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# The Challenges of Cultural Competency Among Expatriate Nurses Working in Kingdom of Saudi Arabia

Dalyal N. Alosaimi, PhD, RN

*College of Nursing, King Saud University, Riyadh, Saudi Arabia*

Muayyad M. Ahmad, PhD, RN

*Department of Clinical Nursing, The University of Jordan*

**Background and Purpose:** To explore the cultural challenges facing expatriate nurses working in the Kingdom of Saudi Arabia (KSA). Women do not have an active role in the workplace in KSA. Concepts of religion, culture, and language are considered to be crucial and often the lack of women's participation is attributed to these factors. **Methods:** A descriptive qualitative approach was used with two methods of data collection: interviews and focus group. The study was located in a hospital setting in Al-Riyadh at KSA. There were 20 non-Muslim nurses of different nationalities who participated in this study. **Results:** Several themes emerging from the nurses' experience of caring for Muslims such as the inability to carry out nursing duties because of religious and cultural factors and language barriers. Most of the nurses have provided similar examples and discussed the same issues, such as patient's families, fasting, and prayer having a negative impact on care from their perspective. **Conclusion:** There is a lack of expatriate nurses' orientation concerning religion and culture. The nurses acknowledged the importance of language when they start dealing directly with patients and associated this language barrier with their inability to provide proper care.

**Keywords:** expatriate nurses; competency; culture; communication; language; Islam

The ability of nurses to develop cultural competency is imperative and can be done by understanding patients' culture and religion and consequently meeting patients' needs (Jeffreys & Dogan, 2013). Professional nurses may enjoy

a long tradition of huge respect from patients if they demonstrate the acceptance of patients' cultures and beliefs (Jeffreys & Dogan, 2013). According to Kirmayer and Minas (2000), a health care system will be ineffective and inefficient unless health care providers understand culturally diverse communities and are able to focus on learning about the strange culture that differs from nurses' cultural norms and faiths. This suggests that health care should be provided based on patient's beliefs and desires. In this case, problems associated with different religious and cultural norms and values will be minimized.

This study targeted non-Muslim nurses working in a major hospital in Al-Riyadh, which is the capital of the Kingdom of Saudi Arabia (KSA). The non-Muslim nurses form about 80% of the total number of nurses in KSA hospitals. Thus, hospitals' expectations are positioned in reference to nurses' attitudes and behaviors, regarding Islamic religion and Saudi culture. The hospital also expects that the health care provided to Muslim patients is not affected by nurses' original culture. Therefore, this study aims to investigate the cultural challenges facing expatriate nurses working in KSA.

## **BACKGROUND**

This study is positioned specifically in reference to religion and culture in KSA. The concept of culture is defined as "the set of values, conventions, or social practices associated with a particular field, activity, or societal characteristic" (Culture, n.d.). KSA is one of the Arab countries. Arab culture draws together the common themes and overtones found in the Arab countries, especially those of the Middle Eastern countries. Arabs have a shared set of traditions, belief systems, and behaviors shaped by their distinct history, religion, ethnic identity, language, and nationality (Ahmad & Dardas, 2015).

The concepts of religion, culture, language, nursing, and cross-cultural care are considered to be crucial, thus, underpin the theoretical framework used in this study. Many people who work in the health care sector in KSA are expatriate workers with varying different nationalities (Almalki, Fitzgerald, & Clark, 2011). Expatriate nurses in KSA, for the most part, have not significantly understood Saudi culture, and Islamic faith has affected the quality of nursing care provided to Muslim patients (Van Rooyen, Telford-Smith, & Strumpher, 2010). Equally, it is assumed that nurses working in KSA have taken some courses on the cultural and ethical issues associated with working in other nations. In addition, nurses may be exposed to training that gives them the opportunity to understand other religions and cultures, suggesting this is an important aspect of providing culturally congruent care, whereby nurses can then understand the needs and sensitivities of patients. Providing culturally congruent care embraces cultural values, beliefs and practices, religious or spiritual beliefs, and family and social factors, all of which are deemed relevant to Muslim patients in Saudi Arabia (AlMutairi & McCarthy, 2012).

Women do not have an active role in the workplace in KSA. AlMunajjed (2010) studied the religion and culture, and the lack of women's participation is often

attributed to these factors. Furthermore, Almunajjed provides a wide-ranging and practical picture of legislative, educational, and occupational issues, among others, as well as the social constraints on women that prevent them from entering the workplace. AlMunajjed also sees the lack of women in the workplace as an untapped resource and attributes the issue of dependency on expatriate workers on this problem. However, this is not to say that the issue of culture and the role of the family is not the most pressing issue because the author suggests that even labor market reforms should include legislation to promote gender equality and family-friendly mechanisms.

As a result of globalization, countries are becoming increasingly multicultural, and people of different religions, ethnicities, and languages are meeting and living in the same locations, requiring nursing practitioners to engage in effective transcultural practice (Hollan & Hogg, 2001). Transcultural nursing focuses on worldwide cultures and comparative cultural caring, health, and nursing phenomena. It has been established as an area of inquiry and practice more than five decades ago, transcultural nursing's goal is to provide culturally congruent care (Leininger, 1997). One of the most fundamental aspects of transcultural nursing is cultural competency. Cultural competency is defined as "a dynamic, fluid, continuous process whereby an individual, system, or health-care agency finds meaningful and useful care delivery strategies based on knowledge of the cultural heritage, beliefs, attitudes, and behaviours of those to whom they render care" (Giger & Davidhizar, 2002, p. 187). Language difficulties are the most significant barrier to providing high-quality health care, and thus, language constitutes an important component of cultural competency in nursing (Jacobs, Chen, Karliner, Agger-Gupta, & Mutha, 2006).

## CONCEPTUAL FRAMEWORK

The field of transcultural nursing involves individual and group behaviors and considers the religion of patients as important for high-quality care (Leininger, 1997). Leininger emphasizes care in nursing, in that it is the essence and unifying feature of nursing. Although care is a universal phenomenon, it varies among cultures and presents itself in different ways in terms of processes, expressions, and patterns. Leininger (1997) focuses attention on the relationship between culture and its significant contribution to the quality of patient care. Leininger introduced the field of transcultural nursing, having formerly been involved in education, research, and publishing (Rosenbaum, 1986). Her cultural care theory has influenced many nurses in their approaches to transcultural care, and she has actively encouraged nurses to employ transcultural nursing principles and practices in their work (Rosenbaum, 1986). This study aims to contribute to transcultural nursing care, by examining the experiences of expatriate non-Muslim nurses caring for Muslim patients in a religiously conservative society.

The reason that this model is included in the theoretical framework is because it recognizes specific aspects of people's culture that are relevant to this study. Although the model is not used as an assessment instrument, for example, to assess

the transcultural competency of the nurses against the six cultural phenomena, it provides an insight into the areas that are important to transcultural care. More specifically, the model provides the dimensions that are relevant to this study, communication between non-Arabic-speaking expatriate nurses and Muslim Saudi patients, physical space between the nurses and patients and the violation of that space, as well as the family and religion beliefs.

## **METHOD**

### **SEARCH METHOD**

Several databases were used in the literature search, including MEDLINE, CINAHL, the British Nursing Index, and Google Scholar. The criteria for this search were that the literature be written in English and be qualitative in nature. Most of the literature that was reviewed consisted of journal articles and books, which together represented the main texts in the relevant subject areas.

From the outset, literature was sought based on the aims and objectives of the study relating to nursing, transcultural care, cultural competence, caring for Muslim patients, nursing in Saudi Arabia, language barriers, and transcultural nursing education.

The criteria for this search were that the literature had to be post-1990, although literature before this date was accepted if it was important to the study, was written in English, and was qualitative in nature. Most of the literature that was reviewed consisted of journal articles and books represented the main texts in the relevant subject areas.

When the articles were being searched on the databases, the first level of sifting was to exclude any articles whose titles were not pertinent to the study. Thereafter, the abstracts of the remaining articles were read to determine relevance. If the abstracts showed the article to be relevant, then the rest of the text was considered, and particular attention was paid to methods, discussions, and conclusions.

### **SAMPLE SIZE AND SAMPLING STRATEGY**

A qualitative researcher is required to continue data collection until they are able to answer the research questions (Smith, Flowers, & Larkin, 2009). Examining interview transcripts on an individual basis enabled the researchers to focus on the amount and quality of information gathered rather than on the number of participants. In this study, purposive sampling technique was used to pick a homogenous sample to describe a specific subgroup; in the case of this study, non-Muslim nurses caring for Muslim patients. The sample size in this study was based on the amount of data collected in the interviews and focus group discussions. However, in this study, a segment of nurses who have some common characteristics such as age, gender, educational level, and years of experience was selected. The nurses targeted by this study are of different nationalities but are all non-Muslim. Thus, the number of

nurses who participated in the interviews was 8, and the number of nurses in the three focus groups was 12, with 4 in each group.

### SAMPLE SETTING

The sample was recruited from one of the largest hospitals in KSA with around 950-bed tertiary care facility. The hospital has a total staff of 6,946, comprising 63 different nationalities. The medical staff includes Saudi residents and fellows, totals 703, 46% of whom are expatriates (including 16% U.S./Canadian and 11% European). The nursing staff totals 1,942 from Philippines, Canada, United States, United Kingdom, Europe, Australia, New Zealand, Saudi Arabia, and other countries. The main departments include Critical Care Nursing, Maternal Child; Nursing, Surgical Nursing, Oncology; Medical Nursing, Infection Control; Ambulatory Care Nursing; Coordination, I.V. Therapy; Discharge Planning; and Quality Improvement and Nursing Education and Research.

### DEVELOPMENT OF INTERVIEW SCHEDULE FOR FOCUS GROUPS AND INTERVIEWS

Permission was first sought from the relevant department in the hospital. The head of nursing for different wards, except pediatrics, identified who the non-Muslim nurses were and found out whether they were interested in participating. Thereafter, they were informed about the times for the focus groups and interviews and invited to attend in a seminar room in the hospital. Each focus group lasted approximately 50 min, all focus groups were audio recorded and transcribed verbatim following each session, and notes were made on the ease of interaction and nonverbal communication. Once the tapes were transcribed, a copy of the typed transcript was given to each participant to read with the invitation to make any additions, deletions, and/or corrections.

All questions in a focus group are carefully planned, follow a particular sequence, and are open-ended (Creswell, 2014). The more important questions should come first during the focus group and more general questions should come before more specific questions, for example, in this study: How do you feel about caring for Muslim patients? Although it seems that these two approaches conflict with each other, it is possible to begin with a general question about one particular topic and then move to a more specific question before moving to another topic (Stewart, Shamdasani, & Rook, 2007). The reason for this sequencing is to create a broad but focused discussion on the topic to achieve the goals of the focus group (Creswell, 2014). However, there should be a degree of flexibility within the structure. Care should be taken in the development of the questions themselves; they should be written, so they are easy for the moderator to ask without stumbling or confusing the participants, and they should be short and open-ended (Stewart et al., 2007).

The interview schedule for the focus groups and interviews with nurses was developed to answer research questions, which consisted of the following: Feelings, opinions, and insights from the experience of caring for Muslim patients, "Is there a difference between caring for non-Muslim patients and Muslim patients?" Religion

as a factor in the experience, "How does religion affect care?" "How does religion (Islam) affect you, as a nurse?" and "Is it easy for you to provide culturally congruent nursing care?" Communication as a factor, "Are there any communication barriers?" and "Do these barriers impact on your experience?"

### DATA ANALYSIS STRATEGY

The analysis of qualitative data begins during data collection by the principal investigator (PI). The data analysis commenced with examining the transcribed focus groups and interviews line by line because digesting all the information is important to fully understand the data. Ideas about the direction of data analysis began to emerge alongside specific patterns and themes. Furthermore, the ideas about the direction of data analysis began to emerge particularly when specific patterns (themes) arose. The reading and rereading process of the transcripts gave the researcher the opportunity to identify nurses' thoughts, feelings, and experiences.

The analysis process of focus group data is different from the analysis of interviews because of the interaction that takes place between participants; this difference is reflected in the different views of participants in the focus groups. The advantage of using focus group not only presents the extent that participants agree/disagree with each other but also as Creswell (2014) suggested that analyzing focus group data, which takes the group dynamics into consideration, may generate more insight. This study addresses nurses' lived experience in relation to patients and everyday experiences in the hospital context. Therefore, in the analysis of the focus groups, the main issue was how nurses discussed different factors, such as religion and culture.

**Data Saturation.** In this study, the researchers used theoretical data saturation because a constant comparative approach to data analysis helped to reach data saturation and data redundancy. A constant comparative approach was used in such a way that the researchers could compare different pieces of interviews that were relevant to the themes and subthemes emerging from the data.

The focus group, in comparison to interview techniques, allows observation of the interaction between participants, which according to Creswell (2014) provides an insight into how people are influenced by other participants, that is, the group dynamics. Focus groups expose the similarities and differences between the experiences and viewpoints of the participants, which are recorded as they occur. Creswell compares this to analyzing individual statements from interviewees after the interviews have taken place. Creswell says that focus groups also reveal the shared understanding of a particular subject and help to generate new ideas on a subject through brainstorming. In the case of this study, all the participants shared similar everyday experiences in the same context, that is, being a non-Muslim nurse caring for Muslim patients in Saudi Arabia.

**Trustworthiness.** The reliability and validity of empirical studies was first addressed by proponents of positivists. Credibility in phenomenological research is measured through judgment of how the researcher is confident in their results. In other words, internal validity depends on the credibility of results.

To promote confidence and trustworthiness in data, the researchers have taken several steps. The PI familiarized herself with the general hospital targeted in this study and obtained relevant documents about services provided, types of nursing services, and the nationalities of nurses working for the hospital. The PI found the nursing team and the director of research very cooperative and friendly. The PI did not make any demands that affect cooperation with the hospital. Second, the PI used triangulation which suggests using more than one data source to ensure the credibility of results. Then, two data collection methods, interviews, and focus groups. Third, the PI tried to ensure honesty in nurses and patients who had the opportunity to reject participation in the study and were genuinely willing to give honest and frank information about their experience in the hospital. Fourth, the PI used probing which enabled the researchers to elicit detailed data. Fifth, the PI experience in nursing was an important factor in how to deal with patients and nurses (Creswell, 2014).

**Transferability (External Validity).** Creswell (2014) argued that the responsibility of the researcher is to collect sufficient information about the phenomenon being investigated. In relation to this context, we believe in this study that we have collected sufficient information to address the research objectives. We conducted a sufficient number of focus groups and interviews with nurses and interviews with patients. Researchers and readers can therefore rely on our results and can be confident in transferring the conclusions to other situations. To transfer the results of our study to other contexts, we were ensured that there were no restrictions from the hospital in interviewing nurses and obtained detailed information.

**Ethical Considerations.** Before conducting the study, ethical approval from the School of Nursing and Midwifery was obtained. An information package about the study was prepared, which included several items such as the study objectives; rationale; a request for potential participants to take part in the study, which was entirely voluntarily; procedures for moderating focus groups and conducting interviews; time allocated for focus groups and interviews; an explanation of privacy procedures, and confidentiality of data. Nurses in this study were informed that their names would not appear on any information sheets, apart from the consent form, which would be secured in a private research cupboard. Anonymity of information was taken into consideration at all stages of this study including transcription, data analysis, and coding as well as when writing up the results.

## FINDINGS

This study has taken a descriptive qualitative approach to reveal the experiences of expatriate nurses caring for Muslim patients in KSA. This approach was employed to understand the care relationship from the viewpoint of the nurses and gain an insight into their experiences. The characteristics of the nurses who participated in the interviews and in focus groups are presented in Table 1.

Seven of the nurses were females and one male in the interview sample, and in the three focus groups, each group was composed of four nurses, all of them were females with only two males over two groups. Nurses came from 11 different



**TABLE 1. Nurses' Profiles (Interviews) and (Focus Groups)**

Nurses' Profiles (Interviews)					
Nurse	Number of years in KSA	Gender	Country of Origin	Nursing Qualification	Previous Experience (Country)
Nurse 1	3	F	South Africa	BSc	United States
Nurse 2	7 months	F	Australia	Vocational	Australia
Nurse 3	10	F	United States	BSc	Japan and United States
Nurse 4	8.5	M	United Kingdom	BSc	United Kingdom
Nurse 5	5	F	Sweden	BSc	Sweden
Nurse 6	2	F	United Kingdom	BSc	United Kingdom
Nurse 7	4	F	Philippines	BSc	Philippines
Nurse 8	3.5	F	Philippines	BSc	Philippines
Nurses' Profiles (Focus Groups)					
Focus Group 1					
Nurse 1	3	M	Philippines	Diploma	Philippines
Nurse 2	21	F	India	Diploma	India
Nurse 3	3	F	Philippines	Diploma	Philippines
Nurse 4	6	F	Philippines	Diploma	Philippines
Focus Group 2					
Nurse 1	27	F	Philippines	Diploma	Philippines
Nurse 2	10	F	Philippines	BSc	Philippines
Nurse 3	5	M	Philippines	BSc	United Kingdom and Philippines
Nurse 4	7	F	Lebanon	BSc	Lebanon
Focus Group 3					
Nurse 1	7	F	South Africa	BSc	South Africa
Nurse 2	2	F	Ireland	BSc	United Kingdom, Ireland, and Australia
Nurse 3	1	F	Philippines	BSc	Philippines
Nurse 4	4	F	United Kingdom	BSc	United Kingdom

*Note.* KSA = Kingdom of Saudi Arabia; F = female; M = male; BSc = bachelor of science.

nationalities, but the majority are from Philippines. The education level for nurses was mainly bachelor degree and diploma. The nurses age range from 25 to 42 years old, with experience in their home countries between 3 and 20 years.

## THEMES

There are various methods of analyzing qualitative data, including thematic analysis and content analysis (Pino, Soriano, & Higginbottom, 2013). The thematic analysis in this study extracted the core meanings of nurse experiences by defining specific themes and subthemes emerging from the data (Table 2).

### PROVIDING RELIGIOUSLY CONGRUENT CARE

It was clear from the semistructured interviews and the focus group discussions that the nurses understood that Saudi Muslim patients appreciated and praised nurses when they used phrases such as “Bismillah” (“In the name of Allah”) or “Alhamdulillah” (“All praise is for Allah”). The nurses recognized the importance of religious phrases to patients and that these words benefitted the patient in terms of pain relief and made them feel more comfortable:

I think using these words, for example, “Bismillah,” makes the patients feel more comfortable. (Nurse 3)

The patient feels good when we use these words. They feel good when I say “Bismillah.” (Nurse 6)

In the nurses’ experience, it was clear that they felt that religious phrases benefitted not only the patients but also, to some extent, themselves. The following conversation occurred between the primary researcher and one of the nurses:

**Researcher:** *What do you think about saying “Bismillah”?*

**Participant:** *I use “Bismillah” just before giving an injection. I adopted this word from my senior. I had one patient who asked me “Why do you say ‘Bismillah’? Are you a Muslim?” I told him no, but I just use this to feel good.*

**Researcher:** *When you use “Bismillah,” do you feel the patient seems more relaxed?*

**Participant:** *When I want to give an injection to a patient, I ask the patient to say “Bismillah” and they feel good about this. (Nurse 8)*

### I AM A PROFESSIONAL NURSE

Most of the nurses emphasized that religion had no detrimental impact on the standard of care and that it was not considered to be an issue. The patients’ religion was, to some extent, seen as irrelevant, as the following statements reveal:

I do not judge patients based on their religion or culture, but I judge the patients based on their personalities and how their behavior is towards me. So, there is nothing specific that can be said about patients of any religion. There are good and bad individuals in every religion, so I generally do not make my impression of patients from their religion. (Nurse 4)

**TABLE 2. Themes and Subthemes**

Themes	Subthemes	Example of Text
Understanding Islam	Importance of religion to patients	We were not allowed to eat in front of patients during Ramadan.
	Respect of Islamic traditions	So now I have tried to convince myself in a way that I am in a Muslim country and I should respect the laws or traditions followed here if I want to stay. In this way, I have overcome these kinds of things.
	Prayer times	I respect prayer. You know when it is prayer time you should respect it.
	Confusion between religion and culture	Some patients are sitting on the floor, which I think is their culture but this is not medically good for patients. So I think sometimes the religion affects the care.  So, we do not get that much information about different cultures and religions during our studies.
Professionalism	Religious phrases and supplications	The patient feels good when we use these words; they feel good when I say "Bismillah."
	Impact of religion on professionalism	I do not judge patients based on their religion or culture, but I judge the patients based on their personalities and their behavior toward me.  I have no particular feelings about whether the patients are Muslims or of any other religion; it doesn't bother me.
	Defending professionalism	To provide care it does not matter because you have to give the best care as a professional nurse. You only have to consider that they might need things for their religious duties, but their religion does not affect the kind of care you give to patients.
Language barriers	Communication	I think the most common difficulty here with patients, which we all face, is the communication and language barrier. We cannot communicate with patients in their own language and sometimes they are unable to understand what we want them to do.

*(Continued)*

**TABLE 2. Themes and Subthemes**

Themes	Subthemes	Example of Text
		As far as the communication with the family goes, I think sometimes we face difficulties regarding the patient's family or sitters interfering with our care, sometimes refusing the things we want to do. I think this is due to things not being well explained, or interpreted, to them in the same way that we want to do things.
	Impact of language on care	They do not follow our instructions, like walking, ambulating; they prefer to sleep and just lie down. So, language is a barrier, which I think if I were able to speak Arabic, I could communicate better with patients.
Gender issues	Impact of gender on nurses' workloads	I had an old, male patient with me who was a religious person and he said he would not like a female nurse to touch him. In that case we had to find a male colleague to help us.
	Male nurse	I found not being able to carry out all of the care for the male patients quite difficult because we have very few male staff and to get certain things done for male patients, you have to wait and wait and wait, because nobody is there to do it. I found that a little bit odd, but it is a religious thing and you just have to accept that.  Sometimes the doctors are in hurry, but we have to wait to see the patient until she covers herself and allows us to come in.
	Additional burden on female nurses	Regarding the female patients, there is sometimes the difficulty that I am always hesitant to enter a female patient's room, because it is against the culture here. So, I am not free in taking care of female patients, and am somewhat restricted.

It does not really make any difference to me. I have no particular feelings whether the patients are Muslims, or of any other religion. It doesn't bother me. (Nurse 2)

It was clear that the nurses felt that, as professionals, they should provide nursing care equally, regardless of the patients' religion. The issue of professionalism (or the defense of professionalism) was very important to the nurses:

I agree that the religion of the patients does not affect the level of care we provide to a patient. We simply take care of patients of every religion in a professional way, so level of care is the same for all patients, whether Muslims or non-Muslims. (FG1 Nurse 3)

### **RELIGIOUS BARRIERS (INCLUDING GENDER, FASTING, PRAYER, COVERING, MODESTY, AND PHYSICAL CONTACT)**

In the nurses' experience, prayer had an effect on care, and this was an aspect that concerned all the non-Muslim nurses in this study. There were different ways that prayer affected care. This included interfering with the timing of the administration of medicine, delaying important procedures, and changing the working routine of nurses. One of the nurses in the semistructured interviews remarked,

Certainly, there are prayer times. When we first got here, we were told that you have to stop doing important care because people want to pray. Initially, I found this somewhat difficult, because surely your health and being alive is more important than absolutely having to say prayers right now? (Nurse 2)

Muslim females are required to wear the hijab, which covers all parts of the body, including the hair. The nurses provided a large number of examples concerning the issue of women having to cover up in front of men, which they felt had an unnecessary impact on their ability to provide care. The reason the nurses felt this was unnecessary was because they themselves were female. However, female patients did not want to risk being seen without the hijab by male medical staff. The following statement shows how covering directly affected patient care:

I work in Oncology, taking care of patients receiving chemotherapy. The only problem I encountered is with female patients. If they are covered when they are on the bed we cannot see if the patient is cyanotic, because they are wearing an abaya. (FG2 Nurse 1)

Another nurse said,

Regarding the culture, I had one patient whom I touched with my hand in order to insert a line. I was palpating the veins, but the patient's sitter told me to wear gloves on my hands because he said, "Our culture does not allow a female to touch a male." So therefore I should wear gloves. (Nurse 5)

### **LANGUAGE BARRIERS**

The semistructured interviews conducted with the nurses indicated that more than half the participants expressed difficulty in understanding the Arabic

language and had communication difficulties with patients. All of these participants specifically referred to this problem as a language barrier. The participants acknowledged the importance of language when they first started dealing directly with patients, and they associated the language barrier with their inability to provide proper care.

One of the participants in the focus groups revealed that

We cannot speak to family members because we cannot speak the same language. They would not take them off to even start some short communication and also it puts up a barrier between you and patient. (FG3 Nurse 2)

Another nurse made a comparison with her own country:

I think that in my country you and the patients can better understand each other because we have the same language, but here sometimes the language is a barrier. (Nurse 7)

### **PRAYER, FASTING, AND RAMADAN**

All of the nurses expressed the view that Muslim patients had to pray five times a day had a significant effect on their working routine and scheduling. More specifically, the nurses had to continuously adjust their working routine to accommodate prayers. This is expressed in the following statements:

Sometimes there is problem with time management, as sometimes the patients and their families are praying together, and it may take too long and we have to wait until they finish their prayer. (Nurse 4)

Also, here there is a prayer time and if you want to give some medication or treatment to the patients, or if they have an appointment, they will first ask you to allow them to pray before being prepared to go with you. So, once we have been here for a while with the patients, we become aware that there are specific times when the patients will be praying. We adjust our plans according to their times, so that we do not disturb the patients during prayer times. (Nurse 3)

Another thing that I understand and I respect is prayer. You know that you should respect prayer time, but sometimes you get patients who know the fact that there is an urgent procedure or they are waiting, but a lot of them say, "I want to pray." Then they will socialise for the whole time, because it is not really a prayer time. They call it prayer time because they want us to allow them some time before going. But once the trolley comes, they start to pray and it is difficult to know what to do. We are being asked why there is delay and all those things. This was my experience, and is really something that took me time to accept and to understand. (FG3 Nurse 1)

The nurses clearly felt that Ramadan had an impact on their working routine. First, during Ramadan patients are awake during the night and asleep during the day, which significantly changed the working routine, many patients did not want to take their medicine during daylight hours, and the non-Muslim nurses had to cover the Muslim nurses' shifts during this month. Ramadan was especially significant for the nurses when they first experienced it, and most of them were

surprised by how everything changed in that month. This is expressed in the following statements:

I know that in Ramadan the things are different as the patients normally stay awake and meet the visitors during evenings and nighttime, and they are sleepy most of the days, but we also change ourselves with this new routine and try to not interfere with the patients religious or other duties. (Nurse 4)

An important issue that had a direct impact on care was the timing for the administering of medicine. Many of the nurses clearly felt that Ramadan had a serious impact on this. Thus, if the patients were fasting, they would have to take their medicine early in the morning or at night. In addition, during this month of Ramadan, patients would be likely to be sleeping throughout the day because their families would only be visiting them at nighttime. One of the nurses commented on this issue:

During Ramadan, also some patients are fasting and it alters the treatment plan as we have to give morning medications early in the morning and other medications we have to give them in the evening after the patients break their fast. (Nurse 5)

## DISCUSSION

It was established that the nurses frequently confused religion and culture, which was understandable given the close link between the two (Ahmad & Dardas, 2015). Several themes emerged during the course of this study related to religion, culture, and language. Overall, it was found that religion and culture dominated the experience of nurses and were negative aspects of their experience of caring. These were followed by issues of language, which were also viewed as being a barrier to communication. Such barriers are considered an impediment in the provision of quality care (Alasad & Ahmad, 2005; Pino et al., 2013).

These findings are supported by several previous studies with similar outcomes, particularly in relation to the practical implications of caring for Muslim patients, cultural issues, respect for nurses and their beliefs, and issues relating to language (Halligan, 2006; Van Rooyen et al., 2010). This study also reveals that the nurses believe that they are acting professionally, which is reflected in the fact that they work to accommodate religious practical needs. They further saw themselves as being pragmatic in their approach to the difficulties they face. However, they demonstrate less concern for the spiritual needs of patients.

The study results indicated that to some extent, non-Muslim nurses understood the different aspects and practices of the Islamic religion (e.g., praying, fasting, and spirituality). However, they did not understand the importance of religion and spirituality to Muslims in general, and to patients in particular. Nurses did not perceive that the Muslim religion consists of faith and spiritual beliefs that assist patients in their reliance on Allah (God) to help them recover from illness. Religion and spirituality are important, not only for Muslims but also for other religions and faiths as well. For example, Ball, Armistead, and Austin (2003) demonstrate that the patients' involvement in religious activities decreased both morbidity and mortality.

The study results indicate that fasting in the month of Ramadan has an impact on the provision of health care because patients slept all day and were awake all night. According to the results of the interviews and focus groups conducted with the nurses, fasting essentially changed their routine and the timings and administering of medication. Many patients refused to take any medication during the day because they were fasting, and hence, it was necessary for nurses to work in shifts during Ramadan. The results also revealed that newly appointed nurses were more likely to face problems during Ramadan and were surprised by the events during that month. Similarly, a study conducted on Pakistani female patients found that physicians and nurses faced the difficult task of advising women about the safety of fasting during pregnancy (Mubeen, Henry, & Qureshi, 2012).

One of the subthemes that emerged from the data was the confusion made by the nurses between culture and religion. According to AlMutairi and McCarthy (2012), Saudi culture and health-related Islamic beliefs and practices are deeply interconnected. There was a clear indication in the findings that the nurses demonstrated understanding of certain aspects of the Islamic religion. Moreover, the literature establishes a strong interconnection between culture and religion (Ahmad & Dardas, 2015; Puchalski, 2013). For example, Arab culture focuses on cleanliness, modesty, and gender-specific needs. These beliefs exist in the Islamic religion because they inspire Muslims to clean themselves five times a day. All these aspects need to be considered when caring for Saudi patients and families.

Language issues not only affect care but also impede the nurses' ability to perform their duties. Communication was particularly important for the nurses to provide care. Communication between health care providers and patients and their families is consistently identified as the most important and least accomplished factor in quality of care (Bauman, Fardy, & Harris, 2003). The results of this study indicate that language was one of the main barriers to the provision of health care to Muslim patients because most non-Muslim nurses were unable to speak Arabic fluently. More than half the nurses who participated in this study reported difficulties when communicating with patients and relatives in the Arabic language. The nurses acknowledged the importance of language when they first started dealing directly with patients and associated this language barrier with their inability to provide proper care. The results of this study were consistent with the results of El-Gilany and Al-Wehady (2001), who emphasize in their own study that the language barrier was considered one of the main barriers to health care provision for Saudi patients in hospitals because of the vast majority of nurses being unable to speak Arabic.

### **IMPLICATIONS FOR PRACTICE**

It is important for expatriate nurses to understand religion of the patients, which plays a significant role in the lives and care of Muslim patients in KSA. Moreover, nurses should understand that their concept of professionalism should be readjusted to include the provision of culturally congruent care; by discounting religion and spirituality, their professionalism in a Saudi context is limited.



### IMPLICATIONS FOR EDUCATION AND TRAINING

Poor training and orientation that the nurses had led to unpreparedness for working in new environment such as the one in KSA. Thus, nurses felt that they lack the confidence to provide culturally competent care regardless of their educational background. However, the blame should not be placed on training and education that the nurses have received in their countries of origin. There is sufficient evidence in the literature that transcultural nursing holds a prominent position in nursing education, the problem lies in the fact that the nurses should have been trained for a Saudi-specific context and the training that they have received is not conducive to the Saudi context.

Moreover, this study has revealed many issues that need to be addressed in training and education particularly in relation to religious practical needs and spiritual needs. The study has shown that the nurses were blind to the fact that they had to be culturally competent and depended on what they described as their professionalism, and to fulfil the first stage of cultural competence, the nurses should be aware of themselves first.

Non-Muslim nurses should be made aware of the procedures and culture of the hospital. This study showed that the organizational culture in the hospital is different to that of other countries both in terms of attitudes toward nurses as well as operation issues such as liaising with social workers and translators.

### LIMITATIONS OF THE STUDY

It should be acknowledged that there were some limitations affecting this study. Although it was an interpretative study, it should be acknowledged that the researchers are Muslims, which means there could be a risk of bias. However, the researchers were aware of this issue throughout the interpretation of results. Moreover, the methodology was designed to reduce the impact of the researchers' position, as shown in the reliability and validity process.

### RECOMMENDATIONS FOR FUTURE RESEARCH

It is recommended to conduct research into either how the quality of training, education, and orientation has an impact on nurses' ability to provide culturally congruent care in KSA or to assess current standards of training, education, and orientation in hospitals in KSA, with a view to improving them and subsequently patient care. Future research could also focus on what constitutes professionalism for non-Muslim nurses working in KSA, with a view to discovering the extent to which cultural competency and culturally congruent care are considered part of a nurses' professionalism.

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Correspondence regarding this article should be directed to Muayyad M. Ahmad, PhD, RN, The University of Jordan, Clinical Nursing Department, Faculty of Nursing, Amman 11942, Jordan. E-mail: mma4@ju.edu.jo