim's conduct before Allah (God) before others and even when one is alone. In the Holy *Qur'an*, Allah says: "O children of Adam, we have provided you with garments to cover your bodies, as well as for luxury. But the best garment is the garment of righteousness. These are some of God's signs, that they may take heed." (Al-Araf 7:26; Al-Hilali & Khan, 2009).

> Bk. 2:1.8: Narrated Abu Huraira: The Prophet said, "Faith (Believe) consists of more than sixty branches (i.e. parts). And Hay' (This word "Haya"' covers a large number of concepts which are to be taken together; amongst them are self respect, modesty, bashfulness, and scruple, etc. Its predominant meaning is: pious shyness from committing religious indiscretions) is a part of faith" (Sahih Al-Bukhari) (Khan, 1997).

It was a shock to OQN Jill when, on the orientation to the ward, the following occurred:

> … that I was standing at the nursing station with my preceptor and we had three women come up to the desk all covered, totally covered. You could only just see black and I can remember, thinking, oh my goodness, oh my goodness and I can remember actually stepping back from them. *(OQN, Jill)*

In order to understand this concept of modesty the following rules and regulations of the Islam Culture of Saudi have been expressed by (Al-Shahri, 2002; Benlafquih, 2012):

Haya should take place during a Muslim's daily life, adhering to good mannered behaviour, speech and appearance in the Eyes of Allah. For many people in the West, the modest dress of Muslim – particularly the woman's head scarf, or hijab – has become synonymous with the concept of modesty in Islam (Benlafquih, 2012).

In Saudi Islamic Culture, modesty is a word that means multiple things such as the haya of women wearing the hijab or having her hair covered, or the male not shaving his beard. OQN Dot described an experience with a Saudi female patient:

> I had an experience with a patient. I got a call from labour and delivery. They were having one of those really wild nights where they pushed the patient out into the hall to be brought to the unit, and they said: "We are just extremely, extremely busy can you come pick her up?" I headed down the hall and there was this woman wailing out in the hallway in the wheelchair. I looked at her, and I do not know what made me think it ... but I looked at her colouring; she had dark hair and dark eyes. On my way I grabbed a towel, I put it over her hair, she stopped crying ... I'd sensed she was uncomfortable being out here in the open but what could I do, so I gave her the towel and helped her put it on her hair and all the crying just stopped. I was used to dealing with culture but with very different cultures and a variety of cultures rather than one specific culture. *(OQN, Dot)*

Modesty is an all-pervasive concept that touched the lives of all Muslim. It is fundamental to the teaching of the *Qur'an*. The notion of not being modest as being sinful brings it closer to an interpretation of haya than a Westerner can imagine. The comment by OQN Steve when there was a failure to observe the modesty and privacy of patients and lead to a stressful situation – where the concept of being 'sinful' because of the reaction of the relatives (the emphasis are those of the researcher):

> ... not adhering to covering the face of female patients can causes issues within the ICU. We have had nurses that have been spit on, hit, and called prostitutes, for not adhering to cultural believes. It is a challenge for a manager to ensure that patients' safety, patients' advocacy, correct communication goes out to family members and staff are supported during these events. *(OQN, Steve)*

Failure to observe patient modesty and dignity leads to patient discomfort. OQN Dot's experience was that a female patient cried because her hair was uncovered. This issue can become complex as OQN Val told:

> ... if you are busy as a nurse and you have been doubled, one patient is female and another is male, then you want the curtain to be opened in order for you to see both of them. So sometimes a nurse needs to be sensitive because if the female patient's husband comes, or a religious person comes and doesn't see any male inside the room ... that may result in issues. *(OQN, Val)*

Observing patients' cultural and religious practices imposes challenges to the nursing care process. Nurses are torn between following the doctor's orders and observing the patients' cultural and religious practices. In order to achieve culturally competent care, the nurses observe the patients' religious and cultural customs and note them to the relevant authorities. This could, however, jeopardise the patients' health outcomes.

> Another one is ... about privacy and dignity for the patients ... when you need to feed women, you need to close the curtains ... it is ... culturally, expected of you to do it. A woman doesn't uncover her hair in front of others ... if you want to wash a patient you must close the curtains. This was a very good experience but I think because privacy and dignity is something very important, you often do things and you have to pay attention ... somebody will not just exposure from the few and if you are a nurse they don't close the curtain ... patients are upset ... a lady who's so sick that she is in the intensive care is still worried about her hair covered up. It is such as … privacy and dignity. It's amazing and I think it reminds you to respect

somebody's privacy in a completely different level ... I must be aware of the patient's privacy, dignity and rights – especially the female patients. For example, when you need to feed women, you need to close the curtains, to keep her privacy and dignity, as you have to do it because of her cultural and religion believes and that it is what is expected all the time ... *(OQN, Shirley)*

I do find it very strange about not being able to touch male, and males not being able to touch females … and I wonder "how can a nurse to be a nurse?" because being a nurse means you look after whoever comes in the door. I find that very difficult to understand, but it's a culture. *(OQN, Georgia)*

5.3 Touching and dress

Haya extends to the gender role, touching and dress codes. The gender role and touching were combined in most of the comments; in relation to the doctors and patients as well as the OQN feeling powerless by not being able to touch and comfort their patients:

Also then the culture, because it's different for male patients definitely they don't like female nurses, you know, nursing is frowned upon in this country, to me as a Westerner, it's a profession but it isn't look upon like that here, and I felt a lot of anxiety from the patients because I was a female, and they were male. I don't have a problem with female patients and the children but the male patients. *(OQN, Liz)*

Touching – indicating caring is used to signify support for the patient. But taking consideration of the patient's cultural and personal feelings about being touched by the stranger outside the family people makes caring touch difficult. *(OQN, Tanya).*

Most of the consultants here are male and nobody has a problem with the consultant touching a male or female patient. *(OQN, Georgia)*

… a lot of … staff nurses work in UK … few nurses who'd been in the Middle East before and also in Saudi, so it's chat to chatting with them but it always gives you, and doctors and another words, I don't know what's the right ideas as well, I think, and then when I came here. As I said, in our hospital there's a nursing orientation,

> there's a cultural. They do have sections for cultural as well they help you, explain it to you. If you meet a Saudi, you never shake their hands unless they offer you to shake their hands, just because some of them they worked a lot with the Westerners they used to do it but others haven't. And it doesn't mean that they are being impolite but it's just not part of their culture especially for me being as a female, they might not want to be touched by me for religious reasons. And also but you don't just walk up to somebody and just tap them on the shoulder. And if they just washed for prayer, I don't know, and tap them on a shoulder by a female, and then he has to wash all over again. *(OQN, Shirley)*

> A man came to visit one of my patients … and I said to him, he's gone for few hours and he wasn't making eye contact with me and I keep moving around to try making eye contact with him. He kept moving his head and I told to myself: "Oh, he must be blind" and then I thought how he could get down to the corridor by himself. Then I realized he didn't want to make eye contact with me and that was really quite kind of shocking ... That little experience is a bit quite kind shocking because you don't understand why they do it … I'm not worthy, or I'm a bad person because I'm not covered. There's a lot of misconception on the Muslim side as many as around else so you know, but it always stuck in my memory. I was thinking why won't he look at me? Actually, I wasn't left the ward and I asked … the ward clerk "why he doesn't he want to make eye contact with me?" and she answered "because he doesn't want to". *(OQN, Sarah)*

Modesty is reflected in the dress codes. The female, especially, will always wear an abaya and even in hospital will wear night clothes that cover the whole body and even in bed will have their head covered. This is critical in nursing where, for the most part, nurses from other cultures think nothing of having their patients take off their clothes or taking off the patient's clothes, such as when a patient is being showered. This is reflected in the responses because the issue of covering was mentioned 95 times. OQN Tanya compares her culture to the present one she is nursing in.

> Especially during physical examinations – as the female patient could not be exposed to any males (doctors) – an examination was done with clothes on (abaya). Yes with my culture we do cover but not always – when we going to the church and funerals as a sign of showing respect to the people involved. But in KSA it is a lifetime thing to cover the head and body especially the women. *(OQN, Tanya)***.**

Understanding the impact of some culture issues such as the face cover while the patients is in Intensive Care Unit (ICU) could expose the nurses to conflict with families and also standards of hospital protocols, especially for female patients.

> ...sometimes the patient is intubated for a week and they don't want to be seen by anyone – they always want to cover the face – it's a cultural thing – mostly females, they wanted their face to be covered then. You need to know why they need to do it, it's like a matter of consideration, and you have to consider their culture. *(OQN, Val)*

And OQN Jill finds that, "I still find that challenging actually not having eyes and a face to actually look at*" (OQN, Jill).*

5.4 Conclusion

Many OQNs come from countries where religious norms do not dictate daily life activities. OQNs experienced challenges in a culture where religion highly influences daily living. Saudi' pray, fast and adopt different religious customs, such as drinking holy water (Memish and Ahmed, 2002; Al-Shahri, 2002). Observing some of the religious practices, such as fasting, may put a patient at risk. Saudi patients want to adhere to religious practices regardless of the diseases they are suffering. Shortages of information about Saudi Islamic Culture have increased the fear of the nurses to ask about the practices, and that prevented

them from delivering the proper holistic nurse care. However many nurses asked their Saudi colleagues to help them to understand some of the issues.

Most OQNs acknowledged the Islamic Culture of Saudi and were happy to be part of the system. A considerable aspect of understanding the Saudi Islamic Culture is due to the significant problems associated with the fact that, in spite of the professed bi-lingual Arabic/English directive, the majority of the Saudi population can only speak Arabic. The difficulties associated with a monolingual population in the hospitals will be dealt with in Chapter 6.

Chapter 6: Communication in a foreign language

My biggest problem is the language. (OQN, Georgia)

6.1 Introduction

Chapter 5 dealt with the OQNs perceptions and problems encountered as a result of the Saudi Islamic Culture, which pervades all aspects of daily living in Saudi Arabia. This chapter focuses on the theme of communication. Chapter Seven will deal with the OQNs perceptions and problems encountered as a result of the pervasive Saudi Islamic Culture.

The central aspect of the communication difficulties was language. A majority of patients speak Arabic and other patients from other countries who were in Saudi Arabia as foreign workers, their own language – they, had only a working knowledge of Arabic that was specific to the type of work in which they were employed. As OQN Georgia forcefully said, language was the "biggest problem".

Problems of communication in Arabic will be included in this chapter, although they are closely related: language; difficulties associated with translation; the inherent problems associated with the Saudi Islamic Culture in non-verbal communication; and the communication problems when dealings with the a multinational team – primarily those who were 'expats' like themselves but for whom English was a second language.

6.2 Importance of communication

More than a century ago, Florence Nightingale emphasized the importance of good communication in nursing (Baly, 1997) and this emphasis has not changed. Many fundamental

texts on nursing begin with a chapter on communication, dealing with its importance and describing strategies that can be used to establish good communication in dealing with patients. Other fundamental texts use communication as a theme in chapters, dealing with concepts such as Palliative care or nursing assessments. Boscart (2009) highlighted the importance of communication when dealing with quality care.

> Effective communication is as a fundamental component of nursing and is recognized as an integral part of delivering high-quality patient-focused care. (p. 1823)

Day and Levett-Jones (2008), in their fundamentals of nursing text begin the chapter on communication with the statement that it is a critical component of nursing that all student nurses should acquire.

In a study to find what nurses thought the central feature of "difficult communication" is, Sheldon, Barrett & Ellington (2006), in their introduction, highlight the importance of communication in nursing:

> The communication in nurse-patient relationships is an important part of daily nursing practice. Communication is a cornerstone of the nurse-patient relationship. The power of effective nursing care is strengthened and enriched by good communication. Because of the unique position of nurses in the healthcare system, they spent extended time periods talking with patients and hearing their concerns, feelings, and needs. Some of these conversations are difficult for nurses, heavy with emotions such as anger and sadness, or complicated by life-threatening illness or family problems. (p. 141)

Communication issues include other factors that are related to the nurse's background, culture and their experiences during their nursing care journey. The authors highlight the importance

of the patient's involvement with the nurses daily care delivery (Sheldon et al., 2006). The limitations in communication extend to nonverbal communication as well. Problems arise when the medium/message is in a language that both the sender and the receiver do not understand.

6.3 Arabic communication is not simply a language problem

> …language was the most difficult and distressing thing to give the good care for the patients. *(OQN, Louise)*

Most patients do not have even a basic knowledge of English. The problem is made even more difficult when there are patients who come from different regions of Saudi and speak different dialects. For these patients, sometimes even standard Arabic is almost like another language.

> … it seems to me that people that comes from the East have clearer accents than those of the South. I think. I mean, we had a ward clerk who came from the north and he said that "don't worry I don't understand a word that came from the south either". It's just frustrating and you don't feel like you're doing a good job because you can't speak to them. *(OQN, Jean)*

The problem of Arabic is that it is often perceived as a difficult language to learn. In addition to it being a foreign language, it has a different alphabet to English, and a different script, with reading carried out from the right to left on the page, rather than left to right as in standard English text. To complicate matters, inflections are different to those in English.

OQNs generally arrive in the Saudi Arabia with virtually no knowledge of Arabic. Patient care where communication is "critical" is compromised and this, therefore, defeats the purpose of the OQN being in Saudi Arabia and in particular the KFMC, because their main aim in coming to KFMC is to provide care for patients.

> …my nightmare began with the language itself. *(OQN, Linda)*
>
> The problem is the language. *(OQN, Mavis)*

The word 'language' appeared extensively in the transcripts, as every OQN talked about the language barrier. This was made even more difficult for over half (12) of the participants for whom English was a second language.

> Patient language: I found this as one of my greatest hindrances in reaching the patients as very few of them understands few English words. *(OQN, Linda)*
>
> It's too hard for the expat dealing with Arabic people, purely Arabic people cannot speak English, cannot understand English, so we are the ones to adjust. *(OQN, Joe)*
>
> …my primary language is English and not Arabic. It was very frustrating when I was faced with the issue of talking/asking a patient some information when there was a need. I had wished to hide in a corner. *(OQN, Tanya)*
>
> …. the patients you are going to deliver care to are all Arabic. They need complete Arabic talk. They understand much better when you talk in Arabic. *(OQN, Mavis)*

OQN Dot was insightful when the issue of language was discussed.

> Of course, the communication was a big issue because I don't speak Arabic, and spoke very little Arabic when I came … patients who knew some English, so often times, with their English and my few words of Arabic we'd somehow come to an understanding of things … I did a lot of acting out of things. *(OQN, Dot)*

The graciousness of how she felt that the patients were accommodating was

> I think what amazed me most is the patients. If I was in Canada and a nurse came in and said in broken English "pills – pain", and gave them to me, I think I'd just be appalled. But what I felt is the Saudis, they're so gracious, you were absolutely butchering their language but as long as you're making an effort they would try to understand you. *(OQN, Dot)*

Communication is among the major aspects of care provision in hospitals. Communication enables nurses and the healthcare team to collect patient medical history in order to get to the root of the patient ailment, establish and maintain effective nurse-patient relationship towards providing holistic nursing care.

> As a nurse, communication plays a vital role in assessing the kind of nursing care needed by patients. This is hard to achieve when there is in congruency in the medium of communication that we use ... primarily the language of the patients ... It seems that the people around do not care at all whether I can speak Arabic or not. It is really hard to provide a holistic and quality cares if you cannot understand your patient. It is very frustrating that I, as a nurse, cannot render even the simplest nursing care needed by my patient due to language barrier. *(OQN, Alma)*

Because OQN Jean was not been able to speak to the patient, she was frustrated "The frustration here is much higher because of communication" ***(OQN, Jean).***

Lack of good communication not only causes frustration but could also jeopardise the patient safety, the safety issue will discussed further in Chapter7).

Beyond individual communication in a foreign language with their patients, the issues of the broader hospital setting was even more difficult. There were issues such as dealing with their colleagues as well as the numerous other members of staff in the hospital. Delivering their nursing care to Saudi patients involved the families and watchers as well as personnel from ward clerks through to the senior doctors.

Unfortunately nurses who lack proficiency in Arabic gain limited support or education from the hospital management. This is indicated by shortage of information during their orientation

programs and failure to teach basic terminology in the Arabic language, as noted by OQN Dot in the quote above. The OQNs dealt with the issue in various ways:

> To deal with the language barrier I just carried a book with me, and every time I learned a new word, I'd write it phonetically so that I could say and understand what the patients were asking me. *(OQN, Dot)*

6.4 Understanding nursing care delivery

As noted, in addition to the problems of language barriers between patient and nurses, problems of communication also exist with other hospital employees. This was in spite of the official language in the health care system being English (Mahfouz, 2006). All patient forms, such as admission, consent to a procedure and so on, are bilingual (Arabic and English). The protocol and policy books are all English (see further discussion in Chapter 7); all official communication and well as information communication in the healthcare system must be in English. In practice, however, this does not always occur.

In addition, problems of communication also exist between the OQN who come from countries in which English is not the main language; the nurses, therefore, sometimes have difficulties in understanding each other.

An additional major issue in Saudi Hospitals is that some of the patients have a watcher to give them extra care. In many cases, this watcher cannot speak English or the particular Arabic dialect of the patient. The nurses then have to find out what Nationality the watcher is so that they can look for someone who speaks that particular dialect so they can communicate or take a patient history and assess the condition of the patient so that care can be planned. OQN George tells of the frustration and difficulties which he has experienced:

> … and maybe that watcher will be a different Nationality who may not speak Arabic or who may not speak English so you have to get someone to interpret, someone who speaks Bangladeshi, Hindi or Tagalog to get the proper information about the patient from the sitter and you may not get that because one person translated to another language who translated it to another language, so chances of miscommunication are getting more and more. As you increase your Nationality mix and then you increase your team of intermediaries. *(OQN, George)*

Nurses need to speak with their patients as soon they get to their rooms or clinics, but in Saudi Hospitals the language is holding them back.

> My biggest problem is the language. To me, to build up your relationship with your patient, you have to be able to get to know them and working in the OR as an anaesthetic nurse, you always spend time with them in anaesthetic room before they went and so you got to know your patient – or you will see them the day before in the unit as pre-op visiting, so we got to build up a relationship. So I missed them a lot and I feel that I can't give much care because of the language barrier. *(OQN, Georgia)*

The barriers to building a relationship with the patient was seen as holding back the capacity of the OQN from delivering proper holistic care to their patients:

> I found that the language barrier interfered ... inhibited me ... from giving ... a 100 per cent holistic care, because, I had to rely on somebody to interpret. So, if I want to give my patient instructions ... I have to rely on someone to interpret, usually to the mother or to the watcher ... and that aspect I found frustrating, that I could not give the education that I wanted. *(OQN, Kay)*

The OQNs highlighted challenges in verbally communicating with the patients. This inhibited the participant's care provision to patients as the nurses are required to explain crucial issues on patients' health and conditions. Building up a relationship with patients from different languages and cultures is not that easy since in some situations the nurses needed to explain to

the patients some of the important issues related to their health and conditions, making verbal communication important:

> The biggest challenge is language. I work in the emergency department and I experience communication challenges. In the department, time is a major factor and information has to be provided within the shortest time possible. Communication challenges are especially witnessed during the first few months as expatriate nurses lack basic skills in Arabic. This is worsened by lack of enough translators. In situations where translators are not available, it is very frustrating since one cannot get a handle of the situation due to lack of understanding of Arabic. *(OQN, Joan)*

Although OQN Linda had mastered some of the basics, it was still difficult for her to accurately take a patient history. Not having an accurate nursing diagnosis would compromise the quality of patient care:

> Firstly, my nightmare began with the language itself that I couldn't speak and was expected to know within three months of my probationary period. I found patient language, who mostly use Arabic, as one of my greatest hindrances in reaching the patients, as most of them understand few English words, and I also learnt basic Arabic which is not very helpful at all as I had difficulties constructing sentences. The only words I mastered were those related to pain, nursing and medical procedures, as well as food and daily activities. Up to this stage I still cannot reach the depth of patient history and come up with nursing diagnosis. *(OQN, Linda)*

Understanding another language is not easy and needs time, especially in a highly sensitive culture like Saudi. Because the majority of patients do not speak English and so they do not understand medical terminology. OQNs are working hard to deliver their care in a safe manor.

> ... we cannot express ourselves well because some or most our patients cannot understand English ... there’s a gap between giving our quality care to the patients because of language barriers ... it’s too hard for expatriates dealing with Arabic

> people, who purely speak Arabic who can neither speak nor understand English, so we are the one to adjust. Some of the colleagues that are older or more senior than us orientate us, giving us simple or basic Arabic language and it is part of our learning because we cannot interact exactly or give our quality care ... to the patient if we cannot speak with them. *(OQN, Joe)*

> I try to respond in English and that's the problem because they respond in Arab language as well. I try to communicate with them in Arab but they also respond in longer Arab sentences which I can't comprehend that easy and fast (*OQN, David)*

Some OQNs found the language difficult to learn. OQNs Tanya and Linda highlighted the difficulties of mastering the tonal aspects of Arabic.

> I found that the Saudi Arabian patients, especially the males – they speak with a high tone … I thought the patient was angry about what I said to her and letting other patient's to listen to her talk about her health problems. *(OQN, Tanya)*

> Hospitals are intimidating, on the whole, so patients usually don't want to put the whole problem on the table, so to speak. My training included the art of drawing on body language and the tone of speech. Here in Saudi, that element is removed completely. The people here are closed in on all levels. *(OQN, Linda)*

> Examining your own values to see if this will be comfortable for the patient to do or say by consulting the correct people or asking help from multidisciplinary team to help with the language to deliver the correct information in the correct way or correct tone. *(OQN, Tanya).*

Truly, it is hard not understanding what patients or families are saying, or unable to assist when it is needed. Even if there is help from others, such as translators, the feeling of not giving direct care is profound.

Nevertheless, the language barrier does not act as a challenge in the long-run as the OQNs gradually learn the Arabic language and are, at times, able to understand the basics. This eases

their career and enables the provision of more effective, efficient and culturally competent nursing care.

6.5 Understanding and the difficulties of 'translation'

OQN Jill felt that there was a gap between the nurses and their patients as they must have someone to translate their care plan them: "… I used to guess speech in Arabic." which would probably magnify the problem from the patient's point of view.

> I try to communicate with them in Arab but they also respond in longer Arab sentences which I can't comprehend that easy and fast. How am I going to be efficient to clients especially when the team got so busy? I cannot ask them all the time to help and assist me in every client I have to deal with. Communication is the most essential in rendering care to clients, without it, nursing care and plans would fail. *(OQN, Jill)*

The problems with communication have resulted in a special department for official translators, and these men and women are supposed to be available at all times. However, even some of the translators are not be able to understand a dialect easily:

> Language is mostly the issue in communication between us and Saudi patients. The hospital does not really encourage us to learn Arabic. I inquired about getting Arabic classes but was told that we (overseas qualified nurses) don't need Arabic since we had translators. Eighty per cent of the job is just talking to patients, educating and listening to their stories and actually being a support, so I felt for a long time that I was almost cut off at the knees in my patient care ... initially if I wanted to communicate ... I used to guess speech in Arabic. *(OQN, Jill)*

In this discussion the word translation has been used in a very broad context. Translators play an integral role in the communication process between OQNs and Saudi patients. Translators at times ease communication between Saudi patients and OQNs, thus promoting effective

delivery of nursing care. Officially, the translators come from the special department set up to translate when the need arises. However these translators are not always available and so there is an assortment of unofficial translators ranging from the hospital ward clerks to patients' family members who possess English speaking skills and thus translate between OQNs and patients. The translation abilities of this second group are sometimes called into question by the OQNs.

> … if by chance you had an interpreter – and it would help if they showed up to work – many of the times they didn't show up to work. This was in the early 90's, more so than it is now. But still the other issue is even if you have an interpreter, well then the interpreter may not actually tell the patient exactly what you are saying, because they may not like what you are saying to the patient, and they will say something different. So even if you have interpreters around, the issue is not whether or not that they can't translate properly but are they actually going to give the information as you intended. *(OQN, George)*

More statements that increase the nurse's fear of losing the caring messages through translation are:

> .... I found the translation process very long and time-consuming and sometimes wondered whether the patients really got the message I wanted to pass ... this was a big frustration and a big challenge for me ... the patient would have questions, and the patients would go on at length and have a conversation and I'd turn to the translator who would say "she said this, and this", I'd say it took you that long to say this and this, and I could tell they would paraphrasing it ... Also when I would tell the staff to tell the patient something, again it felt like they said it in very few words. *(OQN, Dot)*

However, translators are at times not enough or not available, meaning that OQNs are not able to access assistance in order to overcome the communication difficulties they face. Further,

translation may also impose challenges to the communication process. Communication difficulties during the translation process at times result from cultural restrictions on utterance of some words.

Inability to communicate with patients directly engenders a feeling of not giving appropriate nursing care because it goes against what nurses have learned as appropriate throughout their careers:

> The biggest problem is communication. By learning Arabic you develop a lot more mutual respect between you and your patient when you communicate with them independently instead of always having to drag in a translator to help you. *(OQN, Joan)*

Moreover of there is a gap in providing direct patient care:

> It is difficult to gather information on a patient's medical history even with the help of the interpreter as they are not allowed by culture to utter some of the words that might be deemed helpful for history taking. *(OQN Linda)*

> ...communication is hugely difficult in the fact that if you use a translator you lose so much meaning. *(OQN, Jill)*

Moreover

> ... when I first came here I used to be so frustrated and I used to think, I know that I can tell them all these things but I can't explain it, then I tried to get a translator and I didn't know if the translator could translate it properly. Sometimes the translator would say what they thought, so the patient should know what you were telling them and I know sometimes I think I couldn't tell the patient's name, and they would say something else ... so that was really frustrating. *(OQN, Jean)*

An additional factor of the translation process is that sometimes the participants had to use Patients Care assistant (PCAs) and PCAs who are only working as porters. This group of patient carers/porters do not have a good level of English and therefore do not even understand the messages that the nurses are trying to give to the patients or the families.

> ... we are supposed to have translators helping us around the hospital but it comes a time where they never show how the translation is made to the family because often we realized that the family, they're not accepting the information the way we think or the way we expect them to accept it because we are trying our best … when it comes to translation we believe that there's a lot of information missed, so maybe I believe that the hospital should have a good program for translators in the hospital because sometimes PCA's and ward clerks who are supposed to be our translators, their own English is not maybe as good as it should be so they should start by that and then with a good translation program to help us with that. That's all, when it comes to communication and providing care for this kind of patient that's our main frustration. *(OQN, Sue)*

Translation is rather a time-consuming process and inhibits efficient delivery of healthcare, especially when translators are not readily available. Moreover, participants further articulated that OQNs gain more respect from Saudi patients if able to communicate with them independently without translation.

> ...cultural competent nursing care is difficult when patients are covered, and nurses feel dissociated with the added disadvantage of not understanding the language and using interpreters who may or may not tell the whole truth to families or patients. *(OQN, Steve)*

OQN Jean further added:

> Patients want to know everything and keep asking questions even though you can't answer and it's just really frustrating. This at time compromises the quality of the

> care provided to patients since we as nurses cannot communicate with the patients or provide them with the information they require. *(OQN, Jean)*

The translation department plays a major role in nursing care in Saudi – unless there are more Arabic nurses, PCAs or Ward Clerks (WAs) around to communicate with patients and their families. OQNs are trying their best to communicate with their client and families, but it is doubling the time in communication and increasing the risks of misunderstanding.

Communication in a foreign language was difficult enough for the OQNs. A second and more significant difficulty was the challenge of the complex non-verbal communication that faced the OQNs while delivering their nursing care. This non-verbal (voiceless) communication is intricately tied up with the Saudi Islamic Culture.

6.6 Nonverbal – the voiceless Arabic language

The difficulties of separating verbal and non-verbal communication are considerable and so it must be noted that, at times, there is an overlap of these two concepts. Deeply embedded in the Saudi Arabian patients is their Saudi Islamic Culture, which impacts non-verbal communication far more than Western culture does with providing nuances of communication.

> …on many occasions I found myself sinking on a chair because I can't figure out what to do. I had to explain the procedure to my patient and had to secure permission for performing nursing care, especially for giving medication. In most cases I explained to them the thing that is needed to do by using nonverbal communication like gestures. They do understand me but there are scenarios that cannot be explained by gestures. Those times I felt I was in a chaotic situation that nobody will like, but I braced myself, stand brave, and figure out what to do to help myself out. *(OQN, Betty)*

Straight forward communication between a nurse and a patient who both speak the same language still fall into a miscommunication because of the influence of culture on non-verbal communications in the Saudi culture.

6.6.1 Touch and eye contact

Touch and eye contact were the most sensitive areas of Saudi Islamic Culture that the OQN had to learn to deal with in communication. Both of these issues can inadvertently causes much embarrassment for the OQN group:

> I was told that I cannot touch a male patient ...Touch is the most important because it reaches the patient. When you touch him, you communicate, you know you call it therapeutic touch. So it's not allowed in this culture. So it gives us a challenge to work with male patients. Even some of the female patients are not used to touch. *(OQN, Linda)*

> "...I did something culturally insensitive to a female patient by taking her hand to comfort her when she was crying and in pain … which is normal in the UK, but here I was in huge trouble … It was a natural response. *(OQN, Steve)*

The experience faced OQN Steve was lack of Saudi culture awareness. However OQN Dot how patients know if you do care or not:

> Communication was a real concern of mine before I even came, because I'm a very verbal person. I realized really quickly that it wasn't so much what I said, but my non-verbal, what my body language said, and patients know, the patients know if you care, and they know if you don't, and I think that was the biggest lesson to me. So, when you're having a bad day, don't take it on your patients. *(OQN, Dot)*

> I come from a French Canadian culture and we tend to touch when we communicate. In Saudi I may touch a male but I'm not allowed to touch a female. I may not be able to provide comfort. I can't communicate non-verbally and that

> becomes very frustrating. So we're looking at non-verbal communication. *(OQN, George)*
>
> The inability to show affection to an obviously suffering individual; It is relevant to touch, this is a psychologically proven phenomenon and not acceptable in the Saudi culture. Patients are dealing with many trying situations and empathy is shown at a very distant point. *(OQN, Kay)*

Touch is essential in communicating sympathy while other non-verbal expressions such as grimacing may signal patient discomfort. Touching is a very sensitive issue in most cultures; however, in Saudi Arabia it is particularly sensitive because of two indivisible factors: religion and culture.

Caring and support was important for OQN Tanya to show the patient by touching.

> Touch indicating caring is used to signify support for the patient and taking consideration of the patient's cultural and personal feelings about being touched by the stranger outside the family people. The nurse should obtain permission from the patient for touch to occur. This way communication conveys a feeling of comfort and caring. *(OQN, Tanya)*

The sense of touch has a symbolic meaning in nursing care, used to pass feelings and messages to the patients: either emotional messages of support when passing bad news to them, or when they are experiencing fear and anxiety, especially when they are going for major surgery or when their condition worsens.

In many simple daily communications, eyes play an important part in the sending of messages. Parents may, with a single glance, decide what to do with a child who is misbehaving. The eyes can speak as well as the tongue in verbal language. The dress code of Saudi women, who are required to cover their faces, hinders effective non-verbal communication as the eyes are

covered. The participants highlighted misunderstandings due to voice intonations, especially in Saudi males who speak in high tones, which could be mistaken for anger towards the OQNs and restrictions of eye contact and personal space, which is a major issue with male patients for inhibiting non-verbal communication. OQN Alma summarises this and says that it is challenging.

> ...not having a face and eyes to look at during communication is challenging. *(OQN, Alma)*

Eye contact is part of personal communication; however it is different from culture to culture. Some culture will consider eye contact to be part of personal respect, while other cultures interpret eye contact differently – such as in Saudi culture, which considers it as impolite. OQN Joe illustrates that the understanding of the eye contact is very sensitive when examining your patients:

> ... it's hard to look at a woman's face since it's a part of the culture that they ... cover their hair and their face – but in the Philippines, that is part of interacting and communicating with a patient – so it's very difficult when we found out that it is part of the culture in the Saudi Arabia ... in other cultures when you interact, when you assist with a patient, you have also to observe ... look at the face … to see the expression of her eyes because physically you have also take to note because that is part of the physical assessment so it is really hard ... interacting with the patient. *(OQN, Joe)*

OQN Tanya raised other issues such as the distance, space and voice tone when caring for your patients and using nonverbal signs

> Preferred distance and personal space differs across individuals ... I was concerned with confidentiality/privacy especially with male patients, with female patient's the distance is not an issue. Establishing eye contact, or the tone of voice – I found that

> the Saudi Arabian patients, especially the males, speak with a high tone. I once thought a patient was angry about what I said to him. *(OQN, Tanya)*

This overseas nurse, OQN Tanya further talked about the need to be aware of what could or could not interfere with the patient's comfort zones.

> …one has to watch the comfortable distance that a patient keeps when interacting with other patients. *(OQN, Tanya)*

Some of the OQN's felt that they were being ignored when the eye contact was not part of the communication process.

> A man came to visit one of my patients who had gone out for a few hours. I said to him, he's gone for few hours and he wasn't making eye contact with me and I kept moving around to try making eye contact with him. He kept moving his head and I told to me, "Oh, he must be blind" and then I thought how he could get down to the corridor by himself. Then I realized he didn't want to make eye contact with me and that was really quite kind of shocking ... That little experience is a bit … shocking because you don't understand why they do it. *(OQN, Sarah)*

> So that was kind of my surprise, but also they don't look at you and if they will talk to you, they will look at the floor next to you and that used to make me so mad in the beginning. *(OQN, Shirley)*

> The other thing is a lot of people communicate with their eyes and/or with their eyebrows. You may ask a person a yes or no question and they just move their eyes and or eyebrows. They will not give you a verbal response which you are waiting for. You ask the question again and you get no verbal response. You can get frustrated because the person is not responding as you are expecting. So you have to look at the eyebrows to see if the answer is 'yes' or 'no'. *(OQN, George)*

The communication problems as detailed above are complex. In addition, the actual practice of nursing presents its own problems, as in the Chapter 7. Perhaps an efficient translation

system in the hospital would solve some issues, but as noted, translation has its own difficulties.

6.6.2 Gestures and body language

Communicating with the hand is commonly used and in Australia, even before a child speaks, they often learn to say "good-bye" by a simple wave of the hand. However, as with the eyes, the use of hand language has a wide variety of meanings across different cultures. Hand language is very sensitive as it may be rude when misinterpreted. Some of the OQNs group have such experience and challenges in Saudi Arabia during their nursing care of Saudi patients or family members, sometimes getting into trouble with the relatives as OQN. Liz gave two examples in her interview.

> One incident springs to mind immediately is when I was in Taif. A patient was going home, being discharged and we would help them to get to a car by providing a wheelchair. When they want to take a wheelchair and they actually left the driver's license because we wanted to get the wheelchair back because we didn't have that many you know, and they folded it up … put in the trunk of the car to take it home. So this particular relative came up and demanded the wheelchair and I keep asking him, in Arabic, you know, about the driver's license. He got very, very upset and he actually grabbed hold of the wheelchair and rammed it into me, and the handle that is used to steer the wheelchair rammed me in the stomach, and it was very, very painful and I automatically called the security and that was an assault to me. Eventually it was ironed out. I was asked if I wanted blood money but you know it was simple things and was only a misunderstanding and I think that's where a lot of things like that happen where nurses loss their temper with the relatives of their patient because they misunderstand the body language. *(OQN, Liz)*
>
> The other thing is that of body language. Body language varies from one city and country to the next and how one interprets the body language is based on my body language radar that has been configured in my home country. If you try to use body

> language radar configured in Canada in the Arab world then, you're not gonna read the body language correctly because the body language varies from one place to the next. *(OQN, George)*

> I realized really quickly that it wasn't so much what I said, but my non-verbals – what my body language said, and patients know, the patients know if you care, and they know if you don't, and I think that was the biggest lesson to me. *(OQN, Dot)*

> You know but they do really appreciate learning the language. Yes, communication is very, very important, plus verbally and non-verbally. I made a mistake when I first came here, of actually pointing a finger to somebody saying, can you come here, like I would do, because they're far away while they were shouting at the corridor, you know, sort of pointed my finger and beckoned them towards me but whole fingers which I lately discovered that is very rude in this culture. Now I would never realized that until I was actually told because the person concerned was quite upset that I have done this, he didn't come and the ward clerk actually came to my assistance and explained, this was very, very rude, he went out and spoke to the gentlemen concern who then came forward and I went to apologize because I didn't know. The differences in culture, the differences in body language which people really, I think need to try and stop and look and listen rather than jumping in. *(OQN, Liz)*

Even the simple every day good manners such as shaking a person's hand proved to be a learning experience for this OQN:

> I first learned their religion and understood their culture, for example before I used to shake hands to all, it's my culture, now I've just say hello, then I understood by shaking, that I have to marry that person so I should not shake. *(OQN, Mavis)*

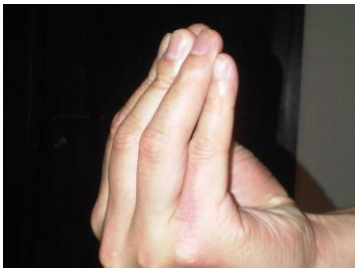
The use of the hands is both individual as well as cultural. It is well known that some cultures use their hand, especially when getting excited, such as the Italians. Some hand language is very specific and this, too, is different across cultures. Hand language can be very sensitive when used while talking, such as the image below is a hand language that means "wait a

minute please" in Saudi Arabia, while in Canada the meaning is insulting as well as being impolite. OQN George explains this:

> The other thing is that of body language. Body language varies from one city and country to the next and how one interprets the body language is based on my body language radar that has to be configured in my home country.... There is an expression that when you'll put all your fingers together in appropriate position and it means "shwaya shwaya" or to slow down. That same hand signal means go away but in a very rude form, where I came from. *(OQN, George)*

Figure 6.1: Slow down (shwaya shwaya) (Mohanalakshmi, 2011)

> … for me as a nurse, I'm challenged to understand the non-verbal communication from a person that speaks a different language from mine … so you might



> misinterpret the sign that he does on the hand, and you think he is telling you to wait instead of hurry. *(OQN, Linda)*

The OQNs expressed very emotional moments they have been through in their nursing care journey in Saudi Arabia that included the misinterpretation caused by their different backgrounds and experiences. However the foreign language and nonverbal language were not the only communication problem they faced. Working with different Nationalities added more responsibilities to OQNs, as Saudi Arabia depends on a multinational workforce to staff the hospitals.

6.7 Multinational – understanding your team

The KSA is a country that depends on the expatriates because there are shortages of local nurses, as already discussed. The mix of expatriates – coming from different parts of the world – creates significant communication challenges OQNs with other team members. Miscommunications can occur in the delivery of daily care tasks.

There seemed to be problems understanding the English from other cultures/nationalities even when an OQNs had a good basic knowledge of English because of accents and grounding in English.

> Another shock was when I discovered that we are all employees from different nations speaking different languages – even English itself with different accents – that made things worse. Despite the institution trying to put up a policy that everybody must speak English, it still does not work as we also have big communication problem with the same English messages understood and interpreted differently … ends up giving different meaning and patients gets compromised in the process. *(OQN, Linda)*

> My main challenge is the language. That affects almost everybody here and the other things, as we are working in Saudi Arabia … we are not only one Nationality. There are multi-Nationalities in Saudi from different walks of the world, so we speak different languages and we understand different body language gestures, which might mean something else to another person. So we have lots of challenges, not only with patients but with other colleagues as well … so what I think is the correct information might be different to the next person. So those are the kinds of challenges that we facing in providing care because some may speak in her own language with her colleague and the other person would not have understood what these other two are talking about. So that may affect the quality of patient care, so we have language problems, mostly. *(OQN, Linda)*

When a group of nurses from the same country tended to talk to one another in their mother tongue, it was frustrating for the OQNs as well as their colleagues:

> Many nurses will discuss things with their co-workers and sometimes it's difficult because everyone is speaking "Tagalog", or speaking in Czech, or Merillam (Indian dialect) making it difficult to have uniformity of care and a holistic approach. It is also difficult when the doctors speak in Arabic on rounds, and the primary nurse (non-Arabic) is left out of the conversation. The nurse feels she is not part of a team and does not understand care for her patient. *(OQN, Steve)*

Moreover:

> Working in a foreign country is hard but working with colleagues who also came from other countries is harder ... How can we provide care to our clients if we healthcare professionals can't understand each other. *(OQN, David)*

A strong English accent, which causes patients and the other nurses to experience difficulties in understanding, was also an issue:

> I communicate with nurses or patients in English ... but they don't understand because I got a New Zealand accent, so a lot of people don't understand it, and they look at you, "what are you saying?" Also that happens with not just the patients but other people that are non-English speakers as well … they look at you and someone said to me once "what is your first language" and I said "English". "Ah, I thought it was your second language because you got a strong accent". It's just the language generally, just not able to tell patients, explain to patients. *(OQN, Jean)*

Efficient care provision requires joint collaboration between nurses and doctors. Such teamwork efforts require effective communication between the healthcare providers in order to achieve a well-coordinated care provision process. However, when the physicians and

doctors speak Arabic language with the local Saudi nurses, the OQNs, who at times happen to be the bedside nurses, are locked out of the conversation.

Additional difficulties for the OQNs when communicating with the Arabic speaking doctors and nurses who come from Arabic speaking countries are not tied to differences in accents:

> I had communication problems with the doctors ...They do not want to listen or could not listen ... they did not understand me ... Difference in Nationalities was a problem ... because you had all these different nurses ... Australians speaks too fast. I am Filipino, your voice is like this; they said yes, when they mean no, they say she when they mean he. (OQN, Kay)

Healthcare team who speak the patient's language could create and more challenges for the OQN. The following quote from OQN Shirley, for whom English is a second language, indicates the complexity of dealing with numerous spoken languages in the clinical setting.

> ... but the communication between me and the doctors, me and the colleagues, because most of the doctors are Arabic speakers, so Egyptian doctors, Jordanian Doctors, Syrian Doctors, Lebanese Doctors, so they always speak Arabic and then the nurses, there are Arabic speakers because they're from Jordan or Lebanon or Egypt and then a lot of the Indian nurses or the Filipino nurses, they're often on a majority group, and second the nurse, they speak probably not enough Arabic to communicate ... in Arabic to some degree. So what I found often is you, for example, while the warden, one of the doctors which usually I'm ordering, doctor what's that, they're asking something in Arabic. all of a sudden the whole dynamic staff, warden, staff go on in Arabic, and you're standing, there thinking about, I'm the bedside nurse, I need to know what's going on, I don't know what to do *(OQN, Shirley)*.

OQN Alma relates a scenario whereby the doctors' converse in Arabic with the patient yet the nurse does not understand Arabic. While this may be correct because most of the local Saudi

patients have minimal understanding of English language, the doctor should have further translated for the nurse since the nurse is supposed to take notes, record the patients' progress and take instructions from the doctor. This brings out the poor perception of nurses by doctors within the Saudi context.

> At first, it's really hard for me because I couldn't understand what my patient was talking about, and even the Doctors, when I was with them during the rounds, they would talk to the patients in Arabic and they would not translate it to me. I even didn't know if they advised the patient. I presume it's medical advice they provided to the patient. As the patient's nurse, I had to know what the patient's complaint was ... I just presumed and I really didn't know exactly what they are talking about because they were talking in their language. I would just read between the lines when is the doctor will be in the station, he will prescribe a medicine and then I will just think over to myself that, maybe the patient, you know, it's not that clear ... I felt left out unlike in scenarios where the patient, the doctor and the nurse would be on a common ground. *(OQN, Alma)*

6.8 Conclusion

In conclusion, the OQNs have had different communication experiences and challenges through their nursing journey in Saudi Arabia and while caring for the Saudi patients as well as the patients' families. They often had to deal with someone who knew no word of Arabic or English. These issues have prevented them from delivering holistic nursing care to their patients.

Communication is an inherent problem. Specifically, many non-Saudi nurses do not speak Arabic. As most of the Saudi patients do not speak English or other languages, nurses and patients often fail to find a common language, thereby increasing the chances of misunderstanding. The inability to communicate also impacts nurses' ability to work

effectively in teams. Differences between nurses' Nationalities/cultures and specific methods of carrying out nursing procedures may not be able to be communicated effectively to develop mutual understanding. Therefore, although policies and procedures for care exist, they may be misunderstood and/or incorrectly implemented.

In health care there is sometimes no time for patience as emergencies arise and patients' lives are at stake. However this is not the norm in the daily care in many wards. Nursing care takes place over days and sometimes weeks and there is an ongoing need for patience in communicating across language and cultural barriers. There was an undercurrent of a lack of patience that was perceived when the research questions were being asked and answered. There was an awareness of the difficulties as expressed and formally recognised by some OQNs.

The next chapter deals with the complexity of practice, discussing the problems that face OQNs in their professional practice, and will illustrate a further challenge while working in KSA.

Chapter 7: The complexity of practice

… no respect for patient safety. (OQN, Steve)

7.1 Introduction

The core of this research was to find out the experiences of OQNs providing care in a Saudi Arabian hospital. Chapter 5 explored the Saudi Islamic Culture and some of the cultural aspects that influenced the OQNs care. Chapter 6 discussed the communication difficulties faced by the OQNs. In this chapter, the important nexus between the Saudi Islam culture and the issue of language on the practice of nursing in the KFMC hospital will be addressed. Some of the quotes have been given in full to capture the sense of the incident; however the salient phrases have been underlined to give the significance of the quote.

The language and cultural environment of KFMC meant that the delivery of care made for complex professional practice, this factor that was echoed time and again by the OQNs group. Two concepts emerged from the research identified as being crucial to the delivery of a high standard of professional practice. The first is patient safety and the second is caring. The context of caring is that of Watson (2007) and Benner (1984) note as the notion of reaching out to the patient and connecting with the patient in such a way that the patient feels cared for.

The complexity of care was increased when the OQNs group were faced by a patient who:

> The kids may have never seen someone like me, I guess, when they're young and they come riding from the desert and then just scream as soon as they see me, so that was difficult. **(***OQN, May)*

Nurses have been aware of their role and part of that is to be an advocate for the patient but unfortunately this is not the case in Saudi and this advocacy and independent decision-making brings problems with other cultures within the expatriate group of nurses. OQN George found this to be the case in the areas where he worked.

> Also, the fact that if you want the nurses to be advocates for the patient, you need to have someone who has been in that role before ... But if your co-workers have been socialized to be handmaidens and not to be independent thinkers then they're not able to provide the care that you expecting from them ... The healthcare practitioners expect to work with Western style nurses and have similar expectations from the Asian and Arab nurses. But that does not occur as the different nurses are trained in different hospital cultures with different role expectations of a nurse. *(OQN, George)*

Who comes first is an issue that faces the OQNs when caring for their patients. OQN Georgia articulates this well when she describes her general impression of comparing her nurse education with those around her.

> I come from the background where the patient comes first no matter what and I find it difficult nursing with people who really just want to get the job done ... but you sometimes have to be understanding since cultural and religious perceptions are also different. *(OQN, Georgia)*

OQN Linda has been able to describe the cultural aspect of the complexity of nursing practice by highlighting a number of issues: patient autonomy, cultural appropriateness and the need for the nurses to have knowledge of the Saudi Culture:

> The patients in Saudi will negotiate as far as he can in terms of his health and the belief of prayer being the primary solution. It is imperative to know that prayer is a fundamental part of the problem solving approach and thus one has to endeavour to use this approach to keep within the confines of the cultural appropriateness. The

> need for this has been due to the fact that our care rendered is of a Western nature and has to be implemented in Saudi Arabia and thus creates some conflict in terms of the culture. It is here that the relevance of a full understanding of the culture is required. *(OQN, Linda)*

The OQNs are mostly familiar with the Western nursing system under which family members are viewed as an integral part of the caring process and thus help out during care provision to their sick family members. Some participants' responses on the issue are:

> Next would be the involvement of the family members in the care for the clients. I was used to the participation of family members in taking care of their loved ones while in the hospital. But as I've observed here, family members are not that much involved, like staying on bedside with the client and giving assistance if necessary. *(OQN, David)*

Moreover,

> In the West, I see families integrated within the care of the patient. Here you have sitters or paid sitters who provide quality care depending on how much they are paid. Sometimes the sitter does not communicate with the family members and communication between the families is very strained. The staffs do not know who the head of the household is and disseminations of information is mixed. I believe families only relate to the medical team and nursing is still not a recognised profession here. *(OQN, Steve)*

An extra challenge to the OQNs is the need to have some who speak more than Arabic as some of the patients are being assisted by someone from India or Indonesia and can speak only their own language.

> I see the family members disassociated from the care, which is sad. When we try to involve family members, they want to be involved in the care, but the doctors do not want them involved ... If I ask a mother to help feed her child ... she says it's not

> her job ... I ask the family members if they want to pray for the patient the families say "No ... we will go to the mosque". It is as if the patient in the bed is not part of that family anymore. When it comes to things like providing basic cares – bed bathing, shaving the patient, we try to involve the family although many families will bring the maid, rather than the family to provide care. *(OQN, Steve)*

This is attributed to the perception of the hospital environment as facilitating inter-gender interaction which is prohibited by the Saudi culture, coupled with the traditional perception of nursing as a low status profession. This is a challenge to the OQNs who are influenced by the nursing systems adopted in their home countries and are treated as an integral part of the healthcare team. The participants highlighted that they cannot start basic lifesaving procedures without the doctors' consent. OQN Linda summed up the divide powerfully.

> There was no nursing regulatory board, no scope of practice, no standards of nursing practice, and no independent roles of the nurse. I was extremely challenged, as I was coming from a country where we were allowed to start lifesaving basic nursing procedures without Doctor's orders – e.g. wound dressings, managing pyrexia by tepid sponge, dysphonic patient by fowler's position and oxygen therapy etc. But this was all no go zones without the doctor's order. *(OQN, Linda)*

7.2 Culturally competent care

In all the transcripts the notion of caring (empathy) was only addressed once. This was done by OQN Linda who indirectly mentioned 'caring' by using the word 'empathy':

> I did something culturally insensitive to a female patient by taking her hand to comfort her when she was crying and in pain … normal in the UK, but here I was in huge trouble and I had to explain myself to nursing administration plus security. I could have had disciplinary action against me. I was very scared at the consequences. It was a natural response. *(OQN, Steve)*

> The inability to show affection to an obviously suffering individual; It is relevant to touch, this is a psychologically proven phenomenon and not acceptable in the Saudi culture. Patients are dealing with many trying situations and *empathy is* shown at a very distant point. In order to reach the patient, being empathetic is core and it is this element that prevents the holistic approach of the nursing care. The inability of a patient to admit that he is having a difficult time dealing with a situation. *(OQN, Linda)*

Although the OQNs were asked about culturally competent care as indicated in the prompts that were used in the interview, the way in which the OQNs responded to these questions indicated clearly and undoubtedly that there were elements of caring/empathy in their approach to nursing care. The participants were required to provide their perception of culturally competent healthcare and the strategies adopted in order to meet the Saudi patients cultural requirements during nursing care provision. The participants view culturally competent care as incorporating the patient's cultural perspectives into the care provision process. In the Saudi Arabian context, the participants highlighted taking into account cultural aspects such as praying and fasting, gender differences, non-medical needs and making an effort to understand the patients' expectations. The participants recommended comprehensive and structured orientation programs to familiarise OQNs to the Saudi culture and religious norms, and facilitating the provision of culturally competent care to local Saudi patients. The nurses further recommended Arabic lessons for the OQNs, as the patients appreciate the qualified nurses efforts towards communicating in Arabic.

> Culturally competent nursing care ... taking into account a patient's culture ... in terms of things like, fasting or praying, different genders ... I think just, it means, to me, just be aware of the non-medical needs of your patients whether it's something during Ramadan, they want to break their fast at this time, they take this medication

> then ... just acknowledging that and understanding that there are differences in cultures ... give the patients a chance to tell you as well as what they expect, what they need from you. Just to be aware and incorporate that into your plan of care. *(OQN, Joan)*

The OQN Joan further emphasised that:

> It's very important to have a clear understanding of the patients' needs like going for prayer, what that means, what's the preparation, how do they perform it, like for example, if they want to go to prayer and they have surgery and he have to wash, they must have to wash (ablution) before they go to prayer ... what he must have do or have to apply to perform that Salah, prayer. *(OQN, Joan)*

> Culturally competent nursing care is where you are able to reach the individual, holistic approach ... whereby the nurse is culturally cognisant through formal exposure to the cultures which she/he will care for. Cultural based nursing care is that care which allows for the patient to receive care, which is pertinent to his/her culture, yet ensuring that the quality of care is not compromised. It should be clear that culture is not a study/theoretical subject … it is a way of life that people share and makes them a community. *(OQN, Linda)*

> Culturally competent nursing care is a care which is sensitive to the culture of the patient. And this can only be fully achieved in two ways. *(OQN, Alma)*

> In addition to – a culturally competent nurse should be flexible on the situation but should be firm too on rendering nursing care if it is really needs to be done and if it has a great effect on patient's recovery. *(OQN, Betty)*

OQN Betty further provided some of the strategies adopted in ensuring that patients receive culturally competent care:

> The strategies I used to deliver a culturally appropriate care is to always talk to patient be a friend with them write the word I don't understand and ask an Arabic speaker for the meaning of nonverbal communication … are always used while talking to them, whenever I feel that verbal communication is not effective, I

> usually used nonverbal way of communicating to my patients, to make sure they got my point and they understand the procedure needed to be done. *(OQN, Betty)*

Other views of culturally competent care were:

> ... culturally competent nursing care is …You have to understand what is your own culture first and how does that culture affect your views on health, healthcare and the delivery of healthcare. You have to know how deal with other races … appreciating the differences can enhance the way you deliver nursing care … failure to understand the patients' culture does not allow nurses to truly understand how to be culturally competent.. *(OQN, George)*

> Even with my Pidgin Arabic, try to and talk to them, I understand that the patient appreciates if you try to speak some Arabic. *(OQN, Liz)*

> My perception of providing culturally competent nursing care is ... when you can integrate your competency as a nurse and you can integrate the culture as well. If you can do that, you are a good nurse in Saudi Arabia. *(OQN, Sue)*

> Culturally competent care ... I would say it's more to do with the religious bonding with the country's religion which is very strong and if you have to work in Saudi Arabia you must remember you must respect the culture and the religion ... you respect the culture you automatically gain the respect of the people, so the first line, the golden line is respect. *(OQN, Bill)*

> My perception of culturally competent care is that expatriate nurses need to be sensitive with the culture of the people here ... because we are nurses, we need to be sensitive with the culture in this place especially when dealing with the female patients. *(OQN, Val)*

Some of the OQNs told of how bad news was given and innate in this is what one might call their caring or empathetic responses to the situation. OQN George emphasised that the doctors do not like providing family members with bad news with regards to the condition of their family members. Due to the difference in cultures or basing expectations under the

Western health care system, OQNs believe in preparing a patient's family members by providing them with information on a patient's progress whether bad or good. The nurses are therefore disturbed with the false assurances provided by the doctors. This is, however, tied to the firm believe in the will of God among Saudi's.

> One frustrating aspect in providing care was delivering bad news. If someone was dying, the doctor may say "Insha Allah he will get better and everything will be fine" which really frustrates me as a Western. Tell the truth to the patient if they are dying. You should allow them to die with dignity; to plan what to do with what little time is left in their life and take control of the latter years, months or days at the end of their life. That does not happen here very regularly because they don't want to say the bad news. And so you have family members who say don't want to tell their parent/child/kin that they're dying and you are caught between a rock and a hard place. So it is very frustrating because you can't do the job *(OQN, George).*

7.3 Patient safety

OQN David made the interesting comment that mistakes should be minimized. This comment was probably an insinuation or implication that there were a lot of mistakes that were not recognised.

> ... medical terms that can be translated so at least we have an idea of the language. Another is the things that should be avoided so as to minimize mistakes in the ward. We also need a brief review of the culture of the Arabs in terms of food, religion, and the like, to avoid the so called culture shock. *(OQN, David)*

The influence of culture when patients attribute their illness to Allah and are resigned to what the future holds to be in the will of Allah resulted in patients and sometimes families being so resigned that compliance in the Western nursing sense of the word did not exist. Some of the

OQNs were sensitive enough to realise the influence Islam had on the patients and their families' lives.

> First thing is to understand the people, who they are and where they came from and to understand their religion – that's what dictates a lot of their attitudes and lifestyle. They are intertwined. You can't separate that two with them. *(OQN, Georgia)*

The OQNs group told of times when the patients and their families would disregard instructions and drink/eat when they were on nil per mouth or would get out of bed to pray when there were intravenous lines attached, dragging on the line or even pulling it out (Personal experience).

Another issue within daily nursing care is that there are some families using traditional medicines and these may create major issues with the patient's family when trying to advise them how much it could harm the patient. They may not listen to what the nurses saying, as stated by OQN Sue.

> I have faced situations with patients' families come with homemade medications and they would believe it's going to work, but it's not acceptable, especially in ICU's, you have to control the environment the most as you can. I try to explain to them that we cannot do that, but their belief is so strong. Then you will find the family doing that behind our back and it is hard to deal with that because they do not care about what I said, they will just do whatever they think that could help their family. It is their belief; they believe on that so strongly and they would just try to do whatever they can, even if they have to cheat. *(OQN, Sue)*

> When it comes to medications, the family members can buy "anything" from the pharmacy or the local markets ... without medical advice ... and give to the patient resulting to complications. Sometimes we have to beg families to come and see the

> patient, which is a huge difference from the West as families want to be involved. We have issues that male family members are right all the time and whatever a patient wants s/he gets. The rights of the patient can be compromised by this, leading to unwanted surgery or no knowledge of surgery performed as the male member is signing the consent. Family members have no respect for a closed door within the hospital unit. It makes no difference if a patient is being catheterised, or undertaking a breast exam, families open the door and come in. Staffs try to stop families although they state this is my right as it is my country – it is so frustrating. (OQN, Steve)

And finally a quote which looks at (Zam Zam), the Holy Water, some of the patients at times ignored the prescribed medicine in favour of holy water and traditional medicine provided by their family members. In such situations, the nurses could not restrict the patients from following their beliefs but could only inform the doctors in charge. Such scenarios made nursing care provision difficult since nurses are supposed to look out for the patients' best interests.

> I found out that there are lots of things that we don't understand in medical aspect ... for example, we have ordering that it is Nil By Mouth (NPO) for the patient ... but the patient wants to take holy water or "zam zam" … we cannot make or discuss with them because they are following their believes ... so the only thing that we do is just inform the doctor, the physician that is handling this patient and we just note and document. (OQN, Joe)

There were 23 OQNs who participated in this research who found the language barrier one of the most difficult stumbling blocks in dealing with patients' needs and more importantly by inference their safety.

> Families don't understand or don't want to understand about no phones in the ICU. Mobiles interfere with the monitors – although Saudi Arabia and phones go hand in

> hand. Every Saudi has a phone maybe two or three. Family members have no respect for patient safety, and when asked to leave to use the phone will become very aggressive as if you are disrespecting them. *(OQN, Steve)*

> And, giving patients directions in what to do or to follow directions for medications, that is difficult when you don't know or the patient don't understand what you are trying to say as you were saying it in medical view as that was the only way you can say it, but they don't understand the medical language, but then as I said I would always get an interpreter or another Arabic-speaking colleague or interpreter to explain to them what I am trying to say. *(OQN, Georgia)*

OQN Linda further emphasised that the medical team relationship should be targeted to perform the proper required and safe medical practice, but it notes that working in teams is poorly carried out and may affect patients' safety.

> The nurse is worried about what the doctor is doing and forgets what she is meant to do. The doctor is so busy feeling important that he forgets that he is here to save lives ... There is no sense of relying on each other as team members and each person being secure within their own role as the health care worker they are trained to be. *(OQN, Linda)*

Although the safety of the patient is reflected in the data an important aspect, the safety of the participants themselves was also evident. This was revealed as a fear by OQNs in reprisal if they fell out of line in obeying some of the cultural aspects in the way nursing care was delivered. It was a very real fear. The OQN Linda has already been cited but it is of importance to repeat her words here: "The constant threat of deportation is a problem, in that staffs prefer to dogmatically follow protocol." (OQN, Linda)

And yet as OQN Georgia notes it is difficult to separate their practice and the belief of the patients:

> First thing is to understand the people, who they are and where they came from and to understand their religion – that's what dictates a lot of their attitudes and lifestyle. They are intertwined. You can't separate that two with them. I've worked with lots of Saudi nurses and I asked about the *Qur'an* and asked about the religion. Why they believe in this and why they believe ... *(OQN, Georgia)*

The following quotes provide a further illustration of the nurse's experience through their time working with Saudi patients and safety issues.

> I feel it's unsafe but it is the culture, so what can I do, and if I got five patients you know what I mean, all behind closed doors, well that worries me. I find it the cultural aspects can really stretch-out the nursing care. *(OQN, Kay)*

7.4 The language issue and its relation to safety

> … it's difficult to accept some behaviour from the Saudi family even the Saudi patients, it's even harder when we can't speak their language or they can't understand what we want from them, what we expect from them. *(OQN, Sue)*

Paynich (1964) in a study in New Mexico, on how teaching occurred in a foreign culture found that one of the primary problems was associated with translation issues was that nurses speak in long sentences/messages that may be able to not be easily translated or the translator does not understand the issues that needed to be translated. Sometimes it was found that the translators simply did not translate what was required of them (p. 88). Of interest is the fact that Leininger found much the same in studies of culture in New Guinea in the early 1960's (Leininger, 1997). Although this research is almost a half a century on, it seems to echo the findings of Paynich and Leininger. This concept is echoed by George who was quoted earlier in a different context.

> If by chance you had an interpreter – and it would help if they showed up to work – Many of the times they didn't show up to work – This was in the early 90's, more so then than it is now. But still the other issue is even if you have an interpreter, will then the interpreter actually tell the patient exactly what you are saying. Because they may not like what you are saying to the patient and they will say something different. So even if you have interpreters around, the issue is not whether or not they can't translate properly but are they actually going to give the information as you intended. *(OQN, George)*

OQN Steve addresses other issues such as gender which made the problems of translation even more complex, where male and female were communicating.

> You mentioned challenges – cultural competent nursing care is difficult when patients are covered, and nurses feel dissociated with the added disadvantage of not understanding the language and using interpreters who may or may not tell the whole truth to families or patients. *(OQN, Steve)*

> Lots of them, the words themselves, you know that sometimes, the patient, when he tells you, he has pain. For me the only communication I hear is pain. And the patient might not be having a headache, maybe this headache is caused by something else that I do not understand, because he will keep on telling me pain, pain, headache and the pain is starting from somewhere, but he cannot tell me the real matter, what is happening with him. Because first of all, I'm working in a male ward and I'm a female. So the headache of a man cannot be a real headache that I'm thinking about, but he cannot go deeper and tell me where the pain is because I'm a female, so that is point number one, communication difficulty I have. *(OQN, Linda)*

Communication issues related to similar words in this quote illustrates the safety issue of perhaps over-sedation.

> … because that patient is looking for a mother, because I'm used with a word of "alam" which is pain … but the thing is that patient is looking for a mother – she wants her mother to be beside her and then I was really trying to understand her. I

> was about to give a pain reliever because I was thinking that the patient is having pain but then it's good that I asked somebody to interpret first otherwise the patient will be sedated again because she's just looking for her mother not for the pain reliever for itself. *(OQN, Val)*

A major issue is teaching patients' how to care for their health because most of the OQNs do not have the ability to speak the patient's language even if they have learned some words. These words would not be enough to teach the patients what is required for his/her self-care when they were discharged, which in this case would mean unsafe self-care when the patient went home. Therefore, nurses are facing unclear rules about the Saudi Islamic Culture and the protocols of the hospital. Hence they are sometimes unsure that they are giving proper care to their patients. Two of the OQNs Liz and Sue acknowledged this and said:

> I think education is very important. I think the patients need to know exactly what is going on, exactly what their treatment is, what the diagnosis is, what is the involved treatment ... the family need also to know. The one thing I found very hard to cope with is the fact that the doctors here were not actually like in UK. If someone has a major cancerous growth in the stomach, they will say "Look, I'm sorry we can't do anymore" whereas here, the doctors don't do that. He will just take the patient to the surgery or in the operating room ... and operates on an eighty year old person who should never be operated on in the first place ... The family don't know that this is what has been done and they don't understand ... they have this operation, so why are they not getting better, why are you not getting out of bed, why are you not taking them for walks?, why are they not eating?, why are you not feeding them?. The nurses get the repercussions because the doctor hasn't told them exactly what is going on and to me I think that is an insult to any patient or family member because everybody has the right to know what is going on with their body and what we are going do to them and eventually what will happen if we don't. I think it's very important. *(OQN, Liz)*

> ... even though I work in an ICU, we have schedule timings for visiting … this … difficult for family members to understand that they have to respect timings. And on top of that, it's to respect the number of visitors per day ... they will come with everything, chips and drinks and the family will certainly, they would just be on top of the patient and they wouldn't be one or two but the whole family like 8 or 10 people there and has to imagine them in ICU, it's not compatible and then to try to get them to understand that it's not possible. *(OQN, Sue)*

Anthony and Preuss (2002) give a model of information characteristics that lead to adverse events in patient care. The primary focus is on information decay, when communication about a patient is left to stagnate as new information comes in. The authors give an example of how a patient's vital signs in an ICU change and the importance of being able to see the changes by having good information. This second aspect of the model is information saliency and it is this area that is most probably seen in KFMC as the problems caused by "Nationality mix" caused by the Saudi practice of employing "watchers" with, sometimes, other languages than Arabic and no English which causes the "… increase your team of intermediaries" *(OQN George)*.

7.5 Conclusion

The complexity of practice in Saudi Arabian hospitals was seen when the OQNs group were interviewed. They were nurses from a variety of other countries who came to Saudi Arabia with high levels of professional experience and skills; however, they lacked knowledge about Saudi culture and were unable to speak Arabic. This diversity in both culture and background may result in nurses not considering the Saudi patients' needs and believes. Non-Saudi nurses might create a gap between themselves and their patients, which can lead to less respect and more miscommunication between nurses and patients. The lack of respect really relates to the cultural issues, while miscommunication relates to a lack of knowledge of the Arabic

language. Consequently, patients may suffer from inadequate care that these OQNs are able to give but are prevented from doing so because of the complex environment that they are nursing in.

The next chapter will provide conclusions and recommendations on how improve and help the OQNs to overcome the issues they highlighted as influencing their holistic care delivery.

Chapter 8: Discussion and conclusion

8.1 Introduction

Communication in a foreign language is demanding and adjusting to a foreign culture is complex, whether it is OQNs working in a KSA hospital where Arabic is the main language of the country or a Saudi student in Australia studying in English. OQNs committed to a contract in KSA are faced with cultural adjustment problems as well as facing the daunting task of communicating in Arabic. This research found that the cultural and communication challenges were often frustrating as well as sometimes rewarding.

The role of nurses is undervalued in the Saudi Islamic culture, where nurses are seen as handmaids for physicians, as morally ambiguous because they break local gender taboos, and as inferior to other medical authorities. OQNs possess different cultural affiliations, norms and values from those held in Saudi Arabia (Halligan, 2006). They have little knowledge of Islam or of Saudi culture; the lack of knowledge negatively affect the provision of culturally competent nursing care.

The sheer numbers of OQNs in Saudi hospitals create difficulties with both spoken and unspoken communication. OQNs adapt to this new scenario and devise innovative ways of ensuring that their patients get the best care possible.

8.2 Challenges of working in a foreign culture

There were two fundamental themes that emerged from the data on the theme of challenges of working in a foreign culture. The first was the challenge of working in a foreign culture and the second was communication challenges.

8.2.1 Foreign culture

Cultural and religious beliefs and practices that present challenges to OQNs in Saudi hospitals range from communication issues to the incorporation of cultural believes and religious teachings into the health care system. Issues arising from cultural norms are particularly challenging to nurses who are attempting to provide culturally competent health care, and it is difficult for them to make the necessary adaptations to conform with cultural and religious expectation (Van Rooyen et al., 2010).

This study has identified several challenges faced by nurses stemming from cultural differences, these challenges are (1) in communication (2) restrictions on delivering care and communicating based on gender (3) nurses in Saudi Arabia are not considered part of the interdisciplinary health care team by physician and are seen as physicians' handmaidens (4) the nursing image in Saudi Arabia poor (5) the nurses have to adhere to a dogmatic approach to care whereby innovativeness is not supported and critical thinking among nurses is inhibited.

The study confirmed that a failure of nurses to observe cultural practices could lead to patient discomfort. One of the study respondents attributed this to the hiring of nurses inexperienced in cultural sensitivity and lack of focus on the local Saudi nursing population. The respondent argued that in the formative years of the development of the Westernised medical system, Middle Eastern nurses were many and this minimised the problems caused by the need to employ OQNs. This calls for exploration of remuneration and employment issues for local Saudi nurses as well as for ways to improve the image of the profession in order to attract locals to the nursing profession.

In opposition to the observations by Al-saggaf and Williamson (2004), who argue that Saudi patients' family members are instrumental in providing care to patients, the current study establishes that OQNs find it difficult to deal with patients' family members who generally fail to be actively involved in their care. Western cultures tend to integrate families into health care provision, while Saudis are likely to pay sitters to look after sick family members. The study further establishes that Saudis' adherence to cultural believes and the failure by OQNs to observe such believes results in conflict. This is instanced by respondent's revelations about the insistence of the use of traditional medications and attributing events such as sickness or good luck to Allah's will. Patients who believe their illness is a punishment from Allah (God) do not view Western medicine as a solution. Western nurses have difficulty imposing a medical regimen on such patients and therefore have their healthcare attempts compromised.

The lack of prior knowledge of Saudi culture leads to various challenges faced by OQNs. This aligns with the finding by Sudimo, Ehlers and Hattingh (2010) that non-Muslim expatriate nurses lack cultural knowledge of Islamic cultural practices in relation to nursing care. They establish that non-Muslim expatriate qualified nurses lack knowledge of the use of herbs as medicines, and of diseases specific to the local Saudi Arabian population. They also lacked knowledge of cultural practices relating to childbirth including rites and medications delivered during antenatal, intra- and post-partum periods, to breastfeeding, to the evil eye, and to practices designed to ward off ill health, including the disposal of the placenta and umbilical cord.

Under culture and religion, the study establishes that the Saudi culture is deeply intertwined with Islam and the teachings of the Prophet Mohammed. The respondents perceive Saudi

culture and religion as deeply woven into the fabric of daily life, and characterise the culture as highly private, which presents challenges in drawing out a patients' medical history. Further, the adamant observation of religious customs by the patients, such as fasting, sometimes presents a challenge to the nurses.

8.3 Communication challenges

The study establishes that OQNs experienced communication challenges ranging from verbal (language) to non-verbal communication. These challenges emanate from the difference in languages, in particular English against Arabic. While expatriate nurses mostly communicate in English, most of their patients do not understand and lack fluency in English. The OQNs do not comprehend Arabic, necessitating the use of translators; but this does not redeem the situation, as much meaning is lost in translation. Moreover, translators are not always available, and this may put patients at risk.

Challenges in non-verbal communication, such as touch and looking into a person's eyes, emanate from cultural practices; in Saudi culture, both touching and looking another person in the eyes, especially between males and females, is uncommon. Such communication barriers not only affect understanding and honouring cultural believes during nursing care but also hinder patient education by OQNs.

Communication challenges not only abound between OQNs and Arabic patients, but also exist among the nurses, many of whom come from countries where English is a second language; this, and the variety of accents, leads to misunderstandings among the nurses.

OQNs experience problems when dealing with family members of Saudi patients, who are not willing to assist in taking care of the patients but rather hire sitters, interfere with the care provision process or with patient medications. The quality of care offered by sitters is highly dependent on the pay provided. OQNs further experience challenges, especially when family members of Saudi patients provide the patients with traditional drugs, which at times result into health complications.

Despite the challenges, that the OQNs working in Saudi Arabia are aware of the notion of culturally competent care, and equate it to taking the patients' culture into consideration with regards to religious and cultural practices. In the endeavour to provide culturally competent nursing care, the OQNs use strategies such as creating interpersonal relationships with patients in spite of strained verbal and non-verbal communication. One of the OQNs voiced that the provision of culturally competent nursing care requires that nurses understand their own cultures and how culture affects personal views to healthcare delivery and how to deal with other cultures, coupled with the need to understand patient cultural expectations during the healthcare delivery process.

The respondents described a variety of communication difficulties when nursing Saudi patients. Effectiveness in communication is achieved when both sender and receiver agree on the same/shared meaning of the message, which is a function of the interpretation of language and associated non-verbal gestures and symbols (Munoz & Luckmann, 2005). Communication difficulties, according to the current study, range from verbal to a range of non-verbal challenges such as touch, which form an integral part of nursing care. The respondents acknowledge that Saudi patients have expectations from their health care system which they

find difficult to voice to nurses with limited Arabic. The situation is made worse in health care units that enforce minimum visitation, such as the ICU where patients cannot use English-speaking family members to communicate with the nurses, and in situations where translators are not available. The study also points to the attitude of some Saudis as a barrier to communication, especially in situations when family members of patients, when provided with instructions by expatriate nurses could perceive the nurses as being disrespectful. Other communication problems arose when communicating medical views to Saudi patients, such as needing translators to explain medical matters.

The current findings confirm those of earlier studies (Anthony & Preuss, 2002) on communication difficulties encountered by nurses in a transcultural context and, especially, in a culture such as Saudi Arabia's, where communication between females and males is restricted except between relatives or family members. The participants described difficulties in speaking, listening to and touching their patients. Lack of fluency in Arabic, the language commonly used by Saudis, was not addressed in educational or orientation contexts, hindering effective communication between nurses and patients. This finding aligns with those of other studies which associate communication barriers, such as loss of meaning due to misinterpretation, gender differences and eye contact or touch restrictions as hindering effective nurse–patient communication (Anoosheh, Zarkhah, Faghihzadeh, & Vaismoradi, 2009; Giger & Davidhizar, 2002; Park & Song, 2005; Sidumo et al., 2010). The findings also align with those of Cass et al. (2002), who attribute ineffective nurse–patient communication to such causes as differences in nurse–patient language, lack of intercultural communication, and lack of qualified translators.

This study, however, contradicts the findings of AlMalki et al. (2011) whose study of nurses working in Saudi Arabia hospitals highlighted effective communication and good relationships between nurses and co-workers, facilitated by effective communication between the parties. This study emphasises in line with other studies (AlMalki et al., 2011), that communication is a crucial aspect of the nursing profession, as communication facilitates teamwork in health provision.

Although translators were at times available, this study establishes that they are not sufficient: as one respondent from a paediatric ward noted, communication was hampered when there were no Arabic-speaking nurses who could act as translators. This indicates that there is a need to train and provide more translators in Saudi hospitals to minimise the communication barriers between nurses and patients. The need to train translators is based on the need to convey the full meaning of communications from a nurse to a patient and vice versa, which is essential for providing optimum health care outcomes (Cass et al., 2005; Giger & Davidhizar, 2002).

8.4 Language

Participants unanimously identified language barriers as the second most important aspect of communication affecting the delivery of culturally competent nursing care. The respondents collectively agreed that passing messages to Saudi patients or their family members were a challenge, and that the inability to cross the language barrier brought about a sense of helplessness. It has the potential to hinder cooperation, both between staff and between nurse and patient, and hampers patients' understanding of the medical procedures and recommendations explained to them by nurses who cannot speak their language.

Communication between healthcare providers is important not only in ensuring compliance with treatment recommendations but also in ensuring patient satisfaction and an overall satisfactory health care experience (Aldona, Piechulek, & Alsabir, 2001; Cynthia, 2001; Hughes, 2003); one participant painted a scenario where patients sat lonely and silent because they were unable to converse with their caretakers. The study also established that language barriers affected provision of competent care by hindering understanding of patient's nursing requirements and making it difficult to achieve a relationship based on tolerance and respect between nurse and patient. Language barriers further limit provision of culturally competent health care to Saudi patients by failing to understand cultural safety, which, in a health care system, focuses on the attitudes of the nurses. Transcultural nursing care should familiarise OQNs with the cultural believes and practices of the society where they intend to practice, so that they can use their knowledge to deliver culturally sensitive health care. Individual patients have a right to retain their cultural and religious values when interacting with nurses from other cultures. Patients have a certain responsibility for acquainting their care providers with their needs, but cannot do so if there is no common language in which to articulate them.

Communication and, specifically, language, serves an important role in cultural transmission and learning of foreign cultures (Liljeroos et al., 2011). Barriers that prevent effective communication between nurses and patients hinder nurses from learning necessary elements of Saudi culture from their patients. This hinders the incorporation of the patients' perceptions and views into their nursing regimen. Nurses' failure to acquire basic knowledge of the Arabic language and the culture prior to their arrival in the hospitals limits their ability to modify their communication approaches to meet their patients' cultural needs.

Health care providers are encouraged to modify their communication approaches to fit the cultural perspectives of their patients, and particularly to pay special attention to cultural communication norms that define communication, such as how, when and with whom to communicate (Sidumo et al., 2010). OQN Betty had taken some basic Arabic lessons and had also taken the initiative to learn about Saudi Arabia and Islam in general, but still had considerable difficulty with the language and cultural behaviours, just like the other respondents. OQNs may learn a little Arabic, but it is likely not to be enough to overcome the particular communication challenges experienced by nurses (Van Rooyen et al., 2010).

8.5 Challenges in non-verbal communication

The findings reveal that another factor hindering the provision of culturally competent health care by OQNs in KSA is the restriction on non-verbal communication, such as eye contact, and touch between individuals of different genders, affirming that non-verbal communication forms an integral part of full communication. The interviews made it evident that non-verbal communication is a challenge for OQNs, especially when dealing with women, because of the cultural restrictions. Saudi citizens' responses to non-verbal gestures that are acceptable in some cultures but not to Saudis do not help. More than one participant had a similar experience of pointing a finger to beckon a Saudi, an action that is offensive in Saudi culture. Other studies also identify non-verbal differences between Western and Islamic culture. AlMutairi (2012) notes that several commonly used gestures in the United States are considered rude in Asian cultures.

Eye contact restrictions by the Saudi culture do not align with communication practices in the cultures from which most OQNs originate. For instance, cultures such as the United States,

France, Spain and Germany consider it proper and polite to maintain constant eye contact during conversations (AlMutairi, 2012) and interpret a failure to look someone in the eye as a sign of shame, guilt, embarrassment or discomfort. Failure by OQNs to understand the cultural implications of non-verbal communication using eye contact violates the patients' cultural values and inhibits the delivery of culturally competent health care.

8.6 Communication challenges in multinational workforces (English as second language)

English is the formal language in the majority of Saudi Arabia hospitals, but most OQNs are drawn from countries where English is the second language. This presents challenges to the nursing staff who come from a variety of Nations and speak with a variety of accents, with a variety of competence in English, and displaying differences in both specialised vocabulary and meanings of nursing care. The participants attested that not only did different accents impede communication with colleagues from different countries but body language also differed between Nationalities, further complicating communication among nurses. The study affirms the findings of other studies, which associates accents with ineffective communication in transcultural contexts, inhibiting the formation of effective nurse–nurse relationships (Park & Song, 2005; Van Rooyen et al., 2010).

8.7 Major conclusions

This section presents the major conclusions in line with the study purpose. The study aimed to explore the challenges faced by OQNs in their health care delivery process in light of the cultural differences existing between their own and the Saudi Islamic culture.

The study affirms the importance of nurse–patient communication in the provision of culturally competent health care, and further affirms the communication challenges faced by OQNs working in Saudi hospitals. The study establishes that differences in culture between Saudi patients and OQNs influence and negatively affect communication during the provision of health care, and are a challenge faced by OQNs. The study finds that teamwork is essential between nurses working in a transcultural environment, and that communication between nursing team members is also essential in ensuring efficient provision of culturally competent health care.

The study confirms that OQNs have a deficiency of knowledge of the Saudi culture, which inhibits them in delivering holistic nursing care to Saudi patients and that various cultural perspectives, religious beliefs and practices are incorporated into the Saudi health care system. It finds that OQNs experience challenges rising from these embedded practices, and that their lack of knowledge of Saudi culture and religious believes affects their provision of culturally competent care. However, the study also finds that, over time, the nurses learn, adapt and come to enjoy working within the Saudi culture.

There is need for an increase in the number of formal interpreters in Saudi hospitals to ease communication between patients and their OQNs. Interpreters, whether formal or informal, are found to serve an important role in the provision of culturally competent health care. In addition, there is a need for the government to boost the image of nursing as a career. This will serve to encourage Saudi natives to take up nursing and ease many of the difficulties currently experienced by the use of many expatriate nurses, particularly in the understanding of cultural needs and the ability to communicate, both essential qualities of competent health care.

8.8 Cultural practices influence nursing care delivery within Saudi Arabia

Sensitivity to culture is integral to providing competent health care, particularly in a country like KSA where the Islamic culture has a strong influence on every aspect of life, including medical care. Cultural practices and believes influencing the provision of health care in the country include restrictions on communication, touch, eye contact between males and females, and modesty in clothing. Strong prohibitions on gender mixing make it preferable for male nurses to treat and take care of male patients while female nurses provide care for female patients. Saudi Arabian hospitals have to ensure that patients are housed and treated differently in line with cultural practices. Local Saudi nurses who uphold Islamic cultural and religious believes are particularly reluctant to go against such cultural restrictions.

Touch and eye contact restrictions limit communication and provision of care by nurses working in Saudi hospitals. The benefits of touch in the provision of health care and communication are clearly brought out in the earlier sectors of this study. On the same note, eye contact, as already established by the study, is an important method of non-verbal communication in nurse–patient interactions. The cultural restrictions on these elements, therefore, influence how nurses deliver care and communicate with their patients. Cultural practices that inhibit touch and eye contact are challenging to nurses from cultures in which touch and eye contact are acceptable and encouraged (Liljeroos et al., 2011).

OQNs face a multitude of particular cultural challenges when caring for local patients. Most lack enough knowledge of the culture, especially of the religious practices impacting on health care, to offer culturally competent nursing. Sidumo, Ehler and Hattingh (2010) argue that, as well as lacking adequate Arabic speaking skills, most OQNs are unfamiliar with issues

relating to patient privacy, religious obligations and visitor or family involvement in patient management.

The KSA culture holds a poor image of nursing as a career, partly because of a perception of hospitals as a platform that facilitates intermixing of genders and requiring long working hours. There is also a traditional viewpoint of nurses as lower-class. This has required the recruitment of OQNs to staff local hospitals, where they significantly outnumber Saudi nurses.

8.9 Poor knowledge of Saudi and Islamic culture challenges OQNs

Religious and philosophical issues arise from the interaction of different cultures in the process of providing health care. Local health care providers in KSA rely on their Islamic knowledge and believes in order to provide effective, culturally competent health care (Lawrence & Rozmus, 2001), made possible by their deep knowledge of the cultural norms and values of their patients (Tumulty, 2001). Expatriate nurses similarly need to combine cultural knowledge and professional values to ensure that their patients receive culturally competent nursing care. However, they lack the knowledge needed to achieve this.

Western cultures and Saudi culture differ considerably. Some aspects crucial to nursing that are taken for granted in Western culture are not acceptable in Saudi and Islamic culture, as has already been clearly established. If OQNs are not provided with induction training before joining the Saudi Arabic nursing workforce, they are not aware of the cultural and religious practices that will affect the way they can provide health care in Saudi hospitals.

There is a need to provide nurses with effective induction into the cultural practices that will influence their nursing practices in Saudi Arabia. It is important that they be provided with

basic information regarding Islam and pertinent Islamic practices and are provided with language classes, either before joining the Saudi nursing workforce or during their practice. Induction training that includes other culturally dictated issues will assist in aligning the views of the OQNs with the Saudi view of their role. This may require radical reassessment of the position of the nurse in relation to the doctor or the health team. OQNs come from the Western cultures where nurses are viewed as important members of the interdisciplinary health care team as opposed to the Saudi culture where they are viewed as handmaidens to physicians. Training initiatives should adapt transcultural nursing models to fit the Saudi Arabian context as a way of providing the necessary cultural knowledge to underpin competent nursing.

8.10 Major conclusions in the context of available literature

These conclusions are discussed within the transcultural nursing models (Giger & Davidhizar, 2005; Purnell, 2002; Campinha-Bacote, 2008) discussed in Chapter 2 and other available supporting literature. The influence of culture on the healthcare system and champions the understanding of cultural elements that influence the delivery of healthcare to patients. The transcultural nursing models (Giger & Davidhizar, 2005; Purnell, 2002; Campinha-Bacote, 2008) also recognise the importance of instilling cultural knowledge to nurses working within transcultural contexts to enhance and facilitate the provision of culturally competent health care services. The theoretical framework recognises the importance of encouraging congruency between the practices adopted by health care providers in a transcultural environment and the patients' cultural expectations of health care.

8.10.1 Centrality of effective communication to delivery of culturally competent health care

The existence of a variety of transcultural models testifies to the importance of nurse–patient communication in the provision of culturally competent health care. Giger and Davidhizar (2002) deem communication as important in the preservation and transmission of culture from one individual to another. Communication also facilitates the transmission of culture from one generation to another. Exposure of individuals to a certain culture facilitates their learning of cultural and communicational expectations of that culture. Because communication elements, verbal or non-verbal, differ across cultures, nurses are encouraged to understand the communication rules of their patients' culture as one way to facilitate their acceptance of treatment interventions. It is evident from the study that effective communication enhances the understanding of patients' health care needs by nurses. Effective and efficient diagnosis is facilitated by efficient and effective communication, which especially facilitates the development of an accurate patient history. It is, therefore, essential that OQNs learn Saudi Arabian culture and the communicative rules governing the culture.

Baker (2006) emphasises the need for effective communication in patient education in Saudi Arabia. The involvement of family calls for advanced and efficient communication among family members, nurses and patients to provide everyone with the essential medical advice necessary for decision-making. This is not possible without first eliminating cultural differences that hinder efficient communication (Baker, 2006).

The Purnell model (2002) for cultural competence characterises communication and the different elements of communication, such as verbal and non-verbal communication, as one of

the innermost domains of culture. This emphasises the importance of encouraging efficient communication to deliver culturally competent health care with due attention to cultural elements that may impede or enhance understanding.

The Campinha-Bacote (2002) cultural competence model categorises cultural skills, cultural encounters, cultural knowledge and cultural awareness as some of the interdependent elements that facilitate provision of culturally competent health care. Nurse–patient communication requires that OQNs gain cultural knowledge that will facilitate the accomplishment of various culturally controlled aspects of nursing care. The OQNs are also encouraged to engage in personal interactions with their patients in order to obtain a mutual understanding of cultural practices, thereby reducing personal biases towards practices that are unfamiliar. Nurse–patient miscommunication due to insufficient cultural understanding results in the sending and receiving of wrong information, which can jeopardise the intended results of care. Patient-centred health care approaches consider communication part of the treatment process; this reinforces the need for health care providers to communicate effectively with patients during the delivery of health care. Conversely, poor or inefficient nurse–patient communication results in patient isolation and stress, which can lead to deterioration in condition.

Effective communication is an important aspect of an effective therapeutic relationship between nurses and patients. Enhancing the communication between OQNs and Saudi patients will result into the formation of valuable therapeutic relationships that will improve the health outcomes of the patients and improve the general nursing experience of the nurses. Effective interpersonal communication also enhances patient satisfaction, a crucial element of a health care system and a significant indicator of its quality. Communication, then, improves

efficiency within a health care system in a variety of important ways, leading to crucial benefits to the health system.

The study categorises communication elements with the Saudi culture as verbal and non-verbal, further subdivided into language and listening under verbal communication and touch and eye contact under non-verbal communication. While all these elements function when communicating within the Saudi culture, there are several pitfalls for nurses unfamiliar with specific cultural usage. Failure to recognise and implement culture-specific idiosyncrasies limits the ability of nurses to provide culturally sensitive care to their patients.

The most obvious and major challenge facing OQNs are that most of them speak English, while most of their patients speak Arabic.

Nursing care calls for a coordination of effort between the caring team. This involves communication between the Arabian and OQNs. While this would appear to be a simple matter the issue is more complex. OQNs coming from different cultures sometimes have difficulty in understanding one another. This need for coordination amongst the OQNs has unspecified problems. Teamwork, an important aspect of nursing care, calls for effective communication to coordinate the delivery of optimum care. Teamwork, facilitated by communication, instils a sense of belonging with the development of collegial relationships with other members of the nursing team, as well as facilitating a sharing of cultural knowledge, helping each team member to adapt to the prevailing culture and, in turn, enhancing job satisfaction (AlMalki et al., 2011).

In tandem with this, effective and understandable communication is required among OQNs. There is a need to devise ways by which the challenge posed by different accents is overcome to permit effective communication and better understanding of each other.

8.10.2 Interpreters and translators enhance culturally competent nursing care delivery

The role of interpreters or translators, whether formal or informal, in enhancing the delivery of culturally competent nursing care by OQNs cannot be downplayed. The current study affirms studies by Misell (2000) and Tod, Wadsworth, Asif and Gerrish. (2001) that translation leads to loss of meaning and is at times troublesome, and also affirms that translators are pivotal in promoting language sensitivity as they act as communication brokers. Irvine et al. (2006) support this view and claim that translators are crucial in enhancing the effectiveness of communication in a transcultural context. Clegg (2003) also acknowledges this, but notes that even with skilled translators language remains a high barrier.

This study finds that the current number of formal translators in Saudi Arabian hospitals is inadequate. There are insufficient Saudi nurses to serve as informal translators and assist OQNs to overcome language barriers, and this compromises the delivery of health care. Sometimes English-speaking family members of patients are required to act in this role; but they are not always present. Translators, local nurses and patients' English-speaking family members all assist OQNs to understand patients' cultural expectations during their stay in hospital. This provides nurses with a chance of learning different cultural values. However, the high workloads may limit them from taking full advantage of such opportunities. Hospitals administrators should ensure that there are enough translators within the Saudi hospitals.

Increasing the number of local Saudi nurses will also ease the communication challenges experienced by OQNs.

8.11 Implications for policy and practice

From the findings, it is clear that a myriad of cultural and religious beliefs and practices influence nursing care within Saudi Arabia. These cultural beliefs and practices differ from those of the nurses who come from other cultures, and this necessitates their training in Saudi religious and cultural believes. This study establishes that the Saudi culture presents significant multiple communication challenges to OQNs. It is clear that most of these nurses are not sufficiently oriented into Saudi culture before beginning their practice in the hospitals. There is a need to implement measures that will eliminate or minimise the cultural and communicative challenges faced by nurses, and enable them to provide optimum culturally competent nursing care.

The researcher hopes that the study findings will gain the attention of policy makers and alert them to the challenges faced by OQNs in Saudi Arabian hospitals. This section describes the implications for policy and practice arising from the study.

8.11.1 Develop induction training programs for OQNs.

The induction programme should be implemented before a nurse starts practising – in the first months of employment or during the course of their nursing care practice. If provided during the course of employment, the programme should not conflict with other the hospital nursing programmes.

The induction programme should focus on holistically educating OQNs on Saudi culture. It should provide information on those aspects of culture most likely to affect the reception of healthcare by patients. Furthermore, it should incorporate Arabic language lessons, to provide the most fundamental of communication skills to the nurses.

The induction programmes should put into consideration the guidelines provided by Gulati et al. (2012), which have proved highly effective in enabling nurses to deliver health care to patients of different cultural backgrounds. The guidelines accentuate the use of cultural information as directions in the provision of health care. Specifically, the induction programme should aim to achieve the following:

- Generation and provision of personnel instruction modules on the common Principals of culturally competent care;
- Generation or provision of personnel education modules focused on increasing specific knowledge of the Saudi Arabian culture;
- Provision of current reviews of the most common cultural aspects affecting nursing care to ensure provision of evidence-based practice;
- Creation of activities aimed at promoting cultural competence;
- Creation of a library to provide information and current cultural knowledge and cultural assessment tools such as diversity websites, cross cultural healthcare case studies, multimedia sources and professional webinars.

Tumulty (2001) postulated cultural competence as a continuous process. Apart from inducting nurses through a cultural competence programme, the skills they are taught should be

reinforced through refresher courses, seminars, and other educational drives in Saudi Arabian hospitals.

In addition to induction programmes, hospitals should develop cultural competence centres to reinforce and supplement the information provided during induction. These should provide information about Saudi Arabian cultural aspects through brochures, literature reviews, and relevant health-related topics. The information centres should take the form of physical or digital resources, perhaps with websites providing links to relevant information. Both physical and web-based resources can be used as the world is highly digitalised, and the role of the internet in conveying information should not be ignored.

8.11.2 Need for recruitment and training initiatives for formal translators within Saudi hospitals

Recruited and qualified translators can also serve as resource personnel from whom OQNs can obtain information. Although Saudi nurses assist their colleagues generously, there are too few to be able to meet all demands for assistance. While the researcher acknowledges that the number of translators cannot match the number of OQNs in Saudi hospitals, where possible each ward or nursing unit should have a minimum of one translator. To achieve this will require policy development at both government and hospital levels. The government should collaborate with individual hospitals to create effective policies to guide recruitment and training initiatives. Each policy should outline the means of making translation an integral part of the health care system by incorporating translators into the administrative framework. Each policy should define the job group, entry point, basic salary and benefits available to translators, and should stipulate minimum educational requirements. To enhance continuity,

each policy should chart career progression paths to enable individuals who take up translation to grow within the career, and should include detailed explanations of how the resources required by translators in the course of their work will be made available and clarify whether hospitals or government should provide such resources.

8.12 Areas for future research

The study's findings serve as a foundation of future research areas. The researcher proposes the following four areas for future research.

- Strategies to increase the numbers of Saudi nurses.
- The effects of miscommunication on patient safety
- The effects of communication on patient satisfaction
- The practice of using Arabic when policy directs the use of English

In the first place research, into the question of the Saudisation of nursing and how this can be accomplished is an enormous area and can be broken down into smaller research projects or large scale funded research by the government. It is evident that the poor image of nursing in the Saudi culture provides a challenge to OQNs. With the projected increase in population and the challenges faced by OQNs working in the country, there is need to develop a sound local nursing labour force. AlMalki et al., (2011) call for the development of efficient strategies by the Saudi Arabian government to ensure an increase in the number of Saudis attracted to the health care systems as an important priority of endorsing health care development in the kingdom.

The poor image of nursing in Saudi Arabia negatively affects the provision of health care, so there is an urgent need for initiatives and research to find suitable ways to improve the nursing image in Saudi Arabia. The lack of native Saudi nurses has necessarily led to an increase in the number of OQNs working in Saudi Arabian hospitals. An increase in Saudi nurses working in Saudi hospitals would enhance the provision of culturally competent nursing care by OQNs and positively affect the delivery of holistic care by the health system (Aldossary et al., 2008).

The second area that warrants further study is the effect of miscommunication between OQNs on health care provision activities. The current study established the existence of miscommunication between OQNs emanating from the different accents possessed by the OQNs. The study has further revealed that coordination and teamwork during nursing care provision process as emanating from efficient and effective communication between nursing care providers. Future research should therefore focus on the specific effects of miscommunication between the OQNs in the provision of health care activities. The study should adopt a qualitative design and focus on OQNs as the study subjects. The establishment of such effects would form the foundation from which strategies would be developed to mitigate or ensure efficient communication between OQNs.

The proposed third study should focus on the effects of nurse–patient communication and patient satisfaction. The current study, while exploring communication issues faced by OQNs establish that nurse–patient communication as one of the critical aspects of nursing. The current study, however, does not specifically pinpoint the effect of nurse–patient communication on patient satisfaction and health outcomes. There is, therefore, need for

nursing researchers to empirically establish the effects of efficient nurse patient communication on nurses, patient satisfaction and the nursing care provision process. The study should adopt a qualitative study and act as a background for further emphasising strategies to ensure effective communication between OQNs and Saudi patients operating within Saudi Arabia.

8.13 Conclusion

This chapter has discussed the study findings and the major conclusions of this study. The results show that OQNs experience particular communicative challenges in the course of providing nursing care to Saudi patients. These include challenges in language and challenges in non-verbal communication; all are related to cultural differences in which nurses lack sufficient knowledge. These problems hamper the provision of optimal and culturally appropriate health care. Although formal translators are provided, they are too few to cope with the number of nurses needing assistance although it is established that they serve an essential role in enhancing communication for OQNs, assisting in the provision of competent care.

The study establishes that the multinational constitution of the overseas workforce, including some from countries where English is the second language, presents a communication challenge because the many different accents hinder effective nurse-nurse communication, affecting coordination and teamwork.

The recommendations cover changes at both government and hospital level, and their implementation would improve the image of nursing as a career in Saudi Arabia and mitigate

the negative effects of the communication challenges faced by OQNs. The recommendations, if implemented, would benefit the entire Saudi health sector, improve the overall quality of care in individual hospitals, and assist in offering appropriate care to individual Saudi patients by OQNs.

The study's unique contribution is that it considers the challenges faced by OQNs working in Saudi hospitals from a holistic perspective. The study's deliberately narrow focus on communication challenges permitted an in-depth exploration of how foreign nurses experience Saudi culture and how those aspects that affect their nursing practice can be remedied. It is evident that if they are to overcome communication challenges there needs to be a critical examinations of the entire Saudi health system and the implementation of policy interventions that encompass every aspect from home remedies to hospital training.

This study will serve as a background for policy intervention in Saudi Arabia, but also has significance for countries whose unique cultural and religious expectations affect the way their healthcare system operates, and those that rely on OQNs to supplement local nursing professionals and provide appropriate and competent healthcare to their citizens.

This study also provides a foundation from which future research on transcultural nursing can be developed. The following chapter is an Epilogue which focuses on the reflexive nature of the phenomenological approach to the study, using a cases paradigm from some of the OQNs experiences while delivering nursing caring to the Saudi patients and families. Importantly, to the researcher, and to underpin this study, the researcher concludes this thesis with an epilogue that reflects his rethinking and learning.

Chapter 9: Re-ordering my thinking – an epilogue

It was a sense of relief that I come to the end of the thesis. I had reflected in Chapter 3 as to how I felt prior to the research and recorded my feelings and thoughts about the environment that the OQNs would encounter on their arrival in the KSA. I had been struck by the dedication of the OQNs group to nursing as a whole that entered my subconscious and had not surfaced again until I started reflecting on my journey. This commitment had not been apparent as a theme as the data were analysed. The end was almost in sight but there appeared to be some unanswered question/s in my thinking. I decided to reflect again on some of the literature that I had read and applied in the research over the past years.

The dedication of the group prompted me to return to Benner's *From Novice to Expert* (1984). As I checked on my understanding of her treatise on clinical practice I realised that some of the interviews had incorporated exemplars that could have been classed as expert practice as defined by Benner. The OQN could have been classified as novice as their practice as it was in a foreign land with patients who were unable to communicate with their OQNs carers, they had in fact demonstrated expert practice. Practical knowledge includes "taking up cultural practices" and I thought about the problems the QRNs group had with culture. (Benner, 1984)

Lindseth and Norberg (2004) are right when they assert that researchers should not judge or conclude and that there should be "critical reflection" which will "revise, broaden and deepen our awareness" (p. 150). Prefiguration, configuration and refiguration, concepts first described by Ricoeur(1991) as cited in Lindseth and Norberg (2004) are briefly described, and I related to their discussion on refiguration which is "an expression that opens up new possibilities in

life" (Lindseth and Norberg, 2004, p. 148). It was a concept new to me and I considered the opportunities that I had been privileged to have as well as the responsibilities and possibilities that awaited me on my return to the KSA. The Lindseth and Norberg (2004) conclusion on hermeneutical phenomenology and interpreting lived experience was influential:

> It is only when the reader can make the interpretation integrated into her or his world (refiguration) that it can become productive in human life, e.g. it can be used to improve care (p. 153).

What was it about? I found the word 'refiguration' difficult to integrate into my vocabulary. I looked it up in a few dictionaries and then I came to the conclusion that it was like a reordering' in my deep thinking so that it became part of me as a person. I came to a realisation that what I had in my deepest thoughts was "to improve care". Perhaps that is also why I returned to Benner (1984) to find the answer to not only improving care but to having expert care for my country.

In their introduction, van Manen and Adams (2007) note that being able to come to an understanding of a phenomenon can change researchers and, in the change that occurs, their practice will be changed. In the conclusion describing reflection and its importance, the statement is made that lived experiences "constitute the immense complexity of the lifeworld" (van Manen & Adams, 2007, p. 454).

Liamputtong and Ezzy (2009) quote Willis (2007) "The more you experience the environment, the more you have the opportunity to understand it" (p. 24). I considered it important that the reader of this thesis should gain an understanding of the perceptions of the OQNs group as narrated by the respondents in this research. Their perceptions were, in

essence, the lived experiences of the expatriate registered nurses who had come to KSA and were the group in which I was interested in the first place. As part of the reflection process I reread the transcripts. As I revisited the transcripts in order to make this important choice of what to use, I found myself gaining new insight and understanding of the environment into which the OQNs enter. I considered that this would not only improve nursing care when I returned to the KSA and would also assist future OQNs to settle into the new environment, but also would facilitate giving expert care to patients in KFMC. These exemplars are presented again for the second time in order to make it easy to understand my refigurations.

The experience OQN Dot was for me a paradigm case by an expert nurse. It reminded me of some of the paradigm cases that Benner (1984) gives.

> I had an experience with a Saudi nursing student when a patient came in pregnant very early on, but with a pulmonary embolism. The patient started on heparin, and the student came out to me and told me the patient wanted to shower, so could she disconnect her IV? I said 'What's in the IV?' The student said "Heparin" I said do you want to disconnect it? She looked at me; I said well why are we running it? Because she might have a P.E., and then I had to take her through the steps, what do we do if her clotting time gets too long, if it's taking too long to clot? She answered "We stop the heparin" "Right" I said, "Do you want to stop it now?" She said "No!" I said "That's right!" taking the time to connect the dots. I could have just said no we can't, and left it at that. She wouldn't have learned. I think that opportunity is at home, when you have new nurses, they all come with this wealth of knowledge, all this book learning, they know all the protocols, they know all the steps and everything they're supposed to do. But it's that whole journey from Novice to Expert that Benner talks about. It's a key in helping them to develop, to get away from the routine, the ritual and the rote, which mirrors the way they are taught throughout their education, and take them to the questioning and taking that step further. I think we all have examples of instructors that pushed us to learn that,

> so I think I would probably include that, that it's an opportunity that's here, and I think back home too, but I think because nursing is still really young here, that the opportunity is greater. *(OQN, Dot)*

I went through the interviews consecutively so that the refigurations that I made on the interviews can be seen clearly.

I started reading through consecutively with some apprehension. What was refiguration about? Was I going to find, for example, this first quotation is about the image of nursing. It was not a theme, although some of the history of nursing in Saudi Arabia was discussed in the literature review. I read the interview with interest and agreed. Maybe I was being too harsh about the state of nursing in the KSA.

My thinking had already been re-ordered. I was surprised already. I had absorbed in my reading some of the history of nursing in other countries. Was this what refiguration was about, I asked myself I think it is.

Important parts of the excerpts have been put into bold.

> The **image of nursing** is not great, but it is improving … Years and years, ago, nurses were considered to be those who were poor people, you know, those that could not get a job, they were uneducated. Some of them were even considered to be drunks. Okay. Um, um … um I mean you read the stories about the nursing history. **So, maybe Saudi is where we were, say 30 or 40 years ago, I don't know.** *(OQN, Kay)*

I continued reading OQN Kay's interview transcript and found the following. It was about the cultural divide mentioned in Chapter 7, but I looked at it from my new perspective.

> And some male patients will say to the Saudi female nurses … **What are doing here? You should be at home** and why are you here and do not come near me**.** (OQN, Kay)

And realised that there was sometimes a strong dislike of Saudi female nurses and I felt a compassion for them. I wondered how much this actual dislike of Saudi female nurses had filtered into the community and whether it was part of the reason that young Saudi girls are discouraged to take up nursing as a career. This is a different angle of looking at Saudisation.

My journey of refiguration was just beginning but the following three extracts, still from OQN Kay, indicate the feeling of being frustrated. The challenges were clear but 'frustration' had not been a theme. And yet, I found, by reflecting on the interview process – and although words like frustration/hindrance/irritation were not used – there was a sense of frustration in some of the voices that could not be translated into words that I was only recognising now. There is a big difference between being challenged and frustrated.

> He would not look at me, **and that frustrated me**. And, he just completely looked away and I did not understand what he was doing. When I speak with someone I feel I need to look at them, So, I was, you know telling him, he was very rude. I needed to speak with him and to stand there and listen to me. And then, the Ward Clerk told me; "No. That is his culture, and that's, what he does". Then I said, "Oh! Okay". So once I became aware then, that's okay, but some of the doctors, you know, there was a difference with the culture and the doctors. Here you just get cut off, and that's it, you're not paid to think, the child will go home, bla bla bla. **So, I find that part of the culture really frustrating.** *(OQN, Kay)*

> So how can I give proper education when I can't speak the patient's language. Should I learn your language? Maybe I should. I did learn a little bit when I came here, but um I have to rely on someone, a ward clerk or other nurse or interpreter to come in and give that information. Then I feel that I am not giving 100 per cent

> holistic care to my patients, **because I cannot even tell you the proper education for your child. You see that is frustrating, for me, when I am used to give 100 per cent holistic care.** *(OQN, Kay)*

The following extract from the same OQN Kay is about frustration and the amount of paperwork – and I needed no refiguration here. I understood. What came as a shock was the fact that it appeared to be a big difference between the management system that the hospital used and the way the OQN Kay was accustomed. It lengthened the way they managed their paperwork as well as having to get used to a system that they were not used to.

> …this hospital is run on an American system and I am used to like an English/Australian system, I suppose, for want of a better word and there is a lot of paper work, it is like triple this and double this and you lose sight of the patient. Underneath there is a patient. It is like you could spend out of your 12 hour day you could spend 5/6 hours on paper work when I am used to sitting with my patient and you know talking about, what can I do to help you, you know, your care of the patient and just being physically with the patient. I find **that very frustrating** the different nursing system they have here that is **very frustrating.** *(OQN, Kay)*

The following feeling of being threatened and deported was only mentioned twice. I wondered if it was a fear that all the OQNs had experienced at one time or the other. I asked myself if it was a pervasive thought.

> The constant threat of **deportation** is a problem, in that staffs prefer to dogmatically follow protocol, even when it is evident that there is need to deviate from the protocol. This is a belief that **it is better to be safe than deported.** *(OQN, Linda)*

It was OQN Linda that also talked about job satisfaction and I found myself thinking about Benner (1984) as well as Watson (2007) and their work on caring, and realised that it was an

underlying caring that this registered nurse was talking about: Firstly that the OQNs found a depth of caring that this registered nurse had.

> **Job satisfaction**, this place has a way of removing that element from the nurse. If you understand that your work is not only a source of income, it's a livelihood. It is part of who you are, so if you are to carry out your duties in a half manner, it has an element of making you incomplete as a person. *(OQN, Linda)*

I smiled to myself. Policies and procedures (IPP below) being called "decorations". It was a good way of saying it and indicated that for some the IPP were not useful. Was this something that I could correct when I returned to work?

> We can develop as many policies and many IPP as we can, but if you can't reach a person, those policies and **IPP are as good as decorations.** *(OQN, Linda)*

My Muslim background is deep-seated and part of me, and I feel it is the same for all Muslim people. Nursing is also a deep-seated part of my being. I had used the Muslim believes and the part it played as being part of the Saudi Arabian culture. It took this new reading of the interviews to give me a new perspective of *Insha Allah* in using this wonderful concept in new ways.

> Tell the truth to the patient if they are dying. You should allow them to die with dignity; to plan what to do with what little time is left in their life and take control of the latter years, months or days at the end of their life. **That does not happen here very regularly because they don't want to say the bad news.** And so you have family members who say don't want to tell their relative that they're dying and you are caught between a rock and a hard place. (OQN, George)

Dying with dignity is part of my philosophy of nursing. This view of Insha Allah was disturbing. But then there was a real positive way of using Insha Allah and it gave me much joy to see that it was being used so positively:

> By fully explaining the disease problems, the possible implications and the possible solutions, the patient is in a better position to agree with the methods of resolving their dilemmas. Problem is, with the manner of thought in the Arab patient, he does not want to hear the factual negatives, and this is where the "inshAllah" (God willing) phrase becomes a predicament. **Thus, one has had to learn the art of using 'inshAllah' (God willing) to convince an otherwise difficult patient.** *(OQN, George)*

And again OQN George shows a caring attitude – perhaps this was a hidden theme that was not found during the analysis.

> In order to reach the patient, being **empathetic**, **is core and it is this element that prevents the holistic approach of the nursing care**. The inability of a patient to admit that he is having a difficult time dealing with a situation. *(OQN, George)*

I believe nursing care comes from the heart and it can be felt, when caring, you touch your patients. And, indeed, this concept came in some of the interviews. In spite of communication difficulties that the OQNs do face, they can send their caring through a sensitivity that only the patient feels. I came to this paradigm case of caring that OQN Jill shared:

> … only difficult circumstances I think, **just like showing people that you really care is still important** and then I think the cross culture as well these moms know if you care and they know if you don't care. I can remember once coming back from 3 days off and this lady that we have had a long time greeted me like a long, long, lost friend and when I went out to the desk and I sit …. I heard her voice and she grabbed me, and gave me a hug, "where have you been?" I explained I had 3 days off and she said, "I missed you" and I said, I couldn't move and say to Irene,

> Irene get this, you know, I can speak 3 or 4 words to like good morning, how are you. *(OQN, Jill)*

I have done some nursing in Australia and I have found that the physicians and nurses are all well respected as professional team – no one is better that the other. This is in spite of the fact that I was an expat as well as being a male. I remembered instances in Saudi Arabia where the majority of the physicians think they are higher than nurses (even me as a Saudi Arabian male) and they should be treated differently and nurses should always obey their orders. The OQN here tells how she managed doctors and I reflected how well she had adapted to a foreign country. How well had I adapted to Australia?

> I was used to a collegial role with my physicians where they saw me as a part of the team, and suddenly I was back in that subservient handmaiden to the physicians' position. It's not a very pleasant place to be especially when you're used to communicating with your physician as an equal, and feeling that you're part of the patient care is as valuable as theirs. Having your opinions listened to, I used to call it the **"mental gymnastics required to get my patient the care they require" so it would be like "oh doctor when I was home we had a case like this, we did such and such do you ever do that here?"** They'd go and check with their senior residents and they'd come back and say sure let's try or they'd say let's try such and such and I'd say ok that sounds like a good idea. I learned really quickly you couldn't have any ego, the important thing was that the patient got their care, and it didn't matter whose idea it was just as long they got what they needed. **So I did learn a certain amount of game playing to get done what I wanted. I realized it was part of a culture, a part of "saving face" for the physician, somehow I feel like they felt it was threatening to be told what they should be doing by a nurse, who in their mind, was beneath them.** So I learned that pretty early on, and that was probably a big challenge for me, just having to take a step back not being able to say "why don't we do this". *(OQN, Dot)*

For me the following from OQN George was an affirmation of my feeling when I went to hospital with my sick father. As a child in a rural area, herding goats, sleeping on the floor was normal for me and all my brothers and sisters. I don't sleep on a floor anymore but I am so used to the culture of rural people that it is something that I do not think about at all. It may seem minor to me but for this OQN it was a real experience. It was real enough for her to include in the interview. I realised once again at the vast differences that exist between the city and rural people, as well as the huge divide between the OQN who come to this country.

> Some of my **Bedouin patients had never been in a hospital and did not like being taking care of on a bed.** We would have to nurse them on the floor – that would be a culture shock for a lot of people dealing with people who would have come out of the desert into the city. That patient is going to be in culture shock because they've not really been in the city and they've been left in the hospital by their family. They may feel sometimes abandoned, especially the elderly. It's very different and so you have to get an understanding of where this person is coming from. There are some people who may be more city educated and understand what they are going through and have different expectations. *(OQN, George)*

> I had two young Bedouin boys who came in to our unit who had lived out in the desert and were in **absolute rapture over an ice making machine.** The nurse's work in the unit would just open the machine, take some of the ice falling from the top of the machine and go to their patient. The two boys had never seen anything like that where we take it for granted. **So you have to do a lot more of education with these boys compared to someone who has lived in the city.** *(OQN, George)*

It was refreshing to find that there were in fact positives. OQN Shirley gives some new insights into the language theme. The non-verbal importance of smiling is emphasized and it gives the reader an indication that the Saudi people are not serious all the time. This seriousness is, I feel, an aspect of the data that, if read by a non-Saudi, would portray them as

serious. This small excerpt gave me hope and comfort that not all that was given in the interviews was negative.

> I've met a Saudi lady … and she's **smiling to everybody** and her husband gets upset that she smiled to everybody and that's not because he's not a friendly man or not a nice man but he just feels that it is not appropriate to smile to everybody … I think you face challenges everywhere and you just need to be aware. *(OQN, Shirley)*

During Ramadan in our culture we love to share what we are eating with others, and particularly favourite foods. Dates are a favourite with most Saudi people. I was surprised because I had not noticed that OQN Shirley did not know what dates were. The detail of some of the interview had been by passed. It was the theme that was being identified and not detail about what the OQNs thought about food. It was so much more evident now after spending time in Australia. I did not know about Pavlova or Vegemite – I like "pav" but unfortunately Vegemite is my least favourite food. The detail of being an OQN was beginning to dawn on my consciousness:

> I remember in Ramadan, I looked up at – in the south, and her family was there the whole time and then they went home to breakfast, and they went like, oh **shall we bring you something back**, let us bring you something from home, oh that's okay, I'm not breaking fast, I'm Christian, no! at least let us bring you back some dates from our house, it's really, really good dates from farm, dates that's the same like, it's a food, **everybody offers you and to be honest I don't know about dates until I came here, it's something you have to try it,** everybody wants to share it with you. Also if they come in the family, they will bring some food for the patient, for example they have patients in there, and everybody wants to share it with you … *(OQN, Shirley)*

I travelled to UK and my English was possibly worse than OQN Bill's Arabic. I found it is very difficult when I met or sat with people who were speaking a totally foreign language. I had no idea what they were talking about. Honestly, it is very frustrating and I felt I was a total outsider. I had forgotten the frustration and although language was one of the three major themes I found reading this excerpt brought back so many memories and I could feel myself feeling for her. I wondered if Arabic was more difficult than English.

> The whole of my conversation till now is all communication problems; yeah initially somebody wants you to know "**Bol**! **Bol! (urine),** I have to run and get the PCA first to translate that for me. It was really difficult, and by the time I come back the bed is wet.
>
> I made sure I learned all these important things in 2 or 3 weeks – at least the things so if somebody wants something urgently just tell them. It was a big hassle initially for me, I had to struggle a lot, and the families come and ask me questions, like back in the UK, culture is like this one, somebody ask you something about the patient, and you know that they are the main family members, you have to give them the information, explain things to them, so that eagerness is always there in you, to deliver the information what the family wants to know, and sometimes you're like lip bound, you can't say anything, like **shwaya**, shwaya **(wait, wait)**, **dagiga (one minute), shwaya**, let me get somebody else to communicate with. *(OQN, Bill)*

I realised as well that this patient was almost surely a Bedouin which made his understanding of the hospital situation very difficult. Using the word 'bol', meaning urine, would have been out of place in an Australian hospital. He would not have known to say 'hamam' which means toilet, while in Western practice a male patient would call for a 'bottle'. In speaking to an Australian I tell them that I enjoy swimming in the ocean and they laugh! I should be saying that I swam in the sea! The difficulty of language was again brought home to me. Language

and communication had been discussed as a theme in Chapter 6 but this brought a new aspect of its complexity home to me.

The concept of patient safety was also discussed previously and was not a theme, although included in Chapter 7 in which practice was a theme. The safety factor was not highlighted and reading through this part of OQN Val, I was struck by the importance of the profound way in which language and safety were interwoven. OQN Val was in the position of putting a patient at risk while caring of patients in PACU (Post Anaesthesia Care Unit) when the patient was looking for the mother and the participant was thinking that she is in pain:

> I worked in recovery room before, so I worked there before and most of the patients came from OR, post op, DR, a little bit sedated and then when they wake up, they're struggling and then they're talking of course in Arabic … that patient is shouting because that patient is looking for a mother, because I'm used with a word of "alam" which is pain most of, which is really expecting, but the thing is that patient is looking for a mother, she wants her mother to be beside her and then I was really trying to understand her, I was about to give a pain reliever because I was thinking that the patient is having pain but then it's good that I asked somebody to interpret first otherwise the patient will be sedated again because she's just looking for her mother not for the pain reliever for itself. *(OQN, Val)*

As OQN Val states, the patient could have been "sedated again". While in this case it may not have been an issue, on another occasion it may have had serious consequences. I wondered as I continued reading and thinking about the concept of caring* and the complexity of the everyday caring* for patients in a holistic manner struck me with force. There is an intermix of OQNs, families (often with the typical authoritarian male head of the family), doctors and, of course, the ancillary Saudi health personnel such as ward clerks who get involved on many

occasions as interpreters. There are two observations from OQN Steve on the matter and I have highlighted them to give emphasis.

> I see families integrated within the care of the patient. Here you have watchers or paid watchers who really do not care* in the same way. For some people it depends on what you pay for the care that's given. If the watcher is paid badly so the care reflects that. Sometimes **the watcher does not communicate with the family members** and **communication between the families is very strained.** The staff do not know who the head of the household is, and disseminations of information gets mixed. I believe **families only relate to the medical team** and nursing is still not a recognized profession here. In the west you find a holistic approach*, family members meet together and come up with a plan of care for their patient with the medical team. In Saudi Arabia, it's not like that. It seems that "I'm the doctor, you are the patient, and you do what I say". I see the family members disassociated from the care, which is sad. When we try to involve family members, they want to be involved in the care* but the doctors don't want them involved. *(OQN, Steve)*

> We have issues that **male family members are right all the time** and whatever he wants he gets. The rights of the patient can be compromised by this, leading to unwanted surgery or no knowledge of surgery* performed as the male member is signing the consent. We have had patients come back from surgery asking "where is my leg?" **She had a below knee amputation and the family didn't tell her.** *(OQN, Steve)*

I have inserted * to indicate that it is the caring philosophy of Benner (1984), Watson (2007) and others that is being referred to, although it may not be what the participant meant. It is I who is interpreting this or perhaps this is the reordering that is discussed in the introduction.

Phenomenology is about the lived experience and sometimes the weariness I had when I was putting the interviews onto the computer, made me loose the depth of feeling that I had when I first heard the OQN in the interviews. Reading their own personal journeys in a strange

country gave me back my first excitement. The difficulties OQN Jean and I remember her as being a good story teller - experienced were the same as the others but her tone of voice and the way the story was told was an emotional moment for me.

> …he wasn't making eye contact with me and I keep moving around to try to make eye contact with him. He kept moving his head and I told to myself, "Oh, he must be blind" and then I thought how he could get down to the corridor by himself. **Then I realized he didn't want to make eye contact with me and that was really quite kind of shocking. I felt you know, because every time I tried he moves his eye and go at the other direction.** That little experience is a bit quite kind shocking because you don't understand why they do it. But sometimes I think, you know I'm not worthy, or I'm a bad person because I'm not covered …
>
> Another time, I've been here 2 or 3 weeks, my patient was in shock and a real drop his blood pressure. We thought he has to go to ICU. Anyway we stabilized him after a couple of hours. I came out of the room and I came back to the room and he was on the floor praying. I thought, **"Oh my God, he can't do this he shouldn't be in the floor". Luckily, I didn't go and stop him.** I told the ward clerk to tell him he has to stop, go to his bed and he can't practice it. The ward clerk said, we cannot interrupt anybody in the middle of praying. **(OQN, Jean).**
>
> One of my patients in the clinic, a sheikh – he's religious scholar and he gave me a beautiful *Qur'an* in English and Arabic. It's gorgeous. Every time he came – he didn't come very often – but every time he comes and says to me, "Have you converted yet? Are you going to?" I can accept that, really, well I don't really mind, I don't mind at all that people would say that to me. It doesn't bother me – though but I know it bothers a lot of other people. **I guess the love of patients and lot of the population here.** *(OQN, Jean)*

OQN Jean had that sense of caring that was so important to my philosophy of nursing. Although she did not understand the cultural aspects of telling bad news being left to the male

members or the family, the feeling that was conveyed as she told the story of the dying young male was intense:

> I met one boy, he was 19 – a lovely, lovely boy. He was dying – sorry – but he was dying. And only His father knew and his mother never knew and she lives in the East. The family lives in the Eastern province. The father would come down in … to his son but he never brought the mother, brothers and sisters because they didn't know and he doesn't want them to know. Imagine what the mother would feel when he dies and he comes and tells her. I will really be angry. I still can't get to grasp of it because it happens quite a lot. I know people think about protecting people, protecting others, the family the mother – there is a perception that they're emotionally fragile so they can't take it. **But having seen that often to really dramatic life of the top responses when people who have died, it's like standing, dropping off something and screaming and pieces of paper of doing anything.** *(OQN, Jean)*

OQN Georgia seems to be the only one who started off in a small town.

> … it was certainly a challenge as I said I went to Yanbu which is a small industry or town, so we had one small hospital there, so there was a lot of Westerners there all of the time. I mean I am settled and fine, but my initial reaction was, I remember I'm in the bus coming from the airport and looking at the town I went to the old part and they were thinking what I thought … I will never forget that as long as I live. Even though I read a lot about Saudi and researched, and still did not prepare me with actual shock or the culture difference. Also I think because of the language you feel very vulnerable. You will feel safe in a hospital because for once you go outside there was a little bit different. I remembered I speak to patients in recovery and relatives, I was just talking to you about the Pope and about my religion, and he had no idea when I saw him and I was shocked because I could not understand nobody knew about Christianity, Rome or the Catholic Church. I was very surprised and that was something I remember. It is just getting to know about the patients and their believes, but there is something again that really I don't know anything about because when you applied for job here, all your thought of is great opportunity,

> living in a nice environment, lovely housing. You can travel and you peep all over the world but you were never really told the difference in your lifestyle and the lifestyle here. It's very different and caring for patient is different. It is more challenging if you do not know the religion, you don't know what is right and what is wrong. You make little mistakes but they understand you don't know but you feel bad because you feel you should know, once they explain to you why and then you were okay but from that point of view I think preparing for the culture was a big difference. *(OQN, Georgia)*

> So I think understanding people who they are, then it helps you to improve the care. I do find it very strange about not being able to touch males, not being able to touch female and vice versa and I wonder how can a nurse be a nurse because being a nurse means you look after whoever comes in the door. I find that very difficult to understand but it's a culture. I think it's slowly changing, it will probably take another few generations but when I teach Saudi nurses, I say to them, "When your patient is going to sleep in their room and they are frightened in a room and nobody takes a look with them, just stand with them. You don't have to touch them, just stand beside them and be there with them when they're going to sleep". I'm trying to encourage them. I know at the end of the day the patients don't mind as long as the person is looking after them. *(OQN, Georgia)*

I am a Saudi nurse and I am so proud that I am a nurse, something that I had wanted to do since I was 9 years old when my father was sick. The reflection is in Chapter 1 told of how I had the interest to be a nurse and not to think of positions or extra money more than what I need to live. Indeed, as Saudi nurses, we need to develop the meaning of nursing care and value and recognize the career as profession and not simply a job.

OQN Dot had mentioned Benner in the final part of her interview. I decided to read something of Benner's (1984) work. I also read some of the work of Watson (2007) and I found to my

surprise that I knew little about the philosophy of caring. I did know it in my heart and here a new world of caring philosophy opened to me.

I believe that nursing is not a job, it is a professional career and it should be coming from the heart, and I trust that the person who works as a nurse will find himself/herself from one day to another to be stronger and have the ability to care for any patient anywhere. Through my reading of the interviews, I found OQN David has the experience that makes him stronger through his working journey as a nurse in Saudi Arabia. I had come to the end of my thesis and I returned to OQN David whose interview I had so recently reread and still echoed in my heart. I could not find any single sentence to highlight. I wanted to highlight the whole paragraph.

> I am a nurse, that's why I should not choose who my patients are. I had the interest to learn and so I learned through the help of my colleagues, but mostly I had to discover things myself. Because, in this country, I believe that I only have myself to rely on and not to trust anyone except for myself. Working in a foreign land and being away from my family and homeland is so hard but these made me stronger, thus helping me to adjust easier here. Another thing that helped me is to love my job. So wherever I'll work, I'll just think that I am a nurse who loves his job and whatever they give me, I'll give my best shot to help other people. And until now I still have problems with dealing with my clients especially in communicating with them. *(OQN, David)*

My PhD journey and my time in Australia have changed me. My views of nursing have changed to being much broader. It has also been a journey of good times, like OQN Mavis who tells of the fun of being in a strange country and being able to laugh at yourself and later be able to tell someone the story:

> My first experience, I should say, I did not know how to speak Arabic so I was learning how to speak, the staff will teach me some amount but it is not enough like, you need to start communicating so I had a patient, the mother who can speak English, as I care for that patient, manage to talk to the mother in English and write down the Arabic translation. So during that time, her husband visited them in visiting time. Mother of that patient told her husband, that I am a new staff to the ward and she doesn't know Arabic, she's learning Arabic from me, so her husband said, he will teach me also. He taught me one sentence in Arabic and he told me to repeat that one, I repeated that sentence to him and he laughed, I said, did I pronounce it wrong? He said no, you repeat one more time. I repeated one more time, so I'm very proud that he's teaching me "good morning" in Arabic but I didn't know that he taught me something wrong. I shared with my colleague on duty with me; I said I learn one more word. I know how to say good morning and I told her how to say good morning in Arabic, she started laughing. I said, why you are laughing, why that man was also laughed, she said do not tell this word to anybody, I said why, and then she said the meaning is "I love you". *(OQN, Mavis)*

My journey could not have been what it has been without the honesty of the OQN group in Saudi Arabia who travelled there in the first place and in the second place were brave enough to tell me their story.

I was dreaming about returning home and my mother. An inspirational moment occurred!

Figure 9.1 A & B: My definition of caring.

فهو العناية بالمريض و لمن يلتمس المريض

يدي الاولى فراش المريض واليد الاخرى غطاه.

واحساس بالمريض كلمس اصابع لقلب والدتي غاية

Translating this was not easy. *My first hand is my patient's mattress, supporting, and the second hand is the patient's covering. The nursing care is sensitivity, as sensitive as if I was touching my mother's heart with my fingers.*

REFERENCES

Aboul-Enein, F. H., & Ahmed, F. (2006). How language barriers impact patient care: A commentary. *Journal of Cultural Diversity, 13*, 168-169.

Al-Busaidi, Z. Q. (2008). Qualitative research and its uses in health care. *Sultan Qaboos University Medical Journal*, *8*(1), 11-19.

Aldossary, A. (2013). The role legitimacy of nurses in Saudi Arabia. *Journal of Health Specialties, 1*(1), 28.

Aldossary, A., While, A., &Barriball, L. (2008). Health care and nursing in Saudi Arabia. *International Nursing Review, 55*(1), 125-128.

Aldona J.M., Piechulek H, & Alsabir A. (2001). Client satisfaction and quality of health care in rural Bangladesh*. Bulletin of the World Health Organisation*, *79*, 512–517.

Al-Farsy, F. (2000). *Modernity and tradition. The Saudi equation.* Channel Islands: Knight Communications Ltd.

Al-Hilali, M. T. -u.-D., & Khan, M. M. (2009). *Translation of the meanings of the Noble Qur'an in the English language*. Islam Kotob.

AlMalki, M., Fitzgerald, G., & Clark, M. (2011). Health care system in Saudi Arabia: An overview. *Eastern Mediterranean Health Journal, 17*(10), 784-793.

AlMutairi, A. F. (2012). *A case study examination of the influence of cultural diversity in the multicultural nursing workforce on the quality of care and patient safety in a Saudi Arabian hospital* (Doctoral dissertation). Retrieved from http://eprints.qut.edu.au/51580/

AlMutairi, A. F., Gardner, G., & McCarthy, A. (2012). Perceptions of clinical safety climate of the multicultural nursing workforce in Saudi Arabia: A cross-sectional survey. *Collegian, 20*(3), 187-194.

AlMutairi, A., & McCarthy, A. L. (2012). A multicultural nursing workforce and cultural perspectives in Saudi Arabia: An overview. *The Health Journal, 3*(3), 71-74.

AlMutairi, D. O., Moradi, E., & Idrus D. (2011). Factors influencing turnover among Saudi nurses: A literature Review. [Paper presented at International conference of human resource development (ICHRD), 22-23 June 2011. Mutiara Johor Bahru, Johor Malaysia]. 1-13.

Al-Omar, B. A. (2004). Knowledge, attitudes and intention of high school students towards the nursing profession in Riyadh city, Saudi Arabia. *Saudi Medical Journal, 25*(2), 150-155.

Al Osimy, M. H. (1994). *Nursing in Saudi Arabia, Jeddah, Saudi Arabia*. King Fahd Hospital.

Al-Rowais, N., Al-Faris, E., Mohammad, A. G., Al-Rukban, M., & Abdulghani, H. M. (2010). Traditional healers in Riyadh region: Reasons and health problems for seeking their advice. A household survey. *Journal of Alternative & Complementary Medicine, 16*(2), 199-204. doi: 10.1089/acm.2009.0283

Al-Saggaf, Y., & Williamson, K. (2004). Online communities in Saudi Arabia: Evaluating the impact on culture through online semi-structured interviews. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *5*(3).

Al-Shahri, M. Z. (2002). Culturally sensitive caring for Saudi patients. *Journal of Transcultural Nursing, 13*, 133-138.

Al- Yousuf, M, Akerele, T. M & Al- Mazrou, Y. Y. (2002) Organisation of the Saudi health system. *Eastern Mediterranean Health Journal*, *8*(4&5). 645-53.

Andrews, I., Sullivan, G., & Minichiello, V. (2004). The philosophical and theoretical context of qualitative research. In V. Minichiello, G. Sullivan, K. Greenwood & R. Axford (Eds.), *Handbook of Research Methods for Nursing and Health Science* (2nd ed., pp. 59-70). Sydney: Pearson.

Anoosheh, M., Zarkhah, S., Faghihzadeh, S., & Vaismoradi, M. (2009). Nurse-patient communication barriers in Iranian nursing. *International Nursing Review*, *56*, 243–249.

Anthony, M. K., & Preuss, G. (2002). Models of care: The influence of nurse communication on patient safety. *Nursing Economics, 20*(5), 209-215, 248.

Baker, C. (2007). Globalization and the cultural safety of an immigrant Muslim community. *Journal of Advanced Nursing, 57*(3), 296-305.

Bahishti Zewar (2013). How are you supposed to offer Salah when you are sick? Retrieved on 29 April 2014 from http://www.alQur'an classes.com/how-to-pray-when-sick-or-sitting/#

Balls, P. (2009). Phenomenology in nursing research: Methodology, interviewing and transcribing. *Nursing Times*, *105*, 30-33.

Baly, M. (1997). *As Miss Nightingale said* (2nd Ed). London: Bailliere Tindall.

Bassett, C. C. (2004), Phenomenology. In C. Basset (Ed.). *Qualitative Research in Health Care*. Whurr, London, pp. 154-177.

Bechtel, G. (2004). *Case managing patients from other cultures*. Retrieved from http://jcaremanagement.com/html/feature_2.html

Benlafquih Christine (2012). Modesty (haya*). Inner and outer; Arab News*. Retrieved from http://www.arabnews.com/modesty-haya-inner-and-outer.

Benner, P. (1984). *From novice to expert excellence and power in clinical nursing practice*. Addison-Wesley Publishing Company.

Benner, P. (1994). Hermeneutic phenomenology: A methodology for family health and health promotion study in nursing. In P. Benner (Ed.), *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness* (pp. 71-72). Thousand Oaks, CA: Sage.

Berado, K. (2007). 10 strategies for overcoming language barriers. *Culturosity.com 2007* Retrieved from http://www.culturosity.com/pdfs/10%20Strategies%20for%20Overcoming%20Language%20Barriers.pdf

Białkowski, J., Etebari, A., & Wisniewski, T. P. (2012). Fast profits: Investor sentiment and stock returns during Ramadan. *Journal of Banking & Finance, 36*(3), 835-845. doi: http://dx.doi.org/10.1016/j.jbankfin.2011.09.014

Boscart, V. M. (2009). A communication intervention for nursing staff in chronic care. *Journal of Advanced Nursing, 65*(9), 1823-1832.

Boyle, J. (2000). Transcultural nursing: Where do we go from here? *Journal of Transcultural Nursing, 11*(1), 10-11.

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

Brown, C. A., & Busman, M. (2003). Expatriate health care workers and maintenance of

standards of practice factors affecting service delivery in Saudi Arabia. *International Journal Health Care Quality Assurance, 16,* 347-53.

Brown, G. (2005). International nursing department. An up close and personal look at Saudi Arabia (Jeddah and Riyadh): History, culture, and health care. *Association of Black Nursing Faculty Journal, 16*(4), 83-86.

Bryant, Nancy H. (2003). *Women in nursing in Islamic societies*. Oxford University Press.

Bruton, B., & Beaman, M. (2000). Nurse practitioners' perceptions of their caring behaviors. *Journal of the American Academy of Nurse Practitioners, 12* (11), 451-456.

Burnard, P., & Gill, P. (2009). *Culture, communication, and nursing*. New York: Pearson Education.

Burns, N. & Grove, S. (2003). *Understanding nursing research (3rd ed)*. Philadelphia: W Saunders Company.

Campesino, M. (2006). Beyond transculturalism: Critiques of cultural education in nursing. *Journal of Nursing Education, 47*(7), 298-304.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing, 13*(3), 181-184.

Campinha-Bacote, J. (2008). Cultural desire: 'Caught' or 'taught'? *Contemporary Nurse: A Journal for the Australian Nursing Profession, 28*(1/2), 141.

Canfield, B. S., Low, L., & Hovestadt, A. (2009). Cultural immersion as a learning method for expanding intercultural competencies. *The Family Journal, 17*(4), 318-322.

Cass, A., Lowell, A., Christie, M., Snelling, P. L., Flack, M., Marrnganyin, B., & Brown, I. (2002). Sharing the true stories: Improving communication between Aboriginal patients and healthcare workers. *Medical Journal of Australia, 176*(10), 466-471.

Charalambous, A., Papadopoulos, I.R., Beadsmoore, A. (2008). Ricouer's hermeneutic phenomenology: An implication for nursing research. *Scandinavian Journal of Caring Sciences, 22*(4), 637-642.

Cioffi, J (2006). Culturally diverse patient-nurse interactions on acute care wards. *International Journal of Nursing Practice*, *12*(6): 319–25.

Clegg, A. (2003). Older South Asian patient and career perceptions of culturally sensitive care in a community hospital setting. *Journal of Clinical Nursing, 12*(2), 283-290.

Colaizzi, P.F. (1978). Psychological research as the phenomenologist views it, In R.S. Vale & M. King (Eds.). *Existential-Phenomenological Alternatives for Psychology.* Oxford University Press.

Converse, M. (2012). Philosophy of phenomenology: How understanding aids research. *Nurse Researcher*, *20*(1), 28-32.

Corben, V. (1999). Misusing phenomenology in nursing research: Identifying the issues. *Nurse Researcher, 6*(3), 52-66.

Crotty, M. (1998). The foundations of social research: Meaning and perspective in the research process (1st ed.). Sydney: Allen & Unwin.

Cowan, D. T., & Norman, I. (2006). Cultural competence in nursing: New meanings. *Journal of Transcultural Nursing, 17*(1), 82-88.

Crookes, P.A., & Davies, S. (2004). *Research into practice* (2nd ed.). China: BailliereTindall.

Cynthia, S. (2001). Importance of communication in nursing care. *Paramedical*, *1*(3), 1-35.

Daar, A. S., & Al Khitamy, B. (2001). Bioethics for clinicians: 21. Islamic bioethics. *Canadian Medical Association Journal, 164*(1), 60-61.

Day, J. & Levett-Jones, T. (2008). Communicating. Fundamentals of nursing, 482-516.

Denzin, N. & Lincoln,Y. (2000). *Handbook of qualitative research* (2nd ed). Sage Publications: London, UK.

Deuraseh, N. (2006). Health and medicine in the Islamic tradition based on the book of medicine (Kitab Al-Tibb) of Sahih Al-Bukhari. *Journal of the International Society for the History of Islamic Medicine, 5*, 2-14.

De Veer, A., Den Ouden, D.-J., & Francke, A. (2004). Experiences of foreign European nurses in The Netherlands. *Health Policy, 68*(1), 55-61.

Diekelman, N. L., Allen, D., & Tanner, C. (1989). *The NLN criteria for appraisal of baccalaureate programs: A critical hermeneutic analysis*. New York: National League for Nursing.

Douglas, M., & Lipson, J. G. (2008). Transcultural nursing: The global agenda. *Contemporary Nurse, 28*(1-2), 162-164.

Dowling, M. (2007). From Husserl to van Manen: A review of different phenomenological approaches. *International Journal of Nursing Studies*, *44*(1), 131-142.

El-Amouri, S., & O'Neill, S. (2011). Supporting cross-cultural communication and culturally competent care in the linguistically and culturally diverse hospital settings of United Arab Emirates. *Contemporary Nurse*, *39*(2), 240-255.

El-Sanabary, N. (1993). The education and contribution of women health care professionals in Saudi Arabia. The case for nursing. *Social Science Medicine*, *37*(11), 1331-1343.

El-Sanabary, N. (2003). Women and the nursing profession in Saudi Arabia. In N. H. Bryant (Ed.). *Women in nursing in Islamic societies*. Pakistan: Oxford University Press.

El-Zibdeh, N. (2009). Understanding Muslim fasting practices. *On Today's Dietician*, *11*(8), 56.

Fink, A. S. (2000). The role of the researcher in the qualitative research process: A potential barrier to archiving qualitative data. *Forum Qualitative Social Research, 1*(3), 4.

Fraser, J. & Alexander, C. (2006). Publish and perish: A case study of publication ethics in a rural community. *Journal of Medical Ethics, 32*(9), pp. 526-529.

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice*, *3*(1).

Gallagher, E. B. (2002). Modernization and health reform in Saudi Arabia In A. C. Twaddle (Ed.). *Health care reform around the world* (pp.181-197). London, Auburn House.

Gardner, D. (2005). Ten lessons in collaboration. *The Online Journal of Issues in Nursing, 10*(1), Manuscript 1.

Gazzaz, L.A. (2009). *Saudi nurses' perception of nursing as an occupational choice: A qualitative interview study*. University of Nottingham, England.

Giger, J. N., & Davidhizar, R. (2002a). The Giger and Davidhizar Transcultural Assessment Model. *Journal of Transcultural Nursing, 13*(3), 185-188.

Giger, J. N., & Davidhizar, R. (2002b). Culturally competent care: Emphasis on understanding the people of Afghanistan, Afghanistan Americans, and Islamic culture and religion. International Council of Nurses. *International Nursing Review, 49*, 79-86.

Giger, J. N., & Davidhizar, R. E. (2008). *Transcultural nursing assessment and intervention*. (5th Edition). St. Louis: Mosby/Elsevier.

Giorgi, A. (2007). Concerning the phenomenological methods of Husserl and Heidegger and their application in psychology. *Collection du Cirp*, *1*, 63-78.

Golding, B. (2011). *Exploring the lived experiences of egg share donors: Can women consent to share their eggs?* (Doctoral dissertation). University of Huddersfield.

Graham, I. W. (2001). Seeking a clarification of meaning: A phenomenological interpretation of the craft of mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, *8*(4), 335-345.

Gulati, S., Watt, L., Shaw, N., Sung, L., Poureslami, I. M., Klaassen, R., & Klassen, A. F. (2012). Communication and language challenges experienced by Chinese and South Asian immigrant parents of children with cancer in Canada: Implications for health services delivery. *Pediatric Blood & Cancer, 58*(4), 572-578.

Halligan, P. P. (2006). Caring for patients of Islamic denominations: Critical care nurses' experiences in Saudi Arabia. *Journal of Clinical Nursing* 15, 1565-1573.

Heidegger, M. (1962). *Being in time*. New York: Harper Row.

Hughes, J. (2003). Satisfaction with medical care. Retrieved from http://www.changesufer.com/hlth/patsat.html.

Ironside, P. M. (Ed). (2005*). Beyond method: Philosophical conversations in healthcare research and scholarship.* Madison, WI: University of Wisconsin Press.

Irvine, F. E., Roberts, G. W., Jones, P., Spencer, L. H., Baker, C. R., & Williams, C. (2006). Communicative sensitivity in the bilingual healthcare setting: A qualitative study of language awareness. *Journal of Advanced Nursing, 53*(4), 422-434.

Jirwe, M., Gerrish, K., & Emami, A. (2010). Student nurses' experiences of communication in cross-cultural care encounters. *Scandinavian Journal of Caring Sciences, 24*(3).

Johnson, M. E. (2000). Heidegger and meaning: Implications for phenomenological research. *Nursing Philosophy*, *1*(2), 134-146.

Jose, M. (2008). *A phenomenological study of the lived experiences of foreign educated nurses working in the United States of America* (Ph.D. 3360534), The University of Texas Medical Branch Graduate School of Biomedical Sciences, United States, Texas. Retrieved from http://proquest.umi.com/pqdweb?did=1785181611&Fmt=7&clientId=20804&RQT=309&VName=PQD

Jose, M. M. (2011). Lived experiences of internationally educated nurses in hospitals in the United States of America. *International Nursing Review, 58*(1), 123-129. doi: 10.1111/j.1466-7657.2010.00838.x

Kadri, N., Tilane , A., El Batal, M., Taltit, Y., & Tahiri, S. M. (2000). Irritability during the month of Ramadan. *Psychosomatic Medicine, 62*, 280-285.

Khan, M.M (1997). *The translation of the meanings of Sahih Al-Bukhari Arabic-English.* Riyadh, Saudi Arabia: Maktaba Dur-us-Salam

Kashima, Y. (2007). Globalization, diversity and universal Darwinism. *Culture and Psychology, 13*(1), 129-139.

King Fahad Medical City, About King Fahad Medical City. Retrieved April 29, 2014 from http://www.kfmc.med.sa/English/Pages/AboutUs.aspx

Korab-Karpowicz, W. J Martin Heidegger (1889—1976) Anglo-American University of Prague Czech Republic. Retrieved April 29, 2014 from http://www.iep.utm.edu/heidegger

Kothari, C. R. (2004). *Research methodology, methods & techniques* (2nd ed). New Delhi: New Age International Publisher.

Kumar, A. (2004). *WHO/Case study at Almana General Hospital, Khobar, Dammam, Saudi Arabia.* Retrieved from http://www.who.int/gpsc/5may/share/case_study_almana/en/

Laird, L. D., De Marrais, J., & Barnes, L. L. (2007). Portraying Islam and Muslim in Medline: A content analysis. *Social Science & Medicine, 65*(12), 2425-2439.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3). Article 3. Retrieved from http://www.ualberta.ca/~iiqm/backissues/2_3final/html/laverty.html

Lawrence, P., & Rozmus, C. (2001). Culturally sensitive care of the Muslim patient. *Journal of Transcultural Nursing, 12*(3), 228-233.

Leininger, M. (1990). Letter to the editor: Leininger clarifies transcultural nursing. *International Nursing Review, 37*(6), 356-356.

Leininger, M. (1997). Transcultural nursing research to transform nursing education and practice: 40 Years. *Image: The Journal of Nursing Scholarship, 29*(4), 341-347.

Leininger, M. M. (1999). What is transcultural nursing and culturally competent care? *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society, 10*(1), 9.

Leininger, M. (2002). Part 1.The theory of culture care and ethnonursing research method. In M. Leininger & M. McFarland (Eds.). *Transcultural nursing: Concepts, theories, research & practice* (3rd ed., pp. 71-98). New York: McGraw-Hill.

Leininger, M., & McFarland, M. R. (2002). *Transcultural nursing: Concepts, theories, research, and practice* (3rd Edition). New York: McGraw-Hill.

Liamputtong, P., & Ezzy, D. (2005). *Qualitative research methods*. Melbourne: Oxford University Press.

Liamputtong, P., & Ezzy, D. (2009). *Qualitative research methods*. South Melbourne, Vic: Oxford University Press.

Liljeroos, M., Snellman, I. M., & Ekstedt, M. H. (2011). A qualitative study on the role of patient-nurse communication in acute cardiac care. *Journal of Nursing Education and Practice*, *1*(1), 17-24.

Lindseth, A., & Norberg, A. (2004). A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences, 18*(2), 145-153.

Liu, R., So, L., Quan, H. (2007). Chinese and white Canadian satisfaction and compliance with physicians. *BMC Family Practice*, *8*, 11.

LoBiondo-Wood, G. & Haber, J. (2002). *Nursing research: Methods, critical appraisal and utilisation* (5th ed.). St Louis, Missouri: Mosby.

Lovering, S. (2006). Cultural attitudes and believes about pain. *Journal of Transcultural Nursing, 17*(4), 389-395.

Lovering, S. (2008). *Arab Muslim nurses' experiences of the meaning of caring*. University of Sydney, Australia.

Mackey, S. (2005). Phenomenological nursing researcher: Methodological insights derived from Heidegger's interpretive phenomenology. *International Journal of Nursing Studies, 42*(2), 179-186.

Magnusdottir, H. (2005). Overcoming strangeness and communication barriers: A phenomenological study of becoming a foreign nurse. *International Nursing Review, 52*(4), 263-269.

Maier-Lorentz, M. M. (2008). Transcultural nursing: Its importance in nursing practice. *Journal of Cultural Diversity 15*(1), 37–43.

McFarland, M. M. & Eipperle, M. K. (2008). Culture care theory: A proposed practice theory guide for nurse practitioners in primary care settings. *Contemporary Nurse,* 28(1-2), 48-63.

Mahfouz, T. (2006). *Speak Arabic instantly*. New York: Lulu.com.

Mebrouk, J. (2008). Perception of nursing care: Views of Saudi Arabian female nurses. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 28*(1-2), 149-161.

Mehrabi, T., Ghazavi, Z., & Malbousizadeh, M. (2010). Experiences of university faculty members regarding communication in work environment. *Iranian Journal of Nursing and Midwifery Research*, *15*(1), 350-355.

Memish, Z. A., & Ahmed, Q. A. A. (2002). Mecca Bound: The challenges ahead. *Journal of Travelling Medicine,* 9, 202-210.

Mertens, D. M. (2010). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods*. Los Angeles: Sage.

Metz, H. C. (1993). *Saudi Arabia. A country study*. Federal Research Division, Washington. Library of Congress.

Miller-Rosser, K. (2009). *Nursing in Saudi Arabia: Evolution or Revolution* (Doctoral Thesis). Monash University, Melbourne, Australia.

Ministry of Islamic Affairs, Endowments, Da`wah, and Guidance in Kingdom of Saudi Arabia. Retrieved 10th October 2013 from http://www.moia.gov.sa/eng/Menu/Pages/About.aspx

Ministry of Economy and Planning, Central Department of Statistics and Information in Kingdom of Saudi Arabia (2009). *Statistical year book 45.* Retrieved 24th November 2013 from http://www.cdsi.gov.sa/yb45/

Ministry of Health in Kingdom of Saudi Arabia (MOH). (2007). *Annual report, health facilities and manpower* (Chapter Two). Retrieved 22 October 2009 http://www.moh.gov.sa/statistics/stats2007/Book%20Seha03.pdf

MOH. (2009). *Annual statistic report.* (Chapter VI: Total Health Resources in Different Health Sectors, pp. 236-246) Retrieved 22nd October 2011 from http://www.moh.gov.sa/Ministry/Statistics/book/Pages/default.aspx

MOH. (2010). *Annual statistic report.* (Chapter VI: Total Health Resources in Different Health Sectors, pp. 236-246). Retrieved 22nd October 2011 from http://www.moh.gov.sa/Ministry/Statistics/book/Pages/default.aspx

MOH. (2011). *Annual statistic report*. (Chapter VI: Total Health Resources in Different Health Sectors, pp. 236-246. Retrieved 18th August 2012 from http://www.moh.gov.sa/Ministry/Statistics/Book/Pages/default.aspx

Misell, A. (2000). *Welsh in the health service: The scope, nature and adequacy of Welsh language provision in the National Health Service in Wales.* Welsh Consumer Council, Cardiff.

Mobaraki, A. E., & Söderfeldt, B. (2010). Gender inequity in Saudi Arabia and its role in public health. *Eastern Mediterranean Health Journal, 16*(1), 113-118.

Mohammadi, N., Evans, D., & Jones, T. (2007). Muslim in Australian hospitals: The clash of cultures. *International Journal of Nursing Practice, 13*(5), 310-315.

Mohanalakshmi, R. (2011) Introducing QATAR .The five pressed together fingers — which is a symbol to wait — is an insult or rude gesture. Retrieved October 22, 2014 from http://globalcoachcenter.wordpress.com/2011/05/11/introducing-qatar/

Munoz, C., & Luckman, J. (2005). *Transcultural communication in nursing* (2nd ed.). Clifton Park, New York: Delmar Learning.

Narayanasamy, A. (2003). Transcultural nursing: How do nurses respond to cultural needs. *British Journal of Nursing, 12*(2), 158-194.

Obermeyer, M.V. (2006). *Communication in nursing: The foundation for caring module 1*. Retrieved from, http://culture-advantage.wikispaces.com/file/view/cutepdfcommunication101.pdf

Omeri, A., & Atkins, K. (2002). Lived experiences of immigrant nurses in New South Wales, Australia: Searching for meaning. *International Journal of Nursing Studies, 39*(5), 495-505.

Park, E. K., & Song, M. (2005). Communication barriers perceived by older patients and nurses. *International Journal of Nursing Studies*, *42*(2), 159–166.

Paynich, M. L. (1964). Cultural barriers to nurse communication. *The American Journal of Nursing, 64*(2), 87-90.

Pinikahana, J., & Manias, E., & Happell, B. (2003). Transcultural nursing in Australian curricula. *Nursing and Health Sciences* 5,149-154.

Polit, D., Beck, C., & Hungler, B. (2001). *Essentials of nursing research: Methods, appraisals, and utilisation* (5th ed.). New York: Lippincott.

Polit, D. F., & Beck, C. T. (2005). *Essentials of nursing research: Methods, appraisal, and utilization*. Philadelphia: Lippincott Williams & Wilkins.

Porter, R. (1997). *The greatest benefit to mankind: A medical history of humanity from antiquity to the present*. London: HarperCollins.

Purnell, L. (2002). The Purnell model for cultural competence. *Journal of Transcultural Nursing, 13*(3), 193-196.

Queensland Health (2010). Five cross cultural capabilities for clinical staff. Division of the Chief Health Officer, Queensland Health, Brisbane, Queensland.

Ricoeur, P. (1991). Between the text and its readers. In M.J. Valde (Eds), *A Ricoeur Reader: Reflection & Imagination* (pp 390-424). Harvester Wheatsheaf, New York.

Royal College of Nursing (2012). Application of transcultural nursing models. Retrieved January 2, 2013 from, http://www.rcn.org.uk/development/learning/transcultural_health/transcultural/adulthealth/sectionthree

Ryan, M., Carlton, K. H., & Ali, N. (2000). Transcultural nursing concepts and experiences in nursing curricula. *Journal of Transcultural Nursing, 11*(4), 300-307.

Ryan, F., Coughlan, M., & Cronin, P. (2007). Step-by-step guide to critiquing research. Part 2: qualitative research. *British Journal of Nursing*, *16*(12), 738-744.

Saadati Mehdi (2008) Jump up Help for the Heavy at Ramadan, *Washington Post*, Retrieved from http://www.washingtonpost.com/wp-dyn/content/article/2008/09/27/AR2008092702592_2.html?nav=rss_world

Schneider, Z., Elliott, D., LoBiondo-Wood, G., & Haber, J. (2003). *Nursing research: Methods, critical appraisal and utilisation* (2nd ed.). Sydney: Mosby.

Sheldon, L. K., Barrett, R., & Ellington, L. (2006). Difficult communication in nursing. *Journal of Nursing Scholarship: An Official Publication of Sigma Theta Tau International Honor Society Of Nursing, 38*(2), 141-147.

Shuster, D. J. (2012). *A Bricolage of Critical Hermeneutics, Abductive Reasoning, and Action Research for Advancing Humanistic Values through Organization Development Practice* (Doctoral dissertation). University of St Thomas, Minnesota.

Sidumo, E. M. (2007). *An investigation into the Saudi Arabian cultural knowledge among non-Muslim nurses working in the obstetric units* (Doctoral thesis). University of South Africa.

Sidumo, E. M., Ehlers, V. J., & Hattingh, S. P. (2010). Cultural knowledge of non-Muslim nurses working in Saudi Arabian obstetric units. *Curationis, 33*(3), 48-55.

Silverman, D. (2001). *Doing qualitative research: A practical handbook*. London: Sage.

Smith, D. W. (2008) *Phenomenology*. Retrieved April 2, 2012 from http://plato.stanford.edu/entries/phenomenology

Spence, S. A. (2001). Alien control: From phenomenology to cognitive neurobiology. *Philosophy, Psychiatry, & Psychology*, *8*(2/3), 163-172.

Starks, H., & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, *17*(10), 1372-1380.

Stein-Parbury. J. (2005). *Patient & person: Interpersonal skills in nursing*. NSW: Elsevier Australia.

Stokes, A. (2001). Using telementoring to deliver training to SMEs: A pilot study. *Education & Training, 43*(6), 317-324.

Suliman, W.A., Welmann, E., Omer, T., & Thomas, L. (2009). Applying Watson's nursing theory to assess patient's perceptions of being cared for in a multicultural environment. *Journal of Nursing Research, 17*(4), 293-300.

Sweeny, J. F. (2005). Historical research: Examining documentary sources. *Nurse Researcher. 12*(3), 61-73.

Tod, A. M., Wadsworth, E., Asif, S., & Gerrish, K. (2001). Cardiac rehabilitation: The needs of South Asian cardiac patients. *British Journal of Nursing, 10*(16), 1028-1033.

Torsvik, M., & Hedlund, M. (2008). Cultural encounters in reflective dialogue about nursing care: A qualitative study. *Journal of Advanced Nursing, 63*(4), 389-396.

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

Turgut, O., Yalta, K., & Tandogan, I. (2010). Islamic legacy of cardiology: Inspirations from the holy sources. *International Journal of Cardiology, 145*(3), 496.

United Nations, World Population Policies; Kingdom of Saudi Arabia. (2007). *Population Age Composition of Saudi Arabia*. Retrieved June 25, 2012 from http://www.escwa.un.org/popin/members/SaudiArabia.pdf

Van Der Zalm, J. E., & Bergum, V. (2000). Hermeneutic-phenomenology: Providing living knowledge for nursing practice. *Journal of Advanced Nursing, 31*(1), 211-218.

Van Rooyen, D., Telford-Smith, C. D., & Strümpher, J. (2010). Nursing in Saudi Arabia: Reflections on the experiences of South African nurses. *Health SA Gesondheid, 15*(1), 1-9.

Watson, J. (2007). Theoretical questions and concerns: Responses from a caring science framework. *Nursing Science Quarterly. 20th Anniversary Edition, 20*(1), 13-35.

Walston, S., Al-Harbi, Y., & Al-Omar, B. (2008). The changing face of healthcare in Saudi Arabia. *Annals of Saudi Medicine,* 28, 243–250.

Ward, J. (2012). The importance of teamwork in nursing. Retrieved from, http://www.nursetogether.com/tabid/102/itemid/2153/The-Importance-of-Teamwork-in-Nursing.aspx

Welsh, E., (2002). Dealing with Data: Using NVivo in the Qualitative Data Analysis Process [12 paragraphs]. Forum Qualitative Sozialforschung / *Forum: Qualitative Social Research*, 3, 2, Art. 26, http://nbn-resolving.de/urn:nbn:de:0114-fqs0202260.

Williamson, M., & Harrison, L. (2010). Providing culturally appropriate care: A literature review. *International Journal of Nursing Studies, 47*(6), 761-769.

Wojnar, D. M., & Swanson, K. M. (2007). Phenomenology an exploration. *Journal of Holistic Nursing*, *25*(3), 172-180.

World Health Organization Regional Office for the Eastern Mediterranean. (2006). *Country Cooperation Strategy for WHO and Saudi Arabia 2006–2011*. Retrieved October 28, 2013 from http://www.who.int/countryfocus/cooperation_strategy/ccs_sau_en.pdf

Yazdi, N. A., Tavafian, S. S., Emadzadeh, A., Kazemnejad, A., & Ghofranipour, F. (2008). Communication training and patient satisfaction: A randomized trial study from Mashhad, Iran. *Patient Prefer Adherence*, *2*, 137-142.

Yegdich, T. (2000). In the name of Husserl: Nursing in pursuit of the things-in-themselves. *Nursing Inquiry*, *7*(1), 29-40.

Yosef, A. (2008). Jump up: Why Ramadan brings us together; *BBC*. Retrieved October 22, 2013 from http://www.bbc.co.uk/birmingham/content/articles/2008/08/29/ramadhan_2008_feature.shtml

Younge, D., Moreau, P., Ezzat, A., & Gray, A. (1997). Communicating with cancer patients in Saudi Arabia. *Annals of the New York Academy of Sciences*, 809, 309-316.

Zakari, N., Al Khamis, N., &Hamadi, H. (2010). Conflict and professionalism: Perceptions among nurses in Saudi Arabia. *International Nursing Review, 57*(3), 297-304.

APPENDIXS

APPENDIX 1: PARTICIPANT'S INFORMATION SHEET AND CONSENT FORM

School of Health

Armidale, NSW 2351 Australia

Head of School: Professor Steven J Campbell

INFORMATION SHEET FOR PARTICIPANTS, STAFF NURSES INVITATION LETTER AND CONSENT FORM

PROJECT NAME:

Nurse-patient communication and care in Saudi Arabian hospitals: OQNs and factors that influence nursing – care delivery

RESEARCHER: Obeid Al-Rashoud
PhD candidate
School of Health
University of New England
Armidale, N.S.W. 2350
Ph.: Office (02) 6773 3893,
Mobile: 0422212472
Email: oalrasho@une.edu.au

PRINCIPAL SUPERVISOR: Dr. Penny Paliadelis
Senior Lecturer, Deputy Head of School, Course Coordinator for Nursing,
Faculty of The Professions,
School of Health
University of New England -Armidale, N.S.W. 2351
Room: Pat O'Shane Building (C13) 225
Phone: 02 6773 3653 (or +61 2 6773 3653 overseas)
Fax: 02 6773 3666
Email: ppaliade@une.edu.au

CO- SUPERVISOR: **Dr. David Briggs**
Senior Lecturer, Course Coordinator, Health Management and Gerontology,
Faculty of The Professions,
School of Health -Armidale, N.S.W. 2351
Mobile: 0411 471 203
Email: dbriggs@une.edu.au

PURPOSE OF THE RESEARCH:

The purpose of this research is to explore how OQNs communicate with the Saudi patients as they are from a different background. The results of this research will form part of a Doctor of Philosophy degree. The researcher is interested in hearing the opinions of the OQNs, regarding the experience of working in Saudi Arabian Hospitals. It is important for participants to be aware that there are no right or wrong answers, and that the researcher is interested in the experiences of the participants.

METHOD:

The method of data collection will be by individual face-to-face semi-structured interviews. This means the researcher will ask willing participants to discuss their experiences of working in Saudi Hospitals and have been caring and communicating with Saudi patients. The interviews will be audio-taped with permission and then transcribed. All the interviews will be conducted in English, and the duration of each interview will be between 45 minutes to one to hour. The location of the interview will be mutually negotiated between the researcher and the participant.

RESPONSIBILITY:

The interviews will be audio taped with permission; the audio tapes of all interviews will be transcribed by researcher and reviewed by supervisors. All data will be stored in a locked

filing cabinet in the office of the researcher. Data on audio tape, computer disc and hard copy will remain in the possession of the researcher and be accessed only by the researcher and her supervisor. Data will be kept for a period of five years in accordance with the National Health and Medical Research Council, Australian Health Ethics Committee guidelines (1995), after which they will be destroyed.

IMPORTANT NOTES:

- NO INDIVIDUAL IS UNDER ANY PRESSURE TO PARTICIPATE.
- THE PARTICIPANT IS FREE TO WITHDRAW CONSENT OR DISCONTINUE WITH THE INTERVIEW AT ANY TIME, WITHOUT EXPLANATIONS.

Any questions concerning the project titled" Nurse-patient communication and care in Saudi Arabian hospitals: OQNs and factors that influence nursing – care delivery" can be directed to **Obeid Al Rashoud** (Principal Investigator) of the School of Health University of New England. Ph.: (02) 6773 3893 or mobile 0422212472; and in Saudi Arabia Mobile (+966)554646940 and Email: **oalrasho@une.edu.au.** Should you have any complaints concerning the manner in which this research is conducted, please contact the Research Ethics Officer at the following address:

Research Services

University of New England

Armidale, NSW 2351.

Telephone: (02) 6773 3449 Facsimile: (02) 6773 3543

Email Ethics@une.edu.au

STAFF NURSES INVITATION LETTER:

Dear Nurse Colleague,

You are invited to participate in a study about nurse-patient communication and care in Saudi Arabian hospitals: OQNs and factors that influence nursing – care delivery. This project is being conducted to explore how the OQNs communicate with the Saudi patient by nurses working in King Fahad Medical City. It is being undertaken in order to identify the factors that influence the nurse-patient communication during their care and its effectiveness. The results of the study will help us to understand the preferred way of communication with the Saudi patients in King Fahad Medical City.

Procedure: Participants are invited to attend an individual interview which will be tape-recorded. The interview will be held in a meeting room at mutually convenient time. Your consent to participate in the study will be indicated by signing this form and if you agree then you will be given the location of the meeting room.

Confidentiality: The information you will give in this study will be kept confidential, no names will be used, and all the data will be kept in a secured, private location and seen only by the researcher.

Risks: There are no known risks (physical, psychological, social or legal) to the participants in this study.

Benefits: There are no direct benefits to the participants for participating in the study, although, we hope that the finding of the study will help in identifying new information that will be helpful to the nursing profession in the future.

This research study has been reviewed and approved by the research committee in King Fahad Medical City and University of New England in accordance with procedures governing human research subjects. The researcher is Obeid Al Rashoud, a PhD candidate in the School of Health, University of New England; Armidale, New South Wales, Australia. Obeid can be reached at the Saudi Mobile Riyadh or Australian. Saudi, +966554646940 \ OR Aus, +61422212472; Email: oalrasho@une.edu.au .

I agree to participate in the Nurse-patient communication and care in Saudi Arabian hospitals: OQNs and factors that influence nursing – care delivery Study.

Name of participant: _____

Signature_____ Date: _____

Demographic data and consent form:

Name of Health Care Facility: .....

Participant Code Number: .....

Please tick choices:

	Male	( )	Female	( )
Age:	20-25yrs	( )	26-30yrs	( )
	31-35yrs	( )	36-40yrs	( )
	41-45yrs	( )	46-50yrs	( )
	51-55yrs	( )	56-60yrs	( )
	61-65yrs	( )	66-70yrs	( )

Nationalities: ----------

Qualifications: Which is your highest level of **nursing** qualification?

Nursing certificate(s)	( )
Nursing diploma	( )
Bachelor degree	( )
Postgraduate certificate	( )
Graduate diploma	( )
Master degree	( )
Other (please specify)	( ).....

.....

.....

Where did you receive your basic nursing training?

.....

.....

How many years have you been working in Saudi Arabia?

2-3 years ( )

3-4 years ( )

4-5 years ( )

More than 5 years ( )

.....

.....

Thank you for your participation

Obeid Al-Rashoud

PhD candidate

School of Health

University of New England

Armidale, N.S.W. 2351.

School of Health

Armidale, NSW 2351 Australia

Head of School: Professor Steven J Campbell

Participant Consent form

I agree to participate in the Nurse-patient communication and care in
Saudi Arabian hospitals: OQNs and factors that influence nursing - care delivery Study.

Name of participant:

_____

Signature: _____Date:_____

APPENDIX 2: INTERVIEW QUESTIONNAIRE

Key question

- Can you tell me about your experiences of providing care for patients in a Saudi Arabian hospital?
- What were the problems and challenges facing you in providing nursing care for Saudi patients?

Prompts:

1. Would you please explain your working culture experience prior to Saudi Arabia?
2. Please explain your experience of working, as a nurse, within the Saudi culture.
3. What do you see as the major challenges in providing culturally competent nursing care? And what is your perception of culturally competent nursing care in the Saudi Arabian hospital in which you work?
4. When you first decided to come to Saudi Arabia, who helped you with the cultural aspects of the country?
5. What strategies have you used to improve your culturally appropriate delivery care within the Saudi hospitals setting?
6. Have you experienced any communication difficulties with your patients? Can you give me some examples?
7. What should be included in a guiding booklet intend to be delivered to all overseas nurse welling to work in Saudi Arabia prior to their arrivals?
8. Did you expect me to ask you any additional question related to this topic? If yes, please specify.

APPENDIX 3: ETHICS LETTERS

Kingdom of Saudi Arabia
Ministry of Health
King Fahad Medical City

المملكة العربية السعودية
وزارة الصحة
مدينة الملك فهد الطبية

Dear Dr Obeid Al- Rashoud,

July 20, 2009
ERRC Number: 09-015

It is my pleasure to inform you that the External Research Review Committee, a subcommittee of the Institutional Review Board, has approved your study titled: "Nurse patient communication and care in Saudi Arabian Hospitals: Factors that influence expatriate nursing –care delivery".

1. Please be informed that in conducting this study, you as the Principal Investigator is required to abide by the rules and regulations of the Government of Saudi Arabia and KFMC/ERRC. The approval of this proposal will automatically be suspended on July 19, 2010 pending the reapplication to renew the approval.

Please observe the following:

1. Personal identifying data should only be collected when necessary for research;
2. The data collected should only be used for this proposal;
3. Secondary disclosure of personal identifiable data is not allowed.

We wish you every success in your research endeavor.

Sincerely yours,

[redacted]

Prof . Faroque Khan, MB, MACP
Chairman, Institutional Review Board
King Fahad Medical City, Riyadh, KSA
Tel# +966 1 288 9999 Ext. 7185/1299

FOR:

Dr. Mohamad AlTannir
Head of External Research Review Committee
Institutional Review Board
KFMC, Riyadh, KSA

المرفقات :

الرقم :

UNE
THE UNIVERSITY
OF NEW ENGLAND

Research Development & Integrity
Research Services
Armidale, NSW 2351, Australia
Telephone: 02 6773 3449
Facsimile: 02 6773 3543
http://www.une.edu.au/research-services\ethics
E-mail: jo-ann.sozou@une.edu.au

HUMAN RESEARCH ETHICS COMMITTEE

MEMORANDUM TO: Dr P Paliadelis, Dr D Briggs & Mr O Al Rashoud
School of Health

This is to advise you that the Human Research Ethics Committee has approved the following:

PROJECT TITLE: Nurse–patient communication and care in Saudi Arabian hospitals: Overseas nurses and factors that influence nursing – care delivery.

APPROVAL No.: HE09/187

COMMENCEMENT DATE: 01/01/2010

APPROVAL VALID TO: 01/01/2011

COMMENTS: Nil. Conditions met in full.

The Human Research Ethics Committee may grant approval for up to a maximum of three years.
For approval periods greater than 12 months, researchers are required to submit an application for renewal at each twelve–month period. All researchers are required to submit a Final Report at the completion of their project. The Progress/Final Report Form is available at the following web address: http://www.une.edu.au/research-services/researchdevelopmentintegrity/ethics/human-ethics/hrecforms.php

The *NHMRC National Statement on Ethical Conduct in Research Involving Humans* requires that researchers must report immediately to the Human Research Ethics Committee anything that might affect ethical acceptance of the protocol. This includes adverse reactions of participants, proposed changes in the protocol, and any other unforeseen events that might affect the continued ethical acceptability of the project.

In issuing this approval number, it is required that all data and consent forms are stored in a secure location for a minimum period of five years. These documents may be required for compliance audit processes during that time. If the location at which data and documentation are retained is changed within that five year period, the Research Ethics Officer should be advised of the new location.

Jo–Ann Sozou
Secretary

06/11/2009