

**Effective Collaborative Working between Nurses in a  
Multicultural Setting in Saudi Arabia: Barriers and  
Solutions**

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## List of Abbreviations

DNR	Do Not Resuscitate
EU	European Union
GCC	Gulf Cooperation Council
GNO	General Nurse Orientation

ICU	Intensive Care Unit
KFUH	King Fahad University Hospital
KSA	Kingdom of Saudi Arabia
MOH	Ministry of Health
NHS	National Health Service
OMH	Office of Minority Health
SBAR	Situation, Background, Assessment, Recommendation
UK	United Kingdom
US	United States
VIP	Very Important Person
WHO	World Health Organisation

## List of Conference Presentations

No.	Title and Contents
1	'Using IT to address issues arising from the deployment of a multinational nursing workforce'. SPARC 2015 Salford Postgraduate Annual Research Conference. United Kingdom- Salford.
2	'Effective Collaborative Working between Multi-cultural Nurses In Saudi Arabia: Barriers And Facilitators' SPARC 2017 - Salford Postgraduate Annual Research Conference. United Kingdom- Salford.
3	'Effective Collaborative Working between Multicultural Nurses in Saudi Arabia:

	Barriers and Solutions' 8 <sup>th</sup> PhD conference Hull University 2017. United Kingdom-Hull.
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## List of Conference/Symposium/Workshop Attendances

No.	Title and Contents
1	The Advances in Cases Study Research Methods workshop held at Manchester Metropolitan University, Manchester, the UK on April 5 <sup>th</sup> , 2017
2	Attended 'Methods Fair Symposium 2016', University of Manchester.

## List of Conference Proceedings

The ideas, development and writing up of all the papers in the thesis were, principally, my responsibility as the candidate working on the Degree of Doctor of Philosophy under the supervision of Professor Nick Hardiker, and Professor Alison Brettle.

No.	Publication title	Publication status
1	'Effective Collaborative Working between Multicultural Nurses in Saudi Arabia: Barriers and Solutions' in 8 <sup>th</sup> PhD conference Hull University 2017. United Kingdom- Hull.	Published in Conference Journals

2	'Effective Collaborative Working between Multi-cultural Nurses In Saudi Arabia: Barriers And Facilitators' SPARC 2017 - Salford Postgraduate Annual Research Conference. United Kingdom- Salford.	Published in Conference Journals
3	'Working effectively in a multicultural nursing environment: barrier and solutions' SPARC 2016 - Salford Postgraduate Annual Research Conference. United Kingdom- Salford	Published in Conference Journals
4	'Using IT to address issues arising from the deployment of a multinational nursing workforce'. SPARC 2015 Salford Postgraduate Annual Research Conference. United Kingdom- Salford.	Published in Conference Journals

### **Dedication**

*By the mercy and grace of God, the completion of this thesis has been made possible through the motivation and guidance of profoundly spiritual and intellectual people.*

*Primarily, I dedicate this work to the memory of the departed soul of my Father "Abdulaziz". I never forget his prayers and his love, which motivate me in going forward.*

*I dedicate my thesis to my mothers, Badriah and Haifa, for inspiring me throughout my life. I appreciate all their support and motivation. Their prayers and love led me to complete this thesis. I appreciate all their efforts, which have made me who I am.*

*Special thanks from the bottom of my heart to my husband Naif. He is the inspiration for my studying and my life. He gave me unconditional love and encouragement. He provided me with strength, courage, and determination to move through my PhD study. Being proud of me without applying any pressure, making the achievement less stressful and more of a pleasure. My dream came true due to his love and sacrifices, and this work is dedicated to him.*

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*I also dedicate this work to my sisters and brother, Khawlah, Khansaa, Abdullah and Rawan, and to my brother-in-law Majid, friend and colleague in the nursing field, for their support and inspiration in my study and my life.*

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## Glossary of Terms

There is no complete or exact definition for many of the terms used in this thesis. Preferred definitions and descriptions of keywords are offered below to assist understanding in the context of this thesis. However full discussions of the concepts are provided in Chapter Three.

**Collaborative:** “Mutual engagement of participants in a coordinated effort to solve a problem together,” (Roschelle and Teasley, as cited in Dillenbourg et al. (1995, p. 2))

**Culture:** Is multifaceted and includes knowledge, belief, fine art, ethics, law, tradition, as well as all skills and behaviours developed by society and its members (Tyler (British anthropologist) 1870, as cited in Avruch, 1998).

**Ethnicity:** Ethnic group and culture tend to be interchangeable. However, ethnicity refers to various sets of people who have the same language, history, beliefs, nations of origin, or culture (Spencer, 2012).

**Multicultural:** Involving individuals who have various beliefs and customs (Dictionary, 2017).

**Multiculturalism:** Refers to the philosophy, actions and guidelines that an organisation uses to manage diversity (Spencer & Taylor, 2004).

**Race:** The distinct and unique genetic or biological similarities between individuals that distinguish groups of people from each other. Nevertheless, the race has more political and social connotations than biological ones (Spencer, 2012).

**Transcultural:** “Equation formed when individuals of different cultures interact. It applies to any interaction between people of different cultural backgrounds and worldviews.” The importance of the transcultural paradigm is on “equal attention and respect to the culture of both parties in the interaction” (Gabb and McDermott, 2007, as cited in Wright & Van Der Watt, 2010, p. 216).

**Cultural competence:** A process that aims to foster culturally aware and effective practice, providing staff with detailed knowledge of other cultures, the skills to handle situations of

conflict and the respect for the differences between one's culture and that of the patient (Suh, 2004).

# **Abstract**

## **Research Aim**

The chief aim of this Saudi-based study is to provide an in-depth understanding of how nurses and nurse managers perceive culture and effective and ineffective collaborative working in a highly multicultural healthcare setting.

## **Methods**

A qualitative case study approach was used. Eighteen semi-structured interviews were conducted to better understand how nurses and nurse managers perceive culture and how this impacts effective and ineffective collaborative working in a large hospital in Riyadh in the Kingdom of Saudi Arabia (KSA).

A literature review guided the development of an interview schedule, underpinned by the Purnell Competence Model (Purnell, 2002). The results of all interview data were collected, transcribed, and analysed inductively and deductively.

## **Principal Findings**

Fourteen items in total from the in-depth semi-structured interview can help to identify the barriers and facilitators of multicultural nurses working together.

The Purnell Model proved its efficiency to be used for multicultural nurses' collaboration in a Saudi hospital, but a further three themes emerged beyond the Purnell Model of Cultural Competence to better describe the current case study.

## **Conclusions**

In order for optimal healthcare to be provided by multicultural nurses, it is essential that they collaborate effectively. This can be accomplished through appropriate practices, training, education, and research, as well as professional and self-awareness through cultural competence; publicising ethical guidelines and enacting regulation by the Ministry of Health in KSA.

## **Importance and Relevance**

This study is the first study to describe the barriers and facilitators of multicultural nurses working together in any context and specifically in a KSA context. There have been no studies into the barriers and facilitators in a Saudi context. Therefore, the academic contribution of this thesis will help to fill the gap in knowledge. A few studies have previously been conducted in Saudi Arabia, but these focus on barriers to nurse-patient relationships, rather than multicultural nurses working together.

The results of this thesis will inform the future multicultural nursing workforce collaboration strategies of the KSA Ministry of Health and ultimately impact on patient care through better working relationships.

# Chapter One

## 1.1 A Reflective Account of Learning through this Study

Being assistant head nurse at the King Fahd University Hospital with multicultural nurses workforce, and now a PhD candidate, all these factors have supported my role on my PhD journey. Studying abroad in a western country in a different language was acceptable, as I completed my Master's degree at the University of Salford. Adaptation to the weather and environment in the UK was a significant change in my life. Living with my husband in the UK was motivation and support for my life during the PhD process. On the other hand, it was stressful, as my husband was studying as well. Nevertheless, both of us tried to overcome the struggles of combining study with home life, as we shared the duties and responsibilities, in particular care during sickness. I think my experience in the PhD journey motivated me in a way to be more patient and confident. Further, it pushed my husband forward to think about higher education abroad.

The topic selection resulted from my interest in issues related to the multicultural nursing workforce. I believe that collaboration barriers and breakdown can be facilitated through provision of culture competence education to local and international nurses. This interest will motivate me to engage in postdoctoral work, to pilot and evaluate these results in practice. Additionally, reading literature regarding multicultural nursing workforce issues supported my selection of this topic.

Having reviewed and critically appraised the literature, I have enhanced my skills in literature searching, and those skills will improve my future role as a researcher.

Data collection started when I arrived in Saudi Arabia in March 2016. Ethical application and negotiation between the University of Salford and the Riyadh research centre took six months in total to obtain. After that, I began my data collection in one of the largest hospitals in Riyadh and

considered the multicultural nurses' environment, and I was an entirely external researcher with no previous agenda. It was an exciting and productive experience for me being in a wholly new environment and interviewing people from different cultures, beliefs, speaking different languages and so on, moreover looking in depth at the barriers and possible solutions.

Also, it was planned to conduct a quantitative survey depending on the outcome of the interviews, but it was decided with the advice of the supervisors and second year examiners not to follow the original plan, as the qualitative part was sufficiently saturated to answer the research question, and so phase two was excluded.

I was aware that considering the importance of the researcher's relationship to the participants would enhance the response rate, and I had an excellent mutual relationship with the nurse managers and the participants themselves. This was due to my skills I developed from working with multicultural nurses. In my study, I knew the participants, and their names were in the interviews, and so during data entry into Nvivo, they were coded. However, the conditions of confidentiality were explained to them and that their working situation would not be affected. Confidence is an essential issue to work through and maintain professional relationships during the research, while ensuring high levels of ethical integrity.

Accordingly, as a researcher, I have to update these competencies and develop an action plan and recommendations for evaluation in the post-doctoral period.

From a more individual perspective, through my involvement in the study, I have come to understand that research theory is at least equivalent to its application. Notably, through the process of learning and doctoral research, I have attended many courses, classes, programmes and workshops in the Manchester area, at the University of Salford, the University of Manchester, and Manchester Metropolitan University, to develop my skills and knowledge regarding research, ethics, research proposals, literature reviews, methodologies, research analysis and the location of relevant publications. I also attended courses at the University of



Salford to develop the personality and motivation necessary for successful study and research in the UK. I have also participated in many conferences in the United Kingdom, to present scientific research papers concerning the issue of effective collaboration in the context of a multicultural workforce. These can be found in the List of Conferences/Symposia/Workshop presentations and Attendances at the beginning of this thesis.

These experiences have enabled me to develop my personality, rigour and confidence, as well as to assist in my development as an open-minded researcher who feels comfortable in a wide range of locations and cultures and can work successfully within different research and teaching scenarios.

## **1.2 Introduction**

This thesis is concerned with the nursing workforce in the Kingdom of Saudi Arabia (KSA), where a survey of Saudi nurses working in the MOH revealed that there were 82,948 countrywide in 2012 (MOH, 2012). There is currently a deficiency of nurses in KSA, and, although the figures quoted by various authors differ slightly, according to Miligi and Selim (2014), there were 30% fewer nurses than required in KSA in 2010. This shortage has led to the call for many expatriates to work in the Saudi healthcare industry (Abdulhadi *et al.*, 2013; Jradi *et al.*, 2013). In 2009, the number of expatriates stood at almost 68% of all nurses working in Saudi Arabia, according to the Ministry of Health, and the number increased in 2011 to 71% of all nurses according to Almalki *et al* (2011).

Nurses from diverse cultural backgrounds came to work together in Saudi Arabia to cover the local nurse shortage, and every culture has its distinctive characteristics, such as language, attitude, values, and habits.

The cultural differences of nurses coming to work in the KSA can profoundly affect the collaboration between them. According to Adahl (2009), culture can impact the manner of interacting with people. The proposed research described in this document is needed to better understand how nurses and nurse managers perceive culture and its impact on effective and

ineffective collaborative working to support the future multicultural work in the hospitals of the KSA. I am a nursing professional from the KSA and have worked for six years in various intensive care units within the King Fahd University Hospital (KFUH). In 2006, I graduated from King Faisal University, Dammam, and joined the newly-founded general intensive care unit of KFUH as a staff nurse. My duties involved working with the charge nurse, arranging the shifts and holiday schedules of the staff, and looking after patients within a multicultural nursing workforce. I noticed issues arising within the organisation's structural function that appeared to be due to the multicultural nature of the workforce, such as the head nurse giving assignments according to staff nationalities and substantial salary differences between Asians with the lowest salaries, Western workers with the highest salaries among nurses, and Saudis in the middle, which compounded barriers and sometimes affected collaborative working. These issues motivated me to understand further what nurses need to help them work effectively and collaboratively.

The subject area was selected to carefully examine the wide diversity of social and language-based characteristics exhibited by the workforce involved in the nursing profession that works with the native and expatriate populations of the KSA. As will be shown, in the literature review, very few studies have focused on multicultural workforce issues within healthcare in the KSA.

This chapter reviews the Saudi Arabian context, the problem statement and the question resulting from the aim and objectives, in addition to the research rationale of the study.

### **1.3 Background**

In the KSA there is a recognised shortage of nurses, as well as a significant degree of turnover (Almalki *et al.*, 2011). According to Abu-Zinadah (2005), the shortage of Saudi nurses has been attributed to different factors, such as increased healthcare demands, advances in medical technology, increased population growth, increased life expectancy and the increased numbers of chronically and critically ill patients.

As a result, a notable portion of the nursing workforce in the country includes expatriate nurses, with Saudis making up approximately 29% of the entire nursing staff population. For Saudi

nurses in the private health sector, this figure is even lower, with local nursing making up only approximately 4% of the whole (Almalki *et al.*, 2011).

The impact of the nursing shortage in the KSA has proven to be a significant challenge for healthcare institutions, with qualified nurse turnover having certain implications for health organisations and the nursing population regarding addressing the requirements of the patient and facilitating primary-level healthcare (Hayes *et al.*, 2006). Importantly, negative impacts can be seen concerning the ability to fulfil the requirements of patients (Hayes *et al.*, 2006). The high turnover rate influences the confidence of both the existing and incoming nurses, as the current nurses' workload is increased by orienting new staff at the same time as providing patient care. At the same time, the new staff are trying to provide patient care while trying to understand a different system or way of working (Hayes *et al.*, 2006). Moreover, a study by Ingersoll *et al.* (2002) focuses on the reasons for nurses staying or resigning, and the job satisfaction levels. Ingersoll *et al.* (2002) emphasise that the reduction in the number of nurses also results in lower levels of morale and further augments stress levels among those remaining in their roles owing to increased workload pressure and obligations. As a result, this causes critical behavioural changes amongst nurses, causing low productivity and low work satisfaction, with nurses ultimately leaving their roles (De Gieter *et al.*, 2011; Rothrock *et al.*, 2007). Importantly, maintaining a positive and balanced atmosphere at work will affect nursing staff satisfaction, as well as lowering loss-of-staff numbers, improving work efficiency and quality and improving the healthcare provided (Almalki *et al.*, 2011).

Nurse shortage is a global rather than merely a Saudi issue; a discussion paper by the World Health Organisation (WHO)/International Council of Nurses in 2009 estimated the global nurse shortage to have been around 2 million in 2005, which is expected to rise to 2.8 million by 2015. This shortage is happening in all areas, but more so in Africa, South East Asia and the Eastern Mediterranean (Fry, 2011). Like many areas of the world, Saudi Arabia is challenged by a shortage in nursing. For example, the UK also has staff shortage problems, but perhaps with different contextual factors, e.g. ageing, transport, racial harassment and job dissatisfaction (Finlayson *et al.*, 2002; Shields and Wheatley Price, 2002). The discussion below considers the UK (western example) and Malaysia (another Islamic context) as examples of other multicultural countries with rich ethnicities that may create specific challenges. According to Likupe (2006),

in the UK, there is a considerable deficiency of qualified nurses. This shortage may be due to certain reasons such as the ageing of nursing staff on a national scale.

In the UK context, significant turnover rates have been considered in the work of Finlayson *et al.* (2002), who suggest that nurses are likely to move towards outer suburbs owing to the lower living expenses. Moreover, travel expenses, difficulties and time are also recognised as factors contributing to nurses wishing to work closer to home. Such obstacles are more visible in London owing to the concentration of teaching hospitals, and thus, higher living and accommodation expenses, with transportation and commuting also recognised as a further barrier. Furthermore, racial harassment has been reported between colleagues, leading to nursing shortages. According to the research conducted by Shields and Wheatley Price (2002) reveals that almost two out of every five staff considered an ethnic minority disclosed that they had suffered some form of racial harassment from colleagues, and over three out of five from members of the public. This harassment correlates with low job satisfaction levels, leading to a higher number of nurses who intend to leave the profession, according to the study.

One main issue facing acute trusts in the UK concerning both recruiting and retaining staff is low morale and job dissatisfaction, meaning that patient care is impacted (Janiszewski Goodin, 2003). Furthermore, it has been recognised that the requirement for nurses is commonly viewed as cyclical in nature, with the US, throughout history, acknowledging a variety of shortages of nurses, followed by surpluses, with the cycle resuming and replaying (Janiszewski Goodin, 2003).

In the specific context of Malaysia, as another example, a similar shortage has been impacted by certain different factors on both demand and supply. This issue may also be linked with a lack of funding in some areas, as well as student graduates not recognising the appeal of nursing as a career (Barnett, Namasivayam and Narudin, 2010).

Studies of multiculturalism in nursing, despite different contexts, are relevant to my research, because they are likely to highlight the range of potential issues that may occur in multicultural settings, even if the setting is not Saudi Arabia. Nursing shortages are a serious issue, as they can play a significant life-threatening role, which may compromise care. For example, within intensive care, many people suffering from critical conditions who arrive in the ICU are far less

likely to survive where there are nursing staff shortages (Arabi *et al.*, 2002). According to Tarnow-Mordi *et al.* (2000), the mortality rates in the UK's ICUs are directly correlated with staff availability; in particular, a lack of available nursing staff was blamed for a decline in patient care standards. Thus, by ensuring that a higher number of nurses are available, infant patients in critical care may have a higher chance of recovery from complications such as low birth weight or preterm delivery (Hamilton *et al.*, 2007). According to Goddard and Lees (2012), the increase in mortality rates in UK hospitals may be attributed to limited medical staff availability. Some organisations face difficulties in allocating specialised registered nurses during the weekend, which has led to a direct impact on increased mortality rates (Bray *et al.*, 2014). According to Aiken *et al.* (2014), the reduction of the nurse/bed ratio can have an adverse impact on the well-being of patients. If a nurse allocates just one more patient, the risk of a patient dying within one month of first being admitted increases by 7%. This figure decreased by 7% with each 10% increase in the availability of nurses (Aiken *et al.*, 2014). As a consequence, issues of nurse shortages need to be addressed, and thus, hospitals across the world are finding new ways to address the shortfall. One of these methods is to recruit from overseas. Recruitment of nurses from abroad to cover this deficiency may result in cultural conflicts between the locals and foreigners, which could hugely impair the collaborative work.

### **1.3.1 Saudi Arabian Context**

Even though the present study considers a multicultural environment, the research is based in the KSA, which represents the dominant context culture. The Saudi Arabian context will be discussed concerning culture and religion, gender and behaviours. Saudi Arabia is a Kingdom with an area of roughly 2,240,000 km<sup>2</sup>. Constituting around 70% of the whole of the Arabian Peninsula, it is one of the largest Arab nation in Asia. The overall population of Saudi Arabia is 27,136,997, a number that is inclusive of 8,429,401 expatriate and foreign individuals (following the Central Department of Statistics and Information census of Saudi Arabia, 2010).

#### **Culture and Religion**

The state asserts that, within the native population, 100% of its citizens are adherents of the religion of Islam. According to Long (2005), the KSA has a distinct culture, which is to a large

extent guided by the beliefs and values of Islam. This religion is a significant factor in this research, as Islam and culture may impact the participants' views or behaviours. Islamic morals shape all aspects of life, as well as the role of nurses in the KSA.

The KSA is the country that witnessed the birth of Islam, which is now one of the world's most prominent religions. It originated in an area in the KSA known as the "Land of Two Holy Mosques". The two most holy religious buildings in Islam are the Masjid-e-Nabwi mosque in Medina and the Masjid-al-Haram mosque in Makkah. Muslim pilgrims travel there each year from all over the world for Haj and Umrah, which make up two of Islam's five pillars (World Population Review, 2014). Muslim pilgrims coming to Saudi Arabia may increase the chance that they will need healthcare, and thus, increase the number of different nationalities that need to be accommodated in the Saudi system.

Saudi Arabia's socio-economic growth has taken place subject to Islamic religious beliefs (Littlewood & Yousuf, 2000). Furthermore, Islam guides Saudi culture. Also, Islamic laws (Sharia) have been formulated based on the Qur'an and prophetic customs, as stated by the Prophet Muhammad (Peace Be Upon Him) (WHO, 1978).

A consistent thread running through all aspects of Saudi Arabian society and the government is Sharia law. Sharia law is the justice system derived from Islamic teachings enshrined in the Holy Qur'an and the teachings and practices of the Prophet, known as the Sunnah (Vogel, 2000). Ijtihad, the application of Islamic thought to contemporary issues including societal, cultural and technological questions, is also influential, although the critique of Ijtihad practice suggests that jurists make pronouncements that are not directly informed by the Qur'an and Sunnah (Vogel, 2000). Certain Muslim scholars released '*fatwas*'<sup>1</sup> against radicals (Ziauddin, as cited in Modood, 2007); a fatwa or ijthihad can play a role in Saudi acceptance or refusal of socially new or different peoples and other cultures.

### **Culture and Gender**

In Saudi Arabia, gender separation is cultural and is compulsory through the Saudi authority structures. Saudi Arabian women still encounter many restrictions in daily life and need male

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<sup>1</sup> A judgment on an opinion of Islamic law agreed by a recognisable authority

family members to complete government papers on their behalf, provide surgery consent and sanction scholarship processes. These cultural factors may well play a role and compound barriers for nurses from other cultures in this research.

Across the KSA, marriage is recognised as an essential priority, with factors interfering with marriage taken very seriously, as noted by Batarfi (2005). In a study carried out in 2001, for example, 69% of male secondary school respondents stated that they would not marry a nurse, as nursing is not a desirable job for their future wife (El-Gilany and Al-Wehady, 2001). This could go some way towards explaining the high volume of single female nurses (37.8%). Also, the researchers further state that young Saudis of both genders select careers that will ensure proper levels of financial remuneration and high prestige. Almutairi and McCarthy (2012) argue that Saudi Arabian society is rigidly segregated to the extent that women are not permitted, among other things, to drive or cycle on public roads. There are demarcated male and female zones in public areas, and only families are allowed to occupy gender-neutral zones, which are also clearly demarcated. This gender demarcation is socially accepted and supported by the actions of the government (Almutairi and McCarthy, 2012). As gender segregation is accepted in Saudi culture, this may cause conflict for those from other cultures coming to work in the KSA.

### **Cultural Behaviour**

Saudi culture is influenced by the concepts of honour and shame; the two concepts have been present in Arabic culture for many years and remain highly significant and interrelated. Honour refers to an individual's standing, esteem and the ideals they are expected by their society to maintain (Maisel & Shoup, 2009). Honour and shame can play roles in this research. An example in a healthcare context could be where an ICU nurse made a medication error and chose to hide the incident to save their honour rather than be shamed. Honour and shame are also recognised as significant in Middle Eastern, Asian and Latin American cultures (Cerulo, 2008).

Hall (1989) divided culture into high and low contexts. This classification offers some understanding of the variance that exists between cultures. The central aspect of Hall's theory is 'context'. Among certain cultures, behaviours and communication are greatly impacted by context, whereas this is not the case in others. Culture is high in context when individuals involve themselves a great deal in each other's lives. The close relationships with one another

create a social ladder, where personal feelings are masked by self-discipline and information that is extensively passed on using essential communications with profound implications (Hall, 1989).

On the contrary, in low-context cultures, people are incredibly private and slightly isolated, and disjointed, and there is comparatively little connection with other people (Lee, Geistfeld & Stoel, 2007). High context culture characterises regions such as Asia, the Middle East (including the present Saudi context), Africa, and South America. The low context culture is common in the United Kingdom, United States of America, Germany, Switzerland, and the Scandinavian nations (Kim *et al.*, 1998).

In high context cultures such as Saudi Arabia, people communicate indirectly and rely on implied meanings that are fixed in the socio-cultural context. Hence, they make use of a mixture of verbal and non-verbal communications to deliver the correct meaning, using the verbal aspects to convey only a portion of the message (Samovar *et al.*, 2009). Notably, individuals who apply indirect communication tend to veer away from direct interactions, which may result in arguments. High context societies typically deal with conflict through passive resistance and using third parties or debating matters in private (Schein, 2010).

In contrast, the low context culture allows people to be more direct in their interaction, preferring to use more explicit communication styles. In such societies, the words can convey the entire meaning of the message. This style of communication is more context-free, with the emphasis resting mainly on the literal and precise meaning of the stated words (Gupta, 2011). People who use a more direct communication style discuss conflicts candidly, usually through face-to-face encounters, in the belief that such discussions will resolve the problem. As this study deals with the multicultural nursing workforce, the understanding of high and low context cultures is relevant to this discussion, because it helps explain the cultural differences that exist among people.

### **Culture and Violence**

In Saudi Arabia, aggressive or 'hot-tempered' behaviour towards others is not unusual, and people may lose their temper in public or toward health staff. This behaviour is a critical issue as



it may cause conflict and barriers relevant to this research. According to Algwaiz and Alghanim (2012), in Saudi Arabia, nurses are more likely than other professionals to be exposed to high-risk violent incidents. Respondents stated that shortages of staff, long waiting times and delaying patients' needs are the main reasons for aggressive behaviour. In other parts of the world, aggressive behaviour and crime have been linked to race and hence become the subject of public discussion, as well as overstated media coverage, according to Hall *et al.* (2013). If the Saudi public's view of the status of nurses is highlighted by the media, and for example, if a programme of zero tolerance is implemented, then it may be possible to improve how nurses are viewed, and thus, increase the number of nurses who are happy to continue working in the KSA.

### **Culture and Family Impact**

There is some suggestion that the nursing profession as a whole is not attractive enough to facilitate the recruitment of large numbers of male and female nurses owing to the social perception of nurses, the shift schedule and the salaries, among other factors.

Within Saudi culture, it is often preferred by nurses and their families' that the nurse works only in mornings and afternoons, which can pose problems for those nurses who are required to provide patients with 24/7 care (Tumulty, 2001). This has led to the increased recruitment of nurses from outside the Kingdom at a cost to the Ministry of Health (MOH). The government in Saudi Arabia is attempting to increase the involvement of Saudi Arabians in the labour workforce. Consequently, a 'Saudisation' initiative has been set up, which intends to substitute non-Saudi with skilled Saudi citizens. The Saudi government is boosting workplace training and pressuring the private sector to nationalise jobs (Alzalabani, 2002). Nonetheless, from the author's view and professional background, irrespective of such factors, more needs to be done, as it remains fundamental that young people across the KSA should be encouraged to consider nursing as a career through providing suitable education and affording financial and employment incentives. Also, media cooperation is essential to increase cultural awareness regarding the importance of nursing and its pivotal role in providing community care, as well as care to the population as a whole. This conveys Kress's (1988) understanding of the culture that is dynamic and based continuously in creating rather than being static and limited.

## **Labour Workforce and Culture Awareness**

During recent times, the KSA's Ministry of Health has directed much attention towards dealing with the shortage of nursing staff in the country. Although the number of nurses training in the KSA is increasing, the shortage of Saudi nurses throughout the country is still high, as there are still relatively few Saudi nationals interested in pursuing a nursing career (Al-Ahmadi, 2002). This situation is typical of all Gulf nations. For example, in the United Arab Emirates (UAE), local nurses represent merely 3% of the total number of nurses working in the health sector (El-Haddad, 2006).

In response to the nursing shortage, the KSA's MOH has been recruiting staff from abroad (Almalki *et al.*, 2011). Staff have been hired, for example, from Australia, Malaysia, the UK, South Africa, other Middle Eastern countries and North America (Aldossary, While and Barriball, 2008). As a result, non-nationals now constitute the majority (68%) of all nurses in Saudi Arabia, according to the Ministry of Health (2009). Such professionals enter the nation not understanding the culture of Saudi Arabia and Islam, which is crucial to understand the people and their cultural lifestyle, as well as their laws, politics, economy and general normative practice (Al-Yateem *et al.*, 2015; Sidumo *et al.*, 2010). Furthermore, they are likely to have different views, working backgrounds and notions compared to the Saudi men and women. This lack of awareness and differing perspective results in communication barriers and ultimately impacts patient services (El-Gilany and Al-Wehady, 2001). According to Almutairi and McCarthy (2012), Sharia law encompasses social life from the intensely personal, including the way of life at the home, bathroom and bedroom, to the public, including customary behaviour in matters of governance, finance, and fiscal policy and working life. Excepting financial issues and issues of governance, cultural artefacts possess both breadth and depth, while also constituting the symbols through which living in the social world is managed (Longhurst *et al.*, 2008). Demonstrating the many facets of the Saudi Arabian way of life and the way in which it is informed by Islamic faith to nurses from overseas is essential in promoting understanding and tolerance in society (Almutairi and McCarthy, 2012).

Matters of faith and religion have a real impact on patients' healthcare and treatment. In considering this subject, Almutairi and McCarthy (2012) point out that the tenets of Islam put

Muslim people's health to the fore and, although the Holy Qur'an is not in any way a medical textbook, it offers advice on maintaining physical condition. Religion can play an essential role in a Saudi culture that needs attention from the multicultural workforce.

As a way of life, Islam promotes healthy activities, including breastfeeding, abstinence, reflection and washing, and when Muslims become unwell, they are actively encouraged to employ medical means to become well again (Almutairi and McCarthy, 2012). Indeed, Islam does not conceive illness to be divine retribution, but rather a blessing through which absolution from Allah (Almighty God) for past wrongdoing may be obtained (Almutairi and McCarthy, 2012). For multicultural nurses working in Saudi Arabia, this cultural knowledge is beneficial.

Almutairi and McCarthy (2012) also note that, in pursuit of absolution for past wrongdoing and to secure Allah's blessing, unwell Muslims are encouraged to undertake beneficial actions including the making of charitable donations, praying and showing quiet perseverance. Saudi Arabian hospital attendees mainly benefit from the opportunity to pray in advance of medical treatment, as religious observance is highly central to their lives (Almutairi *et al.*, 2015). However, an expatriate nurse may have limited awareness of Islam and this aspect of Saudi culture, which could lead to a potential lack of understanding of this critical facet of Saudi life. This type of cultural awareness for non-Muslim staff can help them make sense of what staff need to know about their patients and Saudi hospital settings so as to avoid confusion. Expatriate professionals often come with limited awareness of Islam and Saudi culture, which determines all aspects of life in Saudi Arabia. The nurses' lack of awareness means that they may be delivering care inappropriately and according to their own cultural beliefs. Culture is an elusive and problematic concept, but through cultural awareness and the understanding of cultural differentiation, people from diverse origins and backgrounds can co-operate harmoniously (Almutairi and McCarthy, 2012).

### **Communication and Language Barriers**

Longhurst *et al.* (2008) state that the social and cultural settings are heavily influenced by language and communication. Within Saudi Arabia, the national language is Arabic, although English is taught as a compulsory second language within the Saudi education system. Despite this, the majority of Saudi Arabians are unable to speak English, particularly those who have not

attended a higher educational establishment. This can cause a real language barrier and communication breakdown between patients and staff, as well as between staff from different nationalities. Notably, El-Gilany and Al-Wehady (2001) argue that the language barrier can work as an obstacle to healthcare provision for Saudi people, as most of the nurses are expatriates who do not speak the Arabic language.

As a consequence, this can decrease the role that non-Arabic-speaking nurses can play in health education and reduces their ability to maintain excellent communication with patients, which is a critical element of the nursing role. In a phenomenological study conducted in Saudi Arabia by Halligan (2006), nurses in critical care faced barriers in communicating with patients due to differences in language, which caused a restriction in establishing an excellent patient-nurse relationship. In another qualitative study in Saudi Arabia by Aljadhey *et al.* (2014), communication barriers were also recognised between patients and healthcare providers from different backgrounds and were found to compromise the practices of medication safety.

When speakers in a conversation have an only partial understanding of each other's language or the lingua franca in which both are speaking, interactivity suffers as a result (Almutairi *et al.*, 2015). In a qualitative study conducted by Almutairi *et al.* (2015) to investigate the cultural competence of multicultural nurses towards patients working in Saudi hospitals, the nurses' fluency in Arabic was singularly poor or non-existent, which led to misunderstandings and detrimentally affected their ability to perform their duties. According to Abdulhadi *et al.* (2013), language barriers present a challenge to communication. Almutairi *et al.* (2015) describe an incident with an expatriate nurse whose native language was neither Arabic nor English. The nurse took exception to the words of an elderly male patient, which included the phrase 'ateeni futa', which in Arabic means 'towel'. In the nurse's native language, however, the word 'futa' is insulting, signifying 'prostitute'. The nurse was tearful and upset by what she believed the patient had said to her until the meaning that the patient was attempting to convey was explained to her (Almutairi *et al.*, 2015).

Accordingly, from the abovementioned issues, the author suggests that in order to reduce the negative impact of the notable nursing shortage and consequently enhance multicultural, collaborative working, healthcare entities need to study the factors that promote or impair

effective collaborative working by better understanding how nurses and nurse managers perceive culture and effective and ineffective collaboration.

#### **1.4 Problem Statement**

Over the past 25 years, considerable growth in the KSA concerning population and economic conditions has brought significant benefits to the economy. Saudi Arabia is one of the prominent countries that have made innovative changes in the healthcare sector in the past decade (Almalki *et al.* 2011). Concurrently, the country has also faced some problems with healthcare, including a shortage of local nursing staff and sound nursing practices (Miligi and Selim, 2014; Omer, 2005), arising from rigid gender roles inherent in Saudi Arabian society and the reluctance of Arabian people to take up careers in nursing and steeply rising population levels (Almutairi and McCarthy, 2012). To meet these increasing healthcare requirements, significant numbers of nurses from overseas have been recruited (Almutairi and McCarthy, 2012), resulting in nursing staff in most healthcare centres and hospitals differing with regard to culture, language, norms, tradition, knowledge and education.

The employment of nurses from culturally diverse backgrounds, concerning religion, language, norms and tradition, could affect health and patient care (Al-shahri, 2002), and this could either be directly through nurse-patient interactions or indirectly from interactions between healthcare staff from different cultural backgrounds. Therefore, the research problem is that cultural differences in a multicultural nursing workforce could undesirably impact the effectiveness of collaborative working between nurses in Saudi Arabia. Consequently, attention should be given to investigating and addressing the factors (facilitators and barriers) affecting multicultural, collaborative work within Saudi hospitals. A specialist hospital in Riyadh has been selected for this purpose.

#### **1.5 Research Question and Aim and Objectives**

The research question for this research is “what are the factors that promote or impair effective collaboration between nurses working in a highly multicultural healthcare setting”?

This study aims to provide an in-depth understanding of how nurses and nurse managers perceive culture and effective and ineffective collaborative working in a highly multicultural healthcare setting in Saudi Arabia.

The objectives include:

- 1) To understand the organisational structure/individual barriers that nurses have experienced when working within a multi-cultural setting in Saudi Arabia.
- 2) To understand the organisational structure/individual facilitators that nurses have experienced when working within a multi-cultural setting in Saudi Arabia.
- 3) To identify best practice provided by organisational structure regarding training, education and research to improve collaborative working between nurses.

## **1.6 Research Rationale**

Saudi families do not often allow women to enter the nursing profession, due to the consequential bad impression within society. Despite the long Islamic history of the nursing profession during the period of the Prophet Mohammad (PBUH), Saudi people still do not consider it a respectable profession for women (Miligi and Selim, 2014).

There is a shortage of nurses in Saudi Arabia, and to overcome this shortage, a large number of expatriate nurses have been recruited, resulting in a significant multicultural workforce that provides care in a particular cultural context with different beliefs and values. Expatriate nurses may lack an understanding of the cultural issues and be affected by language barriers, which results in potential difficulties for nurses working together and concerning patient care. Accordingly, there is a need to understand these barriers and seek solutions to overcome them.

## **1.7 Thesis Structure**

The following thesis consists of seven chapters, and the present section will provide a summary of each chapter's purpose, as well as outlining the content of the chapters completed.

The purpose of chapter one, the introduction chapter, is to provide a background to the research, the aim and objectives of the study and an overview of the thesis structure.

Chapter two presents a literature review to provide a rigorous, comprehensive and critical examination of studies relating to cultural diversity in healthcare contexts. The chapter concludes with a brief overview of the key findings in the existing literature and a discussion of how future research can address any gaps in the literature.

The purpose of the third chapter is to describe the theoretical framework used to support the research. Initially, theoretical elements and models of cultural competence are related and, following this, Purnell's Cultural Model is highlighted as a suitable method to guide the study of the multicultural nursing workforce in the Kingdom of Saudi Arabia.

The fourth chapter details the methodology, epistemology and ontology associated with a case study design. In addition to this, it presents a comprehensive account of the methods employed over the course of the research and analysis, and it explains the reasons specific choices were made. Chapter four also addresses the ethical issues associated with the study.

The results from the qualitative case study are presented in chapter five. The chapter also provides an account of the demographic features of respondents who took part in the semi-structured interviews that were used to collect the qualitative data.

Chapters six and seven provide a discussion of the results, recommendations and a conclusion. Chapter six begins by re-examining the study outcomes by comparing them with the research aims outlined at the beginning of the study. Following this, the limitations of the research are discussed, along with future suggestions for studies in the topic area. Chapter 7 presents concluding remarks relating to the investigation.

## **1.8 Summary**

The purpose of this chapter has been to introduce the research background and the Saudi Arabian context surrounding the study. The study aim, its proposed objectives, problem statement and the research rationale have been discussed. A comprehensive review of the existing literature should

be carried out for any proposed study as this allows the investigator to develop an intimate understanding of the topic. The next chapter will present an overview of the related literature.



# **Chapter Two: Literature Review**

## **2.1 Introduction**

The initial chapter in this thesis presented an overview of the Saudi context, which has led to nursing recruitment from outside the KSA to overcome a shortage of nurses in Saudi hospitals. This recruitment leads to variations in knowledge, culture, qualifications, education and language, which in turn can affect patient care and nursing practice (Al-shahri, 2002; El-Gilany and Al-Wehady, 2001; Almutairi *et al.*, 2015). The next chapter (chapter three) considers in detail the definitions, descriptions and discussion with regard to the key concepts in this thesis. This chapter seeks to offer a review of barriers and facilitators faced by multicultural nurses using a comprehensive review of current published academic texts as its foundation.

It begins with a description of the search strategy and the methods of the review. The barriers and facilitating factors as recognised in contemporary texts are discussed, and any gaps identified in the current understanding will be considered.

The chapter concludes with an overview of the main conclusions taken from the literature review and outlines the gaps in the literature that this research aims to fill.

## **2.2 Approach to Literature Review**

A literature review is defined as “the identification and analysis or review of the literature and information related to what is intended to be studied” (Kazdin, 2006, p. 480). Thus, this literature search sought to locate literature that examined barriers and facilitators to multicultural working, and whether this had been studied in a Saudi context, following the research aim and objectives.

The initial search was systematic and considered a range of study designs rather than a single design, which may be regarded as “high quality” such as an RCT, as although randomised, controlled trials are powerful tools, and RCTs cannot be used as reliable tools for ascertaining the understanding of any complicated operation. According to Grissmer *et al.* (2009), to follow an RCT methodology is to overlook the complicated socio-political and cultural dynamics instrumental in the onset of the failure of the system. Such intricate phenomena cannot be

encapsulated within a simplistic explanation. Canter (2012) points out that, rather than relying on an erroneous investigative tool such as RCT, there should be a drive for an alternative, comprehensive and scientifically valid approach, which can better account for the variables mentioned above. Such methods, for example, may include operations research, time-series explorations, case studies, surveys and other empirically based plans that have already proven to be highly useful in delineating the complexities of both individuals and societies. A wide range of study designs was therefore incorporated into the review.

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) organisation (Moher, Liberati, Tetzlaff, & Altman, 2009), which recommends systemic reviews and meta-analyses of the best practice strategies. The evaluation applied the PRISMA flow diagram, which was recognised to ensure that the systematic reviews were provided as precisely as possible. Moher et al. (2009; 2015) articulated the PRISMA statement, which facilitated authors to evaluate the benefits and weaknesses of a health care intervention, following the results of the systematic review. In view of the style in which systematic reviews are significantly useful in the context of health care owing to the effectiveness they offer concerning the preparation of clinical strategies and the achievement of data that fulfil the knowledge gaps (Moher et al., 2015), they produce a unique part in the context of healthcare (Shamseer et al., 2015). Shamseer et al. (2015) emphasise the degree to which systematic reviews are comprehensive and trustworthy is mostly determined by preparation and the application of a systematic method (namely, protocol). It is noteworthy that by extending the Preferred Items for Reporting Systematic Reviews and Meta-analyses (PRISMA) framework, a reporting guide for systematic review protocols has been articulated (Panic et al., 2013; Shamseer et al., 2015). The author will thoroughly draw on this in the current report. As noted by Shamseer et al. (2015, p. 5), the primary purpose of PRISMA is to simplify and direct the preparation of systematic review protocols and meta-analyses which assess the efficiency of useful tools. It will be meaningful to explain what we mean by protocol and, furthermore, to highlight that this paper considers the meaning in an extensive logic; namely, “as constituting a form of plan, prepared before the commencement of the systematic review. Which provides an account of the basis and intention of the review in combination with its methodological and analytical approach” (Khangura et al., 2014, p. 20). As stated by Shamseer et al. (2015) and Tricco et al. (2015), several aspects feed

into the importance of a systematic review protocol, and these will be defined in the next paragraph. First, a systematic review protocol guarantees that the researcher conducting the systematic review involves comprehensive preparation; accordingly, any related concerns or difficulties are anticipated. Second, the protocol helps the researcher's clear documentation of their aims before the beginning of the process of the review; due to this, readers might consider the protocol concerning the completed review. (Thus allowing them to conclude whether selective reporting has taken place), to repeat the review processes if needed, and to assess the level to which the designed methods were effective. Third, the protocol is valuable in allowing the researcher to avoid unplanned decision-making concerning the inclusion criteria and the extraction of data. Fourth, protocols are valued in limiting the researcher's repetition of methods and, on occasions where it is appropriate, improving collaborative practice. It is significant to acknowledge that when researchers involve in selective reporting too straightforwardly and possibly create the importance of results, this has serious consequences for healthcare choices and strategies. This is as the findings of the systematic review are what informed such decisions and policy. As highlighted by Khangura et al. (2014) and Shamseer et al. (2015), it is worthwhile to respect a critical function of systematic review protocols as relating to the part they produce as a documentation of organised review methods, results, and analyses that participants can consider in relation to completed reviewing, thus allowing them to define the amount to which unplanned and unrecorded modifications took place.

To facilitate the literature review process, a number of electronic databases covering a range of health and general perspectives were consulted, including:

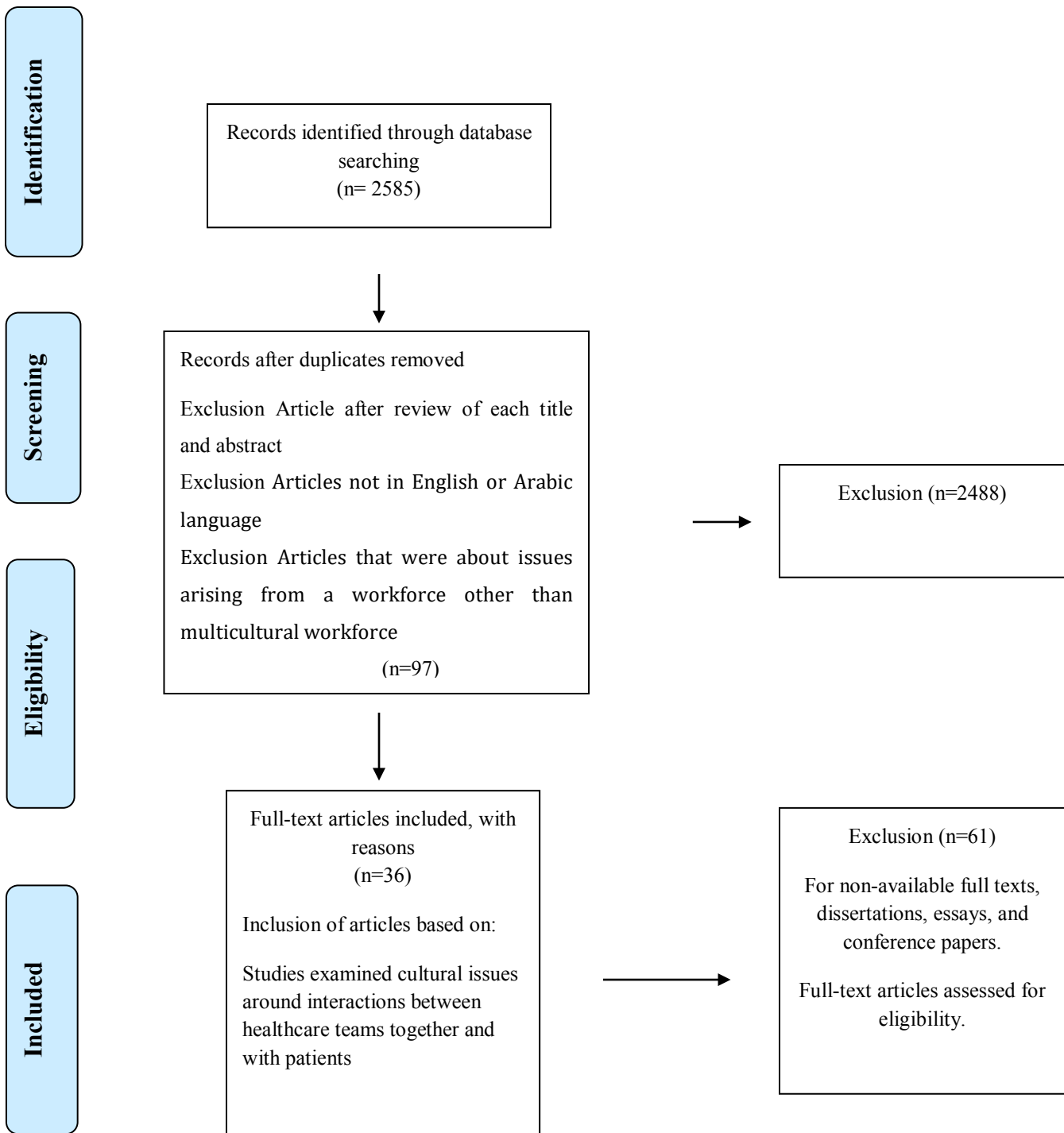
- CINAHL, since this database provides a large number and diversity of scholarly articles (full-text) related to medical care and professional nurses.
- MEDLINE, a resource of international cited papers and abstracts in the field of biomedicine.
- Academic Search Premier, a superior collection of digital assets reflecting a diversity of significant studies from a range of disciplines.

- Science Direct, a prominent and all-encompassing information bank holding research papers of over 26,000 books and 2,500 journals.
- Google Scholar.

Searches were carried out using combinations of the keywords shown in Table 1. The search strategy is shown as a flow diagram of databases, keywords and the inclusion criteria.

**Table 1: Search Strategy**

Keywords	Sources Searched	Result	Relevant	Inclusion criteria & exclusion criteria	
<b>1</b> Multicultural* Ethnic groups Ethnic minority Cultural differences Cultural diversity Cultural competence Cultural assessment Globalisation, globali?tion <b>(Combined with OR)</b>	CINAHL	<i>Initial: 1,419</i>	36 Articles	English studies.  Studies that focused on the issues arising from a multinational workforce.  Exclude reports, essays and assignment papers.	
		Relevant: 8			
	Medline	<i>Initial: 351</i>			
		Relevant: 6			
	Academic Search Premier	<i>Initial: 345</i>			
		Relevant: 7			
	Science Direct	<i>Initial: 69</i>			
		Relevant: 7			
	<b>2</b> Mobile nursing workforce Foreign nurses Immigrant* Race factors Migrant nurses Workforce Manpower Human resources Interprofessional relations Nursing management Nursing practice Personnel management Personnel recruitment <b>(Combined with OR)</b> <b>Then combine 1&amp;2 with AND</b>	Google Scholar			<i>Initial: 401</i>
					Relevant: 8



*Figure 1: PRISMA flow diagram of search strategies' process*

The research parameters applied by PRISMA flow Diagram (Moher *et al.*, 2009). (See Figure 1: PRISMA flow diagram of search strategies' process). All search results were carefully screened for eligibility based on the criteria explained above. Initially, 2,585 sources were found. The list of articles obtained was subjected to further refinement according to the review of each article title and abstract to limit the relevant studies from the original range. Due to the lack of relevance or duplication, some articles were eliminated, which minimised the number of reviews to 97. Using the research aims and objectives to guide the inclusion or exclusion of articles, the final number of papers included was 36 (see Table 1). The results from all databases are presented in Table 2. Studies were considered to be relevant if they were written in English or Arabic, as the author speaks both of these languages fluently, while the focus should be on the multicultural workforce and should have population samples with diverse work team backgrounds.

A narrative approach was employed to synthesise the findings of the literature review, and this was supplemented with support or discussion from other studies that did not meet the inclusion criteria, but were relevant to the study context and concepts: Longhurst *et al.*, 2008; Ingram, 2012; Jeffreys, 2015; Leininger, 2002; Tang *et al.*, 1999. Akechi *et al.*, 2013; Goffman, 1959; Hall, 1989; Abdelkerim and Grace, 2012; McGilton *et al.*, 2006; Nordby, 2006; Steinberg, 2007; Kim *et al.*, 2008; McLeod, 2008; Rask *et al.*, 2009.

**Table 2: Summary of Literature Synthesis**

Author(s), place and date	Title of the paper	Methodology	Findings	Strengths	Limitations
Alexis, Vydellingum & Robbins  2007  UK	Engaging with a new reality: experiences of overseas minority ethnic nurses in the NHS.	Qualitative phenomenological study includes four focus groups of 24 nurses	Several overseas nurses felt devalued and indicated that white UK nurses appeared to place little trust in them. They stated that both discrimination and lack of equal opportunity were present in the workplace, and they also revealed that some white UK nurses were sometimes abusive. As a result, they tolerated such behaviour for fear of being thrown out with their families. Despite such negative experiences, participants indicated that the experience gained whilst	Clear presentation of findings and rigorous discussion.	No specific limitations found.

			working in the NHS was useful.		
Almutairi et al., 2015 KSA	Understanding cultural competence in a multicultural nursing workforce: registered nurses' experience in Saudi Arabia.	Qualitative study: semi-structured interviews of 24 non-Saudi Arabian nurses	Nurses within this culturally diverse environment struggled with the notion of cultural competence in terms of each other's cultural expectations and those of the dominant Saudi culture.	Appropriate method as it achieved the aim of the study.	No official numbers for multicultural nursing workforce
Bernstein et al., 2002 USA	Trained medical interpreters in the emergency department: effects on services, subsequent charges and follow-up	Descriptive study: quantitative Review of medical charts of 500 emergency department visits	Use of trained interpreters was associated with increased intensity of emergency departments' services, lower emergency department return rate, increased clinic utilization and lower 30-day charges, without any simultaneous increase in cost of visit.	Method potentially applicable to the aims of the present study	No specific limitations found
Boi, S. 2000 UK	Nurses' experiences in caring for patients from different cultural backgrounds	Qualitative research design: exploratory semi-structured interviews of seven nurses	A recurrent issue raised was the problem of the language barrier, exacerbated by a lack of knowledge of the patients' culture. Holistic care was not, therefore, possible, so participants felt they were unable to deliver a high standard of care.	Real evidence of the need to increase the knowledge of patients' culture	Cannot generalise the results due to the place of data collection; sample size may affect the results.
Carrasquillo et al., 1999 USA	Impact of language barriers on patient satisfaction in an emergency department	Quantitative study: Cross-sectional survey of self-administered questionnaire of 2,333 patients	Using an overall measure of patient satisfaction, only 52% of non-English-speaking patients were satisfied as compared with 71% of English speakers ( $p < .01$ ). Among non-English speakers, 14% said they would not return to the same ED if they had another problem requiring emergency care as compared with 9.5% of English speakers ( $p < .05$ ).	High response rate  Sample is large.	No specific limitations found.
Cioffi, 2003 Australia	Communicating with culturally and linguistically diverse patients in an acute care setting: nurses' experiences	Qualitative descriptive study interview of 23 registered nurses and midwives	Main findings were: interpreters, bilingual health workers and combinations of different strategies were used to communicate with culturally and linguistically diverse patients; some nurses showed empathy, respect and a willingness to make an effort in the communication process, with others showing an ethno-	Appropriate study design and data collection	No limitations found



			centric orientation.		
Clayton et al., 2016  Australia	Perioperative nurses' experiences of communication in a multicultural operating theatre: A qualitative study	Qualitative semi-structured interviews of 14 operating nurses	Difficulties in communication emerged as the major theme. Difficulties in communication affected patient care and the working atmosphere. In addition, social integration appeared to improve communication.	Appropriate design and method.  Well justified discussion of findings	Possibility of bias
Coffman 2004 USA	Cultural care in nursing practice: a meta-synthesis of qualitative research	Qualitative research: Meta synthesis literature review of 13 articles	The themes include: (a) connecting with the client, (b) cultural discovery, (c) the patient in context, (d) in their world, not mine, (e) road blocks, and (f) the cultural lens.	Suitable methodology as it focuses on the purpose of the study	No limitations found
Cortis, J. D. 2000  England (UK)	Perceptions and experiences of nursing care: a study of Pakistani (Urdu) communities in the United Kingdom.	Grounded theory: focus groups and semi-structured interviews of 30 males and 25 females	Nurses were perceived to have a poor understanding of ethnic needs, portraying ethnocentric attitudes and behaviour. The participants mainly attributed the lack of congruence to the presence of racism in British healthcare systems.	Clear data findings with discussion	Particular study groups without data about other groups.
Cortis, J. D. 2004  UK	Meeting the needs of minority ethnic patients	Qualitative study: Semi-structured interviews of 30 registered nurses	Interviewees had difficulty in explaining the meaning of culture and spirituality and their relationship to nursing practice. They also had limited understanding of the Pakistani community, and deficits were identified in meeting the challenges offered by this community. Inadequate implementation of 'holism', poor preparation to meet the needs of an ethnically diverse society and the presence of racism in practice settings emerged as explanations for the deficits participants identified between their expectations and the reality in care settings.	Appropriate  Sampling and design	Particular study groups without data about other groups.
Del Pino, Soriano and Higginbottom, 2013	Sociocultural and linguistic boundaries influencing intercultural communication between nurses and Moroccan patients in southern Spain: a focused	A focused ethnography including semi-structured interviews of 32 nurses	A substantial language barrier seems to negatively affect communication. Relations between the nurses and their Moroccan patients are also marked by prejudice and social stereotypes which probably	Suitable method used.	Possibility of bias

Spain	ethnography		compromise the provision of culturally appropriate care.		
Divi et al., 2007  USA	Language proficiency and adverse events in US hospitals: a pilot study.	Adverse event data on English speaking patients and patients with limited English proficiency were collected from six hospitals over seven months in 2005 and classified using the National Quality Forum-endorsed Patient Safety Event Taxonomy.	Adverse events that affected limited English-proficiency patients were also more likely to be the result of communication errors (52.4%) than adverse events for English-speaking patients (35.9%).	Clear discussion of the results and how they impact on the health outcomes of patients	Cannot generalise the results due to the place of data collection; sample size may affect the results.
Dywili et al.,  2012  Australia, Canada, New Zealand, the UK and the USA	Experience of overseas trained health professionals in rural and remote areas of destination countries: A literature review.	A systematic literature-review search of 17 original report articles	Overseas-trained health professionals were expected to have appropriate professional and cultural skills, while they themselves expected recognition of their previous experience and adequate organisational orientation and support. A welcoming and accepting community coupled with a relaxed rural lifestyle and the joy of continued patient care resulted in successful integration and contributed to increased staff-retention rates.	Appropriate method	No limitations found
Eckhardt, Mott and Andrew,  2006  USA	Culture and communication: identifying and overcoming barriers in caring for non-English-speaking German patients	Qualitative study interviews of six older German women	Communication affected by language barriers	Method potentially valid for the aims of the present study	Sample only comprised females
Elderkin-et al.,  2001  USA	When nurses double as interpreters: a study of Spanish-speaking patients in a US primary-care setting	Qualitative approach: cross-sectional study  Video recordings of 21 Spanish-speaking patients	Errors frequently occur in interpretations provided by untrained nurse-interpreters during cross-language encounters, so complaints from many non-English-speaking patients are misunderstood by their physicians.	The method is fit for purpose	No limitations found
Esmail & Everington,	Racial discrimination against doctors from	A retrospective study, a pilot study of 46	Only the English candidate was selected or, when both were selected, the Asian candidate	Important evidence of discrimination	Inappropriate ethical

1993  UK	ethnic minorities	doctors' applications	was never accepted unless the English candidate also accepted too.	against doctors from ethnic minorities	consideration  Possibility of bias
Flores et al.,  2003  USA	Errors in medical interpretation and their potential clinical consequences in pediatric encounters	Audiotaping of 13 clinical encounters with Spanish interpreters	Errors of clinical consequence included:  1) Omitting questions about drug allergies; 2) omitting instructions on the dose, frequency, and duration of antibiotics and rehydration fluids; 3) hydrocortisone cream must be applied to the entire body, instead of only to facial rashes; 4) instructing a mother not to answer personal questions; 5) omitting to mention that a child was already swabbed for a stool culture; and 6) instructing a mother to put amoxicillin in both ears for the treatment of otitis media.	Clear discussion and explanation of the results.	Sample size relatively small  Limited to pediatric encounters and Spanish language
Gerrish, K.,  2001  UK	The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carers	Ethnographic case-study approach, in-depth interviews of eight managers and a review of policy documentation  A participant observation undertaken focusing on six district nursing teams.  Purposive sampling	The observed language barriers suggested that the content of advice on matters such as compliance with treatment regimes might not be fully understood. Psychological support for patients and carers was severely restricted. Moreover, the fact that follow-up visits were on occasion made to patients for whom there was no one available to interpret constrained the ongoing assessment of patients' needs.	Appropriate method	Possibility of bias
Halligan, P.,  2006  KSA	Caring for patients of Islamic denomination: Critical care nurses' experiences in Saudi Arabia	Qualitative research design: unstructured phenomenological interviews of six nurses	The results indicated the importance of the role of family and religion in providing care. In the process of caring, the participants felt stressed and frustrated and they all experienced emotional labour. Communicating with patients and families was a constant battle and this acted as a further stressor in meeting the needs of patients.	Clear presentation of methodology, findings and rigorous discussion.	Sample was only females

Hampers et al.,  1999  USA	Language barriers and resource utilization in a pediatric emergency department	Prospective cohort study, quantitative test of 2,467 patients	The presence of a language barriers accounted for a \$38 increase in charges for testing and a 20-minute longer emergency-department stay.	Appropriate method as it reflected the aim of the study.	Caution in generalizing its findings due to a single area hospital for data collection
Henry, L.,  2007  UK	Institutionalized disadvantage: older Ghanaian nurses' and midwives' reflections on career progression and stagnation in the NHS	Qualitative semi-structured interviews of 20 Ghanaian nurses	Ghanaian nurses and midwives can experience difficulty in progressing into senior positions because of cultural differences and gaps in knowledge. Informal system of promotion to management, which is not transparent.	The method is suitable for purpose	Confused presentation of findings
Hoye and Severinsson,  2008  Norway	Intensive care nurses' encounters with multicultural families in Norway: an exploratory study	Qualitative focus group of 16 ICU nurses	The theme 'Cultural diversity and workplace stressors' emerged. This theme was characterised by four categories: 'impact on work patterns'; 'communication challenges'; 'responses to crises'; 'professional status and gender issues'	Research steps well justified	Focus-group method impaired free association
Jarrett and Payne,  2000  Australia	Creating and maintaining 'optimism' in cancer-care communication	Interviews with nurses and patients about their communication experiences and audio-recorded conversations were collected and analysed: 50 participants (patients n= 26, nurses n = 22, relatives n= 2).	This research indicates that both patient and nurse are active in communication construction and argues that the optimistic cheerful nature of nurse-patient interaction may be better viewed as a jointly produced institutional feature of cancer care.	Sampling is large.	No specific limitations found.
Jones,  2008  UK	Emergency nurses' caring experiences with Mexican-American patients	Qualitative study including unstructured interviews of five Caucasian emergency nurses	The language barrier affected all aspects of care. A participant who spoke Spanish at a limited level was the only one to describe the establishment of a nurse-patient relationship.	Clear data findings with discussion	The use of a single geographic location.  Possibility of bias.  Sample size relatively small

Kim, S. R.  1998  Canada	Nurses' descriptions of caring for culturally diverse clients	Qualitative study, interviews of eight nurses	Nurses' commitment to caring for culturally diverse clients varies, ranging from "resistant" through "generalist" to "impassioned." Contextual factors include the healthcare setting, the support of colleagues, the institutional climate, the foundation of education and the presence of racism.	Appropriate method as it reflected the aim of the study.	No specific limitations
Kwate et al.,  2003  USA	Experiences of racist events are associated with negative health consequences for African-American women	Quantitative study: questionnaires of 71 African-American women	Correlational analyses revealed that past-year and lifetime racism were both related to psychological distress. Among smokers and drinkers, past-year racism was positively correlated with number of cigarettes and drinks consumed. Lifetime racism was negatively related to perceived health, and positively related to lifetime history of physical disease and frequency of recent common colds.	Suitable questionnaire as it contains the major items that affect women who have experienced racism	Sample was only females
Marrone, S.,  2008  USA	Factors that influence critical-care nurses' intentions to provide culturally congruent care to Arab Muslims	Quantitative study: descriptive correlational study design. Self-report questionnaires of 208 critical-care nurses	Significant relationships among critical-care nurses' behavioural beliefs, normative beliefs, control beliefs, intentions and demographic variables supported the need for culture-specific debriefing sessions, underscored the importance of collaborative practice and interdisciplinary learning models, and established an evidence-based foundation for the design of culturally-informed approaches to nursing education and service.	High response rate.	No specific limitations
McKinley, D. & Blackford, J.,  2001  Australia	Nurses' experiences of caring for culturally and linguistically diverse families when their child dies	Focus group interviews of six PICU nurses	Nurses' use of controlling practices to ensure families conformed to established routines and values of PICU staff.	Clear research process and data gathering	Possibility of bias.  Sample size relatively small
Murphy, K. &	Nurses' experiences of caring for ethnic	Qualitative in-depth interviews of 18	Difficulties in communication with clients and a lack of	Clear presentation of	No specific

Clark, J. M.,  1993  UK	minority clients	registered nurses	knowledge about cultural differences were highlighted by all respondents The lack of holistic care and the inability to develop a therapeutic relationship were identified as major areas of frustration and stress	findings and rigorous discussion	limitations
Nielsen, B. & Birkelund, R.,  2009  Denmark	Minority ethnic patients in the Danish healthcare system – a qualitative study of nurses' experiences when meeting ethnic-minority patients.	A phenomenological qualitative study. Interviews of four nurses and observation	The study showed three phenomena experienced by nurses: 'problems in communication', 'patients' level of pain' and 'patients' food'. The results indicate that nurses need resources, such as more support in dealing with patients with a minority ethnic background to give care	Important experiences of nurses when meeting ethnic-minority patients.	Small sample size, only female  Use of a single hospital
Omeri, A. & Atkins, K.  2002  Southeast Australia	Lived experiences of immigrant nurses in New South Wales, Australia: searching for meaning.	Phenomenological approach, open-ended interviews of five nurses	Existence of social and cultural distance between nurses from the dominant culture and nurses from culturally and linguistically diverse backgrounds.	Important evidence of the experiences between nurses from the dominant culture and nurses from culturally and diverse backgrounds.	Sample size relatively small
Shields and Wheatley Price,  2002  UK	Determinants of racial harassment in the workplace: evidence from the British nursing profession	Quantitative questionnaires and random sampling of 91 NHS nurses	Nurses who are young, male or from ethnic minorities are most likely to be affected	Good presentation of results	No limitations found.
Vydelingum, V.,  2006  England (UK)	Nurses' experiences of caring for South Asian minority ethnic patients in a general hospital in England.	Ethnographic study: focus-group interviews of 43 members from six wards	Data analysis revealed eight themes: changes in service provision; false consciousness of equity; limited cultural knowledge; victim blaming; valuing of relatives; denial of racism; ethnocentrism; self-disclosure.	Appropriate design, appropriate method.  Data collection and analysis well justified	Possible sampling bias

Wilson, D. W. 2007 Louisiana	From their own voices: lived experiences of African-American registered nurses	Phenomenological study, semi-structured interviews and a focus group of 13 African-American registered nurses	Findings revealed that general perception among participants was that they were not fully accepted as equal professionals by their Caucasian nurse colleagues, other healthcare providers and sometimes patients.	Method is fit for purpose	No specific limitations found
Xu, 2007 Western countries	Strangers in strange lands: a metasynthesis of lived experiences of immigrant Asian nurses working in Western countries.	Metasynthesis conducted on 14 studies	Four overarching themes emerged: (a) communication as a daunting challenge; (b) differences in nursing practice; (c) marginalization, discrimination and exploitation; and (d) cultural differences.	Important evidence of the experiences of immigrant Asian nurses working in Western countries	No specific limitations found
Yi & Jezewski, 2000 USA	Korean nurses' adjustment to hospitals in the USA	Grounded theory, semi-structured interviews, a purposive sample of 12 Korean nurses	Adjustment to USA hospitals as the basic social psychological process. Five categories comprised the process: (1) relieving psychological stress; (2) overcoming the language barrier; (3) accepting USA nursing practices; (4) adopting the styles of USA problem-solving strategies; and (5) adopting the styles of USA interpersonal relationships	Suitable design and clear description of findings	Knowledge of researchers by participants could bias responses

### Appraisal and quality review of the studies included

The literature will be analysed and critiqued in order to understand the issues arising from multicultural nurses. A systematic approach to quality assessment was adopted to appraise each study against the same criteria facilitating comparative analysis and the scrutiny of study rigour and quality. All included studies were subject to critical appraisal evaluation tools developed by the Health Care Practice Research and Development Unit (HCPRDU) (Long et al., 2002), which were used to assess and critically appraise these research papers. These tools comprise a template of central questions to help evaluate the quality of quantitative, qualitative and mixed methods research studies. Table 2 covers the strengths and limitations of each of the studies.

The quality of the available literature is discussed within four key areas: study aims, sample, method and results, and these are considered below.

## **Study aims**

The aims of the (36) studies overlapped with the experiences of nurses caring for patients from different ethnic groups and nurses working in different cultures.

Summary details of the works referenced can be found in Table 2. Each of these articles was studied and some key themes emerged, as outlined in the following sections. After summarising and appraising the articles, it was decided that research referring to the experiences of multicultural nursing workforces and issues arising on account of cultural diversity within a collaborative work environment would be included in this review chapter. The works referenced focus on the situation in different contexts and locations at varying stages of economic development.

## **Sample**

The study samples were drawn from nurses, patients and physicians from different ethnic group to achieve the study aims outlined above. (29) Studies with nurse samples (11) included nurses from different ethnic backgrounds (Alexis, Vydelingum & Robbins, 2007; Almutairi et al., 2015; Clayton et al., 2016; Coffman, 2004; Dywili et al., 2012; Henry, L. 2007; Omeri, A. & Atkins, K., 2002; Shields and Wheatley Price, 2002; Wilson, D. W., 2007; Xu, 2007; Yi & Jezewski, 2000) and (18) local nurses caring for patients from different ethnic groups as a distinct sample (Boi, S., 2000; Cioffi, 2003; Cortis, J. D., 2000; Cortis, J. D., 2004; Del Pino, Soriano and Higginbottom, 2013; Elderkin et al., 2001; Flores, et al., 2003; Gerrish, K., 2001; Halligan, P., 2006; Hampers et al., 1999; Hoyer and Severinsson, 2008; Jones, 2008; Kim, S. R., 1998; Marrone, S., 2008; McKinley, D. & Blackford, J., 2001; Murphy, K. & Clark, J. M., 1993; Nielsen, B. & Birkelund, R., 2009; Vydelingum, V., 2006) in order to examine the interaction between nurses together and with patients that affect health outcomes within the hospital setting.

The last seven studies used samples comprising other than nurses. (2) Studies included review charts (Bernstein et al., 2002; Divi et al., 2007), (3) studies had patient samples (Divi et al., 2007; Eckhardt, Mott and Andrew, 2006; Kwate et al., 2003), one study included doctors' applications for jobs with foreign names (Esmail & Everington, 1993) and one study included nurse and



patient samples (Jarrett and Payne, 2000).

Some of these studies seem not to be very relevant to the present study sample, due to the combinations of samples with patients, doctors and chart reviews within the hospital setting. An implication of this is that it would be difficult to put into practice issues resulting from these studies without considering the opinions of multicultural nurses.

The number of research participants sampled within the research studies ranged from four to 2,467. Within the qualitative studies (25), the sample sizes were considerably smaller, ranging from four (Nielsen, B. & Birkelund, R., 2009) to 55 (Cortis, J. D., 2000). The sample sizes in the quantitative studies ranged from 2,467 (Hampers et al., 1999) to 46 (Esmail & Everington, 1993). These sample sizes were acceptable according to the methodology; as stated by Creswell (2007), qualitative studies tend to use a smaller sample, however, four nurse interviews was considered a very small sample but due to its study relevancy and the contribution it can make it was included, while quantitative studies draw on large numbers of participants.

## **Method**

Both quantitative and qualitative studies have to obtain ethical approval from a recognised ethical committee, such as a university or hospital, as stated by Cohen, Manion & Morrison (2013). All the studies addressed issues related to ethics clearly, through participant consent forms supported by ethical approval from an organisation. Specific data-collection tools varied considerably, however.

Twenty-five studies used qualitative approaches. One of them used a focus group and interviews (Cortis, J. D., 2000) and four of them used focus groups to collect data (Alexis, Vydelingum & Robbins, 2007; Hoyer and Severinsson, 2008; McKinley, D., & Blackford, J., 2001; Vydelingum, V., 2006), while the remaining 20 used interviews (Almutairi et al., 2015; Boi, S., 2000; Cioffi, 2003; Clayton et al., 2016; Cortis, J. D., 2004; Del Pino, Soriano and Higginbottom, 2013; Eckhardt, Mott and Andrew, 2006; Elderkin et al., 2001; Flores et al., 2003; Gerrish, K., 2001; Halligan, P., 2006; Henry, L., 2007; Jarrett and Payne, 2000; Jones, 2008; Kim, S. R., 1998; Murphy, K. & Clark, J. M., 1993; Nielsen, B. & Birkelund, R., 2009; Omeri, A. & Atkins, K., 2002; Wilson, D. W., 2007; Yi & Jezewski, 2000). The selection of

methodology and research tools is dependent upon the objective of the studies. For example, Vydelingum, V. (2006) aimed to explore nurses' experience of looking after South Asian clients. This was suited to a focus-group discussion, as was Hoyer and Severinsson's (2008) study of intensive care nurses' encounters with multicultural families in Norway: an exploratory study. Therefore, the participants can give their opinions of ICU nurses' perceptions of multicultural families via focus groups through interaction and discussion.

Semi-structured interviews were the tool used to explore notions of cultural competence with non-Saudi Arabian nurses working in a major hospital in Saudi Arabia (Almutairi et al., 2015), three (3) studies used systematic literature reviews (Coffman, 2004; Dywili et al., 2012; Xu, 2007). Eight (8) studies used quantitative approaches during data-collection procedures (Bernstein et al., 2002; Carrasquillo et al., 1999; Divi et al., 2007; Esmail & Everington, 1993; Hampers et al., 1999; Kwate et al., 2003; Marrone, S., 2008; Shields and Wheatley Price, 2002). All these studies conducted data collection via survey questionnaires and two of them reviewed charts and reports; however, the aims and participants varied.

## **Results**

The main results of the (36) studies identified that multicultural nurses had issues working together and caring for patients from different ethnic groups.

Some of the findings from the literature review are arranged in themes drawn from the Purnell Model of Culture Competence (see Chapter 3). And some new themes emerged.

The themes highlight the barriers and problems faced by healthcare workers with colleagues and patients concerning issues of cultural diversity and its impact on the delivery of care, and these will highlight the limitations of existing studies as regards justifying the relevance and necessity of current research. The majority of studies examined cultural issues around interactions between healthcare teams and patients. This study included two qualitative studies from the KSA, three qualitative and five quantitative studies from the USA, one qualitative research from Denmark, one qualitative study from Norway, three qualitative studies from Australia, one qualitative study from Spain and one qualitative study from Canada. A small number of studies examined

interactions between nurses, including one systematic review from Western countries, two qualitative studies from the USA and two qualitative studies from the UK. Several studies examined interactions between both, i.e. interactions between nurses or between nurses and patients, including two qualitative studies from Australia, one quantitative study from the UK and one systematic review (of Western studies). Two studies examined institutional issues: one qualitative study from the USA and one retrospective study from the UK (see Table 2). The above clearly addresses a gap for the subject under research.

## **2.3 Findings from the Literature Review**

The principal issues are discussed in the following sections, within the context of cultural diversity among workers. The international studies identified looked at topics both between nurses and between nurses and patients, while the Saudi studies looked only at the interaction between nurses and Saudi patients.

### **2.3.1 Spirituality, Including Religious Practices**

A lack of familiarity with other religions can limit the extent to which a nurse can effectively collaborate with others, particularly regarding religious beliefs and practices. For instance, Cortis (2004) discusses issues such as the gender difference between nurses and patients, the patients' need to pray and for privacy, patients' halal food requirements, and stereotyping experienced in the UK by nurses attempting to treat patients who originate from Pakistan. Many of these nurses are mostly unfamiliar with Pakistani culture and religious beliefs, particularly concerning Islamic traditions and social norms, which leads to a stressful relationship that may affect the collaboration between the patients and healthcare provider and barriers to meeting the patient's needs. In contrast, several of the interview respondents in Vydellingum's (2006) ethnographic qualitative study from the UK displayed a familiarity with cultural diversity and an ability to respect the cultural traditions of their patients, particularly regarding religious beliefs and religious festivals. Consequently, it is vital that healthcare professionals working with patients who celebrate these festivals comprehend their significance. Even though it may take time and work to become competent in dealing with patients from different cultural backgrounds, it is

necessary for healthcare workers to demonstrate sensitivity and respect towards the belief systems and values of others so as to improve the collaborative care between them. Those were the only studies found about religion, and they concerned nurses understanding the religious beliefs of patients.

### **2.3.2 Nutrition, Including Having Adequate Food**

It is common for conflict in the provision of healthcare to be caused by conflicting belief systems, values or moral codes, including food, for example, staff members imposing their food values on others and ignoring the importance of the cultural significance that diet can play. A phenomenological study conducted by Nielsen and Birkelund (2009) found that most of the nurse participants would not agree to accept food prepared by relatives for patients due to its strong smell, which they found annoying. Another example would be when a nurse is knowledgeable about different cultures but lacks the confidence to implement this knowledge, and so they may administer insulin to a patient and then offer them food that their culture prohibits them from consuming (Jeffreys, 2015). Thus, this is a case of indirect negligence, as the patient will not consume the food and the provision of more appropriate food will delay their treatment.

In effect, the outcome of the patient's treatment will be jeopardised through any form of negligence. The patient may also experience anxiety on account of this cultural error, which can have a negative impact on their metabolism and insulin requirements (Jeffreys, 2015). According to Longhurst *et al.* (2008), perceptions of food demonstrate the understanding that people have about individual and collective identities.

Nevertheless, from the author's point of view, the provision of culturally appropriate food is fundamental, as it represents a source of nutrition, as well as adhering to the patient's social or cultural background to facilitate the collaborative relationship. Indeed, food is a vital component of the healing process. According to Leininger (2002), a nurse is better placed to provide effective and appropriate care if they are familiar with a patient's cultural beliefs and practices. Nutrition can often be related to a person's culture. This belief can be explored by analysing the cultural significance of being hungry and having an appetite, as the former is an instinctive signifier of a need from the body, while the latter is a desire emanating from the mind. Hence,

hunger is physiological and natural, while appetite is psychological and cultural (Longhurst *et al.*, 2008).

### **2.3.3 Cultural Knowledge**

A lack of cultural awareness can prevent a nursing professional from offering effective care to patients and can cause them to offend the patient or jeopardise their treatment. According to Lampley, Little, Beck-Little and Xu (2008), some practices may be appropriate in one culture and utterly unacceptable in another. In effect, while it is essential to demonstrate a caring attitude towards patients, it is necessary to ensure that a nurse's actions are not perceived as inappropriate or offensive in other cultures. Longhurst *et al.* (2008) note that, in many social settings, the behaviour of an individual is to some extent formed by the norms and conceptualisations that emerge from their expectations of co-operation with their peers within the context.

Halligan (2006) discovered that all nursing actions in the provision of care must be deemed appropriate in various cultures, and it is imperative that nurses demonstrate cultural sensitivity, especially when a patient or a patient's family is in a state of anxiety.

Cultural diversity can also cause confusion or misunderstandings if a nurse interprets the actions of others based on their cultural norms. Vydelingum (2006) performed an ethnographic study on the experiences of nurses in the UK and discovered that confusion often arises due to an absence of intercultural familiarity. Based on the data generated from interviews and focus group sessions, many nurses showed signs of cultural insensitivity, as they complained about Asian women refusing to undress and refusing to be treated by male healthcare workers. Similar feelings can be prompted by the removal of clothing; in some cultures, even in hospital settings, it is singularly improper for women to undress in the presence of men, whereas elsewhere it is not an issue. Tang *et al.* (1999) argue that the significant influences of culture and family are affecting Asian women's decisions not to perform Pap smear screening tests, unlike Caucasian white women, who are significantly more likely to have the tests.

Also, Vydelingum's (2006) study highlights that some nurses voiced their concern over the number of people that came to visit these patients while they were admitted and revealed that confusion often arose when male Asian patients refused to maintain eye contact. According to Akechi *et al.* (2013), a lack of eye contact displays respect in many Asian cultures but can be

confusing for Westerners who associate eye contact with trustworthiness and communication (Akechi *et al.*, 2013). Misunderstandings also occur if a patient does not maintain eye contact throughout a conversation, as it appears that they have no interest in what is being discussed. However, this mannerism may be a cultural characteristic, as many cultures dictate that people should avoid making eye contact with their superiors, which is a social norm that would prevent a patient from maintaining eye contact with a nurse (Ingram, 2012). In some cultures, eye contact and tone of voice are influenced and modified according to a person's social status.

As observed by Goffman (1959), the social standing of individuals influences how they interact with other people. For example, individuals adjust their behaviour and tone of voice according to their perceived social status.

### **2.3.4 Family Roles and Organisation**

Nurses also experience issues on account of a patient's family, although the nature of these experiences varies widely. In many cultures, the family can be integral to a patient's treatment and recovery, as family members offer a high degree of assurance and support (Coffman, 2004). The study by Coffman performed a meta-synthesis of qualitative research and found that a patient's family could play a significant role in the treatment process, mainly when the patient does not speak English. In effect, a family member who has a better understanding of the English language can provide background information on the patient that may be useful in determining the most appropriate course of action. Moreover, by allowing the family to play an active role in patient care, a stronger sense of trust can be built between the nurse, the patient and his/her immediate family. Thus, in Coffman's (2004) study, nurses perceived cultural awareness as the ability to adapt to the patient's cultural requirements. However, some other studies highlight family as a source of high contention among nurses, as they perceive excessive familial interference as a hindrance to the provision of care (Halligan, 2006; Nielsen and Birkelund, 2009; Vydellingum, 2000). These attitudes can be explained by a lack of cultural knowledge in realising the fundamental role of the family in the treatment and recovery of patients from diverse cultural backgrounds.

McKinley and Blackford (2001) also highlight the impact of limited cultural knowledge on the provision of appropriate care through analysis of the experiences of nurses in Australia, who

dealt with children from different cultures who did not have long to live. Generally speaking, the nurses in the ICU would comfort the family members and invite them to help take care of the patient in an attempt to provide assurance and reduce stress. Nonetheless, although taking part in the effective care of a patient was common practice, being invited to take part in the decision-making process concerning treatment plans was considered inappropriate by those from different cultures. A similar study was performed by Hoye and Severinsson (2008), who discovered that the anxiety or stress of the patient and his/her family had an adverse effect on the nurse's ability to provide appropriate care. In fact, many nurses were unfamiliar with how different cultures expressed their sadness and found it difficult to understand the behaviour of people from different cultures in times of distress, which would lead to barriers between them being reflected in the effectiveness of their collaborative relationship.

### **2.3.5 Workforce Issues**

These are the main studies found that looked at multicultural issues from a nursing not patients perspective. Studies have shown that nurses often use the same nursing practices that are used in their country of origin, regardless of the cultural context in which they are working. For instance, a study by Yi and Jezewski (2000) discovered that South Korean nurses struggle to adapt to nursing standards in the US, as it is perfectly acceptable in South Korea to have a patient's family members participate in the day-to-day care of those who are ill. Thus, when Korean nurses begin working in the US, they are annoyed by the fact that they have to perform all of these duties themselves. In Western countries, the nurse is responsible for all of the patient's needs during their treatment. A meta-synthesis performed by Xu (2007) draws a similar conclusion, as nurses from Asian countries reported difficulty in adjusting to Western standards of practice. For instance, Xu (2007) reveals that while Western nurses operate independently, Korean nurses are more accustomed to a common approach to patient care, as a patient's family members are expected to participate. Xu (2007) also highlights the differences in perspective on the role of the nurse, because Asian nurses prioritise the medical treatment of the patient, whereas Western nurses perceive their role as being more holistic.

In general, nurses who move between cultures and change their country of work need to be aware of the cultural differences in treatment and expectation. For instance, the narrative of

many expatriate nurses express emotions such as worry and alienation arising due to their unfamiliarity with Saudi Arabian culture and being unsure about what is expected of them. These feelings do not diminish even after long periods during which they can become assimilated or at least attain some degree of familiarisation (Almutairi *et al.*, 2015). One participant nurse in the study by Almutairi *et al.* (2015) reported surprise at the behaviour of people visiting hospital patients who behaved as if they were at home, and did not understand the necessity of respecting visiting times, disregarding the hospital rules.

### **2.3.6 Workplace Injustice**

The impact of negative attitudes that conflict with those of people from different cultural backgrounds must be considered, as prejudicial perceptions of those who are of a different race, colour or religion can have a severe effect on the outcome of a patient's treatment (Hunt, 2007). In fact, both nursing professionals and patients can display these negative attitudes. Unfortunately, racist beliefs permeate the classifications of human 'races', as shown through the development by anthropologists during the 19<sup>th</sup> century, as these classifications presented Europeans as the pinnacle of the evolutionary hierarchy, followed by Orientals and Africans at a more inferior level (Longhurst *et al.*, 2008). This is to say 'race' refers to people who are non-white and denotes cultural 'difference' (Pickering, 2004: p.91).

Eventually, when applied to social structure and divisions within a given society, racism takes on the role of a sovereign ideology (Longhurst *et al.*, 2008).

Several studies have been performed to investigate the impact of attitude on the provision of care based on the experiences of nurses, which can at times be affected by changes in culture or racism. However, it has been shown by Longhurst *et al.* (2008) that there is a close correlation between culture and conflict in studies on 'race' (a social construct) and racism.

These studies cover a wide range of contexts, as they examine the issue based on the experiences of African-American nurses working in Western countries (Wilson, 2007), immigrant nurses operating in New South Wales (Omeri & Atkins, 2002) and Ghanaian nurses and midwives (Henry, 2007). The studies below have found that the attitude of the nurse determines whether or not a patient is provided with appropriate care based on their unique cultural requirements. Most notably, based on the findings of these studies, the experiences of nurses vary considerably.



Qualitative research performed by Kim (1998) analysed the experiences of eight newly qualified nurses in caring for patients from different cultural backgrounds. Based on the findings, some of those questioned perceived cultural diversity as an inconvenience, with many simply disregarding the cultural needs of different patients and attributing their unusual characteristics to their culture as opposed to their personality. However, of those who did not perceive cultural diversity as a hindrance, nurses offered a standard level of care to all patients and demonstrated a commitment to providing care that was appropriate to the cultural origins of each patient. In effect, these nurses emphasised the need to exercise respect towards those from different cultures and deemed it essential to the provision of adequate care. Thus, although the nurses were mostly unfamiliar with the various cultural ethnicities of patients, they were eager to learn more about diverse cultures so that they could offer all of their patients the highest standards of care.

Variations in the attitudes of nurses were identified in a study performed by Marrone (2008), which implies that many nurses fail to realise the significance of diverse cultural needs and the impact of cultural diversity on the outcome of patient treatment. Within this research, many respondents signified that they did not have the required education, acquaintance and resource base or administrative facilities to administer care that would be sensitive to the particular needs of an Islamic and Arabic population.

Specific studies highlight that racism, both direct and indirect, is a severe issue in many clinical environments. The prevalence of such prejudicial attitudes can jeopardise patient treatment and exacerbate their condition. For instance, Cortis (2000) discovered that nurses in the UK discriminate against patients from Pakistan and this negative attitude limits their ability to interact appropriately with the patient. Worse still, patients from Pakistan revealed that nurses even display their prejudicial attitudes through non-verbal means. Hence, Asian patients are often subject to racial discrimination by healthcare staff, and this has an adverse impact on their treatment and wellbeing.

Of those questioned in the study carried out by Cortis (2000), many Pakistani patients believe that nurses should be the ones to implement change and to challenge any instances of discrimination on behalf of other patients. Nevertheless, this is not the case in many hospitals, as nurses are often racist towards patients from different cultural backgrounds. Consequently, to

eliminate institutional/organisational and individual discrimination, Cortis (2000) recommends that anti-racism strategies must be implemented at all levels of a healthcare organisation. As the respondents of this study represent an ethnic minority, a similar study could be performed in a different country or context where the nurses represent the cultural minority.

In general, the media plays a significant role in drawing attention to these particular issues, often assisting in dividing society by colour, religion and ethnicity, which has an impact on the social interaction between different people, as mentioned by Longhurst *et al.* (2008). Therefore, stereotypical portrayals of black and ethnic minorities still exist in modern-day mass media, despite not being so openly prevalent in modern times.

These negative attitudes are also experienced by healthcare workers from minority cultures. Indeed it was demonstrated as being common before the 1968 Race Associations regulation (National Audit Office, 2008), when ethnic minority employees steered away from the furthest suitable job positions with discrimination coming from other employees and managers (National Audit Office, 2008). Moreover, nurses who originate from different cultural backgrounds are subject to racism, discrimination and abuse on account of their heritage, and will often struggle to be included in team activities and have their opinions and ideas taken seriously by their colleagues (Alexis, Vydellingum and Robbins, 2007; Almutairi *et al.*, 2015; Esmail and Everington, 1993; Wilson, 2007). For example, Almutairi *et al.* (2015) reported the observations from one participant that Filipinos are typically regarded with contempt by Saudi people and other nationalities, and unjustly characterised as being uneducated and unintelligent, as well as perceived as working in countries such as Saudi Arabia purely for financial gain. Thus, these individuals will be treated differently from other nationalities that are viewed in a better light. Similarly, a small-scale study from the UK carried out by Esmail and Everington (1993) showed that the British doctors with overseas sounding names were less likely to be nominated for senior jobs than others, but as these nominations are secret, the discrimination is not made public. Since this is personal, it means that in most situations little or nothing can be done to prove discrimination and no extent of Race Associations or Race Fairness regulation will make any difference.

According to Wilson (2007), these negative attitudes can have an adverse impact on the mental health of minority healthcare workers. The works cited below contain evidence derived from a diverse range of cultural settings, including the UK, the US and Australia, which discuss the prevalence of prejudicial attitudes within different cultural contexts.

Furthermore, all of these studies highlight the adverse effects that negative attitudes can have on patient outcomes and the mental health of nurses. Shields and Wheatley Price (2002) surveyed the UK healthcare system and discovered that nurses from minority groups are subject to prejudicial treatment by colleagues, patients and visitors to the clinic. Furthermore, it found that African nurses are more likely to experience workplace racism than Asian nurses. In fact, nurses from different cultural backgrounds with better qualifications are more likely to suffer discrimination in comparison to other minority group members of staff. According to Wilson (2007), the requirements, skills or competence of a nursing professional have minimal impact on the likelihood of them experiencing racism in the workplace. A study by Alexis, Vydelingum and Robbins (2007) drew similar conclusions, as they discovered that nurses from minority groups are subject to direct and indirect racism, mainly when they are continually overlooked for promotion. Also, their colleagues rarely value these nurses, and they often show poor organisational commitment, which may naturally have a negative impact on collaborative work and the quality of care they provide to patients.

According to Abdelkerim and Grace (2012), racial prejudice can have a detrimental impact on those exposed to it, and the outcomes of the studies cited indicate that inequity and discrimination can jeopardise a nurse's career prospects (Henry, 2007; Shields and Wheatley Price, 2002). Furthermore, these studies suggest that hospital managers rarely take action against instances of discrimination in the workplace. Based on a quantitative survey performed by Omeri and Atkins (2002) in Australia, nurses from minority groups feel isolated in the workplace on account of their prejudicial treatment by both colleagues and patients.

Prejudicial attitudes and discrimination can have a detrimental effect on the standard of care provided by nurses and can cause anxiety or depression in those affected. In fact, a nurse may develop psychological issues on account of discrimination and their altered mental state will diminish their competence in caring for patients. A study by Kwate *et al.* (2003) substantiates

this stance, as the authors investigated the impact of racism on 71 African-American women. The findings indicate that those who are subject to discrimination in the workplace typically experience more stress and anxiety, consume more alcohol and cigarettes, as well as suffering from weakened immune systems. In other words, Kwate *et al.* (2003) believe that discrimination causes many of the victims to suffer from deteriorating health. However, the findings of the study by Kwate *et al.* (2003) cannot be considered generalisable, as all respondents were African-American women who had been recruited from the same cancer-screening clinic.

Based on the works cited above, it is clear that racism and inequity in the workplace encroach upon an individual's right to equality and fairness. Indeed, Almutairi *et al.* (2015) argue that the diminution of the effects of cultural conflict through the understanding and appreciation of cultural differences can result in practical, beneficial outcomes in patient care in health organisations. Moreover, according to Hunt (2007), fundamental human rights proclaim that each has the right to have their religion, belief system and values respected by others and the right to form part of an integrated workforce where people's attributes such as race, gender, religion, language or nationality have no bearing on a person's ability to do their job.

If nurses experience discrimination or abuse in the workplace, this may affect their ability to collaborate efficiently and provide adequate care to patients, as the negative attitudes of co-workers cause them to grow increasingly anxious and insecure. French and Swain (2008) note that research overwhelmingly concurs that prejudice and unfair treatment on the grounds of social, gender and ethnic differences produce outcomes that are characteristically disempowering for those who are subject to discrimination. Therefore, Spencer (2014) believe that race and ethnicity terms, similar to other cultural terminologies that are essential to social identity, are specifically complicated to describe. Individual researchers and survey users may insist on splitting the terms and consider race as a remarkably different classification grounded on physical and neutral differentiations, indicating nature-culture divided amongst the two terms. Nevertheless, Longhurst *et al.* (2008) conclude that modernity in the contexts of social mixing and life-acquired knowledge could remove barriers engendered by ethnic origin, birthplace, location, social status, belief and politics, and in doing so could bring about the coalescence of humanity.

### **2.3.7 Communication**

Some studies have greatly emphasised the need for effective communication between patients and nurses, and have referred to it as a fundamental aspect of healthcare standards and positive patient outcomes (Clayton, Isaacs and Ellender, 2016; McGilton, Irwin-Robinson, Boscart and Spanjevic, 2006; Murphy and Clark, 1993; Nordby, 2006). Besides, there is a higher chance of misunderstanding if the nurse and patient have different mother tongues. According to Steinberg (2007), communication involves sending and receiving of messages, while each party involved must fully comprehend the meaning of these messages in order for them to communicate effectively. In fact, various forms of communication are frequently used simultaneously. For example, while talking (speech), an individual may gesticulate with his/her hands and make different facial expressions (visual) and may wear clothing that also articulates a specific meaning (written). Nevertheless, the way meaning is conveyed differs according to the channel through which the message is expressed (Longhurst *et al.*, 2008). Although modern places focus on visible media, the primary methods of delivery remain the spoken and written word (Longhurst *et al.*, 2008).

#### **2.3.7.1 Language Barriers**

Patients from low social classes who have received low levels of education may struggle to communicate effectively with healthcare staff. Previously, the correlations between social class, language and speech have been comprehensively addressed in the prominent research of the sociologist Basil Bernstein (1924-2000). The Bernstein (2002) arguments proposed to demonstrate that the failed education of young individuals had a significant impact on the structure and application of educational policies and practices in both the UK and the US during the 1960s, which could then create separations between individual groups through the form of learnt and accustomed language use. The basic concept extended by Bernstein was that people belonging to the English lower class used a less sophisticated style than the upper classes (Bernstein, 2004). Thus, language can ultimately create division between class levels, which can then lead to failings within professional communication, such as in healthcare.

In a qualitative study of experiences of care for multicultural patients conducted with nurses working in medical units in a large hospital in the UK, Murphy and Clarke (1993) discuss the

impact of language barriers on the relationships that are cultivated between nurses and their patients and reveal that nurses become exasperated when looking after patients from different cultures, as they struggle to communicate with the patient and describe to them the cause and treatment of their illness. Nonetheless, the nurses questioned described some measures that could be taken to circumvent linguistic issues, including non-verbal communication techniques and a patient attitude when discussing treatment options with the patient. These measures also help nurses to cultivate a trusting relationship with patients under their care.

As an outcome of this language barrier, many nurses have difficulty understanding the patient on an emotional level and can only assist in treating their physical ailments.

Ineffective communication between a nurse and their patient is a standard issue experienced in multicultural societies and may have an adverse result of the outcome of patient care. For example, if the nurse and patient do not speak a common language, the nurse may struggle to understand the patient when they are describing the location or intensity of pain. Similarly, nurses often have difficulty explaining treatment options to the patient and informing them of the healthcare or counselling services that are available to them (Murphy and Clarke, 1993).

Hampers *et al.* (1999) drew similar conclusions when they conducted a cohort study to investigate the impact of language barriers on effective resource usage in the emergency department of a paediatric clinic in the US. The findings generated by that specific study revealed that patients with limited English language skills typically have higher healthcare bills, as they are required to spend longer in hospital care and are subject to more cost-intensive procedures.

From a practical perspective, the study by Hampers *et al.* (1999) proposes that language barriers increase the rates of admission, the quantities of intravenous fluids required and the likelihood of invasive or cost-intensive procedures performed. The performance of invasive procedures is attributable to the fact that medical practitioners may struggle to make a definitive diagnosis if they cannot effectively communicate with the patient concerning their symptoms and health status. In effect, linguistic barriers typically cause an increase in resource requirements and patients with minimal English language skills often require emergency treatment more often than out-patients or preventative care services (Hampers *et al.*, 1999).

However, communication barriers in the process of seeking treatment can also adversely affect patients, as they may struggle to understand their diagnosis, their treatment or their aftercare advice (Hampers *et al.*, 1999). It is critical to ensure that all patients receive care of the highest standard, as those who experience issues on account of language barriers may be reluctant to seek help in the future for any health problems they may have. Hence, some studies have been performed to investigate the extent to which non-native speakers are satisfied with their medical care. A cross-sectional study was conducted by Carrasquillo *et al.* (1999), which examined the satisfaction rates of 2,333 non-English speakers treated at one of five hospitals in the US. The findings show that patients who do not speak the local language are less satisfied with their hospital experience and are unlikely to return in the future. The primary cause of this level of dissatisfaction is the linguistic barrier between the patient and healthcare workers.

Jarrett and Payne (2000) investigated this issue using evidence derived from nurse experiences in an oncology department. Moreover, using data gathered from interviews with healthcare workers, the authors explored the importance of communication between nurses and their patients, which revealed that people living with cancer with a limited level of English are often unhappy with the quality of their treatment and fail to establish a trusting relationship with those responsible for their care. Similarly, Bernstein (2002) came to a similar conclusion through those questioned as part of his study, as they felt that the language barrier had a detrimental effect on the standard of care they are given. A further survey by Cioffi (2003) found that nurses also use a range of alternative measures, including the use of body language, sign language and illustrations. Nonetheless, according to Longhurst *et al.* (2008), verbal and written communication is seen as being more critical than non-verbal cues such as body language. Unfortunately, although these strategies may help nurses communicate information to their patients, there is just no way of knowing for sure whether the patient has accurately understood what they have been told. In effect, the quality of patient care cannot be guaranteed unless the information can be communicated linguistically (Cioffi, 2003). A study performed by Flores *et al.* (2003) revealed that patients who are mostly unfamiliar with the English language, in a country where English is the official language, demonstrate a greater tendency to discharge themselves regardless of medical advice, alongside misusing medicine and ignoring follow-up appointments. As patients who speak English as a first language do not experience these adverse

outcomes to the same extent, it is clear that language barriers pose severe distress to the patient-nurse relationship and impair effective collaborative care. According to the findings generated by Eckhardt, Mott and Andrew (2006), based on their analysis of six elderly German women who sought medical treatment in Australia, patients with limited English have trouble understanding their diagnosis, their treatment and their pain relief instructions. Language barriers can also increase patient anxiety if the patient is unsure of their health status when being treated by healthcare workers (Eckhardt, Mott and Andrew, 2006). As a result, patients are often unhappy with the level of care provided to them.

Furthermore, Vydelingum (2006), as previously cited in the above themes, suggests that language barriers can generate a considerable chasm between the patient and the healthcare worker, mainly as communication is fundamental in the provision of quality patient care.

Divi *et al.* (2007) performed a comparative analysis of patients with varying levels of English and the impact of their linguistic proficiency on the success of their treatment. The patients included in this study were based in one of six Joint Commission accredited hospitals, and the results of the analysis show that patients experienced adverse outcomes more often when they had little or no knowledge of the English language. The seriousness of these adverse outcomes varied, although some patients included in the study died during the research process. However, as the sample group of that study was limited to a select number of medical facilities, the results cannot be considered generalisable.

Also, Divi *et al.* (2007) warn that language barriers could lead to unnecessary complications, inadequate care or incorrect diagnosis, as in many cases, healthcare workers have difficulty understanding the symptoms of patients and are forced to perform more invasive diagnostic tests to determine the patients' health status (Divi *et al.*, 2007).

Nevertheless, excessive use of colloquialisms by the patient may hinder their ability to communicate clearly with nursing staff (Kim, Heerey and Kols, 2008). Nurses must develop strong communication skills to ensure that they can interact effectively with their patients and these skills are typically acquired over time (Kim, Heerey and Kols, 2008). Nonetheless, even an experienced nurse may encounter difficulties in communicating with those from culturally diverse minority groups. The works cited in this section explore some of the communication



issues that are commonly experienced by nurses in the healthcare industry and highlight how language barriers can hinder the provision of quality patient care. Furthermore, language barriers are significant in the process of erecting cultural defence and dissonance between individuals (McLeod, 2008). A phenomenological study performed by Jones (2008), along with findings generated by Murphy and Clarke (1993), highlight the cost and time implications associated with language barriers between patients and healthcare workers.

Therefore, communication plays a key role in facilitating patient treatment and in informing patients of what they can do to prevent deterioration of their condition and the treatment that is required (Rask, Jensen, Andersen and Zachariae, 2009).

According to Dywili, Bonner, Anderson and O'Brien (2012), a more favourable clinical environment can be cultivated by ensuring that staff and patients can interact effectively, and ensuring that the hospital management implements strategies designed to educate healthcare workers on the needs of diverse cultural minority groups and the need to integrate foreign workers into the clinical community.

Overall, a lack of effective communication can have a detrimental effect on patient care. A study performed by Plaza Del Pino, Soriano and Higginbottom (2013) highlighted the impact of linguistic barriers on communication by holding semi-structured interviews with 32 nursing professionals from three different public hospitals in the south of Spain. The findings generated by that study indicate that errors in pronunciation or an incorrect choice of word can lead to misunderstandings for both the nurse and their patients. Thus, it is common for a negative relationship to develop between the health care providers, both together and between themselves and the patients, which will affect collaboration, which can in turn have a detrimental impact on the result of patient treatment. According to the findings generated by Clayton *et al.* (2016), based on their analysis of 14 operating nurses who worked in a multicultural operating theatre in Australia, the result of difficulties in communication affects the working atmosphere among colleagues and influences patient care. Also, in a separate study, participants claimed that hospital patients would go to the hospital managers with their concerns and subsequently bypass any connection with the nursing staff, which could be due to a result of expectations that the nurses are unable to resolve situations or possibly due to preconceptions regarding the nurses'

language skills (Almutairi *et al.*, 2015). Consequently, the nurses are left feeling professionally dislocated and are shown insufficient professional respect.

### **2.3.7.2 Interpreting Services**

Many medical facilities cannot afford to provide 24-hour interpreting services for healthcare workers, and particularly for nurses, and their reluctance suggests that organisations have yet to acknowledge the impact of language barriers on patient care (Gerrish, 2001; Jones, 2008). As communication of medical issues takes precedence over nursing concerns, nurses often request the use of an interpreter on behalf of a doctor more often than they require one for themselves. Without access to an interpreter, nurses typically convey information using family members as interpreters or translators where possible (Boi, 2000; Gerrish, 2001).

According to McKinley and Blackford (2001), based on the interaction between six nurses based in Melbourne facilities and families with limited English, nurses were only offered interpreting services if they needed to convey crucial medical information to the patients' families. Also, Elderkin-Thompson, Silver and Waitzkin (2001) performed a study in California to determine the competence of Spanish-speaking nurses who also worked as interpreters. Twenty-one patients who spoke Spanish as a first language and used nurses acting as translators for them when communicating with the medical team were interviewed. This study found that mistakes or misunderstandings occurred during at least half of these meetings, particularly concerning patient symptoms or the veracity of the patients' claims. This illustrates the danger in using untrained interpreters to facilitate communication.

The aid of an interpreter or translator is integral to the achievement of effective communication between patients and healthcare workers and can alleviate many of the issues associated with linguistic barriers in healthcare facilities. Flores *et al.* (2003) state that interpreters do not necessarily need to be paid employees, as family members or friends of the patient may be able to help. However, it is important to note that unofficial and untrained interpreters may unknowingly communicate incorrect information, which could exacerbate the situation. Thus, it is essential to use only skilled interpreters, as those who have been correctly trained will not make any grave errors in translation that may affect the patient outcome (Flores *et al.*, 2003; Hadziabdic *et al.*, 2009).

According to Jones (2008), based on a qualitative study of nurses' experiences, many patients use family members as interpreters, especially during the night. The nurses revealed that they avoid using children as interpreters as there is a risk that they will not fully comprehend what they are being asked to convey (Jones, 2008).

Cioffi (2003) also asserts that miscommunications can occur if nurses speak one dialect while the patient speaks another; and this can cause severe misunderstandings as words can have very different meanings in different dialects. Besides, it is impossible to determine the language skills of untrained interpreters, and they may be unable to translate complicated medical words accurately. Furthermore, from the perspective of the researcher, there is a danger that family members acting as interpreters may leave out some information on account of their relationship with the patient; in other words, they may not adequately convey all of the crucial information that healthcare workers are trying to communicate.

The most common mistakes made by interpreters can be divided into five categories: using an incorrect word/sentence; introducing bias; substituting one word with another; leaving out a word/sentence; or adding a new word/sentence (Flores *et al.*, 2003). Also, although there are several stances on the ideal way of providing interpretive services, Jones (2008) suggests that face-to-face interpretation is preferable to over-the-phone interpretation, as body language plays a significant role in communication.

In the process of active communication, many factors can hinder its overall functionality. Amutairi *et al.* (2015) posit that patient care is compromised by the effect of verbal misunderstandings between patients and staff. This is further exacerbated by the frequent non-attendance of personnel employed to perform translation duties, as the concepts of punctuality and presence in the workplace are reported by nursing staff to be lacking among locally-operated translators, which severely inconveniences the nurses in the performance of their duties. However, this does not result in disciplinary action. In fact, an expatriate nurse compared the attitudes of local staff with those of expatriates, complaining that, in their native countries, lack of punctuality and unauthorised absences are punished, whereas, in Saudi Arabia, as far as locally employed staff are concerned, they are not. Meanwhile, unscheduled breaks during the day, such as going outside to smoke, are commonplace.

The language and communication studies above are supported by very early studies that focus on communication between nurses and patients only. This shows the importance of undertaking new work to highlight the necessity of effective communication between nurses in providing quality care; thus, language barriers must be overcome to ensure that all nurses can deliver a high standard of care.

## **2.4 Summary**

This literature review found a range of factors about working in a multicultural healthcare context. The majority of these concern the impact of cultural issues on patient care rather than on collaborative working. However, it is essential to consider the cultural problems concerning nurse-patient relationships, as this is the environment in which nurses operate.

Examples of the themes (some based on the Purnell Model – see chapter three) apparent in the literature include:

- Spirituality, including religious practices
- Nutrition, including having adequate food
- Cultural knowledge
- Family roles and organisation
- Workforce issues
- Workplace injustice
- Communication, including language barrier and interpreting services

Only nine studies (out of 36) were located that examined cultural problems concerning nurses working together (i.e. collaborative working). These were conducted in the UK, USA and Australia and only examined barriers affecting functioning rather than facilitators or solutions or best practice. A couple of studies were located that investigated the Saudi context, but these focused on barriers to nursing-patient relationships only, and did not discuss cultural issues concerning nurses working together. The literature identified that there are no studies that have investigated the barriers and solutions to effective collaborative working as a nurse in a multicultural setting in Saudi Arabia.

The barriers and solutions to effective collaborative working as a nurse in a multicultural setting in Saudi Arabia are complex issues that need a conceptual framework to facilitate the collaboration. In the following chapter, different theories and Models of Transcultural Care and Cultural Competence will be discussed to address the objectives and provide a framework for the study. One model will be selected as the most appropriate model for the research and will be explained in detail.

# Chapter Three: Conceptual Framework

## 3.1 Introduction

The previous chapter demonstrated the barriers that cultural differences present and the potential issues involving communication. The cultural heritage of nurses has a significant impact on their work, as nurses from different countries can have varying values, beliefs and behaviours. These multicultural nurses, therefore, pose a pressing set of challenges regarding cooperation and conflict. The notion of cultural competence represents a nurse's ability to handle such problems and acknowledge the differences between different cultures. The conceptual framework, used in this thesis is that of cultural competence, and this will be discussed later in this chapter. Before this, it is essential to explain the concepts that are relevant to the thesis: those of culture, multiculturalism, transculturalism and collaborative working. This section briefly discusses the main definitions of the concepts and the preferred meanings that will be used throughout.

### Culture

According to Kroeber and Kluckhohn (1952), as cited in Adler (2007, p.14) 'Culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiment in artefacts. The essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other, as conditional elements of future action.' Culture is the relationship between beliefs, behaviours, practices, organisation and communication as a whole (Cross *et al.*, 1989; Mays *et al.*, 2002). Culture defines an individual's perspective and shapes their worldview, with some factors contributing to a person's cultural outlook: their ethnicity, class, level of education, language, gender, sexuality, religiosity and traditions (Heater, 2003; Kleinman and Benson, 2006). As such, 'culture' in this context refers to the sum of human behaviours, the components of an individual's communication and personality (Cross *et al.*, 1989). Upon reviewing the entire concept of what is included in the description of one's attitude, it can be seen to include their beliefs, values and norms, which are capable of directing and harnessing the sanctioned intentions and guidelines of a person or associated group (Griffith &

Vaitkus, 1999). For this thesis, culture is defined as multifaceted and includes knowledge, belief, fine art, ethics, law, tradition, as well as all skills and behaviours developed by society and its members (Tyler (British anthropologist), 1870, as cited in Avruch, 1998). This definition will be used as it is the most comprehensive and meaningful for this thesis.

### Multiculturalism

According to Spencer and Taylor (2004), multiculturalism fundamentally denotes that all cultures are equally flawed and as such all cultures should engage in meaningful discourse with other cultures. Thus it follows that multiculturalism calls for cultures to be open, reticent, and collaborative in their associations with one another. Multiculturalism exists in several forms. A statement released by Lord Parekh, as cited in Modood (2013) expressed the standpoint: Multiculturalism is often interpreted to mean that various cultural groups should live according to their values in an isolated fashion. However, this is not a comprehensive definition and as such has not been used for a long time. The explanation given by Spencer and Taylor (2004) will be used as it is the most simple and suitable definition for the thesis, namely that multiculturalism refers to the philosophy, actions and guidelines that an organisation uses to manage diversity. Moreover, multicultural involves individuals who have various beliefs and customs (Oxford Dictionary, 2017).

### Race

The term 'race' is essential to concepts of culture that have grown through the Enlightenment. The idea appeared in European languages at the end of the fourteenth and beginning of the fifteenth centuries, and the word 'race' was used in English for the first time in the sixteenth century (Goldberg and Solomos, 2002). According to Spencer (2012), race can be defined as the distinct and unique genetic or biological similarities between individuals that distinguish groups of people from each other. Nevertheless, race has more political and social connotations than biological ones. However, this definition will be the preferred usage throughout the thesis.

### Ethnicity

The term ‘ethnicity’ is frequently used as a more respectful and polite expression for race (Popeau, 1998). Less about biological determinism, ethnicity has become the favoured expression in western multicultural societies, to avoid the use of ‘race’ and its consequences of a questioned ‘scientific’ racism. Ethnicity is usually taken to be a more inclusive and less symbolising conception representing the continuously discussed nature of borders among ethnic groups rather than the essentialism implied in separations of ‘race’ (Spencer, 2014). Ethnocentric involves cultural superiority, and the view that one’s own ideals, traditions and culture are better than others (Spencer, 2014). Ethnic groups and culture tend to be used interchangeably. However, the most widely-used definition, which will be used throughout the thesis, refers to various sets of people who have the same language, history, beliefs, nations of origin, or culture (Spencer, 2012).

### Transcultural

According to the Russian cultural theorist Mikhail Epstein, as cited in Wright and Van Der Watt (2010, p. 216), ‘multiculturalism is a form of determinism serving to restrict the individual to a particular culture by his/her physical origins, isolating minority groups and commending ‘pride’ in a single culture’. ‘Transculturalism, however, involves dispersal of symbolic values of one culture across other cultures, thus promoting the integration of these values and habits’ (Mikhail Epstein, as cited in Wright and Van Der Watt, 2010, p. 216). The concept of transcultural is discussed in detail in section 3.4. However, the working definition that will be used throughout the thesis is that transcultural is the ‘Equation formed when individuals of different cultures interact. It applies to any interaction between people of different cultural backgrounds and worldviews’. The importance of the transcultural paradigm lies in ‘equal attention and respect to the culture of both parties in the interaction’ (Gabb and McDermott, 2007 as cited in Wright and Van Der Watt, 2010, p. 216).

### Linking Cultural Competence to Collaborative Working

Effective collaboration is a requirement for safe and culturally competent care in a diverse multicultural setting. Collaboration is defined as ‘work[ing] jointly on an activity or project’ (Oxford Dictionary, 2006). When multicultural staff members collaborate, they can combine the skills and powers of each person involved. For example, a nurse may struggle with patient care



skills, but recognise all the challenges and benefits of a particular assignment. Collaborating may empower the nurse to share the skills and knowledge with a colleague who can assist. This collaboration will improve the nurse's chances of accomplishing the task. Collaboration is broadly defined as 'a situation in which two or more people learn or attempt to learn something together', and in more precise terms, collectively creating solutions to problems (Dillenbourg *et al.*, 1995, p. 1). However, the applicable definition that will be used throughout the research as the clearest and most specific definition, is that of 'mutual engagement of participants in a coordinated effort to solve a problem together' (Roschelle and Teasley, as cited in Dillenbourg *et al.*, 1995, p. 2). Collaboration is not always manageable and can require work, emotional resolve and perseverance. There are several barriers to effective collaboration between nurses together and nurses with patients, which are identified in chapter two in section 2.3: language barriers, workforce issues and workplace injustice.

There are limited studies on the relationship between cultural diversity and effective collaboration, and the following section briefly discusses the relevant issues that have been highlighted in the literature.

Culture is formative in every element of an individual's life and is the predominant force in determining the behaviour of both groups and individuals. Culture is a controversial and complex concept, which continues to gather a multitude of varying opinions including the view of Matthew Arnold (1869), as cited in Spencer (2014), which states that culture is 'the greatest which has been thought and said in the world'. This definition alludes to the concept of 'high culture' as mirrored in literature and philosophy. On the other hand, Kress (1988) proposes that culture is by nature inclusive and involves: 'the collections of human practices that yield meaning as well as the objects that are the outcome of those practices'. Culture includes all types of human involvement in those practices, including their impact on humans collaborating as a "culture". Tyler (British anthropologist) (1870), as cited in Avruch (1998) provides a more in-depth look and reveals additional intricate differences that occur within 'culture': is conventional: this is a fact that is true to every human society. Each society has its unique aims and characteristics, which it expresses through its art and teachings. Two parts make up a culture; namely the known meanings and directions, to which its members adhere; and the new interpretations and values, which are presented and verified. The above components comprise the

normal procedures followed by human societies and the mind, which can be viewed concerning the nature of a culture which has both traditional and creative aspects including the most common shared implications, as well as the best personal implications (Williams, 2011). It is therefore essential to properly understand the culture of each staff member and how culture influences an individual's role in the group to facilitate collaborative working.

It is worth noting that the notion of cultural competence is problematic and contested and cultural incompetence can lead to a breakdown in cooperation. A lack of cultural awareness can lead to the perpetuation of stereotypes that can lead to poor decisions and ill-will between co-workers (Betancourt, Green, Carrillo and Ananeh-Firemong, 2016). Furthermore, if stereotyping persists, it may lead cultural minority workers to feel like they are being marginalised or discriminated against due to cultural misunderstandings. In Cohen, Gabriel and Terrell's (2002) paper, it was shown that healthcare organisations who fail to pay heed to the implications of culture on healthcare (language barriers, religious customs, culture-linked diseases) end up providing sub-optimal healthcare. All aspects of culture shape the life of a group or an individual; it is the central effect on behaviour in any society. Indeed, the ways people interact are influenced by different cultural norms, attitudes and social organisations (Cohen *et al.*, 2002).

This study aims to detail the factors that will have an impact, both negative and positive, on collaboration in a multicultural healthcare setting. The importance of cultural competence should not be underestimated within the multicultural healthcare setting. Cultural competence is likely to facilitate the gap between multicultural nurses to enable them to work collaboratively to provide transcultural care. Furthermore, cultural competence may be linked to increased quality of nursing care, conducive patient-provider relationships, improved treatment efficacy and reduced healthcare costs (Betancourt, Green and Carrillo, 2016). From a philosophical perspective, cultural competence can minimise health inequity between cultural groups (Betancourt *et al.*, 2016).

The Cultural Competence Model, which is used as the conceptual framework in this thesis, will be explained later in this chapter. Before this, it is essential to discuss the meanings and purpose of theory, model and conceptual models.

## *Theory*

The most frequently quoted definitions of theory were framed by Kerlinger (1999: p.9) “A theory is a set of interrelated constructs (concepts), definitions, and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena”. In particular, Polit and Beck (2006: p.57) have described a theory as “a systematic abstract explanation of some aspect of reality”. Burns and Grove (2009: p.39) defined a theory as “an integrated set of defined concepts and propositions that present a view of the phenomenon and can be used to describe, explain, predict, or control the phenomenon”.

Nursing theory offers a viewpoint that forms the basis of how nursing is defined, who is identified as the client when it is determined that nursing is required, and how to locate both the objectives and limitations of the therapeutic activities of nursing (Nieswiadomy, 2011). Accordingly, the theory is crucial to successful nursing research and practice. Nursing theory, in both its use and development, has professionalised the field of nursing.

## *Model*

A model is a representative symbol of a specific phenomenon or phenomena. Bush (1979: p.16) suggested that a model “represents some aspect of reality, concrete or abstract, using likeness which may be structural, pictorial, diagrammatic, or mathematical”. Perhaps the very usual usage of the word model is while arguing structural forms of models, the types of models that nurses are attracted to while running nursing research are typical of the fundamental or diagrammatic method. A figure or a drawing can represent a theory in a technique that noticeably explains the structure of the theory. According to Nieswiadomy (2011), although a theory emphasises the statements or descriptions of the relations concerning phenomena, a model emphasises the construction or structure of the phenomena.

## *Conceptual Model*

A conceptual model or framework constitutes a structure bringing together global ideas and which signifies a cohesive totality of a more comprehensive reality. Phenomena and their

specifics, within a worldwide entirety, are better explained by theory (Babbie, 2001). A concept is characteristically defined as a socially constructed label that can signify multiple phenomena.

There are a wide range of theories and models of nursing (Aggleton and Chalmers, 2000). Over the past thirty years, a new series of models have appeared: Models of Transcultural Care determine that there is a need for transcultural care models to deliver the best care by different healthcare teams for different patients in different settings and across different cultures. These models have much in common with other theories of nursing, as they were created in line with the critical concepts of the behavioural, biological and human sciences (Dobson, 1991). There are significant differences between Transcultural Models and other models of nursing care, however, and some researchers have documented such differences by contrasting a transcultural approach to nursing with the conventional frameworks used in the nursing profession today.

A variety of models relating to culture will be discussed in this chapter: Ramsden's Cultural Safety Model; Giger and Davidhizar's Model of Transcultural Nursing; Madeleine Leininger's Cultural Care Diversity and Universality Theory; Campinha-Bacote's Model of Cultural Competence; and Purnell's Model. The core tenets of each model will be described, and an outline of each model's potential applications and drawbacks will be provided in order that the most appropriate conceptual model can be found to frame the thesis.

### **3.2 Analysis of Potentially Relevant Theories and Models**

This part does not aim to give a final analysis of the theories and models mentioned above, but rather to introduce an outline of a selection of models, and why they appear, or do not appear, to be relevant.

In her 1994 paper, Marriner-Tomey, as cited in Alligood (2014), suggests that theories of nursing aim to enlighten staff and encourage better practice through the description and explanation of everyday occurrences. Giving healthcare workers access to more accurate knowledge allows them to practise with a higher degree of autonomy and confidence in their abilities. As such, the effective use of theories allows for the provision of better knowledge, more thorough analysis, more consistent values and self-aware, self-improving health practice. Marriner-Tomey (1994) as cited in Alligood (2014) breaks theory down into the following components: The origins and

development of a theory; the application of empirical evidence in the testing of a theory; the core tenets and presumptions of a theory; the assertions that theory makes; the logic of the hypothesis presented by a theory; a theory's estimation in the eyes of the professionals; and the future and continued development of a theory.

Theories are not static entities, and change with time; the devisers of a theory may reconfigure their ideas in the light of new evidence or upon seeing their theory used in practice. Marriner-Tomey's framework (1994, pp. 6-7) as cited in Alligood (2014), for analysing theories of nursing, is an invaluable one, and is contingent on four core criteria: 1) clarity and simplicity; 2) generality; 3) empirical precision; and 4) derivable consequences. These criteria have been used to help select an appropriate model/theory for this study.

The following models will be considered:

- *Transcultural Care*
- *Cultural Safety Model*
- *National Culture Differences*
- *Cultural competence*

### **3.3 Models of Transcultural Care (the 1950s)**

In 1979, Leininger defined transcultural care as:

“A substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures. with the goal of providing culture-specific and universal nursing care practices in promoting health or well-being or to help people to face unfavourable human conditions, illness, or death in culturally meaningful ways” (p. 58).

The Transcultural Nursing Theory first appeared in Leininger's *Culture Care Diversity and Universality*, published in 1991, although it was established in the 1950s. The theory was advanced in Leininger's book *Transcultural Nursing*, which became available in 1979. In the third edition of *Transcultural Nursing*, issued in 2002, the theory-based research and the application of the transcultural theory were described.

In this century, all professionals in healthcare, including nurses, have shown keenness to educate themselves on global cultures and wish to offer safe, effective and culturally competent

healthcare. The establishment of transcultural nursing has been evident since the 1990s, bringing with it guidelines and theories about the practice of providing culturally competent healthcare to all, whether they are culturally divergent in their backgrounds, immigrants or refugees. Transcultural nursing represents the original acknowledged nursing discipline, which has findings via research to direct and support the practice of transcultural nursing. Andrews and Boyle (2008) note that this is a considerable and noteworthy development in the discipline of healthcare, and nursing in particular.

Dr Madeleine M. Leininger, a nurse-anthropologist, envisaged transcultural nursing in the mid-1950s as a prescribed area of practice and study for nurses. Leininger's first book, entitled *Nursing and Anthropology* (1970), encouraged nurses to bring into their nursing practice the principles and ideas of anthropology. Since the publication of this book, health professionals have shown a strong focus and interest in providing nursing and healthcare that is culturally competent. Transcultural nursing has been hugely influential and has been disseminated globally. Additionally, its influence has spread to other disciplines of healthcare, including social work, pharmaceuticals and medicine, among others. Andrews and Boyle (2008) state that care that is culturally competent is currently a required criterion in caring for communities, groups, families and individuals. They also observe that some national and state accredited organisations cite principles concerning patients' cultural requirements.

The ultimate goal of transcultural care is to provide a patient with care that does not contradict their cultural values. Hence, much of the literature cited in chapter 2, section 2.3, concerns failures to offer transcultural care.

One significant criticism of the Transcultural Model is that of ignored inequality; by accommodating cultural values or beliefs, the model may not acknowledge the political or sociological inequity facing specific minority ethnic groups concerning their relationships with other ethnic groups (Culley, 1996). According to Mulholland, (1995) the transcultural nursing literature is:

- Unclear, and inconsistent in its use of terms;
- Lacking in any rigorous examination of power;
- Unsure in its conceptualisations of culture;

- Incapable of supporting nurses to assess the socio-economic and political dynamics of relations between nurses and clients in practice and progress plans and policies for addressing discriminations and racism analytically.

Another limitation, tied into the issue of inequality, is the model's failure to examine the association between knowledge and power, and a lack of meaningful analysis of discrimination or prejudice (Mulholland, 1995). It has also been suggested that the Transcultural Model is inherently ethnocentric, as it examines how other cultures diverge from the host culture rather than seeing how the host culture differs from different cultures (Talabere, 1996). The host culture is, in the West, the Caucasian ethnic group; similarly, in the Saudi context, the host culture is the Saudi Muslim population, and it is from this 'baseline culture' that comparisons to other cultures are made. Such criticism has far-reaching implications, not only for the theory, but also for our assumptions regarding others; and for ourselves, every cultural niche has a rich, complex history that can, and should, be analysed. As such, knowledge of the origins of culture (regarding history, politics, religion and economics) is vital for the practice of culturally competent nursing.

### **3.3.1 Leininger's Model**

Leininger's Cultural Care Diversity and Universality Theory (1985) and the Sunrise Model are perhaps the most documented to date and are two of the most widely researched and well-known theories in the public domain (Reynolds and Leininger, 1993).

The theory was derived from the use of anthropological research and the analysis of culture and its trappings (values, beliefs and behaviours). Some of the concepts of the theory are described concerning theoretical development; other concepts are explained regarding their relevance to the nursing profession. The Transcultural Nursing Model is based on a reconfigured worldview, one that views concepts concerning cultural issues and the broader cultural context, considering both culture-relevant matters and culture-irrelevant matters. Leininger (1979) described her model as one that is holistic, and that has implications in every area of the nursing field. Social structural dimensions are identified in Leininger's Sunrise Model as being critical in consideration of the differences that occur among groups that impact the development of worldview and support the description of the meaning of caring in cultural perspectives (Leininger and McFarland, 2002). According to Andrews and Boyle (2008), the Transcultural

Model has seen the application in a variety of nursing specialities such as research and practice, assisting appropriate cultural nursing care.

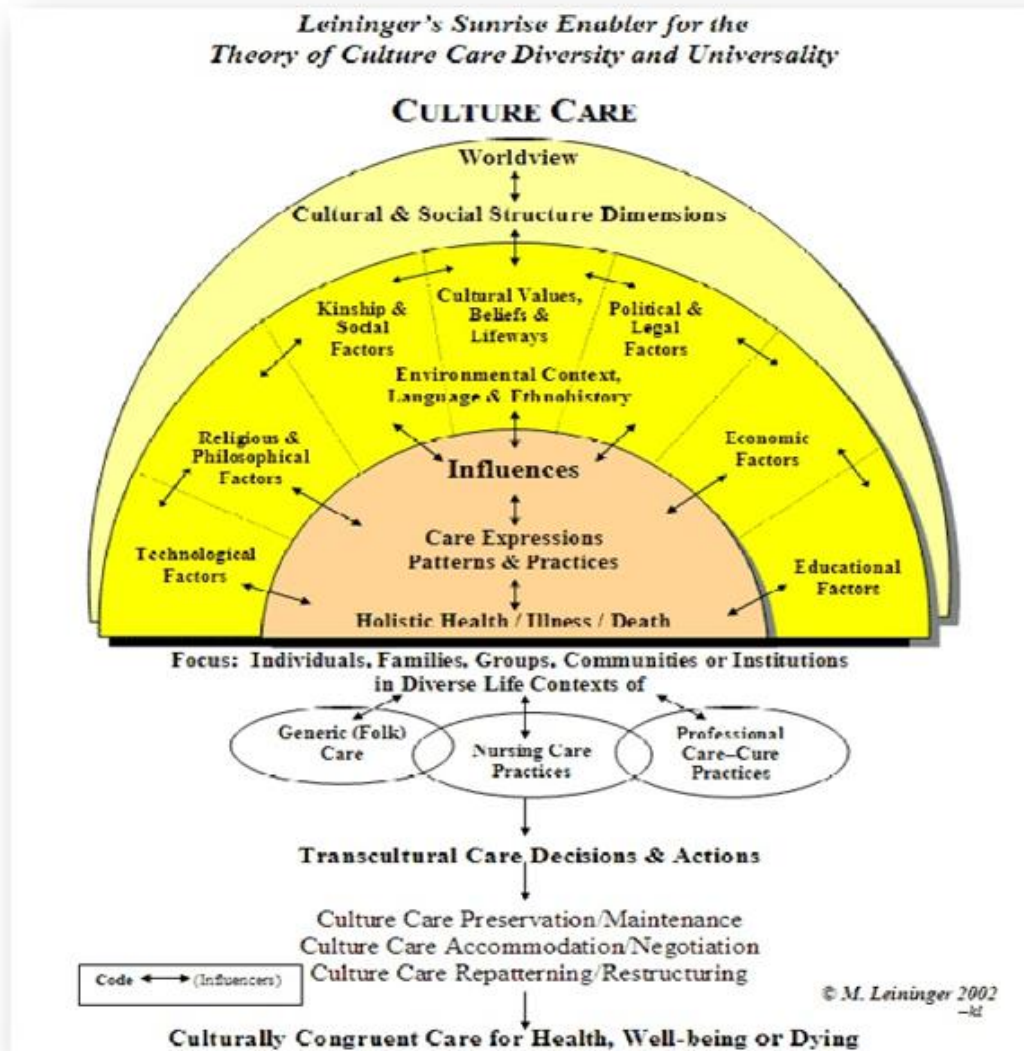


Figure 2: Sunrise Model

\* Permission to post theory by Lucas Melo (personal email contact, December, 2016).

### 3.3.1.1 Critical Overview



The theory is a complex one, as it deals with abstract concepts tightly interconnected with one another; as such, the application of such a theory requires a solid understanding of the concepts studied. Leininger (2002) emphasises her focus on cultural aspects in the very concepts themselves, with most of the critical ideas of her theory being prefixed by ‘cultural’. The beginnings of a new concept and phenomenon related to nursing care were titled *transcultural nursing* in the 1950s. The holistic theory aims to include the concepts of universality and diversity, examining both similarities and differences between healthcare in different cultures. As the concepts are wide-reaching and abstract, the theory can be applied in a variety of multicultural settings. The theory has been examined through the qualitative approach, and the rigour of such cross-examination can be assured by assessing the criteria of credibility and conformability of the data used in the studies. In particular, Reynolds and Leininger’s (1993) theory has profound implications for how the nursing profession should treat patients from other cultures, and how best to adapt care in a multicultural setting (Marriner-Tomey, 1994, cited in Alligood, 2014).

There are, however, specific criticisms that have been levelled at the theory, especially regarding the model’s focus on cultural similarity and sensitivity and the assumption that a better understanding of other cultures will inevitably lead to improved healthcare (Culley, 1996; 1997; 2000). Mulholland (1995) claims that the culturist view does not include the political and sociological elements of ethnic inequity; it is even suggested that, by emphasising differences in culture, any issues that arise will be attributed to the culture itself rather than to underlying causes. By underpinning cultural analysis on differences between cultures, the model risks reinforcing stereotypes and instituting a power imbalance between patient and professional. It is vitally important that patients (especially those from marginalised ethnic groups) are given autonomy and power within the healthcare system; by ignoring political and structural problems and focusing on culture, Leininger’s theory may disenfranchise and further marginalise ethnic groups, making their care culturally unsafe (Coup, 1996).

### **3.3.2 Giger and Davidhizar’s Model of Transcultural Nursing (1988)**

Giger and Davidhizar's (1988) model emphasises the transcultural view of assessment and intervention. In their model, a patient is seen as an individual cultural entity defined by three core concepts: culture, ethnicity and religion.

By examining the literature from all aspects of cultural studies, Giger and Davidhizar present their model concerning six areas of human diversity.

### *1. Communication*

Communication is the core of any human interaction and is what defines culture and society; this makes it an incredibly valuable professional skill. For a person to be treated as a culturally significant individual, their care needs to be culturally competent; this requires effective communication between patient and professional.

### *2. Space*

Space is perceived through our senses and forms the medium in which everything we experience is conveyed. What we have learned through socialising and communication has a profound impact on our perceptions, giving them meaning and significance.

### *3. Social Organisation*

Concerning social organisation, Giger and Davidhizar (2002) argue that culture should be viewed as a whole; for culture-specific beliefs and behaviours to be correctly understood they need to be seen as part of a whole, uninterrupted cultural system, in which every belief or behaviour is interrelated and interdependent. Culture is an amalgamation of politics, economics, religion, family and healthcare, all of which are separate, but interconnected.

### *4. Time*

Time is not a real concept, and its perception, measurement and value differ significantly from culture to culture. Giger and Davidhizar emphasise this variation in the understanding of time; how time can vary concerning growth, duration, externality and lifespan.

### *5. Environmental Control*

In Giger and Davidhizar's Model, the environment is a complex set of systems that influences individuals and institutions, and is in turn influenced by those same individuals and institutions. In the model, environmental control is seen as the ability of a person or people of a particular culture to affect the environment in which they operate. This influence is dynamic and multifactorial, involving a wide range of processes that, ultimately, have significant effects on attitudes to healthcare. Such reactions are the result of a long process of interactions between individuals and their environment and involve beliefs about illness and health.

### *6. Biological Variations*

Giger and Davidhizar's theory acknowledges the variations in physiology between ethnic groups; it is vital that such biological variations are adequately understood if stereotypes are to be avoided. If a healthcare professional is aware of relevant biological changes, they can adjust care so as to be culturally competent and safe.

The model's description of the six areas of human activity is broad and comprehensive and allows the model to be applied in a variety of settings. The six regions also provide a useful framework for understanding differences between cultures without sacrificing diversity and universality. The subdivision of each area also allows for detailed and precise discussion of relevant topics.

#### **3.3.2.1 Critical Overview**

The division of the theory into six regions makes it both comprehensible and applicable. Furthermore, the six areas can be further subdivided to describe cultural differences in more detail; for example, religious denomination can be examined under the broad title of 'societal organisation'. When analysing religion from a transcultural perspective, we can see the influence that faith and faith organisations have on healthcare-related behaviours; spirituality and religion can be thoroughly examined within Giger and Davidhizar's theory.

The six areas mentioned above described within the theory are drawn from in-depth research from a variety of biomedical and sociological specialities. As such, in order for the theory to be genuinely effective, a thorough understanding of the concepts discussed is required; for example,

the notion of time and its implications in different cultures requires detailed knowledge of the subject matter.

Nevertheless, these transcultural care models have been criticised for being too general. However, while the multicultural characteristics of care have been captured, the theories do not go into sufficient detail nor do they catch what happens between nurses working in a multicultural context. Therefore, it is essential to consider other potentially relevant models.

### **3.4 Ramsden's Cultural Safety Model (1994)**

The notion of cultural safety was first conceived in New Zealand in the late 1980s by Maori nurses. Maori nurses developed the idea as a means of improving healthcare for the minority indigenous population of the country (Ramsden, 1990; 1992). The notion of cultural safety arose from the Maori tackling their post-colonial experience and rediscovering their independent identity, as well as redistributing power by means of their newfound equality. Although the concept of cultural safety is rooted in the cultural context of New Zealand (with its European colonisation and native disenfranchisement), Ramsden argues that cultural safety is essential in a setting where there is an unbalanced division of power and resources.

The application of cultural safety involves acknowledging power inequalities between groups and within society as a whole and creating healthcare services that take these inequalities into account. The concept is particularly adept at exploring racism, inequality of opportunity and stereotypes.

#### **3.4.1 Critical Overview**

A critique of the idea of cultural safety by Polaschek (1998) highlights the following:

- The debate between the relative influence of nurse behaviours and nurse attitudes in creating a climate of cultural safety;
- The ambiguity of the scale of cultural safety; it has the potential to operate at an individual level or a collective level; because it seeks to reshape social structure and attract consideration to individuals' attitudes of social influence;

- The uncertainty surrounding the concept's application to society and individuals;
- The concept's failure to address societal factors, such as racism on an institutional level;
- A lack of methodological rigour in theory.

In a paper from 2000, Culley examined several of these issues concerning healthcare training; and emphasised the need to adequately address the economic, social and political aspects of inequality. Most criticisms on a cultural safety stand to its application (Gerlach, 2012). Johnstone and Kanitsaki (2007) highlight that acceptance and use of cultural safety by healthcare teams and patients are limited. Gerlach (2012) argues that there is a difficulty in assessing the use of cultural safety by students and nurses.

### **3.5 Trompenaars' Model of National Culture Differences (1997)**

In their book *Riding the Waves of Culture*, the developers of the model, Trompenaars and Hampden-Turner (1997), put forward the Seven Dimensions of Culture model, which is a framework for cross-cultural interaction in commercial industries. Research for the book involved a survey of 15,000 managers from 28 countries; 500 responses from each country were used for the theory.

The model defines cultures according to their views on the following seven dimensions:

1. Universalism versus particularism;
2. Individualism versus communitarianism;
3. Specific versus diffuse;
4. Neutral versus emotional;
5. Achievement versus ascription;
6. Sequential time versus synchronous time;
7. Internal direction versus external direction.

This model can be used to better understand individuals from a variety of cultural backgrounds, allowing more effective cooperation and preventing miscommunication.

The model must be applied sensibly, however. Individuals need to be treated as such by acknowledging the myriad of factors that determine a person's preferences and without generalising according to their culture (Hofstede, 1996).

### **3.5.1 Critical Overview**

Trompenaars' Model failed to address social influences, for instance, discrimination on an institutional level, and cultural differences, and therefore it does not deliver a straight measure of national culture. Hence, it is excluded from consideration.

## **3.6 Models of Cultural Competence**

The concept of 'cultural competence' was first theorised from transcultural by Leininger in the 1980s, and the idea has its roots in the United States (Burcham, 2002; Cowan and Norman, 2006; Seright, 2007). The idea of cultural competence aims to address issues of cultural knowledge and conflict and to allow healthcare professionals and patients of different cultures to work together harmoniously. 'Competence' refers to the effectiveness of a professional in their interactions, the efficacy of their knowledge and skills (Cross *et al.*, 1989; Sternberg, 2004). Some authors have critiqued the concept of cultural competence. For example, some issues lie in the reductionist nature of the model; the theory reduces a considerable number of anthropological variables, each complex and interdependent, to a handful of markers or requirements that are easily measurable (Carpenter-Song, Schwallie and Longhofer, 2007; Kumagai and Lypton, 2009). Many anthropologists have argued that such an approach is flawed, as it is almost impossible to represent the dynamism and complexity of the actual system of human communication in such a minimalistic model (Carpenter-Song *et al.*, 2007). In a 2009 paper, Kumagai and Lypton state that the immense complexity of human culture is beyond reduction to the categories of skill, knowledge and attitudes.

Several models have been proposed to cater to the cultural competence present in modern healthcare services. Most have their origins in the West; several have been developed in the US, with some produced in the UK and New Zealand (Jirwe, Gerrish and Emami, 2006). The origins of these models have had a profound impact on their nature, as each is shaped by the socio-political context in which it is created.

This section aims to describe the concepts and cornerstones of cultural competence briefly by drawing from the extensive literature on the subject. Following an outline of the principles and assumptions of cultural competence, as well as the provision of empirical data that supports the concept, Reich & Reich (2006) recommend that using a cultural competence model will aid effective collaboration and offer opportunities for different perceptions. This section will make the argument that the Purnell Model for Cultural Competence (1998) is the framework best suited to the study of multiculturalism in the Saudi Arabian nursing profession. To facilitate the methodology structures for data collection, there will be a particular focus on the impact the model will have on effective cooperation among nursing staff.

A full discussion of theories/models of transcultural care and cultural competence lies beyond the scope of this study, and further research and reading are necessary for a complete understanding of these theories/models (e.g. Purnell, 2012; Leininger and McFarland, 2002).

Cultural competence is relevant in several fields and is applicable on several levels; the concept can fruitfully apply to accrediting organisations, policy creation, university curricula and any number of professional organisations (Adams, 2002). The final goal of cultural competence is to train a workforce to provide care that is impartial and excellent; care should not be affected by differences in language, culture or ethnicity (Betancourt, Green, Carrillo and Park, 2016). Cultural competence is claimed to be a valuable tool in tailoring relationships so they can be as conducive and amiable as possible, with such links coming in many forms: nurse and patient, teacher and pupil, social worker and subject (Suh, 2004).

It has been posited that competence is tied to the job at hand, and measured regarding the performance of the stated position. Furthermore, competence goes above and beyond the simple completion of an allotted task; for a professional to be deemed competent, they need to be able to respond to changing circumstances, evaluate available information and critically analyse a situation (Storey, Howard and Gillies, 2002). When viewed in tandem with culture, competence represents something more specific; the ability of an individual or institution to work efficiently in a multicultural environment, and the capability to handle the different beliefs and behaviours of patients (Anderson, Scrimshaw, Fullilove, Fielding and Normand, 2003).

There is no particular description of cultural competence that is universally accepted; each different definition of cultural competence is defined by the discipline to which it refers. In the field of psychology, for example, cultural competence is defined as the group of behaviours, beliefs and mandates that have been unified in a system to allow said system to perform effectively in multicultural settings (Cross *et al.*, 1989). Concerning nursing, there is an accepted definition; a process that aims to foster culturally aware and active practice, providing staff with detailed knowledge of other cultures, the skills to handle situations of conflict and the respect for the differences between one's culture and that of the patient (Suh, 2004). This definition will be used to frame this research, bearing in mind the respect for the differences between one's culture and that of the patient and other colleagues.

Cultural competence can be observed at both a personal and an institutional level. An institution's commitment to the concept of cultural competence is vital; an organisation must focus its resources and workforce on the idea of cultural competence and ensure that awareness of cultural differences is raised among its staff (Jackson, 2008; National Centre for Cultural Competence, 2006). It is also important that individuals do not sacrifice their own culture in the pursuit of cultural competence, and it is imperative that staff should respect and value other cultures and tackle any prejudice that may be present in themselves or others (Scott-Rici and Kyle, 2009).

In a multicultural nursing team, several cultures coexist within one setting; it is this kind of context that will be discussed in this chapter. A philosophy of cultural competence in a multicultural context is particularly important, as individuals may not be aware of or understand the other cultures with which they are working.

Cultural competence can be expressed in many different formats. Giger and Davidhizar (2002) describe it as a constantly moving, non-static process through which a person, a system or a healthcare provider formulates effective healthcare strategies by using the acquired knowledge of a culture's heritage, belief system, behaviours and values.

Purnell and Paulanka (1998) view cultural competence in developmental terms and as a conscious, non-linear process. Different models will be described in the section below.



### **3.6.1 Campinha-Bacote's Model of Cultural Competence**

This part will present a brief outline of Campinha-Bacote's framework for organising cultural competence (Campinha-Bacote, 1994; Campinha-Bacote, Yahle and Langenkamp, 1996; Campinha-Bacote, 1999). According to Campinha-Bacote, in order for an institution or individual to achieve a state of cultural competence, the said institution or individual must demonstrate a willingness to engage with other cultures meaningfully. This concept is one of five that defines the process of becoming culturally aware.

#### *1. Cultural Awareness*

A healthcare professional must profess sensitivity to the beliefs and behaviours of a patient, as well as self-awareness of any bias or prejudice.

#### *2. Cultural Knowledge*

Cultural knowledge describes the research a healthcare professional undertakes to better understand cultures besides their own.

#### *3. Cultural Skill*

Cultural skill involves the assessment of a culture carried out by a nurse in cooperation with the patient through the use of the cultural knowledge gained.

#### *4. Cultural Encounter*

The cultural encounter is the way in which a healthcare professional directly exposes themselves to other cultures and partakes in cultural interactions with individuals who have different backgrounds to the professional in question.

#### *5. Cultural Desire*

Cultural desire is the personal drive of an individual to understand other cultures and the desire to gain cultural competence.

#### **3.6.1.1 Critical Overview**

Campinha-Bacote's Model lacks several descriptive powers. For example, it does not resolve some of the more significant distinctions of cultural beliefs and practices, as there is no capability within the model to justify many influences that formed the culture and the practices of the healthcare provider, which thus limits the use of Campinha-Bacote's Model in this study. There are several other criticisms of the cultural competence models. The models fail to account for differences within cultures adequately; the failure to acknowledge Western biomedicine as a construct of Western culture (Carpenter-Song *et al.*, 2007); and the lack of awareness of institutional racism and prejudice (Abrams and Moio, 2009). There have been attempts to address these criticisms in specific cultural competence frameworks; attempts that have been partially or entirely successful. The Purnell Model of Cultural Competence (described below) has undergone numerous revisions to accommodate such criticism.

### **3.6.2 Purnell's Model of Cultural Competence**

The Cultural Competence Model (Purnell's Model) was created on the foundation of various theories from a plethora of specialities: administration, communication, family development, anthropology, sociology, psychology, anatomy, physiology, biology, ecology, nutrition, pharmacology, theology, history, economics, politics and linguistics. Such research is invaluable in identifying cultural traits and attributes that distinguish one culture from another.

Even though it was initially a clinical assessment tool for student nurses, the addition of meta-paradigm concepts, as well as a cultural competence scale and a schematic, allow this theory to be relevant in all healthcare settings; making it a sophisticated theory (Purnell, 2014).

The textbook that forms the backbone of the model, *Transcultural Health Care: A Culturally Competent Approach* (1998) examines 27 cultural groups and provides both culture-specific and universal guidelines; the textbook has now been translated into French, Spanish, Flemish and Korean.

Figure 2 is a schematic of the Purnell Model, depicting the metaparadigm concepts: the outer rim represents the society of the world as a whole; the rim inside that represents a community; the rim within that constitutes a family, and the innermost ring serves the individual. The concentric circles are divided into 12 domains, each representing a particular cultural construct; these domains are not independent and are interconnected with every other domain. The centre of the

circle is empty, signifying the unknown or uncertain elements of a particular culture. The saw-toothed line along the bottom of the figure is a representation of the cultural consciousness of the individual that is being assessed, together with the factors that may affect their cultural consciousness. For this particular thesis, this relates to the healthcare organisation, but in other settings, this can represent other institutions. As this model is intentionally broad and abstract, each domain does not relate to a single particular ideology or value; it may even be the case that certain cultures have no equivalent concept for a specific area. An excellent example of this is in the distinction between collectivistic and individualistic cultures; whereas Western cultures emphasise the achievements of the individual, persons of other cultures may be defined by their community, family or socioeconomic class.



Purnell's 2002 Model of Culture Competence



Unconsciously      Consciously      Consciously      Unconsciously

**Incompetent            Incompetent            Competent            Competent**

**Variant cultural characteristics:** age, generation, nationality, race, colour, gender, religion, educational status, socioeconomic status, occupation, military status, political beliefs. Urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, and the reason for migration (sojourner, immigrant, undocumented status).

**Unconsciously incompetent:** not being aware that one lacks knowledge about another culture

**Consciously incompetent:** being aware that one lacks knowledge about another culture

**Consciously competent:** learning about the client's culture, verifying generalisations about the client's culture, and providing culturally specific interventions

**Unconsciously competent:** automatically providing culturally congruent care to clients of diverse cultures

**Figure 3: Purnell's Model of Cultural Competence and Broadwell (1969)**

\*Permission to use updated figures provided by Dr Purnell (personal email contact, April 2016).

**3.6.2.1 The 12 Domains of Purnell's Model**

According to Purnell and Paulanka (1998), the 12 domains run from the general to the particular, although the order in which a healthcare professional uses them can change depending on circumstances.

The following is an outline of each of the 12 domains and the core tenets.

*1. Overview/Heritage*

This domain involves ideas that pertain to the country of origin or of current residence; the impact of the geography of the country in question; the economic and political status of the country in question; the educational level and occupation of the individual; and their reasons for migrating.

*2. Communication*

Communication involves ideas about the language or dialect of the individual. The use of the language and how it changes concerning context; the effect of paralanguage variables (volume, tone). The propensity of the individual to share emotions or thoughts; nonverbal communication (eye contact, facial expression, tactile communication, body language, spatial distancing). The orientation of the individual's temporality (past, present or future); the reliance on social time or clock-determined time; the value of names to the individual.

### *3. Family Roles and Organisation*

This domain involves ideas that pertain to relationships within families; gender roles; family roles; developmental milestones of children; parenting practices; the role and value of the elderly; social status; opinions on 'alternative lifestyles' involving non-conventional parenting, sexuality, number (or lack) of children and divorce.

### *4. Workforce Issues*

Workforce issues involve ideas about the role of the individual at work; autonomy; acculturation; gender roles; communication style; individuality; healthcare norms in the country of origin.

### *5. Biocultural Ecology*

This involves the physical attributes related to a particular racial or ethnic origin; skin colour; physical variation; height; diseases tied to a particular ethnicity or area; different physiological reactions to substances.

### *6. High-risk Behaviours*

High-risk Behaviours involves a culture's predisposition to certain behaviours; use of legal or illegal recreational drugs; deficiency of physical exercise; non-participation in safety procedures (wearing of seatbelts, helmets); partaking in risky sexual practices.

### *7. Nutrition*

Nutrition involves an individual's attitudes towards food; the meaning of food; the selection of food; rituals and taboos surrounding food; food's relationship to wellbeing and sickness.

### *8. Pregnancy and Childbearing Practices*

This domain involves an individual's attitude towards fertility and children; birth control (or lack thereof); the role of pregnancy and the pregnant; views on birth, pregnancy and post-natal care.

### *9. Death Rituals*

Death rituals involve attitudes towards death; the rituals surrounding death; preparations before and after death; burial rites and practices; the behaviour of the bereaved.

### *10. Spirituality*

Spirituality involves the religious behaviour and beliefs of an individual; prayer and ritual; opinions on sources of life and strength.

### *11. Healthcare Practice*

Healthcare practice involves the role of healthcare in a culture. Whether the focus is preventative or curative; the role of traditional, non-conventional or magicoreligious practices; the responsibility for one's health; views on self-medication; attitudes towards mental illness, chronic disease and organ donation; barriers to access to healthcare; the response to the pain of an individual.

### *12. Healthcare Practitioner*

This involves the ideas about healthcare workers; the status of healthcare workers; the prevalence of alternative medical practices; the gender of healthcare providers; the perception of medicine, local or foreign.

### **3.6.2.2 Concepts of Cultural Consciousness**

The twelve domains as mentioned above are affected by the concepts of cultural consciousness and characteristics shown below the saw-toothed line in Figure 2. These include various cultural aspects: age, generation, nationality, race, colour, gender, religion, educational status, socioeconomic status, occupation, military status, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues and the reason for migration (sojourner, immigrant and undocumented status).

Individuals or organisations can be assessed as belonging to one of the following states, according to the responses from the 12 domains:

The “Conscious Competence” Learning Model (Broadwell, 1969), or in psychology, the four phases of competence, relates to the psychological conditions involved in the development of progressing from incompetence to competence in a particular skill.

- *Unconsciously incompetent: not being aware that one lacks knowledge about another culture;*
- *Consciously incompetent: being aware that one requires to learn about another culture;*
- *Consciously competent: learning about the client's culture, verifying generalisations about the client's culture and providing culturally specific interventions;*
- *Unconsciously competent: automatically providing culturally congruent care to clients of diverse cultures.*

### **3.6.2.3 Critical Overview**

Some authors have critiqued Purnell's Model. For example, Brathwaite (2003) critiques the model as representing stable values and reflecting more than a single worldview. In a 2006 paper, Tortumluoğlu states that this model is comprehensive and conceptual; it shows and adopts the experiential-phenomenological standpoint. It offers a systematic and concise structure to assist the healthcare team in delivering appropriate culturally competent care to patients. Many anthropologists have argued that such an approach describes the beneficiary of care in a continually moving society. The clients have to adjust to a progressively global diverse culture, while still maintaining their values and beliefs (Higginbottom *et al.*, 2011).

## **3.7. Choice of Conceptual Framework**

Having examined the benefits and shortcomings of the Cultural Competence Models, the Purnell Model seems to address most criticisms while remaining applicable and useful. Furthermore, the Purnell Model is a comprehensive model of cultural competence that is concerned with knowledge and awareness of specific requirements, and the acquirement of necessary skills to meet the needs of cultural competence. Knowledge or lack of understanding of these concepts is key to collaborative working, and as such, the model has been selected to guide the study. There are various uses of the Purnell Model for theory, research, practice and administration, not enough publications exist for evaluation and five of those listed below demonstrate the usefulness of the model to build guidelines for treating multicultural patients and develop a scale to measure cultural awareness amongst nursing students and guide data collection:

### *1. Practice*

The Culture Competence Model is applicable in a variety of settings and can be used by any discipline concerning health professionals (Miguel and Luquis, 2013). Due to the framework's focus on care management and team coordination, current healthcare systems have much to gain from applying the model in multicultural, multidisciplinary settings (Purnell, 2002). The culture-specific data from the model can be abstracted to provide a more general viewpoint of medical practice; it can also be used to create assessment tools, healthcare strategies and personalised treatment plans (Campinha-Bacote, 1999). As the model was developed to apply to every healthcare speciality, there are no explicit guidelines for nurses provided in the model (Purnell and Paulanka, 2008; Shen, 2004).

The model has been used in a wide variety of settings; nurses and physicians have applied it in the US, Canada, Central America and Europe, where it is used in acute and long-term care (Engebretson *et al.*, 2008; Purnell, 2002). In Panama, the model has been used to build guidelines for treating indigenous populations, compiling details of cultural beliefs and behaviours for shared use. The Oncology Nursing Society has also applied the model to improve its standards and tailor them to answer the needs of diverse cultural groups. In New Jersey, chapters from *Transcultural Health Care: A Culturally Competent Approach* (1998) have been made available on one hospital's intranet, allowing staff ease of access to the model.

### *2. Education*

In the academic field, nurses, doctors, anthropologists and social workers have used the model; one university has gone as far as to require students of population-based care to use the model in practical community settings (Lipson & Desantis, 2007; Purnell and Paulanka, 2008).

Due to the comprehensible nature of the model, students do not need to have a deep understanding of the subject matter in order to apply the theory in practical settings (Cagle, 2006). For example Rew *et al.*, (2003) developed the Cultural Awareness Scale based on the Purnell model of cultural competence to measure cultural awareness in nursing students.

### *3. Administration*



Culture extends beyond patients and families and includes institutions of healthcare, education and commerce (Purnell, 2002).

As the model accounts for workforce issues, it can be applied to an institution to examine the culture of an organisation and identify any cultural problems among staff members. Organisational culture is sophisticated and involves many factors; social structure, historical precedents, organisation values, the role of tradition, management structure and processes, policymaking and evaluation. These factors indicate the openness and diversity of an organisation, and whether the institution is welcoming or critical of change. By using the framework provided by the model, managers can encourage multiculturalism and cohesiveness in the workplace. In one case, an ethics committee applied the model to examine patient compliance and the appropriateness of care delivered from the perspective of both patients and staff. In another example, a long-term care institution used the model to create a plan sensitive to the cultural requirements of Orthodox Jewish residents, as many of the healthcare professionals were not aware of cultural norms (Purnell, 2011).

#### *4. Research*

The model has been used extensively in ethnographic, ethnomethodological and constitutive ethnographical research by both healthcare professionals and social scientists (Voyer and Purnell, 2005). The primary and secondary characteristics are particularly useful in gathering demographic data, and the domains (and relevant concepts) have been used as a basis for qualitative questions for further research (Brathwaite, 2005). The model's suitability for guiding data collection has seen it being used in the US, Brazil and Central America (Purnell, 2002).

### **3.8 Summary**

This study is affected by certain concepts relating to culture, although the focus of the research is on effective collaborative working between nursing staff. Indeed, multicultural differences between the team members is likely to affect collaborative working. This chapter has explained the different theories and models of transcultural care and cultural competence that have ultimately not been chosen, due to the limitations in addressing the objectives and framework of the literature review and thesis. The Purnell Model was selected as the framework for the study.

This model is a detailed Model for Cultural Competence, which was established as a classifying structure that has particular questions and a layout that can be used to look at barriers and facilitators to collaborative working in a multicultural setting; therefore, this model was most suitable for providing a framework for the study. It is used as a means of organising the themes of the literature review and to structure the interviews as well as analyse the data.

However, the aim of this thesis is not to test the model in practice. All clinical practice disciplines emphasise the importance of communication and the necessity of understanding the cultural values of others. The central assumptions of cultural competence for Purnell's Model draw on a broader standpoint, which means that they are valid in all environmental frameworks and practice settings. In this respect, a healthcare worker who is culturally competent learns to be aware of their feelings, presence, background and perceptions and does not allow these aspects to impact the effective working between multicultural nurses. Cultural competence entails adapting care in a way that is consistent with the other's culture.

Concerning efficiently working as a nurse in a multicultural setting in Saudi Arabia, barriers and solutions are complex issues that need a research methodology that can deal with difficulty. The qualitative case study method will be explored in depth in the next chapter.

# **Chapter Four: Methodology**

## **4.1 Introduction**

The literature review in Chapter Two focused on barriers to working with patients and highlighted the gap of studies that have been conducted in association with the multinational nursing workforce in Saudi Arabia regarding the barriers and solutions to working effectively. In Chapter Three, the importance of cultural competence in collaboration was highlighted, which represented a nurse's ability to handle and acknowledge the differences between different cultures. For example, Purnell's Model (2002) describes a Cultural Competence Model that includes Overview/Heritage, Communication, Family Roles and Organisation, Workforce Issues, Biocultural Ecology, High-risk Behaviours, Nutrition, Pregnancy and Childbearing Practices, Death Rituals, Spirituality, Healthcare practice and Healthcare Practitioner. Along these lines, Chapter Three identified the value of a cultural competence framework with which to frame this research.

Chapter Four will explore research philosophies and the research approach in application to the research context within a highly multicultural healthcare setting.

As Ojo (2003) explained, the term 'methodology' refers to a structure of clear guidelines and processes that the study will be built upon. Additionally, the methodology serves as a tool that is used to analyse theories and hypotheses. In this chapter, the methods chosen to meet the aims of the present research project are described and discussed. A descriptive holistic case study research design was chosen to complete this particular research, the aim of which is 'to identify the factors that promote or impair effective collaborative working between nurses in a highly multicultural healthcare setting' in a Saudi context (the setting that has been chosen is a specialist hospital in Riyadh). This section of the thesis will present the research design, the sampling approach, the data collection methods, and the ethical factors involved in this research.

The case study is believed to be the most appropriate type of research method for this study in order to examine extensively and in detail a highly contextualised phenomenon that occurs in its social world. Yin (2013) describes case study research as investigating a contemporary phenomenon within its real-life context, mainly when the limits between the phenomenon and

the circumstances are not evident (p.18). There are different types of case study. Yin (2013) summarises three types; exploratory, explanatory and descriptive case studies. Descriptive case studies that are used in this research describe the typical phenomena that happen within the information in question, for example, one of the interview questions was, *could you give an example of where communication has been good, and where it has broken down?* The target required by the investigator is to describe the facts as they happen. As recommended by McDonough and McDonough (2014), descriptive case studies can be used in a narrative method. The difficulty with a descriptive case study is that the study should start with a descriptive theory to sustain the phenomenon's description. This chapter will further discuss the different research techniques to be used that fulfil the research objectives. The next sections present the philosophies, approach and methods used in this study.

## **4.2 Philosophical Assumptions**

Research philosophical conventions lie at two ends of a continuum: positivism and interpretivism (Williamson, 2006). Some would say that interpretivism is in the middle. These are otherwise called research philosophies (Easterby-Smith *et al.*, 2012). These two points of view contrast in the supposition of real life. The positivist angle views the social sphere as a remote location, in which substances should be assessed through target strategies, instead of being derived subjectively by way of sensorial opinion and introspection of initiative (Easterby-Smith *et al.*, 2008). In the scientific realm, positivists believe that information must be founded on that which is quantifiable and experienced (Ijasan, 2011). This point of view is usually combined with the ontological assumption of the truth being outside and objectively attainable (Nawi *et al.*, 2012). In contrast, the interpretivist viewpoint concentrates on how individuals comprehend reality, mainly through sharing their experiences with others using conversation (Easterby-Smith *et al.*, 2008). Interpretivists view the social sphere connected to its attributes and propose that learning built given the experiential field. Thus the phenomena are developed (Tobi *et al.*, 2013). Moreover, Ijasan (2011) has shown that the subjective parts of humanity and cooperation reflect the interpretivist philosophical point of view, which puts greater importance on the significance of construction in the real social phenomena instead of the measurement of the social phenomena.

### 4.3 Ontological Assumptions

Ontology is related to the exploration of real life. It surrounds every inquiry that a researcher could conjure concerning the natural state of existence and the commitment fixated on specific perspectives.

Bryman and Bell (2015), together with Hatch and Cunliffe (2013), have conclusively recognised the two stances of ontology: objectivism and constructivism (subjectivism). Hatch and Cunliffe (2013) compare the state of objectivism with the topic of questioning whether reality exists freely from the individuals living within it. Objectivism infers that social phenomena and the sections utilised in ordinary existence have a presence that is free or apart from actors (Bryman and Bell, 2015). For associations and societies, the social element referred to seems to be something that prohibits the actor, and can be viewed practically as occupying its very own substantial reality. It has the qualities of an object and, subsequently, seems to hold a fact. In contrast to this, constructivism (subjectivism) is an ontological stance that announces that actors in society are persistently achieving social phenomena and their implications (see Figure 3). Meanwhile, Hatch and Cunliffe (2013) recognise that the inquiries that strike a chord concerning constructivism relate to questioning whether the realist can exist through the very existence and experience of it.

Within philosophy, there is an additional characterisation of ontological positions; to be specific, realism and idealism (Aouad, 2011). As per Aouad (2011), realism can be characterised as an ordinarily outer feeling alongside a foreordained natural state and construction, whereas idealism is described mainly as an obscure reality seen in various manners by one or more people. Sexton (2007) depicts ontology as the thought a scientist states concerning the way of truth, which in this manner can be ordered into realism and idealism.

Given the particular setting of this study, which is to describe the factors that facilitate or impair effective collaborative working within Saudi hospitals, this exploration attempts the constructivist ontological assertion that the truth is ceaselessly developed by its social performers, who, in this case, are the multinational nurses employed at the Saudi hospital, instead of the actors occupying their unmistakable reality. This concurs with the idea that constructivism affirms that phenomena and their implications are ceaselessly refined by the

actors (Sutrisna, 2009). This stance is differentiated from the position of objectivism in suspecting that associations and societies have pre-ordained classifications, and thus, they go up against social actors as outside substances that they have no part in manipulating.

#### **4.4 Epistemological Assumptions**

Epistemology is related to what is determined as satisfactory information in an aspect of academic research (Saunders *et al.*, 2009). In epistemology, the primary concern is to understand whether the social sphere can explore in the same comparative way as the ordinary sciences, which can examine through various strategies. Sutrisna (2009) portrays epistemology as the theory of knowledge as to its methods, validation and conceivable methods for obtaining instruction in the accepted reality. The two differentiating stances under epistemological contemplations are known as positivism and interpretivism. Polit and Hungler (1994, p.13) explain that the term ‘research paradigm’ refers to an overall perception of the intricacies of the real world. In research, interpretivism and positivism represent the two main opposing paradigms of the real world used by researchers to gather proof of their hypotheses.

As the initial epistemological stance, positivism perceives reality as it is demonstrated by components that are thought to be genuine, and which possess a particular external presence unique to that which is seen by the positivist specialist. The positivist epistemological stance uses pre-existing knowledge to add to a hypothesis that is tried and affirmed in its entirety or part, prompting the facilitated improvement of a hypothesis (Saunders *et al.*, 2009). A positivist analyst would contend that data collected from an examination process is not as exposed to predisposition and is more objective, thus utilising the deductive response through the entire exploration. Following this contention, Sarantakos (2012) contends that the utilisation of a deductive approach will derive that a positivist investigation is equivalent to quantitative research without seeking advanced confirmation.

The subsequent epistemological stance is interpretivism, which incorporates the perspectives of analysts who believe that the topics of sociologies, individuals alongside their establishments, and associations or societies are in a general sense, unique regarding the issues of the standard sciences (see Figure 3). Bryman and Bell (2015) also express that interpretivism trusts that the investigation of the social world necessitates an alternate rationale of research methodology that

mirrors the peculiarity of people as subversive to the typical way. Following this recommendation, qualitative methods are utilised to inductively and holistically appreciate human involvement in connection with particular settings in investigations exploring the interpretivist epistemological position (Sutrisna, 2009).

Returning to the particular connection of this examination, which will identify the factors that promote or impair effective collaborative working in a highly multicultural healthcare setting, the interpretivist epistemological stance is distinguished as the suitable angle for this research. This is due to the actuality that this epistemological assumption infers information that ought to be assembled by way of investigating the perspectives of the social actors; who are, in this connection, the professional nurses of the multicultural context. The interpretivist epistemological position selected recommends thorough, in-depth examination of the primary data, which is disposed towards qualitative strategies for collecting data.

### **Qualitative Methodology**

A qualitative approach is characterised by its objective, which is to realise the meaning and qualities of social life, and its strategy is to collect words rather than quantities for data analysis (Mackenzie & Knipe, 2006). The unit of investigation (for instance, the subjects' behaviour or words) and the study progression dealing with subjective rather than objective truths affects a qualitative study. It involves a holistic approach rather than considering exact variables as in a quantitative study.

Moreover, it supports the progress of theories and models to recognise the social domain (inductive approach to the progress of theory), rather than a deductive approach. Whereas quantitative studies analyses theories that have previously been proposed. An appropriate research paradigm for this approach is interpretivism since it similarly emphasises social influences that impact the nature and society where humans live as different to nonliving objects that can interpret themselves or their situation. What would a subjective truth be? It cannot be quantified – it is specific, vibrant and expressive. Qualitative studies can report questions, for example why patients may require longer or shorter admission times in hospital (Pope *et al.*, 2007).

The phenomenon and the researcher are linked together dynamically throughout the research,

and the results of the analysis are equally established within the framework of all settings, which supports the question design (Lincoln *et al.*, 2011). Furthermore, the correlation among individual beliefs and social guidelines is essential for qualitative researchers to interpret and realise the performance of participants from specific perspectives. Additionally, qualitative research includes the gathering of participants' particular opinions, afforded in their words in a documented structure, which assists in enhancing theoretical knowledge and increasing the researcher's knowledge (Cohen *et al.*, 2013).

### **Quantitative Methodology**

The principal purpose of a quantitative research methodology is objectivity in its method. This includes the use of objective measures in the confidence that these methods can control or exclude irrelevant variables using assessments via regular tests and parametrics (Cohen *et al.*, 2013). Additionally, Hughes and Sharrock (1997) have identified that objectivists reflect that empirical data is significant in raising the understanding of a phenomenon by reducing it to static, reliable and constant matter.

In a quantitative study, subjects are reduced to simple questions using measurable answers. The results are examined to produce measurable, statistically substantial facts. These results approve (with a degree of confidence) cause-and-effect relationships, e.g. among prescribed medication amounts and specific medical warning signs. The outcomes of quantitative studies are anticipated to be generalisable, i.e. the study method recognises an objective fact that is valid in all similar positions. These outcomes made by a big group of participants. The quantitative study paradigm assumes the presence of an actuality in which knowledge is independent of the individual (Pope *et al.*, 2007). Quantitative methods via positivist study methods include experiments and trials, which can be measured to support a hypothesis if one is involved in the study (Marshall *et al.*, 2003).

There are two primary methods of quantitative approaches: experimental and non-experimental. According to Marshall *et al.* (2003), an experimental method is used to regulate and influence study-related variables; randomisation of the nominated study sample is used to identify cause-and-effect relationships among diverse variables. Moreover, an experimental approach also



allows relations to be recognised through investigations, while the control of future results can be accomplished by influencing independent elements to quantify the effects on dependent elements (Denzin and Lincoln, 2011). The most significant aspect of the experimental method is that it is useful when investigators are exploring a convinced situation and results, or setting up a hypothesis that could later be confirmed through an experimental approach (Creswell, 2013). A non-experimental method in a quantitative setting permits the investigator to build up a picture on an observable phenomenon that usually occurs in the form of an incident, individual or situation (Mackenzie and Knipe, 2006).

The objective of a quantitative method is to reserve an independent opinion, and to understand the facts of studies based on the collected data (Pope and Mays, 2000). There are approaches to quantitative methods that permit direct communication with the participants, such as examiner-administered questionnaires, and additional plans that have no direct contact, such as mail surveys. This can be perceived as a valuable point for researchers, in that it avoids researcher influence through data collection, therefore decreasing bias (Mackenzie and Knipe, 2006). Surveys are usually chosen carefully when data from a significant number of participants or individuals is necessary to answer a clear question. Surveys may benefit from the examination of a considerable number of subjects.

## **4.5 Research Strategy**

Once the philosophies and approaches have decided on a particular research, the next stage is to explore the various strategies available to proceed with the investigation. To ensure congruence within the foundation of the study, the selection of the research strategy should be inspired by the researcher's philosophical stance and approach. Primarily, a research strategy (Yin, 2013) or research design (Bryman and Bell, 2015) provides the researcher with a 'roadmap' or a 'plan of action' to translate the aims of the research into possible results. According to Bryman (2015), the research strategy of a study must be designed in such a way that it enables the study to answer the research questions.

In concurrence, Saunders *et al.* (2009) add to the classification of learning by characterising the seven research strategies, known as grounded theory, experiment, survey, case study, ethnography, action research and archival research.

Before this, Sexton (2003) had classified the research design into five fundamental research strategies, which consisted of case studies, experiments, ethnography, action research and surveys. Details with regard to research strategies are required in order to provide rounded, detailed illustrations of the most appropriate research strategy for this study.

The choice of research strategy ought to relate to answering the research questions. Every procedure is accompanied by its particular benefits, and, also, replies to specific sorts of research inquiries. In choosing the most appropriate methodology for this research, the research question defined at the start of this research ought to be revisited.

The research question is:

What are the factors that promote or impair effective collaborative working in a highly multicultural healthcare setting?

Due to the subject matter of this research, the primary data will seek to illuminate the factors behind effective collaboration of the multicultural nurses in the Saudi hospital under study. In this case, there is no necessity for control of behaviours, as this study values the richness of knowledge provided by these shared collaborations. A research strategy as an experiment was deemed not to be appropriate for this research, as the researcher did not have control throughout the phenomenon under review. This was because experimental investigations try to influence independent variables in order to view the performance of the dependent variables (Collis and Hussey, 2013), which was not likely to be accomplished in this study. The survey strategy is typically allied with the deductive approach (Saunders *et al.*, 2009), in addition to the positivist philosophical standing (Collis and Hussey, 2013). As considered earlier, this study is prone to interpretivism and commenced towards an inductive approach. Hence, a survey strategy was deemed to be inappropriate for this study. Ethnography demands that the investigator be immersed in a situation, and subsequently become a member of the unit to realise the phenomenon being studied (Easterby-Smith *et al.*, 2008).

As the researcher remained external to the setting in this research, ethnography did not appear to be an applicable approach for this study. The depth of data attained from a thorough investigation, including construction professionals; thus, archival research is not the methodological approach embraced in this research, as it requires investigation into archives and periodic documents. Grounded theory attempts to develop a well-integrated set of theories that deliver a thorough theoretical explanation of the phenomena under study (Corbin and Strauss, 1990). Within grounded theory, the theory results from facts, which are critically collected and examined over the research progression in an iterative manner (Bryman, 2015). This study required the description of phenomena in actual settings and studying the barriers and solutions concerning the multicultural nurses in a Saudi hospital. Therefore, it did not attempt to create theory out of the data. Thus, grounded theory was believed not to be appropriate. From now on, the case study has purposively been chosen as a favoured research approach by this study's author. Munhall (2012) clarified that when the examination identifies convoluted, complicated occasions or instances, the case study method is very valuable.

#### **4.5.1 Case Study**

A case study is defined by Yin (2013: p.13) as an “empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not evident”. Luck *et al.* (2006) point out that a case study is described as a paradigmatic bridge that gives the researchers a variety of methods to select. The case study also employs several methodological processes, and, as a result, it may be said to be multifaceted from an epistemological perspective, according to Luck *et al.* (2006). The epistemological view is often accompanied by an interpretivist or positivist perspective (or perhaps both), each of which holds alternative preconceptions concerning the character of information and knowledge, and thus, demands alternative research approaches.

The strength of the case study method is that it permits the assimilation of multiple perspectives on a phenomenon. This methodological process is undertaken in the analysis of the data that is to be used in the study, according to Yin (2013), in which both the qualitative and the quantitative methodological approaches are to be complementary.

A qualitative case-study approach was chosen to conduct this descriptive study to ensure that any results that can be extrapolated from this particular approach are more likely to be respectable and trustworthy (Mills *et al.*, 2010). Consequently, such alternative epistemological perspectives contribute to the respectability and authenticity of the resultant findings.

Descriptive, explanatory and exploratory research represents three individual types of case study research, in which there are four different types of research design: embedded multiple-case, holistic multiple-case, embedded single-case, and holistic single-case (Yin, 2013, p.46). Each of these designs varies based mainly on their multiple, or single case attributes. The difference between embedded and holistic case studies is the number of analytical units. Specifically, holistic studies contain a single analytical unit (semi-structured interviews), which is used for this research, and embedded reviews include at least two analytical units or sources of evidence. Every type has an individual role and application. Holistic research designs evaluate the overall characteristics of a company or scheme and use a single unit. As explained by Yin (2013) and Schell (1992), holistic research design is most relevant when the study's theoretical framework possesses holistic qualities and where analytical subunits cannot be determined. Holistic research designs are most applicable to the analysis of complicated situations.

On the other hand, the embedded research design contains multiple analytical units in one individual study. As Yin (2013) explains, the embedded case study research design offers a descriptive analysis of a situation's characteristics, progression and setting.

Correspondingly, the decision was to use semi-structured interviews as the data collection method, while thematic analysis was chosen for subsequent analysis of the data.

Dainty (2008) recommends better use of qualitative approaches and the implementation of a multiplicity of methods, changing from the usual positivist viewpoint to entirely understand the multifaceted arrangement of relations existing inside the setting. Mills *et al.* (2010) decided that such methods acquire appreciation inside the organisation's structure of knowledge.

Regarding the present research, a holistic single-case research design was chosen. As such, this design can offer in-depth insight into the topic. This research will utilise a qualitative case study, keeping in mind the end goal of acquiring comprehensive data, which will prompt more thorough results. The following section describes the techniques that will be utilised as part of

this research.

#### **4.5.2 Qualitative Case Study Design**

This case study is managed by a qualitative method approach, though this research inclines towards the interpretivist stance of investigative procedures, which is typically connected with qualitative methods that will provide a broad spread of specific data (see Figure 3). Creswell *et al.* (2003) characterised qualitative methodology research as an investigation that includes the accumulation or examination of qualitative information in a single study in which the data, gathered simultaneously or successively, is prioritised and consists of the combined data at several intervals during the research process.

Such a perspective attempts to comprehend a particular phenomenon, as well as the viewpoints of those who are immediately related to the field of study (Cavaye, 1996). In this research, adopting an interpretive approach, the causal justifications of social events or phenomena are influenced by human actions, human interaction and human beliefs (Bhaskar, 2010).

Joubish *et al.* (2011) explain that qualitative methods aim to uncover events relating to the world based on personal opinion, while quantitative methods aim to discover unbiased facts about the world. Furthermore, qualitative research adopts inductive reasoning, which is associated with interpretivism. On the other hand, quantitative analysis takes deductive reasoning, which is associated with positivism, and so the application of a qualitative methodology allows for better validation of data to ensure the reliability of the findings.

Thus, according to Yin (2013), the use of this case study design can be referred to as a comprehensive research strategy (Yin, 2013, p.13). In conclusion, for the benefit of this study, the researcher chose a qualitative case study towards an interpretivist viewpoint, as this will allow the possibility to obtain a cohesive and comprehensive insight into a particular event or occurrence.

(Ontology)	(Focus)	(Epistemology)	(Methodology)	(Method)	(Purpose)
Constructionism	Meaning and interaction	Interpretivism	Qualitative	Interview	Understanding

*Figure 4: Summary of the Philosophical Assumptions for the Thesis*

## 4.6 Justification

Within this research, the assumptions of the case study’s methodological approach have been addressed. Initially, the author confirmed that they assessed a phenomenon or contemporaneous incident in its real, or reality-orientated situation and standing. Secondly, this case was within its contextual setting, describing in depth the attitude and behaviours of multicultural nurses working in a Saudi hospital. Indeed, it demands qualitative methodological processes and sources of information to expansively and adequately comprehend it from alternative viewpoints. This allows research studies to shed considerable light on situations through ‘in-depth explanation’. Yin (2013) reports that this allows a precise and methodical description of all factors that may have affected the case up to the present.

The use of the qualitative case study allows this research to offer a description of the phenomenon (effective collaborative working between nurses in a multicultural setting in Saudi Arabia: barriers and solutions) in its real-world environment (Specialist Hospital, Riyadh). Semi-structured interviews that included core questions formulated following the central themes from the literature review and the Purnell Model of Cultural Competence were conducted, in which the topic was evaluated, relevant scenarios were discussed, participant details were outlined, and the types of influence were considered regarding the phenomenon’s real-world setting (see Appendix 1). According to Yin (2013), case study research projects depend on six possible primary data sources: physical materials, participant observation, direct observation, interviews, archives and documents. There are many pros and cons for every data source. For example, focus group interviews as a qualitative method are believed to improve upon one-to-one interviews

because they offer the opportunity for discussion, which can lead to more varied answers from participants.

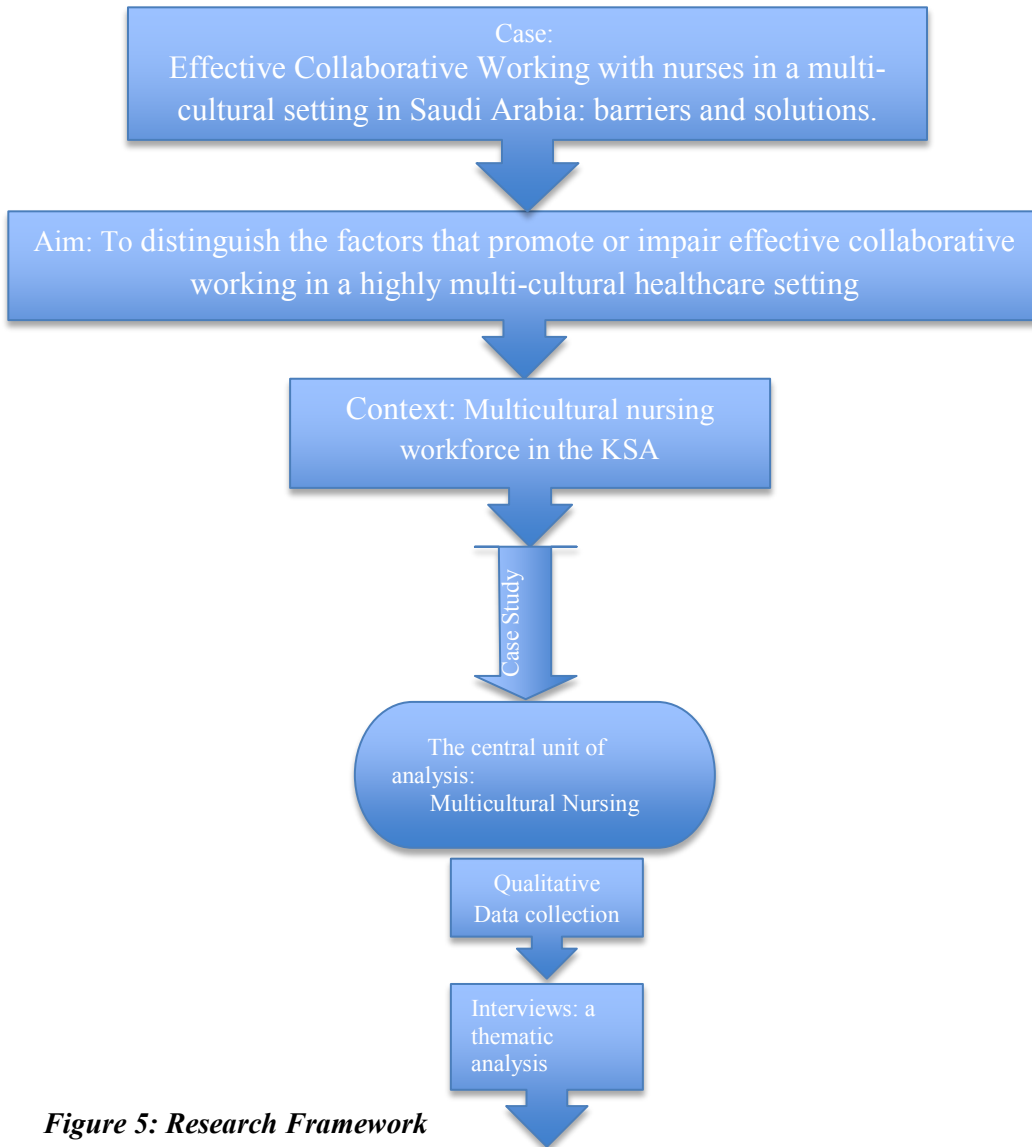
Powell *et al.* (1996) suggested that the focus group method is the primary approach used for obtaining perspectives via the offering of services. However, in this research, due to the sensitivity of the subjects, the focus group may not be a good choice, as a valid method is needed that gives more privacy to participants.

#### **4.7 Data Collection**

This research study utilised the various stages of the interview as elements for data collection, all of which were expounded upon separately.

As recommended by Yin (2013), all participants were selected with consideration of diversity, with individuals of various ages, faiths, genders and ethnicities (to be discussed in detail later). This will allow the results of this study to represent the viewpoints of different types of participant.

There was one approach by which data could be assimilated for the study, which is connected to a specific sub-aspect of analysis. More details about data collection are presented below.



**Figure 5: Research Framework**



#### **4.7.1 Qualitative (Interview Stage)**

The interview method is the most generally used approach for data collection in qualitative studies. Indeed, Yin (2013) notes that the interview stage, as a part of the data collection, is deemed one of the primary significant elements within case study-based research projects, because the data is to be extrapolated and delivered through the minds of the participating sample population. Consequently, the semi-structured method of interviewing was used in this study to identify the factors that promote or hamper effective collaborative working in a highly multicultural healthcare setting.

According to Yin (2013, p.89), semi-structured interviews organised and guided dialogue, as opposed to specific and related investigations, thus indicating that the research author should draw the line of the inquiry and direct the conversation in a direction that describes the issue at hand. Therefore, in the semi-structured approach, a series of questions or statements that are essential to the investigation of each of the research issues and aims are developed. For this research, some leeway about the wording of the question put to each sample member is provided, and the literature review and the Purnell Competence Model (Purnell, 2002) guided the development of an interview schedule (Appendix 1). The research author was also permitted to go off on a tangent in the conversation, as well as to investigate a particular answer further, through the progression of the dialogue. Furthermore, the author should carry on the interview and continue to ask questions until the saturation point is reached, which is when no further data can be extrapolated and where the answers start to be repeated (Merriam& Tisdell, 2015). The strength of this method of interviewing can be seen in the argument that the research author can give full attention to the subject of the case study (Yin, 2013).

Some authors (e.g. Yin, 2013) warn that the process of interviewing may end in biases or warped responses due to the interviewees providing data that they believe the research author wishes to hear. To try to overcome this problem, Costa (2006) suggests means by which this can be avoided throughout the interview. Such factors include accurate and active listening, maintaining eye contact with the interviewee, retaining respectful dialogue, being polite and amicable, and the interviewer keeping a neutral expression on their face (Costa, 2006).

To try to remove the bias in the study, the research author was attentive to the words spoken and the ordering of the questions used in the interview stage (Crouch and Housden, 2012).

#### **4.7.2 Ethical Issues**

This study was guided by:

- Code of Professional Conduct and Ethics of the Ministry of Health (General Directorate of Nursing Affairs), Saudi Commission for Health Specialities/Saudi Arabia (2012):  
<http://www.scfhs.org.sa/en/Reglations/Pages/default.aspx>.
- Royal College of Nursing Guidance for Nurses (RCN, 2009)
- University of Salford ([http://www.pg.salford.ac.uk/page/codes\\_of\\_ethics](http://www.pg.salford.ac.uk/page/codes_of_ethics)).

Every one of the total 18 sample population interviewed was provided with a note on the intention and the procedure of the study itself (see participant information sheet (Appendix 7)), as well as the study author's role and the methodological process. The sample population was also regularly reminded of the anonymity of the research and that all data was given in confidence. More about Sample Population Recruitment can be found in section 4.8.

All participants' information was coded and anonymised. Only the researcher and the supervision team at the University of Salford had access to the raw data. The researcher explained the confidential nature of the data recorded and informed the subjects that the anonymity of their identities would be maintained.

The study had two forms of data – hard copy and soft copy. The hard copy data was kept in a locker accessible only to the researcher. The soft copy data was stored securely on a password-protected external hard disk and was connected only to the researcher's laptop; only the researcher would be able to access the saved study data. Furthermore, during the study period, all data was considered highly confidential and carefully handled regarding the participants' anonymity and dignity, to avoid any breach of confidentiality. All anonymised hard and soft copy data will be kept for two years following the study – while publication and dissemination take place – to allow verification of the data from external sources if necessary, or for longer if used for further research. The data will then discarded following the University's research data management policies.

There were no sensitive issues, such as suspected poor practice, which would need to be raised through the appropriate channels.

Unfortunately, there are no published specific procedures to follow for cases of poor practice in the Specialist Hospital or King Fahd Medical City. Therefore, if an interviewee disclosed illegal or harmful practices or severe concern about another member of staff, the researcher, by means of their professional code of conduct, would talk to the participant individually about the issue, encouraging them to report it as necessary. Depending on the severity of the practice, the researcher would contact the Chair of the Nursing Department to draw their attention to the issue and provide sufficient information to enable them to deal with it effectively. Only in severe cases, where the Chair of the Nursing Department was unable to deal with the issue without identification, would the participant's name be disclosed. The interviewees were given this information before the interview (see participant information sheet (Appendix 7)).

Following ethical approval and permission being obtained from the University of Salford (see Appendix 3) and study site (Appendix 5), a letter to the local research supervisor and information sheet was sent by email to select potential participants.

To achieve informed voluntary consent, the participants were provided with an information sheet for the interviews. Each participant was given respect, time and the opportunity to decide whether or not to participate, with the option of contacting the researcher directly. The information was offered in English (as the sample was chosen from nurses with an English-speaking multicultural background) with sufficient information that was accurate, adequate and relevant to the study purpose. Informed voluntary consent was ensured – participants were asked to sign a consent form before the interviews (see Appendix 2).

All data gathered was treated as anonymous and confidential, with codes replacing identifying information. Members had the freedom to withdraw from the investigation at any stage without prejudice – any data collected before a withdrawal could be used during the research. The timeframe for withdrawal was within a month of the interview, which is in accordance with the University of Salford's research guidelines. Approval from the Specialist Hospital and Research Centre was obtained prior to starting the recruitment and data collection.

## **4.8 Sample**

### **4.8.1 Justification of Sample**

A purposive and non-probability method was undertaken in order to select nurses to take part in the interview and process. Purposive sampling is employed in the case of recruiting those who have knowledge of the phenomenon or expertise with the subject of assessment. Sample members were selected on the basis of their knowledge of the subject area, as recommended by Creswell (2012). Consequently, the criteria for selection were needed for the process of purposeful sampling, according to authors such as Creswell (2012) and Merriam (1998).

Recruitment strategies were important in obtaining a level of cooperation and commitment from respondents. There was a clear channel of communication through the nursing research senior specialist at the study site.

The sites chosen for this study were six inpatient nursing units and nursing manager departments at a Specialist Hospital in Riyadh. The bed capacity of the study site is 1,549, along with a considerable staff strength of 14,650, which includes nursing, medical, administrative, research, and technical staff members.

Purposive sampling was used to select the participants. For interviews, one or two nursing staff members were recruited from each of the nursing units: critical care areas, medical and surgical units, nursing Administration. Eighteen interviews were conducted (with appropriate diversity sampling) to secure a range of views from a cross-section of the sample. The study site employs 2,555 nurses of 25 different nationalities and background (personal communication from the nursing research senior specialist). As for the hospital ethnic proportions there is the Saudi group, an Asian group (Indian, Pakistani, Malaysian), a Far East group (Filipino), an Arab group (Lebanese, Jordanian, Palestinian), a Western group (British, American, Canadian, Irish, European) and an African group.

### **4.8.2 Recruitment of Sample**

The local research supervisor assisted with the recruitment. She helped the researcher to select the participants (staff nurses, head nurses and nurse managers from different backgrounds). Participants were chosen according to the following inclusion criteria (see table 3), which were included in the letter to the local research supervisor:

- Saudi and non-Saudi nurses;
- Nurses of different age groups, education levels, positions, ethnicities, faiths and genders;
- One year or more of nursing experience;
- English speakers

**Table 3: Summary of the Data Collection**

Purposive sample	Target sample	Faiths	Age group	Education level	Ethnicities	Gender
Face-to-face semi-structured interviews 30-60 min	Nursing Managers (n=10).	Muslim=6 Others=4	6=31-35 yrs. 2=36-40 yrs. 1=41-45 yrs. 1 > 45 yrs.	Postgraduate (n=4). Bachelor's (n=6).	White - South European. White British Asian Indian Arab (2) White Canadian Saudi (4)	Male (n=2) Female (n=8)
	Nursing Staff (n=8).	Muslim=4 Others=4	2 < 30yrs 3=31-35 yrs. 1=36-40 yrs. 1=41-45 yrs. 1 > 45 yrs.	Bachelor's (n=6). Higher Diploma (n=2).	Central American. Arab. Black African. Malaysian. Pakistani White Irish Filipino Saudi	Male (n=2) Female (n=6)

### **4.8.3 Procedure: Before Interview**

To begin with, the study site (Specialist Hospital and Research Centre) was contacted to gain permission for the study (see Appendix 4). Once overall permission was granted (see Appendix 5), the researcher contacted the local research supervisor assigned by the study site to supervise the external researcher within all nursing units through an official email (see Appendix 6). The email included the participant information sheet (PIS) for staff nurses, head nurses, nurse managers and policy-making nurses (Appendix 7, and see Table 3 for participants' coding).

The local research supervisor arranged a suitable time by telephone and email to conduct the interviews with the target participants.

#### **4.8.3.1 Piloting the Interview**

Pilot interviews help in recognising strategy concerns with the question design, substance, interview technique, as well as appraising the reliability and validity of the procedure (DiCicco *et al.*, 2006). Furthermore, the capability of the researcher is examined within the pilot management, as they are then capable of practising their interview performance, which was then settled into two distinct pilot interviews for the present study: with staff nurses and with a nurse manager (Waltz *et al.*, 2010). The pilot interviews included those with; a nurse manager, nurse supervisor, head nurse and staff nurse, who guided within the similar manner that planned for the stage of total data collection, and the interviewees delivered comments on their understanding of the interview questions (Kvale, 2006). Therefore, the question's validity to the subject and the researcher's communication skills were assessed within the pilot, which successfully prepared the researcher to conduct the interviews for the relevant study. As there were no changes in the interview dialogue, the pilot sample results are included with the total results.

#### **4.8.3.2 Interview Guide**

The researcher developed an interview guide through the recognised themes within the literature review and Purnell Model of Cultural Competence. This guide allowed the researcher to form the interview continually through the organised questions for all interviewees, although flexibility was provided to permit for investigation where the researcher believed it necessary for each separate interview (DiCicco *et al.*, 2006). The sequencing of questions was essential, and those

questions that were deemed more challenging had to be retained until the participants looked comfortable. After the pilot interview, the sequence of questions was modified, where it was discovered that interviewees preferred an opening so they could become settled before discussing effective collaborative working (see Appendix 1). Hence, positive preparation techniques were utilised, for example, asking nurses general questions about their years of experience with regard to the KSA.

#### **4.8.4 Conducting the Interview**

The interviews were held in a convenient and private place: in a work office and conference room in the study site. They were booked during working hours to make them easily accessible for the participants. There were some cultural and religious issues; for example, the researcher interviewed a Muslim Arabic man who insisted on keeping the office door open to avoid any mixing, as Muslim men and women should be socially isolated, and so to overcome this we chose an office in the middle of the unit with the door open.

Section 4.8.2 contains more details about Sample Population Recruitment.

The length of each interview differed, depending on the amount of detail the participants were able to offer in response to the questions asked. However, it was anticipated that the interviews would be approximately 30-60 minutes long. The conversations were recorded and transcribed with the consent of the participants. An interview guide was used (see Appendix 1).

Polit and Beck (2006) suggested that this combination of questions allows the participants to focus on the essential points of the research question. The questions moved from general to more specific and were related to important issues in the research literature (Fontana and Frey, 2000) (see Appendix 1). The researcher debriefed the participants at the end of the interview.

### **4.9 Credibility and Trustworthiness Issues in Qualitative Studies**

Qualitative methods were used in the data collection; in particular of qualitative data were examined through trustworthiness, which involves credibility, conformability and transferability (Graneheim and Lundman, 2004; Koehn and Lehman, 2008). Trustworthiness is recognised by

revising a multidisciplinary interview of researchers with different perceptions (nurses and nurse managers from different backgrounds, ages, experience levels and qualifications). With respect to achieving trustworthiness, the interview dialogues were managed and transcribed thoroughly by the researcher. The discussions were digitally recorded, thereby assisting accurate and exact transcription, thus further enhancing the trustworthiness (Patton *et al.*, 2002), as recognised by participants and highlighted in Chapter 5. According to Koehn & Lehman (2008), matters of credibility concern the focus of the study; explicitly, the level of confidence displayed concerning how well the data and procedures of the analysis address the objectives of the research.

Content analysis requires researchers to be original (Graneheim and Lundman, 2004). Conformability concerns the objectivity of the data (Koehn and Lehman). The researcher's expectations and prior knowledge can impact the research progression (Mays and Pope, 2000). Accordingly, caution was required to diminish these impacts in particular of whichever the research analysis, as well as to offer other researchers the chance to censoriously review the drawn conclusions (Miles *et al.*, 2013) With respect to achieving Conformability, the thematic analysis was checked with the supervision team. Moreover, every stage of the analysis was cautiously documented and described (Koehn and Lehman, 2008) this was demonstrated by exhibiting rich quotes from the participants that describe each emerging theme. According to Miles *et al.* (2013), the level to which study results are appropriate to other settings or units is identified as the property of transferability. Thus, so as to allow other researchers to evaluate the transferability of these research results, the research method and processes have been offered in detail. Authenticity refers to the level to which the researcher articulates the opinions and emotions of the participant's in authentic and truthful manner (Polit & Beck, 2008). Accordingly, reporting in this descriptive way, will enable readers to understand through the participant quotes, as in Chapter 5.



## **4.10 Qualitative Data Analysis**

According to Elo and Kyngäs (2008), the qualitative data analysis can make use of different methods. The choice of an analysis technique is related consequently to the research subject, the researcher's favourite, and the method.

### **4.10.1 Introduction to Qualitative Data Analysis**

There are three approaches the researcher can utilise when underpinning qualitative analysis (Smith and Firth, 2011). These include: first, socio-linguistic approaches that are utilised to investigate the use and implication of language (for example, conventional analysis); second, approaches that emphasise the theory development (for example, grounded theory); and third, methods to explain and interpret the views of participants (for example, content analysis or thematic analysis) (Smith and Firth, 2011).

In general, thematic frameworks are used in studies that have complicated forms of evidence (Ellis, 2010). Additionally, this is the suitable type of framework to apply to transcribed evidence (Smith and Firth, 2011). Content or thematic analysis is a procedure of shape acknowledgment that is established on reading and rereading the transcribed data (Fereday and Muir-Cochrane, 2006). Content or thematic analysis has a record of practice in nursing, sociology, business, and psychology (Elo and Kyngäs, 2008). The thematic framework encompasses the identification of principal, repeated and very significant concerns, which are recognised as themes that appear from the transcribed data collected (Ritchie and Lewis, 2003). The framework reveals the key ideas and assumptions across the data set (Smith and Firth, 2011). For this study, the analysis was supported by the NVivo11 program, which was used as the ideal technique to support the qualitative data analysis, as it can offer a single storage place, accessibility to data and enhanced stability for analysis (Bergin, 2011). According to Seale (2004), it is important to keep in mind that the data is interpreted by the researcher and not the computer.

### **4.10.2 Adaptive Thematic Framework for Data Analysis**

The six steps of thematic analysis for qualitative data adopted by Braun and Clarke (2006) were used as a framework to analyse the interviews. According to Braun and Clarke (2006), the theme captures essential things regarding the data in relation to the research aim and provides a certain level of sense within the research data. Themes can be recognised through an inductive or bottom-up approach (Frith and Gleeson, 2004), or through a top-down or theoretical or deductive approach (Boyatzis, 1998). Therefore, inductive analysis is a method of coding the data without having to fit it into pre-existing themes or the researcher's conceptual framework. This method of thematic analysis of determined data was chosen for use in the beginning of this research. A theoretical thematic analysis would be managed, as determined by the researcher, in this case the Purnell Model was used to be more specifically fitting the possible themes from the inductive analysis under Purnell themes. This type of thematic analysis delivers a less in-depth description of the data generally, and comprehensive analysis of only specific parts of the data, for this reason, it was chosen following inductive analysis.

Additional choices need to be made regarding the level at which themes are to be classified: at a semantic level, or an interpretative or possible level (Boyatzis, 1998). A thematic analysis at the possible level drives beyond the semantic level of the data set and leads to classify and assess the underlying concepts, statements, and beliefs – and philosophies – that are informing the data of the semantic content. The following section details how to conduct a step-by-step thematic analysis.

### ***Step 1: Familiarising yourself with your data***

The data was collected from 18 interviews. In preparation for the data analysis, audio data was transcribed *verbatim* to a text document, and then uploaded to the electronic data management system, NVivo 11. It was then organised, to enable familiarisation and immersion with the data set. By listening to the recorded interviews, readings and re-readings, it is possible to guarantee that the genuine meaning of the transcribed interviews will not be missed at any step to ensure the data accuracy.

### ***Step 2: Generating initial codes***

This step starts when one has read and become familiar with the transcribed data, and has produced an opening list of opinions about what is included in the data set and what is noteworthy about them. This stage then contains the invention of initial codes from the transcribed interviews. Codes distinguish the data (semantic or latent) that emerge as interesting to the researcher, and indicate “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998: p. 63).

Throughout this step of the present research, initial codes were established. Using NVivo 11 (see Figure 5) to implement the initial-coding step facilitated the data management. NVivo 11 has its particular terminology for every step of the coding method. Within NVivo 11, coding the data set includes the invention of nodes. A node is a group concerning a specific theme or an area of significance (Bazeley *et al.*, 2013). Within NVivo 11, these nodes are noted as case nodes, free nodes, tree nodes and matrices (Bergin, 2011). For instance, among tree nodes there is a categorised arrangement beginning with the parent and going down to the child, moving from a broad theme to a more detailed feature of that theme. Case nodes are involved with participant elements, for example demographic data. Relationship nodes describe a correlation among two or more nodes. Lastly, matrices are the outcome of a matrix coding and are utilised to investigate additional relationships among nodes. This NVivo system was tested against several approaches, and its key advantage is that it assists examination of the data across the use of query instruments, for example matrices, that would otherwise be challenging (Bergin, 2011).

### ***Step 3: Searching for themes***

This step begins once all the data has already been initially coded and organised (Braun and Clarke, 2006), and a list has been produced of the codes that were recognised through the data set. This step re-emphasises the analysis at the wider level of themes, which includes organising the codes into initial themes, and gathering all the similar coded data within the recognised themes. Essentially, through this step, the researcher began to analyse the codes, while bearing in mind how diverse codes may be gathered to produce a primary theme. In this step, some codes do not seem to fit anywhere, and according to Braun and Clarke (2006), it is perfectly conventional to generate a theme named *miscellaneous* to gather the codes that do not seem to fit

adequately into the other themes. Lastly, by this point, I have a sense of the meaning of particular themes.

#### ***Step 4: Reviewing themes***

This step includes two stages of revising the themes. Firstly, it contains refining at the level of the coded data. This required reading all the quotations for each theme, and checking whether they seemed to have a logical form. If the provided theme looks inappropriate, the researcher considers whether the theme is tricky, or whether some of the participant quotations within it are not applicable. Accordingly, the researcher would revise the theme, producing a different theme, allocate a place for those quotations that do not fit into any present theme or exclude them from the data analysis. At the second level, it is essential to recognise the validity of each theme regarding the data set, and whether the provisional thematic map correctly reveals the meanings apparent in the complete data set. Nevertheless, there is a word of warning by Braun and Clarke (2006), as coding data and producing themes can potentially result in over-enthusiastic and limitless re-coding. It is challenging to deliver comprehensive guidelines as to what time to stop; in general, once the modifications are not providing something significant, the researcher should stop. If the procedure of recoding mainly makes a coding structure, which previously works, more nuanced, then it is time to stop (Braun and Clarke, 2006). At the end of this step, I have good knowledge of what every different theme is, how they adequately fit together, whether or not they fit within the Purnell model domains, and the complete story they state regarding the data.

#### ***Step 5: Defining and naming themes***

Step 5 starts once there is a satisfactory thematic plan of the data set. At this level, it is necessary to define further and refine the themes that will present the Purnell model and themes that have newly emerged from analysis. By identifying and naming, this recognises the essence of every individual theme and the overall themes, and determining what characteristics of the data every theme reflects. For every single theme, a comprehensive analysis needs to be written. Moreover, the story needs to recognise that every theme articulates, as it is essential to reflect how it fits into the Purnell Model and broader complete story that the researcher tells with regard to the data, and regarding the research aim and objectives. Lastly, the names of the themes, in the final

analysis, must be brief and directly provide the reader with a logic sense of what the theme is about.

### ***Step 6: Producing the report***

This step starts when there is a set of entirely worked-out themes, and includes the themes corresponding with the Purnell Model domains and newly emerged themes of the last analysis that were impossible to fit within the model. These need to be presented separately alongside subthemes, which will allow the research aim and objectives to be met and allow the write-up of the produced report. The challenge of the write-up of the research's thematic analysis is to inform and convince the reader about the complicated story of the data and validity of the presented analysis. However, the write-up should do more than just deliver data. Participant quotations must be embedded within a critical description that explains the story that the researcher is telling with regard to the data, and the critical description needs to go beyond a simple explanation of the data, which creates an argument regarding the research aim and objectives.

#### ***Table 4: Example of Data Analysis Drawn from the Study***

##### ***Step 1: Familiarising yourself with your data***

Data was listened to and then transcribed *verbatim* and transferred into the NVivo 11 software. The following part delivers an example of one participant's interpretations and reveals how one sentence can enclose themes and sub-themes. Every theme is provided in colour to support transparency in the sample.

##### ***Step 2: Generating initial codes***

The following section of text was allocated and coded to the initial coding theme of "blame culture".

*Participant 1, Female, White - South European: they would hide mistakes from each other because there's no way you can be sent home because we did this mistake ... Certain people here, they have the power to do that. Especially with VIPs that if they don't like you, they can send you home because the hospital allows that to happen because people do have power.*

### **Step 3: Searching for themes**

The parts of text below were given the following codes and then further classified on subsequent analysis. These were merged into themes with sub-themes with additional enhancement and analysis.

Blame culture

*'They would hide mistakes from each other'.*

Threaten culture

*'Because there's no way you can be sent home because we made this mistake'.*

Power/disempowerment

*'Certain people here, they have the power to do that. Especially with VIPs that if they don't like you, they can send you home'.*

Hospital culture

*'Because the hospital allows that to happen because people do have power'.*

### **Step 4: Reviewing themes**

**Theme:** Blame culture and Power/disempowerment

Threaten culture      Hospital culture

### **Step 5: Defining and naming themes**

Theme 1: blame culture

Threaten culture /hospital culture

Theme 2: power/ disempowerment

Nursing staff powerlessness and perceptions of hospital / VIPs power

## **4.11 Summary**

This chapter laid out the research methodology utilised within this research, specified as the case study. The philosophical perspectives analysis showed that the case study could direct from several epistemological viewpoints; for example, interpretivism and positivism. This research utilised a qualitative case study to investigate the effective collaborative working at Specialist Hospital, Riyadh. It is a descriptive research method that uses the embedded case study design, given Yin's (2013) definition. The principal unit of examination is the nursing staff. The data were gathered from the multicultural nursing workforce. The research included interviewing nurses with regard to their experiences in working within a multicultural environment in a Saudi hospital. A semi-structured interview method was utilised with those nurses who fulfilled the inclusion criteria. The analysis of data will be directed inductively and deductively. Subsequently, the findings of this study are introduced in the next chapter.

# Chapter Five: Results

## 5.1 Introduction

The previous chapter presented the methodology and methods of this qualitative case study. The semi-structured interviews included core questions formulated by the central themes from the literature review and the Purnell Model of Cultural Competence. This chapter begins with a discussion of the demographic details of the participants, followed by the findings of the 18 semi-structured interviews. The Purnell Model has been used to structure the findings deductively, and there were themes fitted within the Purnell Model, and some not as new themes have emerged, and stand-alone this allows the research aim to be met.

This study focuses on the following research aim: to provide an in-depth understanding of how nurses and nurse managers perceive culture and effective and ineffective collaborative working in a highly multicultural healthcare setting in Saudi Arabia.

### *The objectives include:*

- 1) To understand the organisational structure/individual barriers that nurses have experienced when working within a multicultural setting in Saudi Arabia.
- 2) To understand the organisational structure/individual facilitators that nurses have experienced when working within a multicultural setting in Saudi Arabia.
- 3) To identify best practice provided by organisational structure regarding training, education and research to improve collaborative working between nurses.

## 5.2 Demographic Data

Of the 18 nurses who took part, 14 were female.



As for age distribution, there were two nurses younger than 30 years of age, nine nurses between 31 and 35 years old, three nurses 36-40 years old, two nurses in the 41-45age group, and two nurses older than 45 years of age. They came from a wide range of different countries, including Portugal, South Africa, Lebanon, Malaysia, the Philippines, India, Pakistan, Jordan, the United Kingdom, Ireland, Canada, the United States of America, Saudi Arabia, Palestine and Australia. The education level of two of them was Diploma of Nursing or Graduate Certificate in Nursing, but the majority held a Bachelor of Science in nursing, and four of them held postgraduate qualifications. Every participant was in employment as a registered nurse and the work experience in nursing was between 5 and 35 years, while 13 of them had already worked in different countries for between 4 to 15 years. Work experience in Saudi Arabia ranged between 1 and 20 years.

**Table 5: Summary of Coding for Individual Nurses**

Participant	Gender	Ethnic group	Age	Level of education	Place of work	Experience (Years)
1	Female	White European	33	Postgraduate	Nursing senior specialist	11 years
2	Female	White, British	32	Postgraduate	Clinical instructor	4 ½ years
3	Female	Mixed American	28	Bachelor	Staff nurse 1	1 ½ years
4	Female	Asian Indian	33	Bachelor	Assistant head nurse	12 years
5	Male	Arab	35	Bachelor	Staff nurse 1	7 years
6	Male	Arab	38	Bachelor	Head nurse	15 years
7	Female	Black African	35	Bachelor	Staff nurse	3 years
8	Male	Arab	39	Bachelor	Assitant head nurse	14 years
9	Female	Asian, Malaysian	44	Bachelor	Staff nurse1	12 years
10	Female	Asian, Pakistani	36	Diploma in	Staff nurse	11 years

				nursing		
11	Female	White Irish	51	Higher Diploma in Nursing	Staff nurse	7 years
12	Male	Asian, Filipino	27	Bachelor	Staff nurse	1 year, 2 months
13	Female	Arab, Saudi	33	Bachelor	Staff nurse	11 years
14	Female	White Canadian	56	Recently Bachelor	Senior Nurse	19 years, 9 months
15	Female	Arab, Saudi	33	Postgraduate	Nursing education	10 years
16	Female	Arab, Saudi	34	Bachelor	Nursing supervisor	11 years
17	Female	Arab, Saudi	35	Bachelor	Head nurse	12 years
18	Female	Arab, Saudi	45	Postgraduate	Nurse manager	19 years

## 5.3 Findings

The interview transcripts had many mistakes in grammar because many of the interviewees did not speak English fluently. However, despite the errors, the transcripts were not corrected so as to avoid changing the meaning of the interviewees' responses. To back up the outlined themes, quotations from the interview transcripts are provided in the present chapter in the original format, except for punctuation marks (e.g. full stop, comma, question mark, etc.), which have been introduced for better coherence, more quotes for the whole findings chapter can be found in Appendix 8. Furthermore, to avoid altering what the interviewees meant to say, irrelevant parts of the transcripts have been removed, as indicated by the ellipsis points [...]. In this manner, it was possible to maintain data consistency while providing the gist of interviewees' answers.

### 5.3.1 Emergent Themes

The literature review had revealed some barriers that could be affecting collaborative working in a multicultural setting, such as religious practices, nutrition including adequate food, cultural knowledge, workforce issues, communication, and so on (see chapter 2).

As the literature review and Purnell Competence Model informed the interview questions, some of the themes that emerged from the interview data were consistent with those from previous literature and the Purnell Model; new themes also emerged inductively by thematic analysis (Braun and Clarke, 2006) (see chapters 4 and 5).

The identified themes and sub-themes analysed by Nvivo11 (See Figure 5) are presented in the following sections (see Table 6). The coding of participant nurses is shown in Table 5.

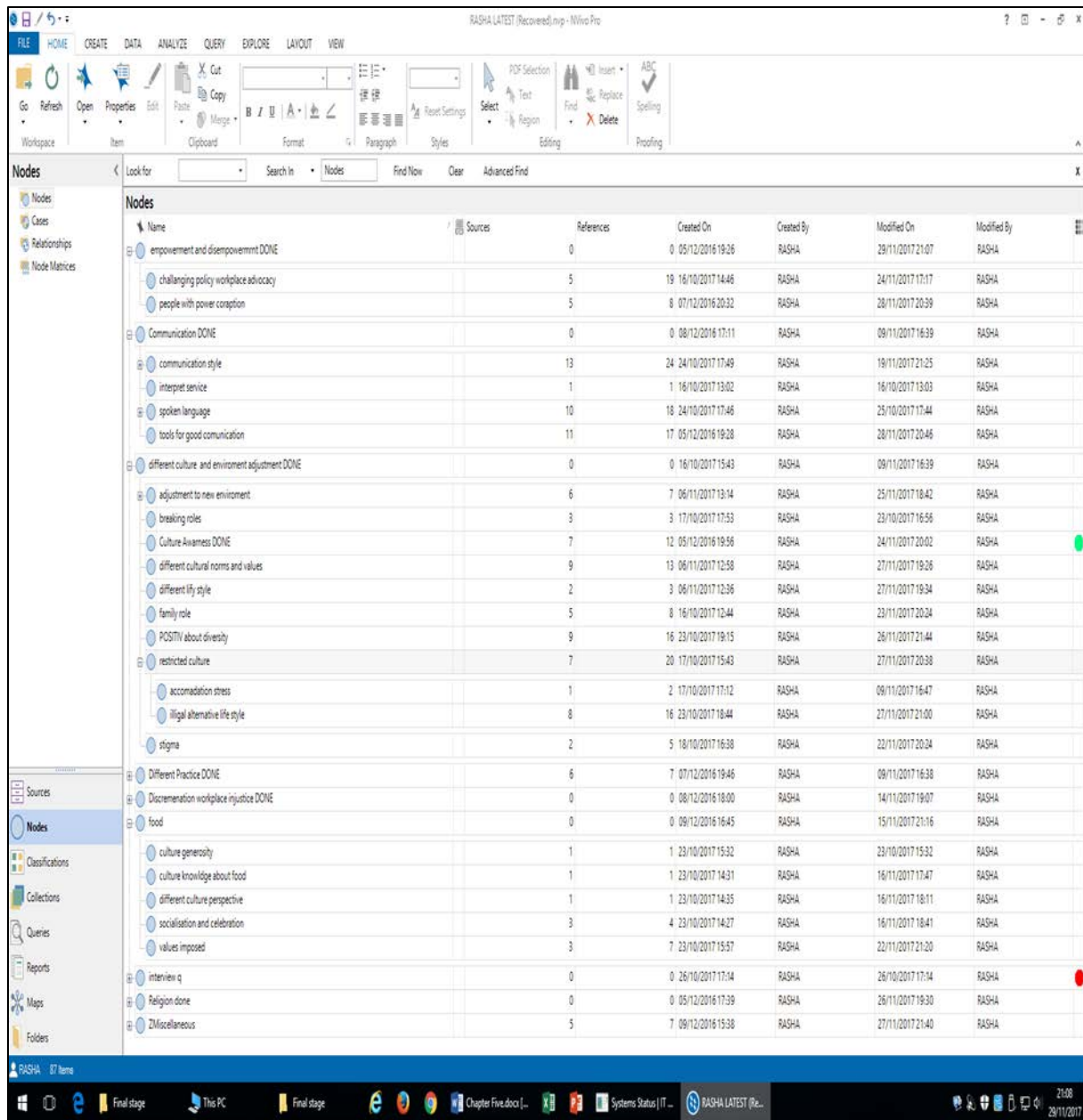
**Table 6: Major Themes and Sub-Themes of Participants' Perspectives in Semi-Structured Interviews**

No.	Theme	Sub-themes
1	Overview/heritage	Reasons for working in KSA and associated economic factors  Politics
2	Acculturation (adjustment to the new cultural environment)	Adaptation process  Education
3	Communication	Language barrier  Nonverbal communication  Communication style  Expression and Interpretation  <i>Translation services</i>  <i>Strategy for good communication</i>
4	Family role and organisation	Head of household  Alternative lifestyle
5	Workforce <u>attitudes</u> , and behaviours	<i>Professional attitude</i>  High-risk behaviours

6	<b>Nutrition</b>	Meaning of food Common food and food rituals
7	<b>Pregnancy and childbearing practice</b>	
8	<b>Death rituals</b>	Death rituals and expectation. Responses to death
9	<b>Spirituality</b>	Religious practice and use of prayer <i>Religious festivals</i> <i>Saudi religious system including religious police</i>
10	<b>Healthcare practices</b>	Healthcare practices from the country of origin <i>Experience &amp; seniority practice</i> <i>Standards of care</i> <i>Role conflicts</i> Folk practices Cultural responses to health and illness Blood transfusion and organ donation
11	<b>Healthcare practitioners</b>	Traditional versus biomedical practitioners Status of healthcare provider
12	<b><u>Cultural differences</u></b>	<i>Cultural norms and values</i> <i>Saudi cultural beliefs and Saudi system</i> <i>The positive aspects of the multicultural workforce environment in Saudi Arabia</i>
13	<b><u>Empowerment and disempowerment</u></b>	<i>Workplace advocacy and challenging policy</i> <i>The use and abuse of power</i> <i>Blame culture and concealing mistakes</i>

14	<u><i>Workplace justice and injustice</i></u>	<u><i>Abuse and bullying</i></u>  <u><i>Discrimination: opportunities, patient care, educational status and occupations</i></u>  <u><i>Salary, skin colour, contract threatened</i></u>  <u><i>Ethnocentric</i></u>  <u><i>Workplace violence and aggression</i></u>
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\*Italic underlined themes and sub-themes were developed inductively from this research and fall outside the Purnell Model structure



**Figure 6: Screenshot of Nvivo 11 Showing Analysis**

Initially, the themes classify inductively. As part of the analysis process when some of the new sub-themes fit with the Purnell model and the deductive analysis appeared to be a useful way of presenting the findings to address research objectives. The Purnell Model of Cultural Competence was used to categorise the participants' quotations in a specific order. Each theme

quotation begins with collaboration issues between the nurse and another individual (nurse, patients, etc.), which is the first inner cycle of the model, followed by a quotation about collaboration issues between the nurse and another ethnic groups instead of the family as prescribed in the Purnell Model. The third circle was developed from references to collaboration issues between nurses and organisational policy and strategy instead of the original community. Finally, the outer ring will cover the collaboration issues between nurses and the dominant system instead of global society, which is the outer circle in the Purnell model. As these four circles were modified and renamed according to the study results (person, ethnic group, organisational policy and strategy, and dominant system), they influence the fourteen domain themes in the study below.

For the identified themes and sub-themes, please see Table 6. For the Extended Cultural Competence Model for Effective Collaboration in a Multicultural Nursing Workforce, please see Figure 6.

### ***Theme 1: Overview/heritage***

This first theme emerging from the data is within the Purnell Model and includes the views of staff, ethnic groups, organisational structure of the dominant system barriers and facilitators when working within a multicultural setting in Saudi Arabia. The prominent impressions were further categorised according to the Purnell Model as reasons for working in Saudi Arabia and associated economic factors, and politics. It is evident from the results of this study that the theme of “reasons for working in KSA and associated economic factors” is significant as a facilitator; as endorsed by participants because of the geographical location. The KSA system can play a role in facilitating multicultural nurses to come and work within the Saudi health system.

*Regarding the above, the interview dialogues highlight the following:*

### ***Reasons for Working in Saudi Arabia and Associated Economic Factors***

This sub-theme was modified to discuss the reason for nurses working in Saudi Arabia, and not migration as described in the Purnell Model of cultural competence.

Participant 11 noted the geographical position as an attractive location for work and a significant reason to work in KSA:

*“I suppose one of the reasons that kept me here and keeps a lot of people here is the geographical position of Saudi. Africa, Asia, Europe, two, three, four hours on a plane and you're everywhere. Saudi has been very good to me. I go home to Ireland three times a year. I've been to America and Australia...China. It's afforded me a lot of things.” (Participant 11)*

Additionally, participant 2 highlights other privileges of working in Saudi Arabia; as western nurses they earn more, they do not pay taxes and can afford to go to places they dream about:

*“You get accommodate, everything provided for you. Especially from the UK's perspective you earn more and you're not paying taxes. You can travel. You can afford to go to places that you would only dream of going to. This is why British Western nurses do this for a few years.” (Participant 2)*

Participant 11 explains that some nurses from different ethnic groups chose to be a nurse for financial reasons, as an export job that can lead to different standards between nurses:

*“Different nationalities have different standards. For me, I got into nursing because I wanted to do nursing. I knew that I would never be rich. ... Sometimes I'm not sure if other nationalities do it because it's an export job.” (Participant 11)*

Participants highlight the different norms and ethics between colleagues reflected in practice:

*“We were raised believing that values and dignity and ethics are more important than money. Those people, they weren't” (Participant 1)*

## **Politics**

In addition, participant 10 highlights that nurses from different ethnic groups are influenced by political issues between countries and this affects the nurse's workplace collaboration:



*“In the beginning, I face a problem with Indian nurses ... I realised how I have to talk with them. Because you know, Pakistan, India we are separated countries.” (Participant 10)*

The above theme emerging from the data is from the Purnell Model explains the views of staff ethnic groups with the influence of the organisational structure and dominant system, as the nurses elaborate on their experiences and the reasons for working in Saudi Arabia and associated economic factors, and politics as barriers and facilitators between them when working within a multicultural setting in Saudi Arabia.

### ***Theme 2: Acculturation (Adjustment to the New Cultural Environment)***

The second theme emerging from the data cluster includes the views of individual/ethnic group/organisational structure barriers and facilitators to acculturation and adjustment when working within a multicultural setting in Saudi Arabia, and where nurses would elaborate on their experiences and perceptions. The prominent impressions are further categorised as adaptation process and education. The participants in the interviews reported their barriers to the “adaptation process and education” as including challenges and struggling to work with nurses from different ethnicities and the organisational barriers toward the Arab ethnic group. There appeared to be limited understanding of the range of cultural backgrounds of the staff working in the multicultural environment.

#### ***Adaptation Process***

One participant explains the challenges and struggles in working with nurses from different ethnicities and the complicated process to adjust and gradually cope with working with different people:

*“Then later, I realised that I have to work with these people if I work, it's very difficult to survive with them. Then, I realised, and then I cope with them gradually. (Participant 10)*

Participants argue that adaptation to a new workplace culture such as this Saudi hospital is difficult for people of Arab ethnicity and Islamic culture, unlike the American staff, as they have the same work standard system:

*“Like maybe the one coming from Muslim countries, they are fighting more for their rights. What about here we are following, it's American standards. Those people that come in from North America, they are living in this system. They don't have a problem when they come here.” (Participant 8)*

Additionally, participant 6 noticed how interested, passionate staff could learn about other cultures and that would help to manage their adaptation and adjustment with differences between people:

*“I'm Arab person, but there is not that much big change in the culture between here and there. Maybe for the other nationality, it might be in the beginning but it when we use to learn about the culture, about the people it will be fine. If they are interested and they are interested in work” (Participant 6)*

## ***Education***

The organisation provides some support for promoting cultural awareness; Participant 1 illustrates that general nurse orientation is focused on an introduction to the Saudi culture only, which she deemed essential, but with what appeared to be limited coverage of other staff members' cultures. Hence if the content is limited to Saudi culture, this will provide barriers to understanding the various cultural backgrounds of staff working in the multicultural environment:

*“When nurses come from GNO, it's a general nurse orientation. One of the things they do, they have a section on Saudi culture. Of course, this is because of the patients. I'm not sure if we should focus on the Saudi culture only. I think we should focus on the other culture because, at the end of the day, you deal with patients but you deal with your colleagues, and this is where the problems come from.” (Participant 1)*

Participant 13 explains that the general orientation provided by the hospital to new staff about Saudi culture is important, especially for patient care:

*“When they come, they have this general orientation, ... they teach them about our Saudi culture, ... and what is it they have to respect, so they know about it. ... If the patients complain here, they listen to the complaint of the patients, and they will take it into consideration.” (Participant 13)*

The only source of knowledge that helped staff to participate in a multicultural atmosphere in the Saudi context was the multicultural night provided by the recruitment and retention department. Any nursing employee can attend these events. The activities aim to acknowledge everyone’s cultures and promote harmony between all cultures in the hospital. There was a cultural awareness course, but it was stopped:

*“We have a department called nursing recruitment and retention, and they do a lot of activities in promoting everyone's own culture. They will have the Malaysian night. ... They will have the multicultural night where everyone can dress up the way they want..... They will try to acknowledge everyone's cultures this way. However, I believe that much more work needs to be done. We used to have a course called Cultural Awareness. We stopped it.” (Participant 1)*

Participant 5 highlights the educational orientation programme provided by the hospital to teach new staff about hospital policy:

*“GNO, this general hospital orientation. It means that through this GNO,.. they can discover what's supposed to be. Also after this, they're going for 15 days as preceptorship...” (Participant 5)*

Additionally, Participant 6 noted that the hospital provides a specific educational orientation programme, internal competence courses and skills courses for new staff to enable them to adjust to the new work environment:

*“Its specific education and we have to go through it then the competency check off plus internal education plus the preceptorship we have to do. ... When they*

*start to work alone within three months, we have to go through all the competency." (Participant 6)*

Participant 3 suggested there was no proper hospital orientation and education within the unit before she started working, and she felt that this was dangerous practice:

*"I don't even have a PALS. I was in emergency taking care of a paediatric patient. I had went to school, ... and they gave me a paediatric course, but here it was like a day, which is not enough for me to be taking care of a very sick child. To me, it felt very, very wrong and dangerous." (Participant 3)*

The above theme from the Purnell Model with data clusters describes the views of staff from different ethnic groups with the influence of the organisational structure and dominant system. The nurses elaborate on their experiences of acculturation and adjustment to the new cultural environment, including the adaptation process and education as barriers and facilitators between them when working within a multicultural setting in Saudi Arabia.

### ***Theme 3: Communication***

The third theme of communication also emerges from the Purnell Model, and the data cluster includes the views of organisational structure/staff/patients' barriers and facilitators to communication when working within a multicultural setting in Saudi Arabia, and where nurses would elaborate on their experiences and perceptions. Data was further categorised into language barriers, nonverbal communication, communication style, expression and interpretation, translation services, organisation communication style and strategies for good communication (see Table 6). It is evident from the results of this study that the theme of "language barriers" includes the poor Arabic language skills of staff as a barrier between nurses and patients. Additionally staff using different languages within in a single unit was problematic. The current study found that understanding and interpreting nonverbal communication such as body language requires cultural knowledge, as certain clues are not acceptable in a different culture and can be offensive.

### ***Language Barriers***

The participants' statements provide an example of the way in which communication is a two-way occurrence, taking place between a staff nurse and other nursing colleagues or clients. Language barriers have a considerable impact on the effectiveness of communication on both sides. Notably, there are many languages mixed in one single unit or in another scenario the participants' Arabic language skills were poor and, in certain cases, non-existent. These issues are the source of a poor communication process that consequently impacts on collaboration. A typical instance of this is presented below between nurses and patients:

*"It's difficult to communicate really with the language barriers. Pretty much that's it, the Arabic, it's hard to explain and elaborate more." (Participant 12)*

Participant 14 noticed how the different ethnic groups and languages in one unit could cause huge communication barriers and lead to collaboration barriers and frustration between staff:

*"Mock code was going on, we had nursing talking in Tagalog, we had nurses talking in Urdu...all trying to do the same thing in the room and speaking to each other. I remember going in and saying, "Everybody speak English please." Mostly because I couldn't understand what was going on but that was very frustrating, ... it would be a huge issue." (Participant 14)*

Participant 1 confirms that different ethnic groups and languages in a single unit will impair the effective communication between staff, which will jeopardise patient safety:

*"I believe that probably half of the safety situations we have that took the patient in jeopardy... It is because there are so many languages mixed in one single unit, and people do not have to stick to one language only. I believe there's so much information lost in between that it's important to know and because we don't understand it, we would miss it." (Participant 1)*

Participant 4 mentions that communication breakdown between staff from different ethnic groups because of language barriers and misunderstandings will affect the delivery of patient care:

*"When we're doing the rounds, the physician Arabic and the nurses our charge nurses Filipino knows Arabic, we receive that this information needs to be done. Sometimes it is not reached in the way of communication in the way of this is supposed to be ... Let us say we need to carry out in this one, but*

*sometimes it is not carried out. There is a miscommunication, misunderstood, misinterpretation" (Participant 4)*

Similarly, participant 3 illustrates the high-risk communication barriers if there is a dominant ethnic group in the unit speaking in their language and not speaking to team members and she is not able to understand anything:

*"I'm in a group with Filipino nurses, and they're all speaking their language, and they're not speaking to me, that's high risk because I need to know, if we're working in a team, what's going on the patient. I need to know." (Participant 3)*

### ***Nonverbal Communication***

One participant noted that nonverbal communication (body language) to overcome language barriers with patients is improving care:

*"97% of our communication is non-verbal, and patients understood that you cared about them... were trying to make it better" (Participant 14)*

Another participant noted that body language between nurses was complex, and always caused conflict because of different ethnicities and different meanings:

*"Body language was always conflict at all times, because of a different nationality...there is a specific nationality. The way they say okay I know is the same body language. I would not know whether you are saying yes or no or okay or not. ... For me, it is confusing, ... That's a big conflict there" (Participant 9)*

### ***Communication Style***

Some problems arose from personal and cultural communication patterns.

Participant 12 explains the western nurse's communication style as direct and straightforward; a different communication style:

*"Westerners... the way they speak, they're very confronting and very straightforward. If you are wrong, you are wrong ... they have strong conviction or... They're very straightforward." (Participant 12)*

Additionally, participant 5 believed that western ethnic groups' straightforward communication style was rigid:

*"Especially the people that come from the north or the west, they are a little bit like rigid or straightforward." (Participant 5)*

One western participant explains the communication style of speaking directly with Saudi ethnic colleagues (physician) will block communication channels between them, unlike back home. In the end, this will affect patient care:

*"I speak clearly, and I say, "I need this and ..." What I learned after a while on the unit was that speaking directly...and having that collegial role with my physicians that I was used to back home... what I found here, I used to call it the mental gymnastics required to get my patient the care they need." (Participant 14)*

*"If I had said to them, "Let's do this." I would have run into a roadblock. Whereas if I said, "You know what do you think? We've done this before at home do you think, ..." You had to be much less direct. You could not just say, "Have you ever tried this? Like do ... can we try this?"(Participant 14)*

### ***Expression and Interpretation***

Additionally, participant 1 explains the different ways of expression between different ethnic backgrounds can cause misunderstandings because of interpretation issues:

*"Whereas other cultures, I've seen from the Arab world, where people are telling you something nice, but the way you see it is "are you telling me off, because I'm not sure." It's the way they express themselves" (Participant 1)*

One more participant stated the same thing about different cultural expression, interpretation and misunderstanding,

*“You say something I understand something else, and it’s different culture, different people and different expression” (Participant 5)*

Participant 7 explained how the person’s ethnic background influences the method of communication and expression and can be interpreted differently by other cultures:

*“That’s with the communications that’s having a problem. You can say somebody is rude but in fact, that person was brought up like that. You have to overlook certain things. Background is a big role. Some people are quiet, some people are talkative, and some people are harsh”. (Participant 7)*

Additionally, participant 1 provided insight into how expression and linguistic interpretation differ among different ethnicities, and accounts of how this affected professional collaboration between them:

*“I would say bad communication because of bad interpretation as well because ... different backgrounds. I say something to you in a manner that to me means something and you will receive it differently. You will think that I am either upset when that is not what I meant, or the opposite. I’m actually quite strong on the message I’m passing and from your background; you take it lightly because you don’t think it’s important”. (Participant 1)*

## ***Translation Services***

Participant 1 raises some fears concerning the accuracy of translation and personal interpretation made by Saudis or Arabic colleagues:

*“Even though we have PCAs and work clerks, they’re meant to be Saudis or Arabic speakers; the frustrating goes as well when you ask them to translate something, and they don’t just translate. They make their own interpretation of whatever they want.” (Participant 1)*

Participant 1 explains how the language barrier between the nurse and patient when the organisation has no translation service can be very frustrating and will affect the nurse-patient relationship and delivery of care:



*"It can be exotic. The frustration comes from the language barrier. It happened to me one time ... none of the nurses was Arabic speakers. No one, not even a physician, not even the RTs. My frustration built to the point that I left the patient. Someone was taking care of him, and I went to cry like a baby." (Participant 1)*

### ***Strategies for Good Communication***

Participants tried to find several strategies to overcome communication barriers. These were at an individual level, such as learning Arabic to communicate better with patients, and self-awareness of different culture communication skills. At an organisational level, the hospital developed new policies such as technology tools for communication between staff, and a new hand over technique that involves the nurse and patients, and a unit-based council team.

Participant 14 highlights a passion for learning personal communication patterns for better communication with the patient:

*"It's me Jenna [Ana momardtk elyom] I'm your nurse today as best as I could say that to them" (Participant 14)*

Participant 1 utilised the multicultural experiences to develop self-awareness and cultural knowledge of other cultural communication skills:

*"I've been here long enough to know that if I speak ... The same message. If I have to say this to a Jordanian nurse, I know I have to say it in a different way than I say it to an Irish, to an American, to an Australian, to even a Portuguese. Being here for this long makes me more culturally aware." (Participant 1)*

One of the strategies that the organisations used to overcome communication issues between the different ethnic groups was to use SBAR technology tools:

*"One of the strategies that we found to overcome the communication issue, to the maximum we can, it was the development of the SBAR tool. SBAR is a tool that we use for handover." (Participant 1)*

Another participant agrees with using technology as a communication tool:

*"SBAR It's a new communication tool that we're using here in the hospital. It is more so when you are giving a report from one nurse to the next. That's a good example of communication." (Participant 14)*

Some participants who had management roles articulated the hospital strategy of introducing the unit-based council team as facilitators to listen to each other and solve problems that staff have in the same unit so as to expedite the communication process between colleagues before the problem became complicated and spread outside the unit level:

*"We are at the moment magnet hospital. We have that unit-based council team, it has a shared course share, and it has the member from the unit plus the leader who will be as a facilitator." (Participant 6)*

*"The unit-based counsel in the unit comes in as well to focus on which of the staff require to give them orientation and all these things..."While the person is new is a transition process..That is valuable between cultures" (Participant 9)*

*"Communication is very important we have round every morning we communicate about all the patients, we do... departmental meeting to solve any problem, we have social care department, pt. relation office "(Participant18)*

*"conflict management; we are doing our best like, communicating more, listen to each other, to solve the problem before the managers."(Participant 8)*

The communication theme from the Purnell Model represents the views of staff from a different ethnic group with the impact of the organisational structure. The nurses describe that their experiences of communication include; language barriers, nonverbal communication, communication styles, expression and interpretation, translation services. These are both as barriers and facilitators with the organisation in a position to promote good communication styles and strategies.

#### ***Theme 4: Family Role and Organisation***

The fourth theme from the Purnell Model to emerge includes the views of the family role and how this affects interactions with patients and how staff are organised about their attitudes within the workplace. The prominent impressions were further categorised as head of household and alternative lifestyle (see Table 6). In this research participants assumed that Saudi nurses will give up their career after marriage for their husband and family and give priority to their husband and children.

### ***Head of Household***

Participant 2 noted that the family role, including the husband's authority in Arab culture, influences the practice of Saudi and Arab nurses:

*"I think it's a big cultural thing. The expectation is I think they -- the way I see it, and I've gotten along very well with a lot of young Saudi nurses, Well, my husband wouldn't let me work nights. I can't work the weekends. I think families. I think the pressure is still very much there on young, not just Saudi nurses, but young girls from Arab backgrounds, the ones that I know and work with closely. The yes, you might have decided to have this career, but we still expect you to get married and have children." (Participant 2)*

The family role in Saudi culture is significant and can cause barriers on some occasions. One participant explains that the family in Saudi culture play a role, especially in patient care, and the family requires further explanation:

*"Family, they need more explanation to understand a case." (Participant 5)*

### ***Individualistic Versus Collectivistic***

Moreover, participant 14 noted the different cultural values behind the negative attitude of the colleagues as an individualistic and collective culture:

*"Part of it is that whole culture of, whereas in the west we tend to be very individualistic and look out for ourselves, it's much more collective. You have that, my brother and me before and me and my clan, my countrymen and me before you." (Participant 14)*

Similarly, participant 9 noted that the staff teamwork is based on one's own culture and this is how they grow up:

*"One big difference is a certain culture, once admission comes everybody will come in to help, so the culture. That's how they grow up if that's their team dynamic, but certain culture you have to call them, "I need help. Can you please help me?" All those things." (Participant 9)*

### ***Alternative Lifestyles***

The quotation below explains how an alternative lifestyle can influence and affect the working relationship, and these are influenced by ethnic group/organisational policy, strategy and the dominant system.

Participants noted the risk concerning discussion of alternative lifestyles, for example, a boyfriend or a single parent with colleagues from different ethnic groups, especially from staff with a profoundly religious background, such as Asians as well as Saudis, as they will be judged as a result:

*"It's quite tricky to speak about single parenting or the lifestyle you have before marriage if you have a boyfriend. I remember when I was in the unit, I couldn't speak about my boyfriend to certain colleagues because, for them, that would be insane; I cannot do this. Difficulty in speaking about alternative lifestyle is not just in Saudi, in Saudi people. Even with powerful religious countries like the Philippines, some background, even Indian nurses, sometimes they do come from an arranged marriage, arrangement background is loud, it's not only Saudis." (Participant 1)*

*“It's very difficult situation. As a Western nurse having a relationship here is a very difficult situation to manage. There are lots of hurdles to overcome that you wouldn't have in the real world as I put it.” (Participant 2)*

Also, some participants expressed their rejection and non-acceptance of single mothers and noted that being a single mother was not reasonable and should not be discussed. These differences can affect the working relationship between colleagues from different ethnic groups:

*“Single parent, it's nothing for them. It's normal. For us, it's not normal for us.” (Participant 4)*

*“Such things like it's not normal here for the culture likes of the single mother, people they don't go to discuss it.” (Participant 8)*

Participant 17 expressed her feelings, and non-acceptance towards a non-Muslim single parent colleague and how the single mother would be stigmatised and treated differently by her Saudi head nurse because of her history:

*“Am feeling bad honestly toward single-parent staff because it is (haram) for us, but am avoiding her and keeping my eyes on her because she has history! Sometimes they speak to me about their boyfriend is not accepting, but it is ok!” (Participant 17)*

Additionally, participant 13 illustrates the lack of tolerance toward socialisation and sharing taboo cultural issues with colleagues from different backgrounds:

*“Even if they talk and they don't know about it, we tell them, “This is prohibited here,” regarding illegal relationships. It's supposed to be a legal relationship, which is married. Again, it's called under-socialisation... If it happens to me, I'll stop her immediately. I'll say, “Hey, be careful. You are talking about something really serious, so watch your mouth.” I would report you, so they get afraid from this.” (Participant 13)*

One participant explains some examples of alternative lifestyles by non-Saudi staff that suggest they are disrespectful of Saudi culture and law:

*“Some nurses will respect our culture, some of them not... There was one nurse hug one of the doctors and taking a picture with him this is against our culture.... One of the nurses get pregnant, and she was single!!” (Participant 16)*

These themes are represented within the family role and organisation section of the Purnell Model. It is demonstrated that the influence of the head of the household and alternative lifestyle factors such as single motherhood or being gay creates barriers within the workplace.

### ***Theme 5: Workforce Attitudes and Behaviours***

The fifth theme emerging from the data includes the views of individual/ethnic group/organisational structure barriers and facilitators to practice when working within a multi-cultural setting in Saudi Arabia, and where nurses would elaborate on their experiences and perceptions. The prominent impressions are further categorised as professional attitude, and high-risk behaviour (see Table 6). There were many instances demonstrating of lack of professionalism among colleagues between the different ethnic groups, such as eating inside the clinical area, Arabs head nurses wearing regular clothes rather than uniform and being bossy towards colleagues, staff who were not making an attempt to learn Arabic to communicate with the Arabic-speaking patients, and lack of responsibility. All of these non-professional attitudes led to malpractice according to participants, and conflict between colleagues.

#### ***Professional Attitude***

One participant suggests that other staff from certain ethnic backgrounds lack professionalism and oversocialise with patients. They speak about other colleagues with them:

*“I have some staff asking the patients how many kids do you have, how many cars and they will tell the patients this nurse doesn't like me!” (Participant 16)*

Additionally, participant 2 noted her cultural view regarding eating inside the clinical area and believes this is not a professional attitude:

*“Some nurses, even Western nurses are like, I don't know why you get so bothered about us having coffee in the clinical area. For me, I know, it's a professionalism thing. I don't think it is professional for your nurses to be seen drinking coffee in the clinical area when they're meant to be working. Have your coffee break. I think that's a cultural viewpoint from my perspective.”*  
(Participant 2)

Participant 2 explained that some Arab head nurses come on duty wearing regular clothes and have a bossy attitude. She suggested they will not be able to help their team if needed unlike British head nurses, and this will lead to a lack of respect from staff:

*“If you have any of your management Arab or too many of them are Arab, then you'll find that they're in their normal -- they love to wear their normal clothes to work. ... I mean in my department I've had one head nurse who was British and came into work in scrubs. I never saw her in anything other than scrubs. She would be in every room in comparison to the other head nurse who I've never seen in anything other than her normal clothes with her laptop... She will come and walk around, but if someone said, “OH, could you give us a hand,” She wouldn't be able to do that. -- clinically she wouldn't be able to help. It's almost like they're kind of for show. They're there to instil this idea that I'm your head nurse and you need to do what I'm telling you to do. The staff don't respect that because they won't respect someone if you have no idea what I'm doing, why should I? I think that's a big issue as well.”* (Participant 2)

For participant 14 the attitude problems from one member of staff who was not attempting to learn Arabic to communicate with the Arabic-speaking patients was the reason for the hospital to terminate her contract:

*“She said to me, “I don't know if you've noticed, but Marlene has left. She said she'd been terminated.” “She didn't fit in; she didn't ... wasn't making attempts to learn Arabic. “She had had several orientations, and I had heard someone say that she didn't understand why she had to learn Arabic. It was attitudinal. I just don't think she had a good attitude regarding, why wouldn't you want to*

*learn some Arabic? You can communicate with your patients better, but her attitude was like, "They need to learn to speak English to talk to me." She just wasn't a good fit." (Participant 14)*

This participant also described the conflict between her and a colleague because of an unprofessional attitude and lack of responsibility, which can lead to malpractice:

*She was like, "Well, you know, I'm a hurry, I don't have time." I said, "You have to have time, and I took the syringe from her, get a new syringe." She said, "Why?" I said "Because if you put that into that vial, the moderate acting, it can deactivate the regular insulin, the fast-acting insulin and the next time I need it, I want to know that what's in that vial is fact acting. If you've contaminated it, you can actually ..." (Participant 14)*

### ***High-risk Behaviours***

Participant 9 described a medication abuse incident by a member of staff and the hospital policy for any abusive behaviour:

*"He takes maybe medication like Ativan and something, a painkiller and all those things. He comes the next day groggy, but then he never tells us everything. He comes groggy. He is very irritable. He is shouting to everybody and all those things. It's not acceptable. I have a charge nurse who take to control the situation. We have code white for any abusive between patient and patient, patient and nurses, nurses and nurses. We have all these policies to support that hostile environment." (Participant 9)*

A participant noted that being obsequious could also become high-risk behaviour that affects teamwork:

*"The kiss-ass personality. Sorry for the word. The worst thing that I could say is the kiss-ass people that would tell or ruin the whole team thing. Because if you're trying to help them to cover things up and fix it, but the kiss-ass people*



*will like, "We're going to tell the manager. We're going to tell someone else. We're going to make this a big deal." Then it will become bigger and everything." (Participant 12)*

The above theme from workforce attitudes and behaviours demonstrates how nurses with different backgrounds develop their experiences and perceptions have different attitudes, and behaviours within the workplace in relation to professional attitude, and high-risk behaviours. These can act as barriers between them when working together and also impact on patient care.

### ***Theme 6: Nutrition***

This theme indicates the food role as a barrier or facilitator between staff and patients and the organisation. This was endorsed to some extent by participants, who discussed the food role as a barrier or facilitator between staff and patients. A significant initial subtheme to emerge was concerned with the “meaning of food, common food and food rituals”. Food is culturally important as a facilitator; to staff, patients and the patients’ families, not only because of nutrition but also as a source of socialisation, celebrations and cultural connections between colleagues from different ethnic backgrounds and to help people to get to know each other.

### ***Meaning of Food***

The respondents contended that food is culturally relevant to staff and patients, not only because of nutrition but also as a source of socialisation, celebration and cultural connections.

Participant 2 describes the importance of food as part of the Saudi culture’s generosity as well as being a cultural interaction between nurses and patients and their families:

*“Culturally that's very strong here. Inpatients and outpatients if they have food they always want to see you eat with them; which is very lovely. Just lends itself to the generosity of the culture and the fact that they always give you whatever they have, all of it. Food is something that plays a big part in cultural interactions between you and your patient and families. Families get a strong liking for you; then mom will be cooking whatever it is you might once*

*have said that you like. The next thing you know the next day she brings in, "Is this what you said you like?" Oh." (Participant 2)*

Also, participant 6 noted the role of food in the interaction, and celebrations and socialisation between colleagues:

*"Internal here we do a different party in the unit, and we do different culture day in each unit. Like for today, we have a Philippine night. Now, all whose Philippine here they go, they prepare food, and they share it with the other staff." (Participant 6)*

### ***Common Foods and Food Rituals***

Participant 9 explained feeling shocked when colleagues commented on her cultural food and imposed their cultural food values. She describes the strong food connection to her cultural values:

*"When you come here you see certain cultures, example, westerners who eat healthy most of them, who do not eat healthy food and all this thing. It's a struggle for us, and then people put comments, "Why are you eating this? Why are you eating this? It's heavy. It's not this. It's not blah-blah-blah." It took me like two years to come out of it. I was just shocked why people are telling me thing. Especially when I go home, if I don't become foodie back there is a change there. Then we will have why because the food is a celebration and together you have fun. You have this and that. You are in this kind of environment." (Participant 9)*

This theme of nutrition from the Purnell Model highlights the importance of food in facilitating the relationship between staff and patients, as well as staff getting to know and understand each other. In contrast, comments and a lack of sensitivity regarding food can create barriers within the workplace.

### ***Theme 7: Pregnancy and Childbearing Practice***

This theme indicates that pregnancy can become a barrier between staff, patients and the organisation. The nursing staff from a different cultural background working in Saudi hospitals explained how issues related to pregnancy can be a barrier within the workplace. And some Saudis will show respect to colleagues even if it is culturally taboo and against their beliefs. Nurses elaborate on their experiences and perceptions.

Another cultural issue was raised by participant 2 about non-married pregnant staff as a problem that the organisation needs to deal with appropriately:

*“Most Western nurses who come here are non-married so automatically if they think they are pregnant we have a slight problem, which, obviously has to be discussed and dealt with appropriately”. (Participant 2)*

Participant 11 explained the challenge to the social values of some colleagues in practice regarding pregnancy tests before x-ray procedures:

*“If I have a woman in her 20s, and she's going for some scanning or x-rays, I will always ask does she have a pregnancy test done? The answer usually is, and this comes from a lot of nationalities, she's not married. That's not the question I asked. And that can open up a whole can of worms, but for me, she's a young woman. I don't know her. She might be pregnant through not her own choice, so I would always ask the question "Has this woman had a pregnancy test?" (Participant 11)*

These themes are represented within the pregnancy and childbearing practice section of the Purnell Model. It is demonstrated that the barriers are created between colleagues within the workplace.

### ***Theme 8: Death Rituals***

This theme emerges from the data regarding staff attitudes to death and dying and the influence of hospital policies on how dying patients are treated and how this creates barriers to working.

The barriers included colleagues from different backgrounds lacking cultural awareness and the sensitivity to deal with the death of a patient from another culture. In particular, this included non-Muslim staff ignoring Muslim practices of washing and dressing deceased patients, which could lead to conflict amongst staff. In contrast, some acknowledged Saudi Muslim culture and the patient's family's beliefs in relation to culture and religion in relation to death; this understanding can improve the relationship and work as a facilitator.

### ***Death Rituals and Expectation***

One participant noted the lack of sensitivity to death by colleagues from different backgrounds, which is different to the attitude in her own country:

*“Some of these nurses, I don't know what background they're from, but they're like, “Is the patients family done? Are they ready? Is he dead? Can we send them out of the room so that we can put another patient in here?” They're maybe not as sensitive to death and dying, and the process of it that they're just kind of like quick, quick, quick, let's just move on. Whereas I think where I'm from we're going to be more sensitive about the whole issue.” (Participant 3)*

Muslim participants noted that non-Muslim staff lack cultural awareness and sensitivity and they should acknowledge the Muslim way of washing and dressing deceased patients:

*“Some non-Saudi staff will laugh about something else in front of the died patient family, which is not accepted... Am always teaching them the Muslim way to wash and dress died patients” (Participant 17)*

### ***Responses to Death***

One participant explains how strange it was that the doctor made the patient's end of life decision, and it was his first time they had seen that, which was unlike back home:

*“First time in Saudi, it’s like the patient’s decision in life, the patient’s condition. Here, the one who is deciding are the doctors like for the signing of the DNR, that’s the doctor’s decision not the family ones. I think that for me is the weird one.” (Participant 12)*

One participant illustrates the different concept of palliative care in Saudi hospitals, and she explains the difficulty in accepting this practice, which is overwhelmed with culture values and society:

*“Being a palliative nurse that was probably the hardest thing when I came here to go through the process of seeing people terminal going through the active process of dying and seeing them still being treated very much as oh... to the thought of giving someone morphine or diamorphine. What happens if they get addicted? It does not matter because they are dying. It's difficult. It's difficult ... It's almost like they have their concept of palliative care here where they understand what should be doing, but they have the demands of the culture and society, so they're trying to find a middle ground.” (Participant 2)*

Another participant highlights the same issue about DNR patients as being treated actively in Saudi hospitals, and how this makes no sense to her as it is different from the real meaning of the DNR concept:

*“But it's not really DNR. DNR, but then we will put a test tube in and then that does not make any sense. Well, they are DNR, and then we will transfuse them with 40 units of blood. Stuff like that, to me, is just ... Where I came from we do not do that to a DNR patient.” (Participant 3)*

Also, one participant explains the policy and concept of conflict with two extremes about death in the Saudi culture: a humble family will accept what happens from God, whereas a wealthy family will use money and power to influence hospital policy and keep DNR patients alive, and the doctor has to follow these wishes:

*“In Saudi or in certain ... in the culture, let's say, I've seen two extremes. I've seen an extreme where death is acceptable as something from God which is*

*accepted, and that's it, and this usually it's shown more by the humble families. The other extreme is the wealthy families where even though they are nobles and they believe that it's something from God, but because they have the power and the money, they will do everything to keep the person alive. I've seen situations, here, even though patients they have DNR, even though they've signed the DNR, as soon as the patient goes into arrest, the DNR was taken away. and they will do manoeuvres on the patient, and the family will ask for that, and the physician will have to do it.” (Participant 1)*

The theme of death rituals from the Purnell Model represents the importance of staff expectations and responses to death in the relationships between staff. Lack of sensitivity regarding the deceased can create barriers within the workplace.

### ***Theme 9: Spirituality***

This theme from the Purnell Model and newly developed subthemes from this research includes the lack of familiarity concerning other religions, or imposing religious values that can limit the extent to which a nurse can efficiently collaborate with others. The prominent impressions are further categorised as religious practice and use of prayer, religious festivals, and Saudi religious systems, including religious police. The results point to the challenges of adopting patients' cultural and religious values when interacting with patients. Where participants illustrate the importance of acknowledging the Islamic culture and respecting the patients' and their families' religious needs, this is not ignored by colleagues, as it facilitates patient-nurse collaboration.

### ***Religious Practice and Use of Prayer***

Participant 2 indicated the challenges of adopting patients' cultural and religious values, and cultural differences, when interacting with patients:

*"It can be very challenging. At first, it's quite uncomfortable because as nurses we like to talk, we like to interact with our patients. Being within a different culture where the way we talk with our patients and the way we interact with*

*our patients has to be adapted due to cultural, religious beliefs. It can be quite difficult at first. What's appropriate in one culture is not appropriate in another."(Participant 2)*

This included the importance of the patients' or their families' religious needs, that should not to be ignored by nurses:

*"Everybody is well versed in making sure we don't offend any of our patients or their families with ignorance of their religion. I think that's the main thing." (Participant 2)*

Moreover, participant 1 explained the importance of knowing about Islamic culture because of the patient's strong religious beliefs:

*"There's a lot of aspects you have to know about the culture of the patient. In this country, it goes beyond that because of their religious involvement and a heavy religious following that patients have." (Participant 1)*

In addition, participant 15 experienced feelings of hate, which impacted on the working relationship following negative verbal attitudes from a Saudi male doctor who thought he had the right to impose his religious values:

*"It happens that one doctor told me you are not scared that your face will be burn because you are not covering ... I really after that avoid dealing with him and his patients and I hate him so much." (Participant 15)*

Participant 14 also noted that Saudi staff's lack of awareness concerning other religions and culture, and the information given to Saudi nurses about other cultures, caused her to change her personal views:

*"We were talking about religion, all the things you're not supposed to talk about. She said, "You know, I never realised that there were people who had a deep faith in the last ..." She had never seen that or seen that represented and it changed her view of westerners." (Participant 14)*

Participant 2 suggested that Saudi nurses use religious excuses to disappear and avoid work, which will affect collaboration in the workplace:

*"You say, "Oh, I'm just going for fifteen minutes," and then you disappear for an hour; then your colleagues are going to get upset with you. I think that's the same through any nationality, but Saudis are far more likely to do it and not necessarily see the problem with it. They're like, oh, no, it's okay. No, that's not okay. I'm British, and nurses from the UK are very routine" (Participant 2)*

Participant 1 indicates that religious practices by Muslim nurses affect teamwork:

*"I have to go and pray five times a day," but then you know that when they go to pray, they disappear and only God knows if they're really praying or not. They probably do pray, but they don't do anything else. Then that affects the care and teamwork as well because then the nurses have to be covering" (Participant 1)*

Ramadan can also affect working relations with non-Muslim staff, perhaps demonstrating a lack of cultural sensitivity, believing that Muslim staff have things easy:

*"They somehow believe they're part of their religion. When it's Ramadan, somehow they will ... because they're fasting and they have fewer hours, they will sometimes make you feel that you have to go easy on them because I'm Muslim; I'm fasting. Don't give me hard work. Don't give me hard assignment because I'm fasting. If you're late for work and you leave earlier, it's because I'm tired. I have to go home and rest." (Participant 1)*

Religious beliefs can influence good relations between colleagues, as Muslim staff can become closer:

*"Saudi nurses, they are already close to us. We are Muslims, and then we know each other's norms." (Participant 10)*

This is not always the case, however, as participant 18 highlighted a conflict between the Shias and Sunnis which could lead to an impact on workplace procedures, such as the authorisation of leave:

*"you can see this between colleague as Sunnis and Shia you find out that people unhappy with each other. Like if there is an event about Shia, the*



*Sunnis people will talk about it in a bad way, but again it is behind the wall nobody saying it frankly or treating them in a bad way. Shia event is taboo nobody can greet them it is easy to say Merry Christmas than greeting Shia, am always supporting my colleague who is religious Shia to take her leave in Shia event I never reject her leave application I do understand her religious event, and I respect.” (Participant 18)*

Similarly, participant 14 noted issues within other religious groups:

*“Christian Filipinos are Catholic but a few of them are Baptist, and she has a friend whose Baptist and Filipino, and she's looked upon differently from the rest of the community. There just seems to be a bit of a pecking order and a lack of cohesiveness between them.” (Participant 14)*

There was disagreement between views in relation to converting to Islam:

*“We never speak to non-Muslim staff about converting to Islam” (participant 18)*

Participant 16 noted that non-Muslim staff are influenced by Muslim colleagues, who caused them to convert to Islam without enforcement:

*“Many of staff convert to Islam by other Muslim staff” (participant 16)*

Some believed it was important to learn about other cultures' religions, which could facilitate socialising, as well as increase the knowledge about different cultures:

*“I like to know about other religions. I like to know about other people what they are doing. I take it as-Socializing and increasing my knowledge about other people” (Participant 13)*

Moreover, participant 17 illustrates the importance of teaching non-Muslim nurses Islamic practice with Muslim patients, and covering the women's hair:

*"We are as Muslim always remind them this is (haram) like to cover the patients and privacy, even patients hair am reminding the staff always to cover"*  
(Participant 17)

## **Religious Festivals**

Participant 3 noted that some Muslim colleagues impose their religious beliefs about fasting during Ramadan on other non-Muslim staff:

*"I had a colleague tell me, "Don't drink water." I was like, "Serious-" One of my colleagues from the ER. They were fasting. I said, "I'm not trying to be disrespectful, but we all feel like we need water. We're working 12 hours." I understand. I'm not going to eat a meal in front of you. I get it. I have friends who were Saudi, and they were like, "We don't want you to suffer, just drink." Then there were some people, from Jordan. I don't know where they from, but they were fasting too, and they said, "No, you can't eat." Then there was like differences." (Participant 3)*

Interviewee 1 argued that it is not permitted to eat or drink during Ramadan, especially if there is a Muslim around, but in contrast the hospital acknowledges the differences and there is a restaurant and coffee shop open for non-Muslim staff. Other responses to this question included:

*"If it's Ramadan, we're not allowed to drink or eat anywhere especially if there are Muslims around. Even though we do have like in our cafeteria, we have a restaurant that it's open during Ramadan and our coffee shop is also open during Ramadan which anywhere else in the city, everything is closed. Because we do have several places here that are open for lunch and our employees. Somehow, the hospital, of course, acknowledges the differences and that we don't practice fasting." (Participant 1)*

Participant 1 noted that Christians acknowledge the Muslim festivals and greet them, but they could be offended if Muslims do not provide the same recognition at Christmas:

*"The Westerns or the non-Muslims will always say, "Ramadan Kareem or Eid Mabrouk." We will recognise this. We will share. We will do Iftar with them. All those things and then usually I'm out during Christmas season, but I know*

*that when it's Christmas probably the unit of the nurses, they will have a special meal. I know stories where people they got offended because you didn't wish me Ramadan Kareem or you want me to say Happy Christmas but I don't have to tell you Happy Christmas because I'm a Muslim and you're in a Muslim country" (Participant 1)*

Participant 6 noted that Muslims do not participate in non-Muslim festivals, but they do allow non-Muslims to celebrate their occasion:

*"We don't participate with them, but we allow them to do their thing" (Participant 6)*

Also, participant 1 noted the organisation's changing values regarding religion and beliefs according to the dominant culture, as they used to acknowledge Christmas when the hospital was more western, but now non-Muslims were not able to greet each other officially for their religious events:

*"Years ago, when this hospital was more Western than what is now, and there are pictures of units with Christmas trees when it was Christmas time. Of course, after a while, the Christmas trees were taken, and no one is allowed to have anything related to Christmas. We just write Happy Festive Season without saying which one is it which is a bit, we shouldn't say it because we're not a Christian culture. We are Muslims, and we shouldn't acknowledge that and it goes against their values and their religion should you acknowledge that. ... There's a bit hypocrisy here" (Participant 1)*

### ***Saudi Religious System, Including Religious Police***

Participant 14 highlighted the old Saudi and media restriction, and the power and influence of religious men:

*"Well, I can remember when I first came because I've been here for 18 years now. Satellites were really rare. Satellite dishes, the Muttawa (religious police) were shooting them out before I arrived. If there was a satellite dish, people were shooting them down." (Participant 14)*

Participant 3 described the religious police's authority to comment and ask for hair to be covered:

*“Outside the hospital. That's the only time I've ever had anyone talking to me like, "Do this. Don't go here. Cover your hair." (Participant 3)*

Participant 2 described the religious police's behaviour when they were patients, and the conflict this led to:

*“But once you're in their room behind closed doors they will have a regular conversation with you. Quite often they're very happy that he's got the Western nurse who's not his son because obviously, they have a perception about different nurses depending on where they come from.” (Participant 2)*

The spirituality theme from the Purnell Model and subthemes newly emerging from the data includes religious practices and use of prayer, religious festivals, and the Saudi religious system including religious police as barriers and facilitators. The lack of familiarity with other religions, or imposing religious values can limit the extent to which a nurse can efficiently collaborate within the workplace.

### ***Theme 10: Healthcare Practices***

This theme from the Purnell Model includes the different practices between colleagues that lead to conflict which can cause barriers in nurses' collaboration with others. The theme was further categorised into healthcare practice from the country of origin, experience practice, standards of care, role conflict, folk practices, cultural responses to health and illness, blood transfusion and organ donation. Barriers discussed included concerns regarding how staff with experience impose their practices on other junior colleagues.

#### ***Healthcare Practices from the Country of Origin***

In nurses' home countries, there may be different policies, resources or other things that affect the working environment.

Participants indicated that different countries practised in different ways:

*“People they learn thing up in the area where they work. Now different thing when they come in here, everyone will use back home. Back home we do that, back home we do this.”(Participant 6)*

*“In here, there are different cultures and different experience. New ones, old ones came from different hospitals. From their experience and their way of working, we do have different ways.”(Participant 12)*

One participant stated that some nurses would practise inappropriately according to their ‘home’ practice, and she will stop them:

*“Some nurses they do the care like back home without proper cleaning and I will stop them” (Participant 17)*

Another participant explained that this would be due to the different resources back home:

*“Sometimes not an advanced country, so they come in. They still use the old resources, because of the nature of the country itself unable to provide.”(Participant 9)*

### ***Experience & Seniority Practice***

Participants explained the difficulties of some ethnicities in following and accepting instructions from young and newly-employed staff:

*“Maybe like this from seniority or age, if you've been working for so long, you already adopt this kind of work. Then someone new or younger is going to tell you that this is not the right way. They feel inferior because they're already working there. They're superior; they're old. They feel more experience with things.” (Participant 12)*

Another participant explains how senior staff with experience impose their practice on other junior staff:

*“Sometimes they're not even right. We had a run in today this morning with one nurse, and she's been here for ten years. I don't know, maybe 15 years. I can't remember. A long time. This nurse was like, "No, this is how it's done," blah, blah, blah, blah, blah. She was very firm on what she was saying.”*  
(Participant 3)

*“we have the old nurses with experiences 20-30 years always want the junior staff to follow them. some staff they have a different way, the senior not happy they said we are the senior they should follow us, am telling them if it's correct to let them do it their way”* (Participant 17)

Participant 2 explain that male Arab staff with experience are overconfident and want to change the doctors’ orders or give medication without doctors’ authorisation as they feel they are experts. This is high risk behaviour:

*“Arab men. Arab men who worked there a long time and oh, yeah, no, no, that's fine. They can have this over this amount of time. It's okay. That's not what the doctor ordered. They've changed the order themselves I have staff nurses where hydration will be ordered one litre with ten of KCL over one hour. They put a line through the one litre and put five hundred miles over thirty minutes that's high-risk. They've changed the order themselves. They've been there a long time and its okay to do this. .... They give a patient medication without order because they know that that patient has that treatment, so they give it anyway. Then they say, "Oh, it's okay because I know this off by heart." I had someone say this to me before.”* (Participant 2)

Also, participant 2 noted that Indian nurses will very easily accommodate the practice of senior staff, even if they know the proper practice:

*“The Indian nurses are very much if you tell them how to do something, they will always do it that way. It's only if they get corrupted by -- they're easily corrupted, the Indian nurses. They're very accommodating. If one of the senior nurses says to them, "No. No. You must do it this way," they will do it that way even though you've taught them, no, this is how you should do it. There's a level of corruption that goes on.”* (Participant 2)

## ***Standards of Care***

One participant noted different standards of care regarding patient privacy as a big criticism towards her colleagues from another ethnicity:

*“If you have to expose them cover the top or the bottom with a towel while you wash another, and that would be one of my biggest, if not my biggest criticism about working within a multi-disciplinary area where the standards are different.” (Participant 11)*

The participant indicated that patients sometimes noticed the different standards of care:

*“Different standard of care, I had a patient’s husband saying to me, my wife tells me that you check her more thoroughly than the other nurses... Then have people point out to me, I have never seen any of the other nurses do it.” (Participant 14)*

Additionally, participant 14 explained the difficulty as a western nurse to change her standards of care:

*“What I realised really quickly, and this is going to sound awful, is it wasn't the standard of care that I was used to working on in the same type of unit. You have two choices you lower your standards, or you continue to work to your standards as best you can in the environment you're in” (Participant 14)*

## **To Overcome Standard of Care Barriers**

It is suggested that a model of practice is followed by all staff:

*“Suppose we all bring our practices, and we all have a professional model that we must follow. so your practice has to be the same as mine regardless of our background, and if my practice is not as good as yours well then the hospital should and does give us the courses, and the clinical experience that we need, so that we're all at a level.” (Participant 11)*

Participant 10 noted the hospital strategy for managing staff diversity in practice:

*“We have the professional practice model, although we are different nationalities, the practice and everything is same.” (Participant 10)*

In this regard, participant 11 noted that being a ‘Magnet’ hospital helped standardise care and bring all nationalities together:

*“What is acceptable in one person's standard of care may not be the same standard as another, so that's where the hospital here has a lot of work to do in merging those standards. I know that Magnet was a component in trying to bring all the nationalities together. I'm not sure that it's working completely, but it's a step in the right direction.” (Participant 11)*

Similarly, participant 8 explains a project by the organisation to standardise policy, aiming to provide high-quality care:

*“Standardise our care. We have guidelines; we are putting the policy to meet the guidelines and to get to the standards. The improvements project to standardise all the care to reach the high quality. Because you know, there is a deviation. This deviation will kill the colleague. We are aiming to provide the highest quality for our patient, so we would like to standardise all the care.” (Participant 8)*

### ***Role Conflicts***

A Saudi participant describes role conflicts with western colleagues as they expect her to do everything:

*“Sometimes when there is a misunderstanding for the roles of the job, or something, sometimes who is supposed to do what. They think that I supposed to do everything for the patient because I'm the coordinator, while they left their very simple task of a day-to-day basis, I'm supposed to do it for them, and*



*just throw it on me because you are the coordinator. I just tell them, I said, "No, this not my role to this and this, and that. I have a specific role for the patient." This is a simple example of things happening." (Participant 13)*

### ***Folk Practices***

According to participant 12, some staff act on practice based on their personal beliefs and motherly instinct. That is considered a dangerous method in practice:

*"She told me like, "He took more fluids," I said, "Why? Why did you give the fluids? I told you specifically don't." she said, "You will never understand. This is a motherly instinct. You're not a mother." It's funny and dangerous." (Participant 12)*

Participant 16 highlights that spiritual beliefs influence her practice as a nurse and patient care and even if sometimes it is against policy, she will still follow her feelings:

*"for me, if patients dying even if he is NPO and ask for water I will give sips of water because in my belief we should do that, sometimes if the patients very sick we will allow visitor even if it is not visiting hours" (Participant 16)*

Also, participant 16 noted the influence of cultural and spiritual beliefs in patients' healthcare and the critical role of religious men in diagnosis:

*"Sometimes we have patients like one lady very beautiful after attending wedding party she becomes sick and the religious man came and said she is affected by evil eyes! And one other lady they said there is a ghost inside her and then they find that she has congenital disease!" (Participant 16)*

Additionally, participant 17 explains the different beliefs within Saudi Muslim culture, and even if she does not like it, she will acknowledge and respect it:

*“Sometimes even for Muslim Shia, they have special green tie material to tie patients hand and foot I don't like it, but I have to respect, and I don't believe from inside” (Participant 17)*

### ***Cultural Responses to Health and Illness***

Additionally, it is evident from the results of this study that the theme of “cultural responses to health and illness” is a crucial barrier between staff from different backgrounds,

Participant 2 suggests staff stigma toward one Arab nurse with cancer and the spreading of rumours about her instead of support:

*“She is one of the Arab nurses, and that was very sad to deal with. You're like; this is your colleague. She's going through one of the worst things anyone will ever go through; we should be supporting her not spreading rumours around about the fact that you might be exposed. That was a hard process to manage, and some serious education have to go in and make sure people were treating her appropriately.” (Participant 2)*

One participant explains the lack of sensitivity to people with learning disabilities people by one of the doctors:

*“It was a mismanaged fertility issue, but anyway, when she went for delivery, this neonatologist said to my friend. She said, “You know, really you're 22 weeks, anyway in the world you're not going to make an effort, they are not viable, they are not going to survive. And he said something, well, we can't all be doctors and teachers, some of us have to be maids and drivers. His feeling was these babies if they were to survive, even though they would be developmentally delayed and everything, they could be maids and drivers in his mind I guess.” (Participant 14)*

### **Mental Illness**

Participant 2 noted the mental illness stigma among doctors in practice and the difficulty of diagnosing or treating patients with mental illness:

*“Maybe they are experiencing depression. Getting appropriate antidepressant medications to the patient is very difficult here because even the doctors aren't necessarily that good at identifying, okay, this patient needs support.”*  
(Participant 2)

Commenting on mental illness issues and organisational consideration and support from mental illness staff:

*“Staff from Libya she looks psychiatric to me the way she was interacting, I report her, and they move her to a regular ward, and she is fine”* (Participant 17)

### ***Blood Transfusion and Organ Donation***

Participant 2, regarding blood donation and transfusion and restrictive regulations in Saudi Arabia, mentioned this issue:

*“Blood transfusion regulations are so tight here with regards to who's allowed to donate. They are very, very strict. If you are unmarried and have -- let's say you're Western, not married, and have had any formal relationship outside of marriage you can't donate here.”* (Participant 2)

Also, there will be implications because of these different beliefs among colleagues, and the participant added that in the UK it is a very different system concerning organ donation:

*“In the UK I carry a card that says if anything happens to me, please use my organs. What the UK is working towards is having a system where you opt out if you do not want to. Everybody is a donor unless you turn around and say I don't want to be.”* (Participant 2)

One Muslim participant explains that he is not really sure about organ donation because the approval of organ donation in Islam is not yet clear although they accept organs from outside the country:

*"Culturally it is difficult. Still, by religion, there is no clear thing we can donate organs. There are some people they approve it, some people they didn't approve it, but it's not affecting the outcome. We get more donation when that meet." (Participant 6)*

Other participants explain the same conflicting idea of Saudi culture accepting organ donations from abroad but not allowing donation:

*"You could have a young man who was killed in a car accident, and his heart is not donated. I don't know, that's the Saudi culture... it's often a topic of conversation that Saudis don't donate, but they will receive the heart of an Indian or a Bangladeshi." (Participant 11)*

*"Organ donation in Saudi, it's still almost inexistent. There's a lot of transplants, but they don't come from Saudis, they will come from all the other cultures we have here." (Participant 1)*

This theme of healthcare practice from the Purnell Model includes the healthcare practice from the country of origin, experience practice, standards of care, role conflict, folk practices, cultural responses to health and illness, blood transfusion and organ donation between colleagues. It leads to conflict and barriers in collaborating with others, and there was an organisational strategy identified to work as a facilitator.

### ***Theme 11: Healthcare Practitioners***

This theme can limit the extent to which a nurse can effectively collaborate with others, mainly when working within a multicultural setting in Saudi Arabia, and where nurses would elaborate

on their experiences and perceptions. The theme is further categorised into traditional versus biomedical practitioners, and status of healthcare provider. What is evident from the results of this study is the theme of “traditional versus biomedical practitioners”, including Saudi culture gender segregation in general, and influence on healthcare practice as well as significant barriers between nurses and patients.

### ***Traditional Versus Biomedical Practitioners***

In Saudi culture, there is gender segregation in general, and this appears in healthcare practice as well.

One participant adds that Saudi culture traditions sometimes interfere with practice and cause barriers to patient care:

*“Sometimes Saudi nurses refuse to touch a male patient without gloves or to do procedures like foley catheter! Sometimes social barrier affects their work.”(Participant 15)*

*“The Saudi nurse will not dare to touch the patient. Tell me about adult assessment. She will not probably dare to ... the genital area, if that nurse is with the patient for days” (Participant 1)*

On the other hand, the female patient’s cultural values will influence the patient-doctor relation, and lead to lack of comfort and barriers:

*“They don't want to be examined by a male and when they are made fully aware that it might be a male resident on duty when they come and ... they've agreed to it in principle, but when it comes down to it, they're not comfortable with it” (Participant 14)*

One participant explains the different cultural views of male/female patient assignment, and the limitation of his role as a male nurse:

*“Maybe being the male Filipino, only male Filipino here is one big difference. We have limitations for a male so we cannot handle female. We cannot see or come inside female rooms unlike in the Philippines, and we can pretty much take care of any patient given to us or assigned to us, but here, limitation.” (Participant 12)*

## ***Status of Healthcare Provider***

One participant suggests that male doctors here are the dominant culture and this will affect the nurse-patient relation, as the patients and family will talk and listen to male staff even if the nurse knows better about the patient's condition:

*"Males here are very dominant, so it's one of the things you get used to... Doctors are very male-oriented and things like that. Even the families, sometimes they don't listen to you, they want to go and talk to a male while you are the one who knows what's going on with the patient." (Participant 7)*

She added that the culture here is led by doctors, for example if the doctor says something the patient will follow, unlike with the nurse, where the patient would fight back:

*"Here patients are very doctor-led. If the doctor says, the patient will do. If the nurse says, the patient will fight, or the patient's family will fight. " (Participant 2)*

One participant highlights the nurse-doctor relationship in Saudi hospitals by stating that doctors from the Saudi ethnic group view the nurses as lower level and this affects the collaboration between them:

*"I came out to the female resident, and I said, "You know regarding so and so who's just come from labour room she's in a great deal of pain, can I give her anything?" She said, "Mina, I'm reviewing the charts right now, write it on the whiteboard... a little bit passive aggressive because I couldn't get her to hear me. It's like, "You're the nurse, I'm the doctor, I know better." (Participant 14)*

One participant explains the Asian ethnicity concept of doctor-driven culture that exists in Asian hospitals, and this affects their future communication and relation with the doctor:

*"Communication has been very weak, but then when you dig further it's not just communication, it's also the fear. You know what, he is a doctor because I*

*must say for Malaysia we have a doctor driven hospital management. Here, doctor and nurses are the same levels." (Participant 9)*

*"I notice that in the Asian countries most of the doctors the demand is ... The nurses have to listen to whatever the doctors say. The autonomy is not there" (Participant 4)*

Participant 2 noted the lack of critical thinking and decision making within nurses from some ethnic groups as it is linked with doctor status in their culture, unlike western nurses:

*"The critical thinking aspect is not always prevalent in some nursing groups because of the way in which those nurses see the status of the doctor. You'll find a lot of Western nurses get a bad reputation for being difficult. We're not difficult, we just ask. We ask questions. Here, like the doctors, don't like necessarily to be asked. Their rule is the rule." (Participant 2)*

Moreover, another participant noted that the Indian staff needs control and initiation by another team:

*"Asian like Indian nurses, for example, let's say in here. Because like we are controlled, people. Sometimes, they need somebody to control them. They are not like initiated people." (Participant 5)*

Also, participant 11 noted that some nationalities do the same work without critical thinking:

*"I just think some people come in, some nationalities and do a day's work, and they don't change anything. Like I mentioned about the restraints. If somebody restrained yesterday, do they need to be restrained today?" (Participant 11)*

Also, participant 5 suggests his beliefs about Saudi nurses being incapable of doing the nursing job by themselves:

*"Usually, they are choosing the easy work. They are going to an easy job. It means like they already choose to nurse at the beginning, but they prefer to do*

*the easy way to reach their goal. They need to take the preceptorship, they need to take the scholarship and need to go out to study, and they come back to reflect this to their country. For the Saudi usually, they happy like to do the work, but they cannot do it by themselves till now, till this moment." (Participant 5)*

Moreover, participant 2 highlights the flexibility of the organisation and that the nature of colleague relationships differs according to staff background:

*"She was very supportive. She hired me. She knew my background. She knew when she hired me what I came with. When I said, I'm not willing to do this; she was like, no. I understand that the policy is in the process of being updated so continue to do as you feel appropriate for your patients and just document what you're doing, so I did." (Participant 2)*

The above theme from the Purnell Model with data clusters represents the views of staff from a different ethnic group. The nurses develop their experiences about the healthcare practitioners including traditional versus biomedical practitioners, and status of healthcare provider as barriers and facilitators between staff and organisation policy.



## **The Conclusion to the Deductive Analysis**

The Purnell framework used in this analysis emphasises that the 11 domains discussed above are essential in order for a nurse to become culturally competent. The interviews were accordingly analysed deductively to these domains, which illustrates that the participants had different levels of barriers and facilitators in achieving cultural competence that would affect the collaboration between them. Barriers to competence development and collaboration include a lack of educational preparation and language barriers among other things are explained in the analysis. Facilitators of collaboration and competence were the acknowledgement of others' cultures, an appreciation of others' cultural beliefs and a need to understand and learn about them. For this theme, deductively analysing the data according to Purnell Cultural Competence Model framework resulted in some valuable perceptions. It could not, however, be justified entirely for all the data. There was a significant part of the dataset that could not be merged in the deductive analysis, as it did not fit efficiently within the domains of the Purnell Cultural Competence Model. Therefore, the following part illustrates an inductive review to comprehensively describe the nurses' experiences in this multicultural setting.

### ***Theme 12: Cultural Differences***

The twelfth most notable theme of cultural differences regarding multicultural nurses working in Saudi hospitals, as ascertained from the semi-structured interviews, were: cultural norms and values, Saudi cultural beliefs and the Saudi system, the positive aspects of the multicultural workforce environment in Saudi Arabia. These were the elements of cultural differences. Regarding the above, the participants' dialogue highlights that overall, healthcare professionals were seen to have barriers among them as staff and between them and a new culture and system adaptation, and on the other hand there was positivity about these differences. This was indicated in the findings demonstrated in the statements made by those working in the Saudi organisation. Healthcare professionals were seen to have barriers and facilitators among them as staff and between them and the new culture and system. It is evident from the results of this study that the theme of "cultural norms and values" includes different social reactions and greetings. Personal customs and hairstyles differ between different ethnic groups and women laughing in public is

considered inappropriate, and on the other hand personal issues may not be valued and considered by other cultures. All these cultural barriers lead to the collaboration between colleagues from different backgrounds being limited.

### ***Cultural Norms and Values***

Participant 11 noted how the cultural norms regarding grateful reaction are different between people here and back home:

*“Sometimes it's difficult here because what I would consider what are the cultural norms, here can be different. It's not just obvious here when somebody is grateful for what you do for them on occasions. That's not to imply that back home people are always grateful because they're not, but that's the cultural barrier.” (Participant 11)*

Participant 8 noted how the different values could cause limitations in relationships and lead to collaboration barriers between staff:

*“You feel what I want to tell you about things because we have the same values if you are coming from so far those things like maybe make borders between anybody. Because they are from totally different cultures, they will not value the same thing because this will effect on the relationship to go strong.” (Participant 8)*

According to one Saudi participant, there are personal issues that may not be valued and considered by other cultures that can affect the communication between them:

*“Saudi staff maybe can understand me better with no barriers; non-Saudi sometimes will not understand some personal issues and will not make consideration. Finally, communication will be better with someone who understands your culture.” (Participant 15)*

### ***Saudi Cultural Beliefs and Saudi System***

Below, it is explained how the Saudi cultural system is affecting feelings and practices that will consequently impact the collaboration between colleagues.

One participant indicated that Saudi Arabia is a conservative culture and it might be difficult to develop relationships with Saudi nurses:

*"It's hard to make friends with Saudi nurses; you have to have been here for a long time. I guess it is culturally their families are not comfortable. Some families aren't comfortable with their children intermingling with westerners, so I have now a few Saudi friends that I consider very precious" (Participant 14)*

In addition, participant 1 suggests the private Saudi culture influences care, and sometimes the nurse's family name will affect the care and collaboration between the nurse and the patient:

*"Saudi population are private. They're private between themselves and having a Saudi person ... If they know their last name, they will link to the tribe this person comes from. If it's from the tribe they actually can get along with, fine, fair enough; if not, I don't think this nurse to take care of me." (Participant 1)*

One participant expresses her concept of the white privilege and different treatment she received from other colleagues because of having white skin and blue eyes:

*"I am in that unique privilege of being white, although it's clean hands, blond hair and blue eyes and so I understand the concept of white privilege. I know I get treated differently than my colleagues who aren't light-skinned," (Participant 14)*

Also, the participant highlights that Saudi culture values and believes in western people, as blue eyes and white skin means better knowledge and skills:

*"We need somebody for the VIP unit Mina we'll send you because you have blue eyes and white skin and you'll just ... They'll trust you better than even their own nurses to take care of them, even though their own nurses are very skilled at what they do" (Participant 14)*

According to this participant, this different treatment occurs even outside the hospital:

*"It's a thing we take for granted that people don't question us, people don't question your motives behind things. I've noticed when I'm out with my white*

*friends, we don't get hustled by Mattawa but if I go out with a Filipino friend or a South African friend, cover your hair, cover your hair. I get hustled a lot more if I'm out with people that are from different nationalities and have darker skin.” (Participant 14)*

The participant stated that the Saudi culture has a different lifestyle and engages mainly in indoor activities, which is different from back home, and it was difficult to find any organised sport for kids:

*“Back home... There was a lot of activities. I belonged to a youth group so we had lots of activities like we had a precision drill team and a choir and we had all of these activities that kept us busy and what I find here is the kids, there's not a lot for them to do. They can go to these entertainment centres, family entertainment centres and play video games and the boys will play soccer but there's not an opportunity, and there's not a lot of people's life lived outside of their homes. Because there doesn't seem to be organised sport or at least I'm not aware of it where kids can go and play on an intermural team or something.” (Participant 14)*

Besides, participant 2 explains that within a restrictive organisational culture, there is accommodation stress and gender segregation, which is something hard and not usual for her:

*“From the hospital's perspective, it's accommodation here. It's very hard. It's very restrictive. It's separated into female and male where other hospitals have compounded for their nurses. With regards to that, that's probably the hardest thing that I know myself and other Western nurse's experience because we're not used to that. You're used to being in an environment where men and women mix far more. Even at university, we would have lived in mixed households, so it's a lot different. Having so many women together in such a small space isn't always the easiest of situations to manage... For all the nurses, but we do get the security can give you a hard time if you're coming back from the airport at 4:00 in the morning and you don't have your badge on.” (Participant 2)*

One participant explains the gender segregation in practice, and even socialisation is very different in Saudi Arabia and very limited with a male, and it might be risky to do so:

*"I mean back home we don't have especially the male cannot come into the female room, the socialising. There is a limitation. In our country, a female and male talk is nothing. Here, it's restricted. For them, it's totally not acceptable. If you speak to somebody who is a different male, who is not related to you, they say they will caught you and all these things, a lot of things. It's frightening" (Participant 4)*

In addition, participant 2 referred to difficulty in the dominant system for those who wish to go outside to a mixed party or restaurant without the risk of questioning by religious police:

*"Being able to go out in a mixed party to a restaurant on [tahlya] Street without being worried that someone is going to come in and start questioning you. Unless you are an old female group unless you are going out with a married couple, in which case it is more socially acceptable." (Participant 2)*

Moreover, she added that there is more restriction among Arabs mainly:

*"If we got caught we might be in trouble. The situation would say I was with one of my friends. Some of my friends are Jordanian, so Arab man, Western woman, if we were pulled over, he would probably get in some level of trouble for sure. Western guy, the Western woman, probably not so much. They probably would leave you alone, generally because quite often the people who pull you over do not speak that much English. If you do not speak enough Arabic to be able to have the conversation, they will just send you on your way." (Participant 2)*

Also, the lack of female authority to drive and lack of public transportation makes it a difficult culture:

*"Then another side is obviously drivers to get anywhere you have to have a driver. No public transportation" (Participant 2)*

Participant 1 explained the limited stay in Saudi Arabia, as they do not belong to Saudi Arabia, and they will never be a citizen or have a passport or be able to buy a house, and also they should leave the country once they reach the age of 65:

*“You belonged to the US because you have citizenship; you pay your taxes, and you benefit from the same benefits as any other American. You get the same level of salary of any other nurse that works with you. Whereas here, Saudi will always remember you where you come from, starting from your salary because you know it's linked to your passport. You will never be able to ... Even if you're born here, you don't become a Saudi. You will never have a Saudi passport. You will never have the same benefits of a Saudi person. You will never be able to buy a house unless you have really good connections and a really good person that will sponsor you buying a house here. You never become a Saudi. As soon as you're 60 or maximum 65, even if you spend your whole life in Saudi, you have to leave the country.” (Participant 1)*

Also,

*“I mean in my case, most of Westerns, we want to leave anyway because of the different culture, because of the way you private yourself from things here, because of the lack of independency, to some extent freedom.” (Participant 1)*

Another participant stated the limitation of Saudi culture as it is very conservative and there was nothing much for them to do and no reason to stay longer:

*“It's much more fun in with your own people. Nobody wants to live in a foreign country all alone. Maybe if it was much more open country and I there was much more things to do besides shopping, I will stay longer. Now it's limited.” (Participant 7)*

Also, participant 8 suggests the lack of a settled environment to stay in Saudi Arabia and lack of long-term security:

*“Here, things not making my need. If you compare between people who are living in Saudi Arabia and people who are living in England, your kids, they could live in England, they could live with a passport. You would be settled to have kids, and kids will go to the schools, go to university, they have health insurance. Maybe you like that; maybe if you have ties here if the living there does not make you value, you will go back home. Here, things not like this.” (Participant 8)*

Moreover, one Saudi participant noted that the non-Saudi staff lacked sensitivity about Saudi culture and the Saudi system, and they were always trying to criticise it:

*“Other nationality and countries, where they are free to do whatever and the woman is not covered, and those things, because they are criticising that a lot, and the women not driving, blah, blah, blah. All the same stories.”*  
(Participant 13)

*“It sometimes happens to have people like that, but you have to stop them right away. He didn't stop. He continued. I just keep ignoring him. I said, “Okay, are you done now? Can we continue our topic, what we are here to talk about? We are not here to talk about Saudi Arabia, excuse me.”* (Participant 13)

Participant 13 explained the upsetting feelings toward the private places provided to non-Saudis within Saudi Arabia, where there is a more relaxed culture, and the Saudis are not allowed to enter:

*“You know here in Saudi Arabia; we have special places for them. We are not allowed to go in it. No Saudi allowed in the compounds, things like that. Here we are not allowed to go as Saudis.”* (Participant 13)

Additionally, participant 2 noted the benefits of the Saudi conservative culture in order for her to be away from men and drinking, as her boyfriend dumped her, and that caused her to search for a place like Saudi Arabia:

*“A lot of Western nurses come here after a breakdown of a relationship in the country that they're coming from, which tends to be the process. You meet a new nurse, and they'll say, “Oh, so what brings you to Saudi Arabia?” Because it's not exactly the first place, everyone picks. They're like, “Oh, you know, the travel, the money,” and then a few weeks down the line they'll be, “Okay, so well, my boyfriend dumped me after three years, and I couldn't bear being at home anymore. And I decided I wanted a new start. So I thought I'd come to a country where I can't drink, and I can't go out and enjoy myself as far away from men as possible. So I thought Saudi would be a good choice.”*  
(Participant 2)

Also, according to participant 9, breaking of the country's regulations by staff should not happen after they have signed the contract and accepted to work in this country:

*"This is the country's culture to wear an abaya, not to have sex and all these things. I mean you came here you signed a contract; you came. I think there is no need just to break the law. I don't believe in that." (Participant 9)*

As a result, we can use the participant examples of other countries as an example of multiculturalism in order for staff to embrace the Saudi culture.

Moreover, participant 3 explains the different countries' awareness about the multicultural concept, and that they would not hold anyone's culture against them:

*"Canada we're very multi-cultural, so we have nurses from different backgrounds as well. From everywhere. I wouldn't hold it against somebody if they were from China, or if they were from Pakistan, or from India, or from wherever. I would never hold it against them because I know that they went through a lot of work to get to where they are." (Participant 3)*

Additionally, participant 14 illustrates the concept of multiculturalism in Canada and England, embracing people as a citizen without changing their personal identity:

*"I think with England, with Canada, it's not that prejudice doesn't exist, but we've embraced multiculturalism. You want to go to the temple? Great. You want to go to a Shinto shrine? Okay, that's fine. Whatever your faith is. As long as you obey our laws, we're happy with it. Whereas what I find with the States, the States is more about assimilating and becoming an American. They want you to go and become an American whereas in Canada and Britain it's like, "You know to come, be who you were but just follow our laws and we'll embrace you as a citizen." (Participant 14)*

### ***The Positive Aspects about the Multicultural Workforce Environment in Saudi Arabia***

Participant 9 indicated the adaptation of a new culture, and a new practice that changes her and gives her self-awareness:



*“If you ask me now to go back to work in Malaysia I will struggle if their culture does not change because I have changed. My background has changed. Does it make sense?” (Participant 9)*

The participant noted that Saudi Arabia’s special experiences and multicultural environment gave her the understanding to deal with different ethnicities:

*“To me, actually, it's an experience nobody will ever take away from me, and I'll never regret that I came to Saudi. Saudi gave me the worst and the best moments of my life. I will never regret that, and I know that I am a better person today and a richer person today regarding understanding and seeing others” (Participant 1)*

One participant highlights the positive aspects of the different culture by gaining knowledge, experience, and technology from the multicultural environment:

*“It is increasing our knowledge. It opens us from inside to increase the experience and knowledge, and everything. It is nice. I am not saying it is not nice. Also, we don't forget that the rules also, they are coming from other countries who are maybe more civilised and have more technology than what we have, so they are adding to us. We cannot ignore that part,” (Participant 13)*

Here the participant appeared to believe in learning from another culture, and the participant noted that he could learn new skills, practice and life concept which are different from his own culture:

*“The diversity strength us. Learn from each other. Like when you see like western. They are fighting for their rights. They know how to fight? You are going to learn from them better practice, one day you will learn from them. Like people coming in from the Far East. They have very, very strong social lives. Very strong family relationships. They support each other; they have families to support. They like to live their life. They enjoy their life. Maybe our culture is not like this. Maybe we are more conservative.” (Participant 8)*

The above theme beyond the Purnell Model with data represents the views of staff from a different ethnic group. Healthcare professionals were seen to have barriers among them as staff, and between them and a new culture and system adaptation, and on the other hand there was positivity about these differences.

### ***Theme 13: Empowerment and Disempowerment***

Another significant issue evident in the data is empowerment and disempowerment. As ascertained from the semi-structured interviews, the sub-themes were: workplace advocacy and challenging policy, use and abuse of power, blame culture and concealing mistakes, and how to deal with it to collaborate effectively in the multicultural environment. For example, some participants reported that staff challenge the policy and advocate for patients' safety while the disempowerment and lack of advocacy may have been a result of culture. The participants described their disempowerment as a lack of confidence, the inability to challenge safety issues, and bullying by the local and dominant people, as well as intimidation by management. Additionally, the lack of organisational support for nurses from different ethnic groups contributed considerably to the development of such feelings.

#### ***Workplace Advocacy and Challenging Policy***

Participant 1 noted the unsafe practice and interesting answer from one of the doctors in the investigation into discharging patients with high INR, as the nurse did not advocate for the patients:

*"We had a situation where a patient discharged with a high INR. Nurses have the knowledge to know what's up the high INR. Still, the patient went home and then he died at home one hour later. When I was at that meeting, there were physicians there, and we were trying to find out where was the problem in that episode. A physician didn't take the guilt or didn't say, "It was my fault." It was*

*interesting to see other physicians saying the nurse also missed to advocate for the patient. Also missed to make the physician aware.” (Participant 1)*

According to participant 1, the staff are usually disempowered and feel insecure to speak up, and even the managers sometimes feel that way:

*“The problem to me is that they have to feel that they can speak up because they have to feel they have management that won't allow them to be sent home just like that. Unfortunately sometimes, managers themselves, they feel that way.” (Participant 1)*

Participant 14 noted that an Australian nurse refused the risky order by a doctor and challenged him:

*“They wanted to then rupture her membranes which would have further complicated it, and the resident said, “Give me an amnihook to rupture the membranes.” My Australian colleague just stepped back and said, “You want one you get it yourself.” You know like, “Let’s not put this baby at any more risk.” (Participant 14)*

Moreover, participant 14 stood up for patient care and challenged the physician:

*“I remember, probably again an instance with a patient where we walked out of the room and I was uncomfortable with the way the physician had examined a woman. He was checking her dilation, and we walked out of the room, and I said, “Excuse me, there is no reason why that woman needed to be that uncomfortable.” I said, “Woman has a natural anatomical curve you need to follow it when you examine them.” I was respectful, I said it outside the room, and he said, “Oh you know it's because ... I did, it's because I'm left-handed, you didn't see.” (Participant 14)*

Similarly, when she came to the hospital, participant 2 noted different and unsafe practice regarding the line flushing that risked patient safety. She challenged the policy and refused to follow it, and accordingly the policy was changed after her actions:

*“When I came here the practice was to ritualistically flush the line every twelve hours no matter what. I came in, and they said, oh, 4:00 in the afternoon we flush our lines. I'm like, why? Why are you flushing the lines? Well, because we have to flush the lines. Why are we flushing the lines? I said there are mountains of evidence that supports the fact that we should go into lines minimally. What it was doing was putting the patient at risk. I said this to my manager I said to her, look, I'm not going to do flushes at 4:00 in the afternoon. I said, and I will document why on all of my patients. At that time they were actually in the process of updating the policies within the hospital and that 4:00 flush was being removed. The staff on the unit were just absolutely in an uproar that new member staff I walked in and said, no. I'm not doing that. I had what I needed as a nurse to say” (Participant 2)*

### ***The Use and Abuse of Power (Corruption)***

Participant 3 noted the staff with power and connections were able to abuse authority and sack nurses who were trying to speak up:

*“We had a lot of issues with our last head nurse. She wasn't very nice. She fired one of the nurses for something that was ... One of the nurses wrote a letter to the CEO of the hospital, and she was talking not just about the head nurse, but management. She was talking about everything that was happening on the unit. Like, “This needs to be improved,” blah, blah, blah, so-and-so. That head nurse, I think she had some connection somewhere, and she was able to fire that nurse. For specific people. For some people, it doesn't matter, but for people that you know, you write a letter, and then you ... Yeah.” (Participant 3)*

What is more, Participant 2 noted that some staff are abused substantially during work because of their attitude and response toward others colleagues, and will always say yes to anything they are asked to do:

*“They are easily they do get abused massively for the fact that they'll never say no to you. They will always say, “Yeah. Yeah. Yeah. I will do that. No worries. Yes. Yes. Yes. I will do that. No worries.” It's not fair.” (Participant 2)*

Moreover, participant 13 explained the fear of higher authority and lack of organisational guidance:

*“I believe at that time, nobody guides us, that we have this and that, and this and that approach, and we can do it, and we will be heard. They create on us the fear from the higher management, "Oh no, no, you're not allowed to go. Don't do that.", and not knowing your rights exactly, and there is no guidance.”*  
(Participant 13)

A participant noted that bullying and abuse could be carried out in a very professional way, especially if it is coming from higher position colleague, and can cause emotional harm to staff:

*“It can happen like bullying or abuse. Sometimes it could happen, believe it or not, in a very professional way. If you have a manager or a supervisor who is having a higher position than you, they know the rules, they know the policy, the procedure, and know how the things can go, they have the connection with the higher management. They abuse you and do the bullying in a very professional way. This is the real harm thing. They know the rules. They know how to play the game, and they can make you very emotional harm, but nobody can say anything about that.”* (Participant 13)

### ***Blame Culture and Concealing Mistakes***

Participant 1 explains that frightened nurses conceal mistakes and there is a different concept of blaming culture for nurses from different backgrounds:

*“Frightened people. Everything they were scared of. I could imagine what they were told before they came. They were probably told, don't do anything. Don't say anything. Just do whatever they say. They don't see mistakes as we do at home. I was taught that you have to tell me a mistake, not because you're going to be blamed about it, but because we need to correct it.”* we encourage people to believe here that we are a non-blaming culture. (Participant 1)

Also, participant 1 illustrates that some staff from different nationalities lack understanding of the non-blame culture concept:

*"We have much more reporting than before, but not to the level that we would like. Even though we believe it's a non-blaming culture, sometimes it can be blaming. Still, a lot of nurses from some nationalities, they don't even understand what that is. What is this a non-blaming culture? What if I do something wrong, I'm going to be blamed for it. They won't believe "I have to say it because it's to improve the process to see what did go wrong." (Participant 1)*

Moreover, participant 17 explains that usually staff from the same nationality will hide mistakes between them:

*"Because if they are from the same nationality, they will hide mistakes" (Participant 17)*

Also, participants confirm the idea of hidden mistakes between the dominant culture nurse group:

*"Filipino nurses specifically, they will always do the same thing, even if it's not what they meant to do. They will always cover each other." (Participant 2)*

*"And this true if mistakes happened between Filipino they will not report." (Participant 16)*

The above theme, empowerment and disempowerment, is beyond the Purnell Model, and contains workplace advocacy and challenging policy, use and abuse of power, blame culture and concealing mistakes in the multicultural environment and their impact as barriers and facilitators. Some healthcare professionals reported challenging the policy and advocating for patients' safety, in contrast to the disempowerment and lack of advocacy as a result of staff culture.

#### ***Theme 14: Workplace Justice and Injustice***

Another significant theme evident in the data, which is not accounted for in the Purnell Model, is workplace justice and injustice and how to deal with it in order to collaborate efficiently. The most notable origins of barriers regarding efficient collaborative working between nurses are: dominant culture abuse and bullying, discrimination, ethnocentrism, workplace violence and aggression. These were the elements of workplace injustice and may indeed exacerbate the barriers to collaboration. Regarding the above, the participants' dialogue highlighted that overall, organisational strategy toward Saudi staff and multicultural healthcare professionals, in general, is unequal, and staff patients discriminated relations. And colleagues together were seen to have unacceptable behaviour. It is evident from the results of this study that the theme of "dominant culture abuse and bullying" and these professional abuse actions are barriers to collaboration between staff, harming the emotional status of the staff, and the outcome of the care, and organisational facilitators to overcome those barriers. This was indicated in the findings and demonstrated in the statements made by those working in a multicultural field.

### ***Dominant Culture Abuse and Bullying***

Participants noted in the semi-structured interviews discussion that these tendencies are happening among healthcare staff, and these actions are barriers to collaboration, harming the staff's emotional feelings and care outcomes, and that there is a possible strategy provided by the hospital to overcome this abuse. Such viewpoints are likely to be connected to professional abuse.

One participant explains how the economic background factor and financial status cause the nurse to choose to work abroad, and causes other colleagues to sometimes verbally abuse them:

*"This nurse from poor family and poor village she came her for money only, and if they fight with each other they will tell her yes because you are from this poor place!" (Participant 17)*

Participant 12 noticed how the dominant Filipino nurses gave staff from other nationalities a hard time and bad evaluations, or said bad things:

*"Other Filipino women, they have this, I don't know really with them they have like saying that they're giving others a hard time... For Filipinos, we will have this crab mentality thing. Do you know what that is? That's when someone is going up, and you want to pull them down like try to say bad things or say bad evaluation to them." (Participant 12)*

Additionally, participant 2 explains the staff dominant culture's control and bullying of other western staff, which causes them to leave the unit:

*"Filipino [group or mafia] was running the unit, western nurses transferred to another unit because they didn't like the dynamic that was going on between the two groups. From their perspective, it was the bullying. Manipulation of the assignment, manipulation of the schedule, little things that impact massively on a nurse's life." (Participant 2)*

According to participant 3, the rude behaviour from the dominant culture nurses bullying staff caused her friend to leave the hospital:

*"Yeah, her contract was one year, but she was planning on maybe staying another year. She left because first, she was not happy at work, and then all these different experiences with these nurses that were so rude to her. Yeah, like they would tell her. Like high school stuff. Stuff that you do as kids. You saw that, and I was just so shocked that they would always tell her, "That's not our practice. That's not the way to do it. Like Filipino mafia. That if this unit is mostly Filipinos, they'll try and be mean to the so-and-sos so that they quit, or leave, or transfer, or whatever." (Participant 3)*

In this regard, participant 6 explains that dominant culture nurses work as a team against other ethnicities:

*"When you have a number from certain nationalities sometimes it makes a team working together against some but likely here I don't allow that thing to happen." (Participant 6)*



Moreover, participant 1 noted that some head nurses were removed from their position because of the dominant cultural influence and power:

*“Some head nurse is somehow being removed from their posts because of the force that the mafia did next to both that make decisions to make that happen. We've seen that.” (Participant 1)*

### **Organisational Strategy to Overcome Abuse and Bullying**

Interviewee 12 argued that there was a hospital strategy to overcome these issues, through the provision of an anti-bullying programme and retention group that would stop this from happening if the staff report it:

*“We have that programme here, the anti-bullying. We have a retention group here. You can report anyone, and they will see and investigate. If it's proven true, you can be kicked out from the hospital.” (Participant 12)*

Moreover, participant 4 noted the organisational support and magnet hospital action (code white) toward harassment and bullying from a physician or patients:

*“Before we don't have. Here now it's even among the team members with a physician or the patient's family, if there is a bully or you feel like harassment and all those things you can call for the code white. They will investigate. It's improving a lot of things. This is more protecting for the nurses, which before it was not. Since it's changed to the magnet hospital here, it's more...” (Participant 4)*

### ***Discrimination***

All the participants noted in the semi-structured interviews discussion that discrimination plays a significant role in creating barriers, especially concerning organisational opportunities toward Saudi staff, patient care, salary, skin colour, contract threats, and how the professional health team can be affected by the discrimination which can lead to collaboration barriers among them and with patients.

Participant 1 noted that the culture could lead to discrimination, and thus, those people who were living in a discriminatory environment may not be aware and that this would affect their

relationships with other staff. Cultural influences caused those with other ethnicities, especially some groups believing that they are in Saudi Arabia to serve, to be considered as dangerous, which could in turn lead to abuse within Saudi society:

*“Saudi raised believing that there are ranks of people. There is people of lower class, middle class, high class, VIP class... I have colleagues that the way they talk about certain ethnicities, you can see the way they talk about it. It can be quite discriminative as well.” (Participant 1)*

According to participant 1, the situation will be worse if nurses from those ethnicities take care of Saudi patients, as the patients and the family will treat them as maids and this will affect the collaboration between the nurses and patients:

*“Families here, they tend to see nurses as inferiors as well especially if you see a Saudi patient and a Saudi family being cared for Filipino nurse or an Indian nurse. If they already have that constantly mind that those nationalities are lower because you're a nurse and you have to take care of me, and if you are from that nationalities, even worse. They treat nurses like maids sometimes here.” (Participant 1)*

Also,

*“The worst of this is that unfortunately those people; they were raised believing that they are there to serve. I know people that their dream or all their lives what they're trying to do was to leave their countries and come to Saudi Arabia to serve because even though I am sometimes treated, I'm treated like "ma'am" all the time. I hate that. This "yes ma'am" says so much about how someone was raised.” (Participant 1)*

As a result, those discriminated-against staff will usually not fight for their patients' rights:

*“Why will I fight for a patient that most of the time don't even respect me because I'm seen as a lower nationality? While I do that taking the risk of being sent home and losing all my money and losing the opportunity of a better life back home” (Participant 1)*

### **Organisational Opportunities Strategy toward Saudi Staff**

Saudi staff express the organisational discrimination and lack of support and other ethnicities' (western) favouritism in education and development opportunities that lead to frustration, upset, emotional feelings toward the organisation, Saudisation department and other colleagues.

Participant 13 noted that there are different institutional opportunities for Saudi staff and westerners, and the organisational discrimination role and barriers toward Saudi staff that caused her to feel challenged, unhappy and be upset toward western colleagues:

*"I'm not happy about it because I think they are taking most of the privileges. I am a bachelor's degree nurse and most of the westerns that are coming to our hospital they are diploma. Sorry, I studied five years, and they just study one year or 2 years, and they come, and they take higher positions than us, and they are allowed to continue to their master's and PhD online, while we are not allowed. It is a must for me to go outside abroad for studying master nursing and PhDs, going away from my family and friends. When you come back, they said, "Oh, you've been away for a while for your master's. Things change. You have to have some experience first," (Participant 13)*

Also, participant 17 highlights the organisational management toward Saudi staff and lack of educational opportunities that lead to a gap in the relationship between them:

*"I want to do my master but the administration did not allow me to do and that time the voices came to be loud, and this make gap between us" (Participant 17)*

Also, participant 13 suggests that Saudi nurses should have opportunities from the hospital as they are more oriented about the patients and culture, unlike other nurses:

*"Our hospital should give us more opportunities, to believe in us. Please see the people who are working hard. A lot of people are working hard, but you are not noticing them. The other people that you are giving the opportunity to them, they are not really working hard. They think they are smart enough. They think they are doing better than us, but they just a mouth. The just talk, but inside they are really empty. They don't have the experience, they don't*

*know the culture, and they don't feel the empathy with the patient like we do. Believe me, and they are hollow from inside. They are just a mouth. Take the people who are really working, who really know the culture, who really, really care for the patient” (Participant 13)*

### **Patient Care**

Patients can be jeopardised due to barriers between nurses’ ethnicities and different cultures.

Participant 1 noted that patient care was jeopardised because the colleagues were from different ethnicities, and they delay patient care that can lead to medication errors, giving priority to staff according to ethnicity:

*“I have faced situations where nurses because of different ethnicity, they will delay, or they will give priority to double checking to people from their own ethnicity than others. Then will affect the practice because either you delay your medication or you will do without double-checking, and that is dangerous. That is really dangerous for the patient.” (Participant 1)*

Moreover, participant 1 illustrates that patient care is jeopardised because of nurses being of different ethnicities:

*“I had a colleague where she was new to the critical care area. She had done a critical care course, but she was never a critical care nurse, so she was starting. Her colleague from a different nationality ... This colleague of mine, she went and asked her. The patient had arrived at the unit, and she needed to change the lines to the central line, and she was unsure how to do it. She called the senior nurse to help her, and the senior nurse said, "You are critical care nurse now. Manage yourself," and she turned her back.” (Participant 1)*

Similarly, participants noted that staff support and help people from their own culture during patient receiving and general patients care and this is not happening with colleagues from other ethnicities:

*“This is their problem; if one Indian nurse she received the patient, you will see six Indians there. If me, will receive a patient, nobody will go there.” (Participant 11)*

*“I have this friend; he's Saudi. No one is helping him. When I'm on duty, I'm helping him, and he's so happy I'm working because, "I'm going to help you, bro." Others, they don't. It's like he's an invisible person in the unit.” (Participant 12)*

Also, patient care can be jeopardised directly from nurse to patients due to different reasons, such as a patient's social level and ethnicity:

Participant 18 explained that some staff care differs according to patients' social level, which leads to unequal care:

*“Because of social status of the patient, if they are house-made they will not take care of like highly educated people, unfortunately.” (Participant 18)*

### **Educational Status and Occupations**

Participants noted the organisational discrimination and differentiation between ethnicities: salary discrepancy according to nationality, different lifestyle and restriction among specific ethnicities, differing levels of personal growth and lack of educational support made the staff unhappy:

*“Many things. In salary, it can be. In the personality to growth also. Also, the lifestyle that's been accepted by certain people not accepted for another people, this is also can make people not happy.” (Participant 6)*

Participant 7 explained the lack of organisational support for staff to engage in further education:

*“Education. It's not allowed to go for education; there is no support also. For example, I see the organisation or the company, that if you plan to go for different degree or to do specific things they will not support it should be from your pocket and your Time also.” (Participant 7)*

## Salary

Participant 14 highlights discrimination and unfair assignment from other staff, as a result of which organisational issues developed between nurses because of salary discrepancy, which would in turn influence collaboration and patient care:

*“A classmate of mine from nursing school said that she had difficulties because the nurses would say, “Well, you go do it, you’re getting paid more than us.” If you are, looking at Filipino nurses and things like that. I do know that if there were really sick patients on the unit or if there were a heavy load, I would get it.” (Participant 14)*

Participant 12 noted that salary discrepancy caused conflict and feelings of unfairness between colleagues:

*“They feel maybe that, okay she is Canadian, I am sure she gets paid more than I do. That happens a lot, and I have seen it happen to some of my friends. They feel a little bit it's unfair so maybe I'm not going to treat her fairly as I would treat the rest of the staff or people from the same nationality. “They give us a list of Canada, the USA, and Australia, they all make this much.” (Participant 3)*

Another participant illustrates that salary discrepancy is the central and main clash between all nationalities:

*“I think the issue with other nationalities here is the fact that this is the only place I have ever worked where you get paid according to the country you come from. I think, to be honest with you, that's the main sticking point between nationalities is the fact that if you're Western or if you come from America you're going to get paid more than if you come from the UK. If you come from the UK, you are going to get paid more than if you come from India or the Philippines and so on and so forth, when we're all doing the same job day in and day out. We are all putting up with the same horrible situations day in and day out. I think that is the biggest clash.” (Participant 2)*

Participant 11 explains that salary discrepancy leads to animosity between staff:

*“There is a different level of pay for various nationalities. That pay is relative to where you come from, so I think that sets it up for there could be a little bit of animosity maybe” (Participant 11)*

### **Skin Colour**

One participant explains that black people are still discriminated against due to their skin colour, even if they live in a western country:

*“I feel they have this feeling are the black people. If they come from Africa, or they come from western country, but they are originally not western. I know they face the same thing previously in their life, this is what happened historically” (Participant 6)*

Also, one participant noted stereotyping among black people:

*“I must say for myself in relation to those days, I mean before I came here at least, we don't see as many as black people around. The way you communicate with black people we do not know. That's a big difference. They have a very strong personality.” (Participant 9)*

### **Contract Threats**

Below, participants express the organisational threat culture among colleagues that affects staff confidence and disempowers the staff's work role, which will impact the relationship with other colleagues.

One participant explains the lack of support from other colleagues as they are always afraid and feel threatened that the hospital will send them home:

*“Usually they are not supporting and not good backup, they are always afraid always will through things on you, they are afraid of anything they will terminate them and send them to their country. And it is really happening.” (Participant 17)*

Another participant illustrates the threat culture in the hospital toward staff:

*"Don't you criticise me." There's a bit of culture to where, or at least I've been led to believe that it's easy for some nationalities to fire." (Participant 11)*

Moreover, participant 1 adds that there is a constant fear of being sent home for people feeding the whole family back home, and there are people who have power within the hospital who can make this decision:

*There is this constant fear of "I can be sent home anytime." We have enough power for people within the house to make those decisions. Certain nationalities that to come here, they spent probably all their savings back home. Being here for them, it's as important as feeding a whole family back home" (Participant 1)*

In contrast, participant 1 noted that some nurses do it the other way around by threatening the head nurses that they will leave if they do not comply with what they want, and misusing the magnet concept:

*"We are a magnet institution. Magnet among many, many concepts, it's about retaining nurses. Head nurses, they have a somehow target of reducing their turnover to a certain percentage. When you are head nurse, and you know you have to reduce turnover, you have to try to do everything you can to keep your nurses. Then you get to the extreme, which is nurses saying to the head nurse, "If you don't do this to me, I will leave." (Participant 1)*

### ***Ethnocentrism (Own Culture)***

Ethnocentrism is the belief of superiority of one's own ethnic group, racial or religious differences. Ethnocentrics consider themselves to be better than other persons for reasons based mainly on their culture. These are feelings which lead to superiority and discriminatory behaviours that appear in healthcare practice as well, sometimes between patients and nurses, or among nurses.

Participant 3 noted the feeling of superiority from Saudi VIP patients toward them as nurses, and that they treated them like servants:



*"If anything I've ever felt something of anything about social status has been a VIP patient that treats us like we're housemaids or something, or even worse than that, like servants." (Participant 3)*

One participant explains the Saudi staff's feeling of superiority toward them:

*"Saudi, from what I hear, they feel they're superior with the things. Because, first of all, they're from here and then they know how things work... Like when we try to maybe correct them at some point. Nobody is perfect. When you try to correct some people professionally, they will get angry, or they will say something, "This is the right way." This is a strong conviction that this is the right way." (Participant 12)*

One Saudi participant expresses their ethnocentric feeling toward any other staff trying to speak up against or criticise the Saudi culture:

*"This is our culture, and this is our religion, and you are not allowed to talk about that here, in this place... but trying to come and talk about our culture in a very not nice way, at that point, they should be stopped. Or criticising our culture or criticising our thoughts, or criticising our religion, no sorry, you have to be stopped that then. Other than that, if you don't like the culture of our religion, you are welcome to leave, sorry, but not to talk about us, because we are not judging you, so you are not here to judge us. Excuse me, this is our culture, this how it is, and you have to accept it, or you don't. If you don't, go, bye bye." (Participant 13)*

Another Saudi participant explains their mixed feelings toward non-Saudi staff and feeling of superiority feeling toward a non-Saudi colleague:

*"I feel pity because the staff leave their country and family for financial reasons. If someone in my position or higher position will do something to me I will say why she is not respecting herself she is non-Saudi" (Participant 17)*

## ***Workplace Violence and Aggression***

The participant below expresses aggressive behaviour and violence toward them from a patient's family or staff in a managerial position, and the strategy developed by the hospital to overcome these issues.

Participant 3 explain the patient's family's violence toward a doctor in the emergency room:

*"In ER I saw one patient's family punched one of the doctors. Yeah. That was like last year" (Participant 3)*

Similarly, a participant noted that it was her first time in life to see a patient's family's violence toward a doctor and nurses:

*"First time in my life I saw the family members screaming and trying to beat the doctor because she's demanding. I have seen the patients' family members beat the nurses." (Participant 4)*

Participant 18 highlights the aggressive behaviour of non-Saudi Arab staff in the operation room, and she calls it unacceptable and risky behaviour:

*"I still remember in Saudi people throwing instrument in operation room when they are getting angry, and this is completely aggressive and unacceptable and risky." (Participant 18)*

Participant 2 noted the defensive and aggressive attitude from Saudi colleagues in higher positions to manage people, which is probably not acceptable:

*"You end up with somebody in a position where they don't know what they're doing. They don't know the answer to the questions that the staff are asking them; which makes them go one of two ways and generally with male Saudis is the fact that they go on the defensive. They just get shouty, and you're going to do it this way. This is the way I've told you to do it. Even if that's not even the right way, that's not the way to manage people." (Participant 2)*

Similarly, participant 12 noted that some head nurses are approaching staff to correct mistakes in a tough, angry way, which causes the staff to feel unconfident:

*“Our head nurse. He was a male. He was, I think, Lebanese. And the head nurse will talk to you like, “Why you left this? Why you do this?” Something like that. Then, of course, the person will be degraded and feel not confident. Why he approach me like this, in my opinion. If you lack something, nicely tell them, something like that.” (Participant 12)*

Also, participant 2 explains the physical violence by a manager toward a staff nurse that was not appropriate, and furthermore, there was no real action taken from the hospital regarding the incident:

*“Between a manager and a staff nurse that got physical, two Saudis. We had to pull a code white for that situation to be dealt with. Once again, nothing has ever been discussed it. It's not been discussed within the department to say, look, this happened. It wasn't appropriate on either side because the management should never be seen to be physical with anybody. It wasn't appropriate. Apparently, there's an ongoing feud between these two individuals, and one of them shut the other one in the store cupboards. They were both shut in the store cupboard. One of them hit the other one, and one of them was shouting, “Let me out. Let me out,” (Participant 2)*

### **Strategy to Overcome Violence and Aggression**

Interviewees argued the action of verbal attention before termination of staff having an attitude problem with patients and colleague. As participant 18 commented:

*“One non-Saudi junior colleague she has attitude problem she is aggressive with patients sometimes with colleague. She didn't get her promotion even she is eligible to get. And she has been told because of her attitude, and she got verbal attention that she will terminate if did not correct her attitude I think this has relation with the way she raised.” (Participant 18)*

There was a code white developed by the hospital if the nurses were physically or verbally harassed by a patient or the patient's family:

*“Patients to nursing. Here, we see that a lot especially ... I wouldn't say the patient because I know they're so weak that they can't do it but will be more the family, the sitters, the children, children as in the daughters and the sons of*

*the person that we have. We even developed a white code which is if the nurse is being harassed physically or verbally by either patient or family, they call the white code which is a group of people that will come and usually involves security, patient relations, a manager, the supervisor.” (Participant 1)*

The workplace justice and injustice theme beyond the Purnell Model included dominant culture abuse and bullying, discrimination, ethnocentrism, workplace violence and aggression in the multicultural environment and the impact of barriers in the workplace and provided the organisational strategy to overcome workplace injustice.

## **5.4 Summary of the Findings**

The study consisted of semi-structured interviews that addressed the key research question related to barriers and facilitators of nurse-nurse collaboration in a Saudi Arabian context. The hospitals under study symbolised a heavily diverse workforce and were in general representative of those in Saudi Arabia and both genders with regard to their collaborative experience with multicultural nurses in KSA hospitals.

A total of 18 consenting participants were from either Saudi Arabia, the Philippines, India, Pakistan, Malaysia, Lebanon, Jordan, Canada, Ireland, the United Kingdom, Portugal or South Africa. The findings showed that there were individual nuances, which included language barriers, cultural barriers and gender barriers, which hindered effective nursing collaboration. According to the nurse participants, these were: reasons for working in Saudi Arabia and associated economic factors, adaptation process challenges, the different communication style, non-standardised language and that they had to contend with different accents and unknown abbreviations. The differing cultural backgrounds among the multicultural nurses and with Saudi patients posed a difficulty that nurses had to overcome. The nurses also had to deal with cultural complexities such as family role and husband authority in Arab culture and alternative lifestyles, the colleagues’ attitude and high-risk behaviours. food as barriers and facilitators between different cultures, pregnancy and death and dying concept, the spiritual practice of Ramadan and fasting, the issue of religious practice, of the Saudi system affecting their way of collaborating,

as well as the effects of care delivered. Also of considerable concern were the healthcare practices and practitioners, including role conflicts and folk practices, gender barriers nurses had within the cultural context, as seen in that male nurses in Saudi Arabia were culturally restricted not to care for female patients. The nurses also had to deal with different cultural norms and values, disempowerment, blame culture and concealment of mistakes.

According to the nurses, their salary was among other factors that affected their collaboration and justice in the workplace.

The nurse participants recommended specific economic factors that influence feelings of job satisfaction in Saudi Arabia, education, communication approaches and policies that would shape their collaboration levels effectively.

The finding of insufficient knowledge of staff from different cultural backgrounds, including Saudi Arabian society and the associated cultural context, needs to be addressed through targeted education. The current study findings recommend that KSA hospitals develop guidelines such as cultural and contextual courses to facilitate effective collaboration. The use of technology in nursing can also help in making communication effective and culturally competent. The participants also claimed that there should be educational offerings and orientation programmes in both basic and in-service nursing education. In particular, for newly-recruited international nurses, education programmes should be developed supported by celebrations about how to be accepting of others. The nurse participants also claimed that the hospital should provide professionally educated translators on each shift on call as well as several multilingual signs and directional markers.

## **5.5 Conclusion**

The interview data demonstrated the complexity of a multicultural working setting. The Purnell Model can help frame the data to clarify how cultural issues can act as both a barrier and facilitators to a significant level. The deductive analysis commenced according to the framework to usefully explain the differences in standards, behaviours, languages and practices of managing

in this organisation, and the barriers these posed for the multicultural nurses working there. The inductive analysis was beneficial in articulating the themes of cultural differences, empowerment and disempowerment, workplace justice and injustice in order to enhance the model to relate to multicultural working. Moreover some of the Purnell Model's sub-themes were modified to make the domain theme more suitable for explaining the presented data, that precisely reflected the multicultural nurses' experience of this context, and demonstrated how things beyond the nurses' control could not only threaten the cultural collaboration and delivery of care to patients; they could also negatively distress the emotional safety of the nursing staff. Subsequently, from these results it will be possible to provide practical recommendations for how organisational support might be implemented to help nurses overcome the barriers they often experience. These issues, together with recommendations for future studies, will be presented in the following chapters.

# **Chapter Six: Discussion**

## **6.1 Introduction**

This research aimed to gain an in-depth understanding of how nurses and nurse managers perceive culture and effective and ineffective collaborative working in a highly multicultural healthcare setting. Qualitative case study methodology was utilised and the case examined was the multicultural nursing workforce.

The study context was a large hospital and research centre in Riyadh in the Kingdom of Saudi Arabia (KSA). Most of the nurses in Saudi Arabia come from outside the country due to the significant local nursing shortage in the KSA. Each international nurse brings to the new place different cultural norms, values, languages, attitudes, beliefs, and practices that differ from other nurses and the dominant Saudi culture. Accordingly, to examine the complexities of this case, an in-depth semi-structured interview research method was used.

The research question guiding the study was “what are the factors that promote or impair effective collaboration between nurses working in a highly multicultural healthcare setting?” That indicated by the nursing staff opinions, experience and institutional support.

The previous chapter presented the findings of this research.

In this chapter, the findings are discussed from two standpoints, 1) what is the contribution of the results to the existing research literature? and 2) how will the research findings enrich knowledge and experience?

## **6.2 Discussion of Thematic Findings**

This section illustrates a summary discussion of the findings of this research in the context of barriers and facilitators of effective collaborative working between multicultural nurses.

Qualitative data on nurses' perceptions and experiences were analysed inductively following thematic analysis and deductively according to the Purnell Model of Cultural Competence. The findings were categorised into fourteen central themes that were further divided into more subthemes using Nvivo 11 software.

These themes are Overview/heritage, Acculturation, Communication, Family role and organisation, Workforce attitude and behaviours, Nutrition, Pregnancy and childbearing practice, Death rituals, Spirituality, Healthcare practices, Healthcare practitioners, Cultural differences, Empowerment and disempowerment, Workplace justice and injustice.

It is noteworthy that my personal experience in the UK informed my interpretation of the findings; I arrived in Manchester in September 2012, eager but worried and anxious to begin my higher studies in a different country, as an international student from the KSA. I chose to travel to the UK for my degree to broaden my academic and personal horizons.

I found the facilities and resources at the University of Salford outstanding for me as a Muslim and Saudi student, with equal treatment and no prejudice. The university and the support team were always available and helpful.

The diversity of my fellow research students from all over the world and the sheer range of issues made for a sizeable multicultural academic community of mutually supportive researchers. This healthy environment helped me to understand better and respect diversity.

The feeling of being accepted and supported as a person from a different ethnic group in a multicultural setting was terrific and helped me to understand the feelings of others, who inspired me in my research, which was reflected in my results interpretation without holding anything against them.



### *1. Overview/Heritage*

The framework that guides this study suggests that the individual is formed by their specific cultural background, such as concepts related to the country of origin, current residence, the impacts of the topography of the country of origin and current residence, economics, politics, reasons for emigration, educational status, and occupations (Purnell, 2002).

This research's semi-structured interviews reported on the theme of "overview/ heritage", which was consistent with the subthemes of (a) reasons for working in KSA and associated economic factors; (b) politics (endorsed to some extent by most participants). As Purnell used this domain mainly for migrant people, in this research the theme was suitable for nurses who had travelled to KSA for work, which addressed the research question indirectly by acknowledging the nurses' facilitators and barriers with the new cultural system that would influence their behaviours and attitudes in dealing with others in practice. Therefore, the findings of this study inform the discussion of the "overview/ heritage" theme. In this research, the participants illustrate their satisfaction about working and staying in Saudi Arabia. It is considered a perfect travel spot and financial benefits include tax-free earnings, free accommodation and a good salary, which attract nurses and work as facilitators for multicultural staff to stay and work in Saudi Arabia and enjoy their job. Similarly, as described in this study, another article has shown that the first attraction for foreign employees to work and stay in Arab Gulf countries is the attractive financial benefits, compared to what they can earn in their own countries (Sidani & Al Ariss, 2014). This attraction may reflect their satisfactory attitude and behaviour in practice and facilitate collaboration with other staff and patients. As mentioned in the literature, research concerning the issue of migrant nurses' satisfaction and the fact that they enjoyed better pay scales, a more relaxed work atmosphere and more facilities may have also played a part here (Kingma, 2001; Thomas, 2006).

On the other hand, participants illustrated that some issues could work as barriers; that some people chose nursing not as a vocation but for financial reasons, and not purely for patient care. This can lead to standard conflict between colleagues and is a barrier to their collaboration, corresponding with Mooney et al. (2008), who recognised that not all nurses had an inherent

desire to care and to be involved with helping others. For some, nursing is perceived as a career that offers variety and opportunities to travel. It also is seen as a worthwhile profession. Percot (2006) argued that thousands of young girls register at nursing schools all over India with the purpose of travelling after graduation. Therefore the nursing diploma is apparently considered as a passport to access the world not only for the nurses themselves, but also for their families, since it is very intentionally considered as an advantaged opportunity to increase social mobility. Saudi nurses show their passion for working and improving the workplace, unlike other colleagues who come only for financial reasons. The findings of this study are consistent with Almutairi *et al.* (2015), who reported that Filipinos are typically regarded with contempt by Saudi people and other ethnicities, being perceived as working in countries such as Saudi Arabia purely for financial gain.

Finally, within the second subtheme in this section “politics” can be seen as a barrier between colleagues, some nurses were influenced by political factors between the countries of their nationality which affects their working relationship. It is evident in the literature that the clinical environment is complex, with both political and social pressures contributing to a feeling of pressure for staff (Maben *et al.*, 2006).

## ***2. Acculturation (adjustment to the New Cultural Environment)***

The second theme in this study of “acculturation adjustment to a new cultural environment” was identified, as endorsed by participants, included (a) adaptation process: and (b) education. Additionally, the findings of this study are consistent with Purnell (2002). The participants in the interviews reported their barriers as the hospital following standard American system (Nursinginsaudi.net, 2018). Xu (2007) draws a similar conclusion, as nurses from Asian countries reported difficulty in adjusting to Western standards of practice. Concerning the nurses’ facilitators in the adaptation process, they modify their cultural food to be accepted within dominant culture food. According to Black and Stephens (1989), food and drink, along with climate and living conditions, is one of the three core areas to which expatriates must adapt; to be able to function without undue stress and be accepted by the hosts (van Vianen *et al.*, 2004).

Moreover, the attentive staff learn about other cultures to manage their adjustment with other ethnic groups and experience a “self-transformation” that can facilitate collaboration with others. If a nurse fails to adapt to the new department, usually they shift the nurse to another area matching their skills for all parties’ satisfaction. The participants in the interview discussions reported that their adjustment to the new cultural environment was associated with the “education” provided by the organisation for facilitating and promoting cultural awareness. Purnell (2012) found that administration and management initiatives to support a diverse work environment include cultural competence and diversity workshops and cultural celebrations. The nursing education and orientation needs to be holistic and accommodate all cultures not only the dominant Saudi one, but the scenario was different in this study. The General Nurse Orientation (GNO) focused solely on Saudi culture, and hospital policy deemed essential for patient care within the dominant culture. The only source of social activity between cultures is a multicultural night provided by the organisational recruitment and retention department. A cultural awareness course was stopped in favour of GNO, internal competency courses, skills and a preceptorship programme, it is worth noting that sometimes the preceptor personality can play a significant influence in getting most of it or not. It seems more is to be done, as there was a lack of management and organisational support, and not enough orientation and education within the unit before starting work, which can lead to dangerous practice. According to Thobaben (2003), the organisation must ensure constant training in cultural competence for all staff in all disciplines. Competence training suggests the critical role that can be played by an organisation in the delivery of culturally appropriate services that eliminate nurses’ disparities and improve the healthcare outcome.

The findings obtained from these interviews are unique to the study’s context and suggest that the organisation does not provide appropriate support to ensure effective collaboration and mitigate the risk of barriers due to cultural diversity in the multicultural health organisation. There is no obligatory cultural competence education before work, nor is there sufficient training and support post-employment. There is a lack of literature on proper organisational support through policy and standards to ensure effective collaboration between nurses in the context of a multicultural workforce, and the results revealed that nurses were struggling to collaborate efficiently and they also struggled to perform nursing care. This study recommends that there is a

requirement for education about other cultures to tackle the barriers between multicultural nurses regarding cultural awareness, as the nurses in this study were inefficiently prepared in this respect.

### **3. Communication**

The semi-structured interviews reported on the theme of "communication", which included the themes of (a) language barrier; (b) nonverbal communication; (c) communication style; (d) expression and interpretation; (e) translation services; and (f) strategy for good communication. According to Purnell (2003) no other domain has the complexities of communication and is interrelated with all other domains; this corresponded with Longhurst *et al.* (2008), who stated that the social and cultural settings are heavily influenced by language and communication. Therefore, the findings of this study inform the discussion of the theme "communication", although the Purnell Model discussed that the theme is related to the dominant language. This was also mentioned in the literature review, which located research concerning the nurses' issue of communication within a multicultural setting (Clayton, Isaacs and Ellender, 2016; McGilton, Irwin-Robinson, Boscart and Spanjevic, 2006; Murphy and Clark, 1993; Nordby, 2006;). However the Purnell model does not accommodate multicultural teamwork, where there are communication issues between staff, hence the modification of the model to accommodate this subtheme.

The study findings support its conceptual assumptions concerning communication. The results indicate that the concept of cultural knowledge includes knowing about cross-cultural communication, whether verbal, written or conveyed through body language, and reinforce the essential role of effective communication in the collaboration between nurses and patient care. Effective communication and collaboration are intended to get everybody on the same page (Leonard *et al.*, 2004).

Furthermore, nurses from a dominant group speak their own native language during teamwork, which is against the hospital policy of language standardisation and leads to clashes between them which will risk patient care and safety. Leonard *et al.* (2004) argued that using standardised communication to make the day go more smoothly and keep everyone safe is effective.

Moreover, different accents and the use of unknown abbreviations are significant barriers between nurses. The findings also revealed the risk that cultural and language barriers pose for communication, both verbal and written, which is consistent with the conclusions of other disciplines. For instance, in aviation settings, many authors emphasised that cultural diversity, combined with language barriers, can lead to misunderstandings and miscommunication (Alderson, 2009; Merritt & Ratwatte, 2004). As a consequence, sometimes staff feel socially isolated and left behind, which will significantly impact their collaboration and teamwork. Moreover, even though nurses learn Arabic, for patients it is considered hospital Arabic (broken Arabic), which will not be sufficient for social situations.

The participants in the interview discussions also identified “nonverbal communication” as a facilitator between nurses and patients and a barrier between nurses’ different backgrounds working together, because it leads to confusion. This fact accords with the research of Cioffi (2003), who discovered that nurses also use alternative measures, such as body language, and sign language. Unfortunately, although these strategies may facilitate nurses’ communication with their patients, there is no way of knowing for sure whether the patient has correctly understood what they have been told. As a consequence, the quality of patient care cannot be ensured unless the information can be communicated verbally (Cioffi, 2003).

Nurses must understand that nonverbal communications and body language may vary from one culture to another to enable them to collaborate efficiently. Consequently, they must be aware of and sensitive to differences between cultures (Fatahi *et al.*, 2010; Huang, Yates, & Prior, 2009; Hultsjö & Hjelm, 2005; Jirwe *et al.*, 2009).

Additionally, the nurses in this study lacked knowledge about other nurses’ and patients’ cultures and languages, which created many struggles and challenges for them when interacting and performing care. It is evident from the results of this study that the theme of “communication style” is a barrier between staff from different backgrounds. Differing direct and indirect communication styles can cause misunderstandings between cultures. This can cause a block in communication. For example a western nurse who uses a direct communication style is considered challenging in the Arabic culture, especially for Arabic men; this could impact patient care as a result. This finding was similar to the results of Cioffi (2003) and Gupta (2011). To

overcome communication blocks with colleagues and acknowledge another cultural style, some staff will avoid direct communication. This finding supports the work of Samovar *et al.* (2009) and Schein (2010). In high context cultures such as Saudi Arabia, people communicate indirectly and rely on implied meanings that are fixed in the socio-cultural context. Notably, individuals who apply indirect communication tend to veer away from direct interactions, which may result in arguments. High context societies typically deal with conflict through passive resistance and using third parties or debating matters in private. In contrast, a low context culture allows people to be more direct in their interaction, with a preference for more explicit communication styles. In such societies, the words can convey the entire meaning of the message. The direct form of communication is context-free in comparison to high context culture, with the emphasis resting mainly on the literal and precise intent of the stated words (Gupta, 2011).

As a consequence, organisation communication style was identified as a significant barrier between staff and management. One participant was frustrated by the hierarchical structure, which meant that communications to the nurse manager had to go through a long chain of command, which became a barrier to communication. As indicated in the literature review, the strict hierarchy with a tight chain of command may work best in a military setting. This same structure can be complicated in relations of open communication and collaboration in an organisation that succeeds on creativity (Braudy, 2010).

Another concern discussed by participant nurses in this study was regarding “expression and interpretation”, such as tone of voice, which can be interpreted differently by people from different cultural backgrounds. This causes misinterpretation and barriers between colleagues because people’s perceptions when attaching connotation and suggesting meanings of certain words differ across cultures (Jain, 2005). Some languages do not have certain terminology, which can lead to misunderstandings (Jain, 2005). According to Alderson (2009), high levels of linguistic competence are critical in the related context to ensure safe communication, precisely as certain concepts can be interpreted differently from one culture to another. Due to English being the second language of most of the nurses, albeit with variable competence, misunderstandings can occur. Consequently, effective cross-cultural communication is vital to prevent misinterpretation and misconceptions that may adversely affect the collaboration of both

the nurses and the patients (Alderson, 2009).

These findings from the literature and those of this study reveal the requirement to consider differences of culture and language in cross-cultural communication to ensure the adequate understanding and comprehension of messages.

“Translation services” was identified in this study as a significant barrier. Lack of interpreting skills and the fears of interpretation and translation accuracy made by Arabic-speaking colleagues can pose risks to the clinical collaboration that will impact, and be a barrier to, patient care; for instance, by not interpreting everything in the personal belief that something is not necessary, by commencing opinions, and so on. This result is supported by a number of studies in different countries (Flores *et al.*, 2003; Hultsjö & Hjelm, 2005; Lee, Sullivan, & Lansbury, 2006; Tuohy *et al.*, 2008). Moreover, some participants show that absence of organisation translation services can increase the patient’s anxiety to refuse the care delivered by the multicultural nursing staff. These findings are consistent with Eckhardt, Mott and Andrew (2006), in that language barriers can also increase patient anxiety if the patient is unsure of their health status when being treated by healthcare workers, and can harm the nurse’s emotional status and cause frustration which, in turn, can affect the process of care. This finding similar with some works in the literature (Aljadhey *et al.*, 2014; Almutairi *et al.*, 2015; Halligan, 2006), which found that nurses in Saudi hospitals faced barriers in communicating with patients due to differences in language, which caused an obstacle in establishing an excellent patient-nurse relationship. Elderkin *et al.* (2001) and Flores *et al.* (2003) debated that a well-trained interpreter is essential to maintain effective communication, increase satisfaction and protect patient safety.

Gerrish *et al.*’s (2004) study that examined the utilisation of interpreters in UK primary health care services stated that training for both nurses and interpreters essentially results in progress in proper interpreting and interaction with patients.

With regard to this, it is vital that professional interpreters are readily available in the clinical environment and that they understand that communication is not simply the spoken word. The data emphasises that the interpreter’s personnel should know themselves how to minimise the

clinical and cultural risks that could arise during translation and interpretation by attending to all facets of the communication process.

Finally, there was “strategy for good communication” from the individual staff level facilitators. The nurses in this study used their critical thinking to work around the challenges created by the cultural diversity in their work environment, and one participant illustrated the Arabic learning passion for communicating better with patients and developing self-awareness of other cultural communication skills to collaborate with and better understand other colleagues and patients. This result is significant, as it explained the nurses’ skills and efforts to overcome the difficulty of their multicultural environment and strive to sustain effective collaboration and quality patient care. According to El-Gilany and Al-Wehady (2001), lack of awareness and differing perspective results in communication barriers and ultimately impacts patient services. Some participants identified the organisational facilitators to overcome some previously mentioned barriers by using technology in patient handover, such as SBAR. According to Leonard *et al.* (2004), SBAR is a handy tool that delivers a standard and expected the structure to the communication concisely and briefly, critically significant parts of information are conveyed in a predictable structure. Not only is there understanding in how people communicate, but also the SBAR structure supports the development of desired critical thinking skills. The handover process was modified so that only relevant nurses would be at the patients’ bedside instead of sitting at a roundtable in the presence of the patient to obtain better discussion between staff.

Also, a frequent meeting between staff and managers, which previously existed, but had been stopped recently, needs to be reactivated. Similarly, as described in this study, many articles have shown the importance of frequent meetings of the organisational manager staff (Halvorsen & Sarangi, 2015; Holmes *et al.*, 2007; Svennevig, 2012) and the unit-based council team to solve problems. These findings are compatible with those of a study by Wilson *et al.* (2008), who reported that implementing shared governance, through nurse-led unit-based councils, may lead to greater job satisfaction.

According to Pearson *et al.* (2007), the organisational obligation to cultural competence will guarantee the delivery of care that is efficient and responsive to patients’ cultural needs. For this purpose, the United States Office of Minority Health (OMH) established a set of principles for



culturally adequate services. These principles outlined three core themes: culturally competent care, access to interpreter services, and organisational support for cultural competence (Thobaben, 2003).

#### **4. Family Role and Organisation**

The semi-structured interviews reported on the theme of "family role and organisation", which was consistent with the themes of (a) head of household; (b) individualistic versus collectivistic; (c) alternative lifestyle as real barriers between multicultural colleagues, Patients, organisational strategy and dominant system. For the theme of "head of household", it was explained by Purnell (2012) that in previous decades, gender roles were more clearly defined: men were supposed to do physical work, to support the family financially. The woman took responsibility for the house and children, and things have now changed with more women working outside the home. In this study a participant explains a similar situation about the influence of Saudi culture and the family expectation for Saudi nurses. This theme emerged from the results and shows the family barriers to work for Saudi nurses and the need for a multicultural workforce in Saudi hospitals (Almalki *et al.*, 2011; Batarfi, 2005; Miligi and Selim, 2014; Omer, 2005), as well as the possible influence of this situation on nurse disempowerment, punctuality and future performance, such as lack of self-efficacy, and limited feelings of control, confidence and autonomy in a given situation (Eckermann *et al.*, 2010; Hardina *et al.*, 2006) that may affect the relations and expectation of other colleagues. Saudi families preferred the nurse to work only in mornings and afternoons, which can pose problems for those nurses who are required to provide patients with 24/7 care (Tumulty, 2001).

Additionally, the role of the family in Saudi culture continues to play a role in the care facility as their family-oriented nature can lead to interfering in patient care. Similarly, as described in this study, Tang *et al.* (1999) have shown that the significant influences of culture and family are affecting Asian women's decisions not to perform health tests, unlike white women, who are significantly more likely to have the tests.

The findings explain that Saudi family members can sometimes cause barriers to nursing care by interfering, which is an unusual occurrence for non-Saudi nurses. Sometimes this can result in management becoming involved to change the nurse so as to please the family. This can disempower and harm the nurse's emotional status and affect the relationship between the nurse and the nurse manager. These findings are consistent with the study by Kai *et al.*, (2007). Disempowered nurses felt intimidated and unsupported by the management as well as the representatives of the local culture.

In relation to the “individualistic versus collectivistic” subtheme that falls within the main theme of family role and organisation, this study revealed different cultural values behind colleagues' attitudes in practice. This is because western culture is more individualistic and other ethnicities are more collectivistic cultures, who are raised believing teamwork is based on your ethnicity, and that it is very typical to favour a person from the same ethnic group. According to Gorodnichenko & Roland (2012) an individual culture is likely to behave in the same way regarding all other individuals. In contrast, in a collectivist culture, responsibilities within the group and community will be imperative and probably more demanding, but they will be much more loosely defined, or possibly not defined at all, concerning people who are outside the group. Moreover, the attitudes towards immigration will also be different between an individualist and a collectivist culture. An individualist culture will be much more open towards immigration as the allocation of talent and workforce to society will be considered positively. A collectivist community will, however, be much more closed towards immigration as the incoming of individuals or groups who do not belong to an existing group within society may be seen as intimidation to social constancy (Gorodnichenko & Roland, 2012).

Another subtheme that belongs to family role and organisation is “alternative lifestyle”. This was discussed in the Purnell Model as same-sex couples and single parents are accepted in some countries (Purnell, 2012). In this study, this causes real barriers between colleagues from different ethnic groups holding different concepts and beliefs about alternative lifestyles, including boyfriends, single parents and sexual orientation. As a western participant explains, they can be judged and offended if discussing alternative lifestyles with colleagues from a

profoundly religious ethnic group such as Saudis, Indians and Filipinos. Moreover, Muslim colleagues describe their feelings of unacceptability and complete rejection of single mothers and consider it abnormal, and the staff will be stigmatised and treated differently because of these cultural taboo issues. These findings in my study are consistent with research in New Zealand by Harding (2007) that these stigmatising discourses create a barrier to caring and, aligned with the presence of homophobia in the workplace, causes avoidance of contact with gay colleagues and there may be issues concerning their retention.

Moreover, participants explain that these alternative lifestyles are disrespectful to Saudi culture and law and they would stop it and report it to hospital administration in order to make them leave. The above describes how alternative lifestyles create barriers to effective collaboration between colleagues from different ethnic groups. Discrimination remains part of the everyday experience of homosexual people worldwide. Such discrimination includes political and cultural exclusion, cultural abuse and legal violence, according to Gray et al. (1996). This insecure feeling will influence the nurse's behaviour towards collaboration with others. For example participant illustrates that one staff may be threatened with not being re-contracted if their child is gay, and this can affect their feeling of job security.

Finally, some participants describe the Saudi system is a barrier to them, as alternative lifestyles are considered illegal and admitting to them would result in being arrested by the police. Longhurst et al. (2008) notes that offensive behaviour towards others, which can stem from racism in public settings, includes verbalisation and action towards individuals through double entendres, direct negative statements and casual observations. Often, it is the subjective opinion that focuses on the victim's appearance, sexuality, gender and colour that prompts the offender's actions. For example in this research one nurse was dragged to the Saudi embassy for further questions because of the way he looked in his passport photo. This had an emotional effect on the nurse which can reflect on his behaviour when dealing with others colleagues especially those who are Saudi and Muslim.

##### ***5. Workforce Attitudes, and Behaviours***

The semi-structured interviews reported on the theme of "workforce Attitude including high-risk behaviours", which was consistent with the subthemes of (a) professional attitude; (b) high-risk

behaviour (endorsed to some extent by most participants), that addressed the research question of this study. The fifth theme that emerged from the data corresponded with the sixth domain of the Purnell Culture Competence Model (high-risk behaviours), including the use of drugs. However, the central themes were modified and renamed, as the discussion here is all about workforce issues. Accordingly, attitude and behaviours were used to be specific, and more sub-themes were added according to the results found.

In the semi-structured interviews, participants noted the significance of a “professional attitude” as a theme that causes a barrier to collaboration between multicultural nurses, as endorsed by participants. Based on the participants’ responses, some staff’s attitude lacked professionalism and they over socialised with patients and tended to speak about other colleagues with them. The findings of this study also corroborate elements of the existing research evaluated in the literature review, including work by Marrone (2008), which indicates variations in the attitudes of nurses; that many nurses fail to realise the significance of diverse cultural needs and the impact of cultural diversity on the outcome of patient treatment. Participants linked professionalism to the social values and views of nursing as a career. For example, in the UK it is given a high value, unlike in Saudi Arabia and other Arab countries, which have strong indications and expectations of future nurse professionalism. This result agrees with Azim & Islam (2018), who found that nursing is not seen as a prestigious career in Saudi Arabia, as it has been linked among other jobs to non-Saudi nationals after the discovery of oil in the early 1970s, as the Kingdom experienced a massive arrival of workers from abroad. Such practices carry an undesirable aspect in the Saudi work culture and are subjected to humiliation by members of their tribe, clan, or even family. Thus, it is not unusual to experience apathy among Saudi nurses in showing a real sense of professional pride in their jobs.

Moreover, in this study, participants indicated cultural stereotyping towards certain ethnic groups. This attitude is not accepted by some participants, which affects their teamwork and collaboration, which in turn influences care. This result is in line with Cortis (2004), who discusses issues such as stereotyping experienced in the UK by nurses attempting to treat patients who originate from Pakistan. Cultural incompetence tends to result in stereotyping that can negatively influence decision making and behaviours (Betancourt *et al.*, 2016).

Issues relating to a lack of compassion also fall within the theme of workforce attitude. Some colleagues from multicultural backgrounds are perceived as having a lack of compassion towards patients, and as this is a core function of nursing, this results in barriers to teamwork or collaboration. Additionally, the findings of this study are consistent with some of the literature reviewed (Bramley & Matiti, 2014; Johnston, 2013; Well *et al.*, 2012). Tackling nursing culture is fundamental in the improvement of attitudes, because the most powerful figure in the group decides what practice is acceptable and a change in culture can often be enough to change compassionate behaviour. The problem of a lack of deep-rooted compassion is endemic not just in the KSA, but further afield, with a culture of just ‘getting the job done’, where values such as compassion are often not seen as essential or are simply ignored. The culture of compassion should be promoted throughout the entire healthcare organisation.

A sub theme of “high-risk behaviours” was also highlighted by some participants as a barrier to collaboration, for example, a medication abuse incident by staff that leads to irritability and shouting between colleagues when there is a code white as a hospital strategy to deal with such attitudes and protect others. Moreover, the participant indicates stereotyping about certain ethnic groups and obsequious behaviour as high-risk behaviour that affects their teamwork, which in turn influences patient care. Cultural incompetence tends to result in stereotyping that can negatively impact decision making and behaviours (Betancourt *et al.*, 2016).

## **6. Nutrition**

The theme reported by the participants within the interviews in respect of “nutrition” was consistent with the subtheme of (a) meaning of food (b) common food and food rituals. As discussed in the Purnell Model, nutrition includes more than having adequate food to satisfy hunger (Purnell, 2011). The Saudi Arabian culture was recognised by the participants as a very generous culture. The literature suggests that food is important and that as boundary objects they offer possibilities for both action and negotiation of meaning (Jahoda, 2013). Team members have, in food, a focus allowing a grounded discussion and understanding of culture without requiring an agreed definition (Jahoda, 2013). Food, as Jackson *et al.* (2013) maintain, works as

a channel for the exchange of a variety of related concerns. Multicultural teams can usefully exploit these insights, by concentrating on the opportunities afforded by commensality for bonding and participating. Food can be the starting point for acknowledgement and discussion of the power of cultural difference, which may be otherwise easily underestimated (Means *et al.*, 2015).

However, the participants also identified barriers in relation to food between multicultural workforces. Indeed, this was believed to operate at personal levels. Hence a significant subtheme of “common foods and food rituals” emerged from the participants. The findings of the present study also indicate that nutrition is significantly linked to the barriers between colleagues, as colleagues impose their cultural values about healthy and unhealthy food on others. This can cause shock and unpleasant feelings, especially when food is linked with cultural beliefs. As mentioned in the literature review, perceptions of food demonstrate the understanding that people have about individual and collective identities. Hence, hunger is physiological and natural, while appetite is psychological and cultural (Longhurst *et al.*, 2008).

Additionally, Saudi participants demonstrated a lack of sensitivity toward other cultural foods, for example by asking staff to eat elsewhere with their food because it smells unpleasant to them. This result is in line with the literature review of a phenomenological study conducted by Nielsen and Birkelund (2009), which found that most of their nurse participants lack sensitivity toward the food prepared by relatives for patients, as they did not like its strong smell, and found it annoying.

### ***7. Pregnancy and Childbearing Practice***

As discussed in theme three about alternative lifestyles, any relationships out of marriage are considered illegal in the dominant Saudi system; accordingly any pregnancy that occurs as a result of these relationships will be unlawful and will not be accepted in the Saudi culture. Another significant theme to emerge from the present study concerns “pregnancy and childbearing practice”. Laschinger and Finegan (2005) found that compliance is related to positive outcomes for both staff and patients. Another issue in this theme is that some western

nurses think the Saudi organisation is influenced by cultural beliefs and this can sometimes put patients in jeopardy. In Saudi Arabia, the pregnancy test is considered taboo for the non-married woman, which is completely culturally different for other staff from different ethnicities. Some western nurses explained this challenge in relation to the social values of the organisational culture and practice with regard to pregnancy tests before x-ray procedures. Asking an unmarried Saudi woman if she has had a pregnancy test can lead to conflicts at work and nurses will be reported to management for asking such a question. The United States Office of Minority Health (OMH) also highlights that an organisation should ensure that the healthcare provided corresponds with the patients' cultural beliefs, values, and practices.

This theme considers significant barriers between colleagues from different ethnic groups holding different beliefs and concepts working within an organisation influenced by a dominant social culture. Specifically, the participants showed limited knowledge of the views associated with healthcare in Saudi culture. This result is confirmed by many studies in the literature, which showed the difficulties that nurses experienced due to working in another cultural context (Boi, 2000; Cortis, 2004; Høye & Severinsson, 2008; Lampley *et al.*, 2008; Murphy & Clark, 1993). From this research for example, if an unmarried western nurse becomes pregnant, this is considered a problem and the organisation needs to deal with it appropriately. This research highlights the importance of cultural knowledge as a facilitator of effective collaboration, and this is considered to be a crucial component to overcome the complications of cultural diversity.

## **8. *Death Rituals***

The theme reported within the interviews in respect of “death rituals”, was consistent with the theme of (a) death rituals and expectation (b) responses to death. As endorsed to some extent by all participants, the theme of “death rituals” was explained by Purnell (2012) as how the individual and society view death and prepare for death. The “death rituals and expectation” theme was discussed by the multicultural nurses, alongside related barriers and facilitators, to describe the case of efficient collaborative working practice in Saudi hospitals. Furthermore, as mentioned by Purnell (2012), some staff may not understand the value of customs with which

they are not familiar, such as the ritual washing of the body. Death practice, belief, and rituals very vary significantly among different cultural and religious groups.

To avoid cultural taboos, the health professional must become knowledgeable about various practices related to death and dying (Purnell, 2012). According to Coffman (2004), nurses perceived cultural awareness as the ability to adapt to the patient's cultural requirements.

The organisational solution was to provide courses to staff about death and dying and how to deal with the patient's family in Saudi culture during this difficult time. According to Krakauer *et al.* (2002), staff training in relation to death and dying can be effective in promoting cultural sensitivity and removing the barriers. The participants in the interview discussions also identified barriers in the responses to dying as a second reason, informing death rituals and their effect on collaboration between multicultural nurses. Indeed, this was believed to operate at personal, ethnic group and organisational levels. Hence, the significant subtheme of "Responses to death" has emerged from this study, as endorsed by participants.

The findings also indicate that barriers in relation to death rituals are linked to different cultural backgrounds as well as conflicting organisational policies. Some participants described feeling shocked when doctors made decisions regarding a patient's life. Saudi hospitals hold different beliefs about palliative care that staff from other cultures struggle to accept in practice, which is overwhelmed with cultural values and norms. Treatment or non treatment for Do Not Resuscitate (DNR) patients is also problematic. Hospital policy about DNR is influenced by religious and cultural values for turning some life support machines off, however this policy is accepted by families from humble backgrounds who believe it is Gods way, whereas a wealthy family will use money and power to influence hospital policy and ensure that the doctors and health team keep DNR patients alive. This leads to confusion amongst staff regarding the actual policy. In the context of healthcare, the literature also revealed the issue of Islam not conceiving death and illness to be divine retribution, but rather a blessing through which forgiveness from Allah (Almighty God) for past wrongdoing may be obtained (Almuairi and McCarthy, 2012). For multicultural nurses working in a Saudi Arabian setting, this cultural knowledge is beneficial. It is very clear from the participant responses that organisational policy is unclear and not



observed, leading to conflict between staff as well as significant organisational barriers affecting multicultural working.

### **9. Spirituality**

The findings reported by the interviews in respect of “spirituality” were consistent with the theme of (a) religious practice and use of prayer, (b) religious festival, (c) and the Saudi religious system, including religious police. The theme of “spirituality” was explained by Purnell (2012) as being more than formal religious beliefs related to faith and affiliation and the use of prayer. A significant initial theme to emerge was concerned with “religious practice and use of prayer”. As mentioned by Purnell (2012), the healthcare practitioner who is aware of the patient’s religious practice and spiritual needs is in a better position to promote culturally competent health care.

This finding is in line with the work of Campinha-Bacote (1999, 2002, 2003) and Jirwe *et al.* (2006) in that cultural awareness suggests an awareness of oneself that involves an understanding of one’s attitudes toward patients from other cultural backgrounds. Without such understanding of one’s own attitudes, healthcare staff may impose their own culture on others (Campinha-Bacote, 2003).

Issues also occur when patients and families and staff impose their religious values on non-Muslim staff. One example was when a male doctor from the socially male-dominated culture believed he had the right to impose his spiritual values on other female nurses, resulting in feelings of hatred and an impact on the working relationship. According to participants, in Saudi culture everything in life is firmly connected to faith, even law and business, unlike other cultures such as those of the West. Therefore, the Saudi ethnic group’s acceptance of other people is influenced by belief. It is difficult for Saudi people and nurses to understand people who have no faith, or they may lack awareness about different religions, which can cause barriers. Further obstacles occur between colleagues because they believe that some Saudi and Muslim nursing groups use prayer as an excuse to disappear for long time and avoid working. These findings are consistent with the work of Amutairi *et al.* (2015), who posit that patient care is compromised by the attitudes of some Saudi staff, expatriates complain that, in their countries,

lack of punctuality and unapproved breaks is not acceptable and punishment will be applied, whereas in Saudi Arabia, it is more acceptable for some staff (such as smokers) to take unscheduled breaks during the day.

Ramadan can also create barriers to working. While Muslim staff expect to not work hard during Ramadan, non-Muslim staff can see this as having it easy, suggesting a lack of cultural sensitivity toward Muslims. There is an essential need for a non-Muslim group to acknowledge the Muslim cultural, religious requirements and practice in order to facilitate their working relationships. Issues can arise between staff who are from different groups of the same religion (Sunni and Shia Muslim, Catholic and Baptist Christians), although participants described a need to show respect and not let this affect the working relationship, such as granting time off for different festivals.

Learning about other religions might facilitate socialising, as well as increasing knowledge about different cultures. In the Saudi context, it is important to teach non-Muslim nurses Islamic practices. Also, the theme of “religious festivals” can become a barrier between staff, as highlighted by participants through imposing religious beliefs about fasting in Ramadan by Muslims on other non-Muslim team members. In contrast, the organisation acknowledges the differences and provides a restaurant and coffee shop open for non-Muslim staff, although it is not permitted to eat or drink in public during Ramadan.

Offence can be caused between colleagues who do not acknowledge each others’ religious festivals, for example a greeting in Ramadan not being reciprocated at Christmas, although it was noted that Muslims will not participate in the non-Muslim festival but will allow them to celebrate their occasion, and in the past the organisation was more western and facilitated an acknowledgement of Christmas. Two studies considering organisational culture found that the cultural background or ethnicity of healthcare providers influences the perception of that culture, but now non-Muslim cannot greet each other officially at their religious event (Seago, 2000; Staten, Mangalindan, Saylor & Stuenkel, 2003). In recognising the growing number of people from different ethnic groups and cultural diversity, UK policy healthcare makers began to deem the requirement to address the religious and cultural needs of ethnic groups in healthcare organisations (Vydelingum, 2006).

In consequence, “Saudi religious system including religious police” was identified as an indirect barrier to staff from a non-Saudi background within the Saudi system, and the religious men have the authority to comment on others, for example to ask the nurse to cover their hair, which works as a barrier to staff to accommodate themselves to the Saudi system, and this will influence their behaviour in practice. According to Percot (2006), nurses currently value their life in the Gulf, and a lot of them have prolonged their stay for a lot more than prearranged without real complaints, with the exception of one country: Saudi Arabia. Being women and Christians, they are mainly disturbed by the laws of this country.

Religion encompasses social life from the intensely personal, including the way of life at home, to the public, including common behaviour in matters of governance, finance, fiscal policy and working life (Almutairi and McCarthy, 2012). Accordingly, religion can play an essential role in Saudi culture, which needs attention from the multicultural workforce. Demonstrating the many aspects of the Saudi Arabian way of life and the way in which Islam informs multicultural nurses is vital in promoting understanding and tolerance in society (Almutairi and McCarthy, 2012).

### ***10. Healthcare Practices***

The theme of “healthcare practices” was consistent with Purnell’s (2012) themes of (a) healthcare practice from the country of origin; (b) experience and seniority practice; (c) standards of care; (d) role conflicts; (e) folk practices; (f) cultural responses to health and illness; (g) and blood transfusion and organ donation. Sub-themes emerge from the results that are not in the Purnell Model and have been added and discussed accordingly. Therefore, the findings of this theme will focus more on the barriers and possible facilitators of the healthcare practices regarding the collaboration between multicultural nurses. It is evident from the results of this study that in the theme emerging from the present study concerning “healthcare practices from the country of origin”, the barriers arise because of practice in the home country, which differs according to each country’s hospital resources, education and available technology, and sometimes these practices fall below the standards of the current place, which leads to conflict among staff. Likewise, previous studies have supported these outcomes (Al-shahri, 2002; El-

Gilany and Al-Wehady, 2001; Almutairi *et al.*, 2015; Yi and Jezewski, 2000). The organisational solution to overcome these discrepancies was to have a policy that should be followed regardless of the staff background.

The findings from the present study revealed another significant theme of “experience & Seniority practice”, as endorsed by participants as a barrier between the different ethnic groups. The interview participants explained the difficulties because of older staff with experience imposing their practice on other junior nurses, especially Indians, as they tend to be led by a senior member of staff’s practice, regardless of the hospital policy. In contrast, some older staff struggle to accept instructions from young and newly-employed staff and some senior Arab men behave overconfidently and change doctors’ plans or give unauthorised medication. These kinds of issue lead to conflict between colleagues due to patient safety, as well as highlighting negative attitudes toward policy and procedures and resistance to change. One organisational solution is to practise based on evidence rather than staff experience, which is different from the practice of some countries practices, but there are still organisational barriers such as lack of clarity dealing with such incidents. According to Schnackenberg & Tomlinson (2016), organisational transparency contributes to trust in stakeholder relationships.

A significant theme also emerged concerning “standards of care”. Interview participants also reported that studies have shown that nurses often use different nursing standards, despite the cultural context in which they are working. Yi and Jezewski (2000) describe how South Korean nurses struggle to adapt to nursing standards in the US. As endorsed by most participants, different standards of care due to varying backgrounds will lead to conflict in practice and collaboration barriers between ethnic groups, such as patient privacy. Even patients sometimes notice different standards of care. As nurses, they do not conduct equal assessments for the patient, carry out improper cleaning or care more about documentation rather than patient care. This concept is supported by certain managers or ethnic groups, such as some Asian groups who have difficulty following the proper policy and procedure and considering the high value of patient safety. It is very challenging and difficult for some ethnic groups such as western nurses to continue giving the best standards of care within this challenging environment, and it is clear that a nurse's background can influence colleagues’ relations in practice, which will act as a

barrier to collaboration between them. There were certain organisational facilitators provided to overcome barriers caused by different care standard such as suggested model of practice to be followed by all staff. The Magnet Recognition Program of the American Nurses Credentialing Center is one initiative designed to recognise healthcare facilities with an obligation to quality enhancement, particularly in relation to nursing care delivery (American Nurses Credentialing Center, 2015a). Founded in 1994 by a subsidiary of the American Nurses Association, hospitals that join in this voluntary programme pay a fee for the credit process. The process contains rigorous documentation and location visits to assess adherence to five main principles: transformational leadership, an organisation that empowers staff, a recognised professional nursing practice model, help for knowledge application, and robust quality development (American Nurses Credentialing Center, 2015b). This organisation strategy acts as a magnet component to standardise the policy and bring all ethnic groups together and will enhance the collaboration, which will contribute in turn to the provision of high-quality care.

Concerning the causation of workforce issues and the reasons associated with a multicultural workforce barrier, the theme in this study of “role conflicts” was identified, as endorsed by one participant, who said that western managers expect Saudi staff to do everything without a proper job description, which leads to conflict between them. In a study of 98 groups, Mitchell *et al.* (2011) discovered evidence that collaboration among colleagues with different preferences, diverse interpretations and unique values was enough to generate behaviours to challenge each other’s views and rationalise alternative approaches. Forbes and Milliken (1999) uncovered that an organisation consisting of members with multicultural backgrounds would be involved in more arguments concerning goals, choices, and practices than a homogeneous group because diverse members outlined the problems differently and arrived at different conclusions about proper possibilities of action. The above empirical results propose that as multicultural members share their different knowledge, altered values, new ideas, different practices, unique interpretations and different approaches, role conflict increases.

The theme of “folk practices” is evident from the results of this study, including practices based on nurses’ spiritual belief, such as staff changing medication dose based on mother instinct or giving water to patients who should not receive anything by mouth. This can be a dangerous

practice and is sometimes against hospital policy. That is a significant barrier and caused conflict in practice between nurses holding different beliefs, as endorsed by participants, and it is important to note the influence of cultural and spiritual belief in patients' healthcare and the vital role of religion. The Saudi people consider the reason for illness to be predestination or fate, and that this results from the will of God (AlGhamdi, 2010; Lovering, 2006). Other cultural attributions of disease are that it is a consequence of supernatural powers such as the evil eye, or Jinn possession (evil spirits) (AlGhamdi, 2010).

Moreover, sometimes there is a different belief within Saudi Muslim culture and following of different spiritual convictions, and although the nurses may not agree with it, they will still acknowledge the patient's spiritual needs in care and respect, which will facilitate the collaboration between them.

Furthermore, the staff cultural responses also differ toward mental illness, and staff stigma in practice and the difficulty of diagnosing or treating mentally ill patients. This will affect healthcare relations as well, where mental illness is still considered a stigma in the dominant Saudi culture, where patients with depression will try to pray instead of seeking treatment, as depression is seen as a weakness in their culture. In response to the patient suicides concerning mental illness issues, the hospital identified a solution with a new psychological assessment tool for the nurses to carry out organisational support and consideration provided to any mentally ill staff. The participants in the interview discussions also identified the theme of "blood transfusion and organ donation". Concerning blood transfusion, there are dominant system barriers; toward unmarried western nurses as they are restricted from blood transfusion, which works as a barrier for them to merge with the Saudi system. It can be argued that every country follows a specific policy regarding donation, for example, the United Kingdom analysed their HIV surveillance data and initiated a change in deferral policy in 2011, and now restricts only men who have had sex with another man within the preceding 12 months. Men who have sexual relationships with men are banned from donating blood in most European countries (Schink *et al.*, 2018). Thus, the Saudi policy regarding alternative lifestyle blood donation can be explained.

Organ donation beliefs and systems cause barriers between nurses from different backgrounds. For example, in Saudi Arabia and the UK, there are very different systems concerning organ

donation, this is further complicated by interpretation of Islam. In KSA some Muslims are not clear whether organ donation is approved by Islam and consider it taboo although they would accept an organ from outside the country. In contrast some Muslims consider it useful in Islam as part of helping others. Hospital policy can also cause barriers; as an unclear policy about DNR with a family not accepting organ donation can lead to confused practice, which will be reflected in their behaviour and collaboration in practice. As mentioned by Purnell (2012), healthcare professionals should provide information regarding organ donation, be sensitive to individual and family concerns, explain procedures and answer questions, and one key to successful marketing approaches for organ donation is cultural awareness. The hospital has a significant role of supporting organ donation awareness and changing views on the concept through the mobile bus to educate university students across campuses about organ donation. However, there is still much more needed regarding clear policy and guideline implementation concerning DNR and organ donation.

### ***11. Healthcare Practitioners***

The semi-structured interviews reported on the theme of “healthcare practitioners”, which was consistent with the themes of (a) traditional versus biomedical practitioners; and (b) status of healthcare provider; this was in line with the Purnell Model of Culture Competence domains, as healthcare is interconnected with family, organisation and spirituality. Also, the gender of the healthcare provider may be significant (Purnell, 2012). Saudi cultural traditions sometimes interfere with practice and cause barriers to patient care where Saudi female nurses refuse to touch a male patient without gloves or refuse to carry out specific procedures, as that would affect her role as a nurse on duty which would lead to conflict with other colleagues due to not being able to deliver full care as expected. A similar situation may arise with female patients and a male doctor. The female patient’s cultural values will influence the relation, and lead to lack of comfortability and barriers. Similarly, as described in this study, Purnell (2012) has shown that not all ethnocultural groups accept care from someone of the opposite sex, and as a result may feel uncomfortable and refuse care. Moreover, organisation barriers were mentioned by participants, where male/female patient assignment restrictions are in place, and there is role

limitation for a male nurse in Saudi organisations. In this regard, participants explained gender segregation in practice. Consequently, “status of health care provider” has been identified in the study as a significant barrier between healthcare providers and patients. The participants endorsed that hospital culture led by doctors and males in Saudi hospitals are unlike other organisations, and this will affect the nurse-patient relation, as the patients and family will talk and listen to doctors or men, even if the nurse knows better about a particular patient’s situation. Del Junco, Dutschke and Petrucci (2008) refer to a social system in Saudi Arabia where men are regarded as the authority within both the family and society. According to Purnell (2012), public opinion places patients’ respect of nurses higher than that of doctors, and they are seen as equal or preferable to the physician. This is the opposite to participants’ perception of Saudi people’s view toward nurses as a lower level, which affects the collaboration between them. Therefore, Asian ethnicities supports the view of nurses having a lower status than doctors, as they have the concept of a doctor-driven culture. This exists in Asian hospitals, and affects their future communication and relation with doctors and is influenced by other nurses’ ethnicity as well, where conflict may occur between colleagues from different ethnic groups if the nurse follows the physician, not the policy. According to Mooney (2007), low confidence is commonly seen in the nursing profession and is also linked with oppression and professional socialisation. As endorsed by participants, staff from certain ethnic groups lack critical thinking, decision making, and the ability to speak up. As significant as barriers between colleagues was staff from certain Asian ethnic groups feeling less self-confidence in practice, which requires control and initiation by other colleagues, and they sometimes lack critical thinking, which leads to conflict between them. These findings are similar to Chesser-Smyth and Long’s (2013) study that advocated support of nursing students as being pivotal in enhancing their self-confidence while on clinical placement and also suggested that the lack of support can stifle critical thinking, problem-solving and decision making.

Similarly, as described in this study, many articles have shown that cultural differences related to assertiveness influence how healthcare colleagues view each other and act in the workplace. Specifically, western nurses were more assertive with physicians and males than others. The concept of nurses being dependant on physicians and men is inseparable from the Muslim idea of a woman being subject to the authority of the husband, fathers, and elder brothers (Harner *et al.*,



1994). From the results, participants illustrate the dominant male culture and the doctor status in their culture as always being seen in a leading position, and how this affects their performance and causes conflict with nurse colleagues. Western nurses are seen as assertive and firm because they question rather than simply follow, and this always lead to conflict between western nurses and Arab male managers. In addition to this, the conflict in expectations may be due to the cultural diversity between the nurses and their managers in the hospital, as a leadership style is affected by the cultural norms (Carland, 2008; Hale & Fields, 2007). The interesting thing about that from the participant's quotation is that the western nurses can self-facilitate the collaboration and obtain respect from the physician and male staff by speaking up and standing up for themselves and patients, which in turn leads doctors and male staff to respect western nurses more, unlike another ethnicities, where doctors and male status are different culturally, and the nurses simply follow. According to Wilson (2007), the qualifications, skills or competence of a nursing professional have minimal impact on the likelihood of them experiencing racism in the workplace. The findings of this study are in line with the conclusions from Kuokkanen and Leino-Kilpi's (2001) study of the characteristics of an empowered practitioner. They found that the following components promote empowerment: moral values, a nurse who considers others with respect, acting justly, personal integrity, looking after his/her health, challenges to speak and work, operating efficiently under pressure, acting flexibly, acting proficiently, making decisions, acting independently, discussing and communicating with colleagues, finding creative explanations, encouraging new ideas, sociability and working for a common goal, and solving problems. These qualities are essential for collaboration and empowerment. Aiken *et al.* (2012) identified that, where the work environment was described as being positive (i.e. good doctor-nurse relations, nurse participation in decision-making, managerial support for nursing care, and organisational priorities on care quality), there was a significant association with positive nursing outcomes. In this regard, the organisation and nature of colleague relationship differed according to staff background.

Participants indicated that organisational barriers include a lack of standardised policy, as care is led by doctor's personality, not by hospital policy, which means that the ease of the nurse's job will depend on the doctor. Despite this response, the participant contended that the Saudi system is seen as much better for Asian groups compared to back home, where they look at nurses as

being of a lower level, while Saudi hospital culture encourages the nurses to speak to the doctors based on evidence, and the doctors listen to them. This result aligns with Percot (2006), who explained that for young Indian nurses, migration to the Gulf means not only more prestige and a better economic condition, it is moreover a way to acquire more autonomy or organisational support, as females, than they can get in their own country.

### **Themes outside the Purnell Model of Cultural Competence**

The following themes emerged from the participants' responses, and did not fit with the Purnell Model of Cultural Competence.

This study also revealed significant knowledge related to diverse ethnic groups in a multicultural context. Three new themes from the findings were identified as having an influence on the collaborative working process between nurses as well as on the delivery of patient care. These themes, which were beyond the nurses' control, were cultural differences, empowerment and disempowerment, and workplace justice and injustice. Many of the participants experienced a twofold cultural emotional distress because of their immersion in a different culture, compounded by interacting with various ethnic groups that were different from their own. Such immersion led to barriers, including fear, frustration, insecurity, and incompetence to adjust to their new cultural environment, which also influenced their interaction with their patients. They did not know what nursing practices were acceptable within the Saudi culture, which often adversely affected their professional performance, and the quality and safety of care they were able to provide. The literature suggested similar barriers from cultural distress. However, these arose in different contexts (Brown & Holloway, 2008; Lin, 2006; McLeod, 2008; Pyvis & Chapman, 2005). The majority of investigations that have been carried out so far have studied the experience of students studying overseas; no research studies have yet examined the influence of cultural distress from immersion with nurses from other ethnic groups in a multicultural context such as Saudi Arabia, and its consequences on workplace collaboration; this is a unique contribution of this study.

## ***12. Cultural Differences***

The semi-structured interviews reported on the theme of “cultural differences”, which was consistent with the subthemes of (a) cultural norms and values; (b) Saudi cultural beliefs and the Saudi system; (c) positive aspects of the multicultural workforce environment in Saudi Arabia. Furthermore, it is evident from the results of this study that the theme of “Saudi cultural beliefs and the Saudi system” is a crucial barrier between staff from different backgrounds, as it was confirmed by participants that the Saudi cultural system is affecting feelings and practices that will consequently have an impact on the collaboration between colleagues. Conservative Saudi culture influences nurses’ social relations and makes it difficult for multicultural nurses to engage in friendship with them. In addition, Saudi staff have an intolerant attitude toward others and take things personally if colleagues from other ethnicities make comments, and one nurse explained the resultant stress, disturbing feelings and work isolation. These study findings represent a significant observation, as they indicate the barrier of staff attitude, as well as staff emotional and mental health status. According to Omeri and Atkins (2002) and Wilson (2007), these negative attitudes can have an adverse impact on the mental health of minority healthcare workers and can result in a feeling of loneliness in the workplace on account of their prejudicial treatment by both colleagues and patients.

Also, some Saudi nurses and patients may ask personal questions that may make nurses from other cultures uncomfortable. This result, as well as results from the previous research, highlighted the culture is high in context when individuals involve themselves in each other’s lives a great deal (Hall, 1989), for example in regions such as Asia and the Middle East (including the present Saudi context). On the contrary, in low-context cultures, people are incredibly private and slightly isolated, and disjointed, and there is comparatively little connection with other people, such as in the United Kingdom, the United States of America and Germany (Kim *et al.*, 1998; Lee, Geistfeld & Stoel, 2007).

Moreover, the Saudi culture views jobs done by non-Saudi cultures as lower class and humiliating. In general, ethnic minorities tend to be over-represented in low-skilled occupations and under-represented in managerial and other high-skill occupations (National Audit Office,

2008), and those jobs are linked to these cultures, and therefore people from these cultures will be seen as lower in status.

Saudi private culture influences patient care also where the nurse's name would be linked to a particular tribe, and the patients may not be happy to be treated by a nurse from this family, which will cause barriers in collaboration between the nurse and the patient. Moreover, the influence of Saudi culture affects the organisation's policy, as a restrictive organisational culture includes accommodation stress and gender segregation and socialisation difficulty as led by the dominant system not only organisation and it might be risky on legal base to do so which is something hard and not usual for staff from the different background. This understanding is relatively similar to Almutairi and McCarthy's (2012) work, as they argued that gender segregation is socially accepted and is supported by the actions of the government.

In addition, the influence of the dominant system can be a barrier to nurses' relations and collaborations. One western nurse expressed the concept of white privilege as better knowledge and skills and the different treatment she got from Saudi people in general inside and outside the organisation, unlike colleagues from other backgrounds, where Saudi culture associated the dark skin with lower class. These findings are constant with those of a study by Longhurst *et al.* (2008), who reported the classifications of human 'races', as shown through the development by anthropologists during the 19th century. These classifications presented Europeans as the pinnacle of the evolutionary hierarchy, followed by Orientals and Africans on a more inferior level.

Moreover, differences between the dominant Saudi lifestyle and life back home will influence the staff's feelings and adaptation to the new system. Western staff will consider the Saudi dominant system strict as in public they are not allowed to attend mixed parties, go to restaurants or go out with Arab men friends without the risk of questioning or potential trouble from the Saudi religious. Another issue regarding the Saudi system mentioned by participants is that of transportation. In KSA, there is no public transportation available and females are not allowed to drive, which makes it a difficult culture for nurses from other backgrounds. This result is in line with Almutairi & McCarthy's (2012) and Mohamed & Bromfield's (2017) argument that women in Saudi Arabian society are not, among other things, permitted to drive and are the only country

worldwide that bans women from driving. This recently changed and the transition, which will come into effect in June 2018, was declared in a royal order read live on television and in a concurrent media event in Washington. The resolution emphasises the damage that the ban on women driving has caused to Saudi Arabia's international reputation and its expectations for a public relations advantage from the modification (CBBC Newsround, 2018; Hubbard, 2018). Additionally, participants mention the limited stay in Saudi Arabia, as they do not belong to Saudi Arabia, and they will never be a citizen or have a passport. This means they will never have the same benefits as a Saudi person or be able to buy a house, and it is also necessary for them to leave the country once they reach the age of 65. The participants add that Saudi Arabia has a very conservative culture and there is nothing much for them to do and not much reason for them to stay longer. This result is in line with Percot's (2006) finding that there is no way to settle down in the Gulf, since even children born there will not systematically obtain a permit once they become adults and because it is also impossible to retire there.

All the above factors will influence their emotional status as well as the lack of ability to stay in Saudi Arabia and lack of long-term security. On the other hand, the Saudi staff members are of the view that non-Saudi staff lack sensitivity about the Saudi culture and system, and that they are always trying to criticise it, and insist that they provide private places for western people that are more relaxed, where Saudis are not allowed to enter, which in general leads to nurse colleagues becoming upset.

From the above, it is very clear that this indirect factor caused by the dominant system leads to an enormous emotional effect that will influence their behaviour and collaboration in practice. Moreover, one participant mentioned the bright side of the dominant system's culture, as she came here based on emotional and social reasons, as the conservative Saudi system culture would keep her away from men and drinking. One participant noted that multicultural staff have signed a contract and accepted work in Saudi so therefore should not break Saudi regulations. Moreover, the participants discuss the awareness of the multiculturalism concept in the UK and Canada, where everybody should follow the law, and they will not hold a person's culture against them and will embrace people as a citizen without changing the person's identity, and consequently this works to facilitate people from different ethnic groups living together. The

reason behind that is that the UK and the US, Australia and EU countries such as France and Germany are countries used to receiving employed skilled health workers who migrate to the rich world from the needy world (Raghuram 2009). That can help to embrace the meaning of multiculturalism. Going back to 1994, Fleras defines ‘multiculturalism’ as ‘a set of principles, policies, and practices for accommodating diversity as an official and essential part of a culture or organisation (Fleras, 1994). That is in line with the participants’ concept of multiculturalism.

Finally, there was “positive aspects of the multicultural workforce environment in Saudi Arabia” subtheme, as there were facilitators at the personal nurse, ethnic group and organisational levels. Practice within a multicultural environment gave staff self-awareness and understanding to deal with different ethnicities, learning from other cultures, gain new knowledge and skills, experience, be introduced to new technology, and new life concepts. Furthermore, most of the Saudi nurse group were welcoming and accepting of other ethnicities working with them, and Saudi people in general were kind and generous in all aspects to staff from different ethnic groups. There was an open organisational culture concerning other religions without imposing, which led some nurses to convert to Islam by personal choice.

### ***13. Empowerment and Disempowerment***

Chandler (1992) described power as being associated with control, influence and domination. Power can be seen and understood in observing how people or institutions (or in this case healthcare) are influenced, controlled and organised. The hierarchical authority has long been associated with nursing, from both an organisational and an educational perspective (Fletcher, 2006; Manojlovich, 2007). Fletcher (2006) argued that nurses need power and empowerment if they are to be capable of having the authority they need to provide care and to influence the health of patients. Manojlovich (2007) supported this contention and stated that powerless nurses are ineffective as they are not able to control patients and physicians. According to Brenner (1984), the importance of empowerment in nursing is concerned with the ability of the nurse to influence the health of the patient in a positive direction.

The semi-structured interviews reported on the theme of “empowerment and disempowerment”, which was consistent with the subthemes of (a) workplace advocacy and challenging policy; (b) use and abuse of power; (c) blame culture and concealing mistakes.

A key barrier emerging from the results was within the theme of “workplace advocacy and challenging policy” for example when practice is seen as unsafe in one country but accepted in another due to cultural issues, for example discharging patients with high INR, which is connected to nurses from certain ethnic groups, and profoundly affects patient care and safety was an area where some nurses challenged policy but this caused barriers amongst colleagues with different cultural beliefs. Similarly, as discussed by Leonard *et al.* (2004), power distances, cultural norms, and uncertainty as to the plan of action further complicate the situation. It was recommended in the literature that the adoption of critical language in conjunction with standardised communication procedures such as SBAR, derived from the CUS programme at United Airlines, can be beneficial. CUS stands for “I’m concerned, I’m uncomfortable, this is unsafe, or I’m scared”, and is adopted within the culture as meaning: “we have a serious problem, stop and listen to me”. This technique to get everyone to stop and listen is essential for the provision of safe care (Abha Agrawal, 2014; Leonard *et al.*, 2004). CUS can be implemented in different settings with other groups such as nursing care, critical language can help multicultural nurses to advocate for patients and report any problem that needs serious consideration such as the issue about the patient with high INR.

Unfortunately, some staff ethnicities are more likely to feel disempowered or unable to speak out, even those in management positions. This will be discussed more in the next subtheme. On the other hand, western nurses are more likely to challenge orders from doctors or policy if they believe them to be risky. However this has resulted in a change in organisational policy. This research illustrates that a nurse’s ethnicity plays a role in their empowerment. Those who have learned to practice according to best evidence advocate firmly and have the leadership skills and competency to stop procedures which are against policy or risk patient safety. In contrast other ethnicities or nationalities are more likely to follow orders.

Participants recognised the importance of the organisations’ speak up campaign which aims to maintain the same level of communication between nurses and doctors and facilitate colleagues

from different ethnic groups to speak up without feeling afraid, but there is still much more needed from the organisational policy and administrative support. Hierarchy, or power distance, often impedes people from speaking up. Effective leaders flatten the hierarchy, build familiarity and create an environment where people feel secure to speak up and participate (Leonard, 2004). Clarke (2004) argued that the organisations with good quality improvement practices and those that empower nurses to advocate for patients and facilitate decision making are more likely to provide evidence-based care.

It is evident from the results of this study that the theme of “use and abuse of power (corruption)” is a critical barrier between staff from different backgrounds. As endorsed by participants, this allows a team with power and connection to abuse authority and fire staff who were trying to speak up, which will thus make them afraid to speak up again in the future. Accordingly, some Asian staff are abused to a great degree during work because of their attitude and response toward other colleagues, and they will always say yes to anything asked of them so as to avoid any career insecurity. Abuse and discrimination, negative attitudes, and cultural differences are recognised in the literature as causing feelings of disempowerment (Smith, 2014).

Also, Saudi participants discuss different factors of disempowerment, two of them being fear of higher authority and lack of organisational guidance. An extensive study commenced by Al-Meer in 1996 compared Saudis and Americans. Saudis recorded high on power distance, which could be related to the social gap between the manager and other staff.

Other factors of disempowerment can lead to professional bullying and abuse, especially if it comes from a higher position colleague, and can cause emotional harm to other staff. As most western people hold high level positions in the organisation where this research was carried out and are socially connected with other western nurses, they will abuse authority and give the staff empowerment based on social relationships. This power sometimes leads the western staff to lack sensitivity toward Muslim colleagues in Ramadan by eating in the nurse station in front of everybody without consideration of culture. Moreover, western nurses emphasised that some Saudi managers lacked qualification or skills and had been pushed for a position simply because they were Saudi. Furthermore, colleagues’ manner of treating each other is different according to their social status, as some staff have *Wasta*, which means the ability ‘to utilise connections with



people, who are both able and prepared to change the course of natural events on that person's behalf. According to Sidani & Al Ariss (2014), Wasta is the traditional management style in the Gulf Cooperation Council (GCC) context, and most study participants illustrated a gloomy perspective concerning current managerial practices in the Arab/GCC context. They highlighted that such practices produce an environment that is not encouraging to proper talent desirability, progress, and retention. These factors from different ethnic groups' perspectives will be barriers to collaboration between them that affect the work and care delivered.

Another significant theme that emerges concerns the "blame culture and concealing mistakes", which leads to barriers between colleagues from different ethnic groups and disempowerment for frightened nurses who hide mistakes. The different concepts surrounding blame and a lack of understanding about blaming culture for nurses from different backgrounds, negatively influences their relationships. This result is in line with the study conducted in 2010 in Saudi a hospital, which shows that the prevalence of medication error is low, in comparison with that found in the global literature. This low medication error could be due to under-reporting of errors and the belief that reporting such errors could result in punishment making it difficult to actually study and prevent medication errors (Ahmed *et al.*, 2010). A similar result was found in the literature (Almutary & Lewis, 2012; Mayo, 2004; Ulanimo, 2007). According to Leonard *et al.* (2004), it is a significant success to focus on the problem and avoid the matter of who is "right" and who is "wrong". Unsafe work and workplace design and punitive cultures are hindering reporting and error prevention (Heath, Johanson & Blake, 2004).

#### ***14. Workplace Justice and Injustice***

The semi-structured interviews reported on the theme of "workplace justice and injustice", which was consistent with the subthemes of (a) dominant culture abuse and bullying; (b) discrimination; (c) ethnocentrism; (d) workplace violence and aggression.

Unhealthy work environment characteristics discussed in the literature include poor communication, abusive behaviour, disrespect, resistance to change, lack of concept or

leadership, lack of trust, conflict with standards, mission and vision and loss of understanding of core professionalism (Heath *et al.* 2004).

To be in a state of good health involves much more than the apparent requirement of the absence of illness and disease. It requires an environment in which core human needs are adequately met (World Health Organisation, 2010: 7).

Bullying is defined by Cooper *et al.* (2011, p. 2) as: “long-term aggressive or negative acts or behaviours carried out repeatedly over time, and directed at someone who finds it difficult to defend him/her self because of a relationship with the bully that is characterised by an imbalance of power”.

Participants reported verbal abuse and rudeness by colleagues from a dominant culture towards other staff because of economic background and financial status, which caused the nurse to choose to work abroad. A clear example was where there was a group of Filipino nurses were considered dominant and known by the other nurses as “mafia”. This led to inequity and discrimination between colleagues; for example abuse toward the western nurses group that caused them to leave the unit, unfair assignment of tasks for Saudis and other ethnic groups, and a non-welcoming work environment by the dominant Filipino group towards newly-arrived Indian nurses. These findings are consistent with French and Swain (2008), who found unfair treatment on the grounds of ethnic differences produces outcomes that are typically disempowering for those who are subject to discrimination.

These findings are also consistent with the studies cited which indicate that inequity and discrimination can jeopardise a nurse’s career prospects (Henry, 2007; Shields and Wheatley Price, 2002), and cause people to give up their jobs to avoid the perpetrators (Rippon, 2000). Roberts *et al.* (2009) described bullying as belittling and downgrading others, impacting both self-esteem and job satisfaction. Participants noted that the presence of a large number of nurses from the same ethnic group leads them to work against different ethnicities within the unit as they become a predominant ethnic group, although these are not usually not from Europe or western countries, as there are less of these. This research finding also suggests that abuse and a sense of intimidation are caused by gender and ethnicity together, for example within a male

Arab-dominant culture. The consequences of intimidation and bullying can have a considerable influence on a nurse's mental, physical and emotional well-being. According to Edwards & O'Connell (2007), the consequences of such behaviour can be direct, short term and long term, causing distress in their personal and work lives.

However interview participants noted that there was organisational facilitators to support staff to prevent harassment and bullying from physicians or patients and encourage the nurse to follow hospital policy rather than male or physicians orders; this was provided through magnet hospital action (code white). Essential solutions to improve the work environment that was recognised in a study conducted by Heath *et al.* (2004) confirmed those that are consistent with a Magnet set. These involved feeling appreciated by their organisation, having standardised procedures, staff empowerment, strong leadership, a feeling of community, a strategic organisation that suggests the mission, vision and goals. A healthy work environment is critical to job satisfaction, best practices and retention, including many of these vital principals. Hospitals with Magnet designation demonstrate considerably higher levels of advanced healthy work environments, communication, collaboration, decision-making, staffing, recognition and leadership, promotion of retention and reduced number of errors than those without (Ritter, D, 2011; Schmalenberg 2008; Ulrich *et al.*, 2007).

An additional hospital management strategy in Riyadh to overcome these issues included an anti-bullying programme and retention group with a power to prevent any negative behavior reported to them. This result is in line with the UK's numerous national and governmental policies, strategies and regulations from 1974 to the present day to protect them from such behaviour (HMSO, 1974, 1977, 1996; Upson, 2003). A directive termed 'Zero Tolerance' from the Health Minister John Denham in 1999, in conjunction with the NHS (NHS, 1999), set about stopping occurrences of violence and bullying. This directive not only focused on the physical and verbal abuse that staff were exposed to by patients, and visitors of the community, but was directed at staff attitudes regarding other staff members (Edwards & O'Connell, 2007). We can learn from this experience by applying zero tolerance and anti bullying programmes within Saudi hospitals to stop workplace injustice issues that become barriers between multicultural nurses in practice.

Moreover, it is evident from the results of this study that the subtheme of “Discrimination” is a key barrier between both staff and patients from different backgrounds. It can be further subcategorised into organisational discrimination toward Saudi personnel, patient care, education status and occupation, salary, skin colour, and contract threats. As noted by participants, Saudis are raised believing that there are ranks of people in a lower class, middle class, high class, and VIP class. These classes are linked to ethnicity and based on this, they treat people differently, sometimes leading to discrimination from patients and families towards nurses. Similarly, Shields and Wheatley Price (2002) conducted a study on the UK healthcare system and discovered that nurses from minority groups are subject to prejudicial treatment by colleagues, patients and visitors to the clinic.

The worst part of this is that unfortunately some of the nursing staff were raised believing that they were in Saudi Arabia to serve. Consequently, those discriminated-against staff will usually not fight for their patients’ rights.

This presents a significant barrier to collaboration between nurses, and patient care can be affected. The conclusion reached by many studies is that the nurses who originate from different cultural backgrounds are subject to racism, discrimination and abuse on account of their heritage, and will often struggle to be included in team activities and have their opinions and ideas taken seriously by their colleagues (Alexis, Vydellingum and Robbins, 2007; Almutairi *et al.*, 2015; Esmail and Everington, 1993; Wilson, 2007). Similarly, in this study, participants indicate discrimination would be on account of ethnicity and gender, as Arab males in this Saudi hospital were very dominant. In addition, colleagues usually judge, listen and respect according to the person’s ethnicity, religion, and beliefs. For example, the Saudi ethnic group view nurses from India and the Philippines as lower level and not well trained, although this is against the Islamic belief. Abu Nadrah stated that The Messenger of Allah, peace and blessings be upon him, declared through the middle of the day at the end of the pilgrimage, “O people, your God is individual and your father Adam is one. There is no favour of an Arab over a foreigner, nor a foreigner over an Arab, and neither white skin over black skin nor black skin over the white skin, except by righteousness. Have I not delivered the message?” They said, “The Messenger of Allah has delivered the message.” Source: Musnad Ahmad 22978. Grade: Sahih (authentic)

according to Ibn Taymiyyah.

According to Saudi interview participants, it is also essential to highlight as part of the discrimination theme, that the organisational opportunities strategy results in discrimination towards Saudi staff. This was apparent in relation to opportunities to access higher education (Saudi staff are not able to participate in online courses whilst working to obtain higher degrees) although from literatures it has been recognised that nurses with a master's degree report the most positive work environments (Schmalenberg, 2008). Furthermore Saudi staff described favouritism in progress opportunities, where managers from other ethnicities were more likely to provide an opportunity for a member of staff from their own background rather than a Saudi national causing barriers for Saudi career development that leads to frustration, and negative emotional feelings toward the organisation and multicultural colleagues. Daiski (2004) described the pent-up feelings of anger and frustration of nurses frequently leads to staff reacting in a hostile way and furthermore contributes to feelings of disempowerment. Moreover, the Saudi participants feel that they should have more rights to better opportunities as they are citizens and more oriented about Saudi patient culture than other nurses. Although there is a Saudisation department in the organisation, unfortunately, they provide non-effective support, and a lack of action, which is frustrating for them. This organisational discrimination can cause a barrier between colleagues. Furthermore, patient care can be jeopardised by barriers between a nurse's ethnicity and different cultures if a colleague from the same ethnicity is given priority above patient care needs. For example in medication checking when a member of Saudi staff asked for support, this was not immediately provided because a member of staff went to support a colleague with the same ethnicity in a different task, this has the potential to affect patient care and safety. In the healthcare context, the literature revealed that the issue of inequality due to cultural differences is the base of the social safety concept (Polaschek, 1998; Ramsden, 2002).

Considering one's own attitudes before interacting with people from another cultural group is essential; it is about assessing personal bias, prejudice and stereotyping of other people. This step helps nurses adjust to different cultural contexts and to develop respect for other people's cultures. Examples where this was not the case could be where staff give care according to their perception of a patients' social level (a Saudi patient may be viewed as less educated by some

ethnicities and therefore given a different level of care or staff may provide a better level of care to patients of their own ethnicity). This finding is supported by the work of Campinha-Bacote (1999, 2002, 2003) and Jirwe *et al.* (2006) in that cultural awareness indicates self-awareness that involves the self-reflection and understanding of one's attitudes regarding patients from other cultural and ethnic groups. Without such reflection on personal attitudes, healthcare workers may impose their own cultural concepts on patient care (Campinha-Bacote, 2003).

Furthermore, one participant illustrates the importance of staff self-awareness to overcome the nurse-nurse and nurse-patient background differences, and give equal patient care to everyone. The present study revealed that cultural awareness was very essential for effective collaboration between nurses from different cultures. Similarly, the previous research highlighted the importance of developing cultural awareness when looking after patients from different cultures (Campinha-Bacote, 1999; Jirwe *et al.*, 2009; Purnell, 2012).

At the same time, the participants noted the significance of educational status and occupation as organisational barriers. Based on interview participants' responses, the organisation's lack of educational support for staff further study and discrepancies in salary and benefits (including education) according to staff ethnicities will impact staff relations and collaboration, which will in turn affect staff satisfaction and cause them to leave. This result is in line with a study conducted by author Al-Turki *et al.* (2010) in a Saudi hospital including multicultural nurses and Saudi nurses, and the finding suggests that the increased state of emotional exhaustion and prevalence of low personal achievement leading to burnout is quite high in both groups when compared with the international literature.

In addition, there is growing acknowledgement in the literature that the environment in which care is provided impacts job satisfaction and staff retention (Coomber & Barriball, 2007; North, 2012; Norman, 2013).

Participants referred to the discrimination and unfair assignment from colleagues from different ethnic groups as a result of organisational salary discrepancy as the main reason for clashes that caused conflict and inequitable feeling between colleagues, which would influence the collaboration between them and lead to a feeling of hatred that would be reflected in patient care.

Although the staff complain to the organisation about salary discrepancy and dissatisfaction, still the institution ignore the staff needs, which will affect the quality of patient care. On the other hand, participants explain the reason behind that as being that each nation's cost of life differs. Saudi participants illustrate workplace justice toward other ethnic group staff, and they should be thankful, but staff are resigning and looking for an opportunity in a more free system such as that in Dubai. According to Percot (2006), more prestige can be gained by working in Dubai, the top place in the Gulf for Indians, than by working in Jeddah or Riyadh. It is thus pretty standard to see young nurses who have obtained their first contract in Saudi Arabia coming back home as soon as it is over to look for a contract in another Gulf country. In places such as Dubai, social events may be more abundant, unlike under strict Saudi law. The tolerance prevailing in the Emirates predominantly be they to dress traditional custom, to practice one's religion, and in any case, the home country is not very far and very accessible (Percot, 2006).

Moreover, staff are sometimes discriminated against because of their skin colour, as published by UnfairCampaign.org (2012). Access to better jobs, better salary, better treatment, and better opportunities are all dependent on the person's skin colour, which is unfair.

Additionally, there was discussion by participants regarding the stereotyping of black people due to their perceived awkward method of communication. Furthermore, speaking about discrimination, there is an organisational contract-threat culture among colleagues from different ethnic groups which affects staff confidence and disempowers their role, which will impact the relationship with other colleagues. For example, Asian nurses such as Indians and Filipinos usually do not support other colleagues, as they are always afraid and threatened by the hospital that they will be sent home, which is difficult for people who are earning to feed the whole family back home. Unfortunately, there are people within the hospital who have the power to make this decision. Subsequently, some staff use it the other way around as part of the Magnet hospital concept concerning staff retention, where staff would misuse it and threaten the head nurses to leave if they did not comply with what they wanted. Additionally, the interview participants' discussion also identified "Ethnocentrism" as a barrier among nurses and between nurses and patients, by considering themselves better than other persons for reasons based mainly on their culture, leading to feelings of superiority and discriminatory behaviours that also

appear in healthcare practice. Regarding nurse-patient relations, there is a feeling of superiority from Saudi VIP patients toward nurses from other ethnic groups and they are treated like servants. On the other hand, the Saudi staff show an attitude of superiority toward other Asian ethnic groups or any staff trying to speak up or criticise the Saudi culture, and it was agreed by Saudi participants that Saudi staff have their own cultural feelings toward staff from other ethnic groups. Similarly they perceived that white English speaking western staff acted in a superior manner towards Saudi and Asian staff. Significantly, the study's findings indicated that the nurses' ethnocentric viewpoints impeded the efficient collaboration process and negatively affected the patients and the care they provided. From the perspective of ethnocentrism, the participants used their cultural lens to view, evaluate and judge the behaviours and practices of people from other cultures (Dayer-Berenson, 2013). This study concurred with evidence from previous studies, which also support the contention that the clinical environment can be aggressive and challenging (Jackson *et al.*, 2002; Duchscher & Myrick, 2008).

Furthermore, "workplace violence and aggression" has been identified in the study. The aggressive behaviour and violence toward them from patients' families or staff in a managerial position has been mentioned as a significant barrier. Examples of this are a patient's family's violence toward the doctor and nurses in the emergency room, and aggressive behaviour from a non-Saudi Arab doctor throwing instruments in the operation room. Additionally, there is the defensive and offensive attitude from Saudi colleagues in a higher position to manage people from other ethnicities, which is probably not accepted according to participants. The literature review indicated that similar complications from aggressive behaviour had been linked to race, according to Hall *et al.* (2013). Moreover, Arab men head nurses approached staff to correct a mistake in an unfavourable angry manner, which caused the staff to feel unconfident and sometimes the violence escalated so that it became physical. There was physical violence from a manager toward a staff nurse and furthermore, there was no real action taken from the hospital concerning the incident. This finding is consistent with Algwaiz and Alghanim (2012), who demonstrated that in Saudi Arabia, nurses are more likely than other professionals to be exposed to high-risk violent incidents.



An “Organisational strategy was developed to overcome violence and aggression”, this included a verbal warning before termination for staff displaying attitude problems with patients or colleagues, and a “code white” if nurses are physically or verbally harassed by staff, patients or patients’ families. This strategy should help support staff to overcoming some of these issues and barriers occurring within the multicultural sitting. As discussed earlier, this directive focused on the physical and verbal abuse that staff were exposed to by patients and visitors, and staff attitudes towards other members of staff (Edwards & O’Connell, 2007).

### **6.3 Benefits and Limitations of the Purnell Model as a Conceptual Framework**

The conceptual framework directing this research suggests that a multicultural nursing workforce can become culturally competent through the development of cultural competence skills, including awareness and knowledge. This theoretical model was examined against the multicultural nursing workforce in this case study. It was discovered that participant nurses did not consistently encounter these domains of cultural competence. This study is the first time where the Purnell Model of Cultural Competence has been used to examine a workforce where the nurses are culturally different from each other and from the patients they care for, this is one of the studys unique contributions to knowledge. At the beginning of the study, the conceptual framework appeared to be an efficient approach to guide the research and to evaluate the research problem. As the study progressed, however, the framework displayed both strengths and limitations. These concerns are addressed in the following paragraphs.

The Purnell Model (2002) conceptual framework aims to address 12 domains of cultural competence. In particular, it provided a credible initial organising arrangement for the collection and analysis of the data and helped to explain certain critical issues; the significant result illustrates 11 domains from Purnell’s Model were suitable to assess nurse-to-nurse collaboration. One domain concerning ecology was excluded from the analysis, as it was more concerned with diseases concerning patients’ skin colour, which was not applicable to this particular study.

Additionally new themes were created to adapt the model to suit the needs of staff working together rather than a sole patient focus as in the original model. Workforce issues and high-risk behaviour were joined together to create a new theme labelled workforce attitude, and behavior. In the context of the research, however, this model did not account for all of the nurses' experiences in this multicultural context. As a result, the dataset, which was not adequate within the framework, was analysed inductively; this approach generated significant themes that revealed the risk to physical, emotional and psychological safety status for nurses due to cultural differences, workplace injustice and disempowerment. These relevant themes emerged beyond the Purnell Model and have been added to the model and form part of the researcher's academic contribution to knowledge. Together with the modified themes from the current study, the results suggest a new model for effective collaborative working.

The Purnell Model conceptual framework in this context provides descriptive power as it reconciles some of the subtler nuances of cultural beliefs and behaviour. For example, there was capacity within the framework to describe the numerous endogenous and exogenous factors that shaped people's cultural and healthcare practices. The study revealed a range of examples of culturally different beliefs and practices that could inform the concept of cultural knowledge. For example, an area that related to nonverbal communications such as body language clues may have various implications from one culture to another. In addition, an area of difference is the family structure, which includes the family role, head of the family, gender roles, extended family network and individualistic versus collectivistic family members. Another area of difference is related to the rituals and practices that inform care for death and dying, as the nurses' experience in this study reflected the importance of cleaning the body of a deceased Muslim patient and giving space for family religious practice. Moreover, there are differing areas relating to healthcare practices and practitioners such as folk practices, responses to health and illness, blood transfusion and organ donation. Furthermore, other general characteristics that differentiated cultural groups in this context included gender issues, dominant culture and educational opportunities. All of the abovementioned themes are important factors to aid understanding multicultural nursing workforce behaviour and the many barriers and facilitators across cultures.

Table 7 below summarises the barriers and facilitators found within the study. These were developed from initially from the themes within the Purnell Model and then extended through the findings which emerged from the participant interviews. Almost all themes have both barriers and facilitators linked to them. The Purnell Model confirmed that cultural competence plays an essential role as a facilitator within a multicultural workforce setting and that barriers occur if competence is absent from the personal to organisational level. According to Purnell (2002) “Cultural competence in today’s borderless societies is not a luxury; it is a necessity.”

**Table 7: Summary of the Barriers and Facilitators to Multicultural Working**

	<b>Barriers</b>	<b>Facilitators</b>
1-Overview/heritage	<p>Reasons for working in Saudi Arabia and associated Economic factors:</p> <ul style="list-style-type: none"> <li>• <i>Choosing nursing not as a vocation but for a financial cause can lead to standard conflict</i></li> </ul> <p>Politics:</p> <ul style="list-style-type: none"> <li>• <i>Political issues between countries can affect nurses' relations</i></li> </ul>	<p>Reasons for working in Saudi Arabia and associated economic factors that influence feelings of satisfaction:</p> <ul style="list-style-type: none"> <li>• <i>Saudi geographical location; travel spot.</i></li> <li>• <i>Financial benefits include tax-free status, free accommodation and good salary</i></li> </ul>
2-Acculturation (Adjustment to the new cultural environment):	<p>Adaptation process:</p> <ul style="list-style-type: none"> <li>• <i>Challenges and struggling</i></li> <li>• <i>American work standard system</i></li> </ul> <p>Education</p> <ul style="list-style-type: none"> <li>• <i>General nurse orientation about Saudi culture only</i></li> <li>• <i>Preceptor personality</i></li> <li>• <i>Lack of management and organisational education support</i></li> <li>• <i>No proper orientation or education for a specific unit.</i></li> </ul>	<p>Adaptation process:</p> <ul style="list-style-type: none"> <li>• <i>Modified cultural food habit</i></li> <li>• <i>Interesting to learn about others' culture</i></li> <li>• <i>Self-transformation Organisational skill matching</i></li> </ul> <p>Education:</p> <ul style="list-style-type: none"> <li>• <i>GNO about Saudi culture and hospital policy</i></li> <li>• <i>The multicultural night provided by the recruitment and retention department</i></li> <li>• <i>Cultural Awareness course, but stopped</i></li> <li>• <i>Educational orientation programme, internal competence courses and skill learning</i></li> <li>• <i>preceptorship programme.</i></li> </ul>

<p>3-Communication</p>	<p>Language barriers:</p> <ul style="list-style-type: none"> <li>• <i>Staff: poor Arabic language skills</i></li> <li>• <i>Mixed language in a single unit</i></li> <li>• <i>Dominant group non-English language on teamwork</i></li> <li>• <i>Unknown accent and abbreviations</i></li> <li>• <i>Resistant to organisation policy of standardised language</i></li> <li>• <i>Socially isolated feeling</i></li> <li>• <i>Hospital Arabic vs. Social Arabic</i></li> </ul> <p>Nonverbal communication:</p> <ul style="list-style-type: none"> <li>• <i>The body language between staff</i></li> </ul> <p>Communication style:</p> <ul style="list-style-type: none"> <li>• <i>Direct and indirect</i></li> <li>• <i>Organisational communication style: Hospital hierarchy</i></li> </ul> <p>Expression &amp; Interpretation:</p> <ul style="list-style-type: none"> <li>• <i>Different culture interpretation &amp; expression</i></li> <li>• <i>Voice tone</i></li> </ul> <p>Translation services:</p> <ul style="list-style-type: none"> <li>• <i>Translation accuracy and personal interpretation made by Saudis or Arabic colleagues</i></li> <li>• <i>Frustration because of the absence of organisational translation service</i></li> </ul>	<p>Nonverbal communication:</p> <ul style="list-style-type: none"> <li>• <i>Body language with patients</i></li> </ul> <p>Communication style:</p> <ul style="list-style-type: none"> <li>• <i>Acknowledge other culture styles</i></li> <li>• <i>Use smart communication style</i></li> </ul> <p>Expression &amp; Interpretation:</p> <ul style="list-style-type: none"> <li>• <i>Cultural knowledge</i></li> </ul> <p>Strategy for good communication:</p> <ul style="list-style-type: none"> <li>• <i>Staff Arabic learning passion</i></li> <li>• <i>Self-awareness and cultural knowledge of other cultural communication skills</i></li> <li>• <i>Technology, SBAR tools</i></li> <li>• <i>One-to-one handover process at patient's bedside instead of roundtable</i></li> <li>• <i>Meeting with higher administration regularly. Now stopped</i></li> <li>• <i>Unit-based council team</i></li> </ul>
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<p>4-Family role and organisation</p>	<p>Head of household:</p> <ul style="list-style-type: none"> <li>• <i>Family role &amp; husband authority in Arab nursing practice</i></li> <li>• <i>Interfering with the patients care</i></li> <li>• <i>Organisation strategy to please family and disempower the nurse</i></li> </ul> <p>Individualistic versus collectivistic</p> <p>Alternative lifestyle: (boyfriend, single parent, homosexual)</p> <ul style="list-style-type: none"> <li>• <i>Judged by heavily religious background</i></li> <li>• <i>Treated differently</i></li> <li>• <i>Bad feeling, non-tolerance, disrespect to Saudi culture and law</i></li> <li>• <i>Reported to the hospital and leave, threatened regarding renewal of contract</i></li> <li>• <i>Illegal status in the Saudi system (offended, police arrest)</i></li> </ul>	
<p>5-Workforce attitudes, and behaviours</p>	<p>Professional attitude</p> <ul style="list-style-type: none"> <li>• <i>Oversocialising with patients and speaking about other colleagues with them</i></li> <li>• <i>Eating inside the clinical area</i></li> <li>• <i>Head nurses with regular clothes and bossy attitude</i></li> <li>• <i>Staff wasn't attempting to learn Arabic</i></li> <li>• <i>Lack of responsibility</i></li> <li>• <i>Society value and views for nursing as a career</i></li> <li>• <i>Cultural stereotyping</i></li> <li>• <i>Lack of compassion in patient care</i></li> </ul> <p>High-risk behaviours:</p> <ul style="list-style-type: none"> <li>• <i>Medication abuse by staff</i></li> <li>• <i>Obsequious behaviour</i></li> </ul>	<p>Overcome high-risk behaviours:</p> <ul style="list-style-type: none"> <li>• <i>Code white</i></li> </ul>
<p>6- Nutrition</p>	<p>Common foods and Food rituals:</p> <ul style="list-style-type: none"> <li>• <i>Imposing personal values on other colleagues' cultural food</i></li> <li>• <i>Lack of sensitivity</i></li> </ul>	<p>Meaning of food:</p> <ul style="list-style-type: none"> <li>• <i>Cultural interaction, socialisation, celebration among nurses and between nurses and patients and patients' families</i></li> </ul>
<p>7- Pregnancy and childbearing practice</p>	<p>Respect, Non-married pregnant staff, pregnancy test for non-married patients.</p>	

<p>8- Death rituals</p>	<p>Death rituals and expectation:</p> <ul style="list-style-type: none"> <li>• <i>Staff lack sensitivity</i></li> <li>• <i>Islamic washing practice</i></li> </ul> <p>Responses to Death:</p> <ul style="list-style-type: none"> <li>• <i>End life decision</i></li> <li>• <i>Palliative care overwhelmed with cultural values</i></li> <li>• <i>DNR concept</i></li> <li>• <i>Hospital policy and power</i></li> <li>• <i>Brain-dead patients</i></li> </ul>	<p>Death rituals and expectation:</p> <ul style="list-style-type: none"> <li>• <i>Staff acknowledgement of Saudi Islamic culture and patient's family culture, religious need</i></li> <li>• <i>Organisational death and dying courses</i></li> </ul>
<p>9-Spirituality</p>	<p>Religious practice and use of prayer:</p> <ul style="list-style-type: none"> <li>• <i>Challenges to adopting patients' cultural, religious values</i></li> <li>• <i>Patients and families impose their religious values on non-Muslim staff</i></li> <li>• <i>Doctor imposes religious values leading to feeling of hatred</i></li> <li>• <i>Saudi culture and colleagues influenced by faith</i></li> <li>• <i>Lack of awareness</i></li> <li>• <i>Use of prayer, disappear and avoid working</i></li> <li>• <i>Ramadan and working</i></li> <li>• <i>Muslim Shias and Sunnis conflict, Christian Catholics and Baptists conflict</i></li> </ul> <p>Religious festivals:</p> <ul style="list-style-type: none"> <li>• <i>Imposing religious beliefs about fasting during Ramadan</i></li> <li>• <i>Greeting</i></li> <li>• <i>Influence of dominant culture on organisational religious festival policy</i></li> </ul> <p>Saudi religious system including religious police:</p> <ul style="list-style-type: none"> <li>• <i>Old Saudi and media restriction, the religious men's power and authority</i></li> <li>• <i>Religious man conflict role as patients and in public</i></li> <li>• <i>Saudi cultural, religious system: shop closed during prayer</i></li> </ul>	<p>Religious practice and use of prayer:</p> <ul style="list-style-type: none"> <li>• <i>Acknowledge patients, families' religious need and Islamic culture</i></li> <li>• <i>Acknowledge the Islamic cultural, religious needs and practice</i></li> <li>• <i>Religious belief influences staff's good relations</i></li> <li>• <i>Acknowledge and respect Shia colleagues</i></li> <li>• <i>Care is away from religious imposing</i></li> <li>• <i>Influence of the Muslim colleagues and conversion</i></li> <li>• <i>Culture religious knowledge and socialising</i></li> <li>• <i>Staff learning Islamic practice</i></li> </ul> <p>Religious festivals:</p> <ul style="list-style-type: none"> <li>• <i>Hospital acknowledges the differences (restaurant and coffee shop open for non-Muslims)</i></li> <li>• <i>Allow non-Muslims to celebrate their religious festivals</i></li> </ul>
<p>10- Healthcare practices</p>	<p>Healthcare practices from the country of origin:</p> <ul style="list-style-type: none"> <li>• <i>Back home practice</i></li> <li>• <i>Different resources</i></li> </ul> <p>Experience &amp; Seniority practice:</p> <ul style="list-style-type: none"> <li>• <i>Refuse instruction from young and newly employed</i></li> <li>• <i>Experience imposing</i></li> <li>• <i>Arabs overconfident to change</i></li> </ul>	<p>Healthcare practices from the country of origin:</p> <ul style="list-style-type: none"> <li>• <i>The culture of the following policy</i></li> </ul> <p>Experience &amp; Seniority practice:</p> <ul style="list-style-type: none"> <li>• <i>Hospital practice based on evidence</i></li> </ul> <p>To overcome standard of care barriers:</p> <ul style="list-style-type: none"> <li>• <i>Model of practice</i></li> </ul>

	<p><i>the doctor's order or giving medication</i></p> <ul style="list-style-type: none"> <li>• <i>Indian nurses accommodate senior practice</i></li> <li>• <i>Resistant to change</i></li> <li>• <i>Lack of organisation action and transparency</i></li> </ul> <p>Standards of care:</p> <ul style="list-style-type: none"> <li>• <i>Patient privacy</i></li> <li>• <i>Patient assessment</i></li> <li>• <i>Environment challenge to keep high standards</i></li> <li>• <i>Unclean care</i></li> <li>• <i>Documentation rather than patient care concept supported by managers</i></li> </ul> <p>Role conflicts.</p> <p>Folk practices:</p> <ul style="list-style-type: none"> <li>• <i>Mother instinct and dangerous practice</i></li> <li>• <i>Spiritual beliefs in practice against policy</i></li> <li>• <i>Cultural spirituality and religious man diagnosis</i></li> </ul> <p>Cultural responses to health and illness:</p> <ul style="list-style-type: none"> <li>• <i>Lack of sensitivity to learning disability</i></li> <li>• <i>Cancer and mental illness stigma</i></li> </ul> <p>Blood transfusion and Organ donation:</p> <ul style="list-style-type: none"> <li>• <i>Blood donation system restriction for non-Saudis</i></li> <li>• <i>Organ donation different concept between colleagues</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Magnet component to standardise the care</i></li> <li>• <i>Standardised policy and guidelines</i></li> </ul> <p>Folk practices:</p> <ul style="list-style-type: none"> <li>• <i>Acknowledge patients' spiritual needs in care that are different from staff beliefs</i></li> </ul> <p>Cultural responses to health and illness:</p> <ul style="list-style-type: none"> <li>• <i>The organisational psychological assessment tool</i></li> <li>• <i>Organisational support to staff with mental illness</i></li> </ul> <p>Blood transfusion and Organ donation:</p> <ul style="list-style-type: none"> <li>• <i>Public education and awareness about organ donation</i></li> </ul>
<p>11-Healthcare practitioners</p>	<p>Traditional versus biomedical practitioners:</p> <ul style="list-style-type: none"> <li>• <i>Culture gender segregation; barrier to Saudi nurses' role with male patients and relation of male doctor with female patients</i></li> <li>• <i>Assignment gender segregation</i></li> <li>• <i>Culture Gender segregation</i></li> </ul> <p>Status of health care provider:</p> <ul style="list-style-type: none"> <li>• <i>Doctor, male-dominant culture</i></li> <li>• <i>Saudi people view nurses as lower level</i></li> <li>• <i>Asian doctor drove culture</i></li> <li>• <i>Ethnic group lack critical thinking and decision making and initiation</i></li> <li>• <i>Lack of speaking up</i></li> <li>• <i>Male-dominant culture concept</i></li> <li>• <i>Lack of hospital standard system</i></li> </ul>	<p>Status of healthcare provider:</p> <ul style="list-style-type: none"> <li>• <i>Nurses status on Saudi system much better compared to other Asian cultures</i></li> <li>• <i>Doctor-western nurse relations</i></li> <li>• <i>Get self-respect by strong, assertive personality</i></li> <li>• <i>Organisation flexibility</i></li> </ul>

	<p><i>policy as care led by doctor's personality, not by policy</i></p>	
12-Cultural differences	<p>Cultural norms and values:</p> <ul style="list-style-type: none"> <li>• <i>Grateful reaction</i></li> <li>• <i>Different values</i></li> <li>• <i>Personal issues and values</i></li> <li>• <i>Laughing in public</i></li> <li>• <i>Hairdressing</i></li> </ul> <p>Saudi cultural beliefs and Saudi system:</p> <ul style="list-style-type: none"> <li>• <i>Conservative culture</i></li> <li>• <i>Intolerant</i></li> <li>• <i>Nurse family name on patient care</i></li> <li>• <i>Lower class job</i></li> <li>• <i>Personal questions</i></li> <li>• <i>White skin and blue eyes privilege</i></li> <li>• <i>Cultural dark skin associated with lower class</i></li> <li>• <i>Indoor lifestyle</i></li> <li>• <i>Accommodation stress</i></li> <li>• <i>Gender segregation</i></li> <li>• <i>Lack of female authority to drive and lack of public transportation</i></li> <li>• <i>Saudi limited stay and lack of long-term security</i></li> <li>• <i>Non-Saudis criticise Saudi culture</i></li> <li>• <i>Private places for non-Saudis</i></li> </ul>	<p>Saudi cultural beliefs and the Saudi system:</p> <ul style="list-style-type: none"> <li>• <i>The social benefit of conservative Saudi culture</i></li> <li>• <i>Staff awareness of cultural regulation norms and values</i></li> <li>• <i>Learn the concept of multiculturalism from other cultures</i></li> </ul> <p>Positive aspects of the multicultural workforce environment in Saudi Arabia:</p> <ul style="list-style-type: none"> <li>• <i>Self-awareness</i></li> <li>• <i>Understanding others</i></li> <li>• <i>Gain knowledge, experience, and technology, new skills, practice and life concept</i></li> <li>• <i>Saudi nurses welcoming and accepting</i></li> <li>• <i>Saudi culture kindness and generosity</i></li> <li>• <i>Organisational open culture about other religions</i></li> </ul>
13-Empowerment and disempowerment	<p>Workplace advocacy and challenging policy:</p> <ul style="list-style-type: none"> <li>• <i>Nurses lack advocacy</i></li> <li>• <i>Insecure to speak up</i></li> </ul> <p>The use and abuse of power (corruption):</p> <ul style="list-style-type: none"> <li>• <i>Staff with and without power</i></li> <li>• <i>Fear of higher authority</i></li> <li>• <i>Professional bullying and abuse</i></li> <li>• <i>Good connection outside work</i></li> <li>• <i>Managers' lack of qualification or skills, pushed for the position</i></li> <li>• <i>Wasta</i></li> </ul> <p>Blame culture and hiding mistakes:</p> <ul style="list-style-type: none"> <li>• <i>Frightened staff</i></li> </ul>	<p>Workplace advocacy and challenging policy:</p> <ul style="list-style-type: none"> <li>• <i>Stand up for patients</i></li> <li>• <i>Speak up and challenge policy</i></li> <li>• <i>Leader skills, work based on evidence</i></li> <li>• <i>Organisational speak up campaign</i></li> <li>• <i>Self-protective</i></li> </ul>



	<ul style="list-style-type: none"> <li>• <i>Lack of understanding of non-blame culture concept</i></li> <li>• <i>Dominant group and same ethnicity colleagues cover for each other</i></li> </ul>	
<p>14-Workplace justice and injustice</p>	<p>Dominant culture abuse and bullying:</p> <ul style="list-style-type: none"> <li>• <i>Verbal abuse and rudeness</i></li> <li>• <i>Hard time &amp; bad evaluation</i></li> <li>• <i>Staff leave unit and hospital</i></li> <li>• <i>Work as a group against others</i></li> <li>• <i>Power to change nurse position</i></li> <li>• <i>Unfair assignment and overtime</i></li> <li>• <i>Non-welcoming environment</i></li> <li>• <i>Mainly from Asia or Arabs</i></li> <li>• <i>Gender abuse and intimidation</i></li> </ul> <p>Discrimination:</p> <ul style="list-style-type: none"> <li>• <i>Saudi culture ranks of people</i></li> <li>• <i>Other ethnicities believed to be raised to serve</i></li> <li>• <i>Will not advocate for patients</i></li> <li>• <i>Gender or ethnicities</i></li> <li>• <i>Religion and belief</i></li> <li>• <i>Support own group culture only</i></li> </ul> <p>Organisational Opportunities strategy toward Saudi staff:</p> <ul style="list-style-type: none"> <li>• <i>Unequal institutional opportunity between Saudi staff and western staff is upsetting and leads to feelings of unhappiness</i></li> <li>• <i>Lack of higher education opportunities</i></li> <li>• <i>Managers highlighting staff more than Saudis</i></li> <li>• <i>Western favouritism upsetting</i></li> <li>• <i>Saudisation department; Ineffective support, lack of action, frustration</i></li> </ul> <p>Patient care jeopardy:</p> <ul style="list-style-type: none"> <li>• <i>Delay patient care, staff priority according to ethnicity</i></li> <li>• <i>Lack of support</i></li> <li>• <i>Unequal patient care based on patients' social level and ethnicity</i></li> <li>• <i>Favouritism toward Saudi patients</i></li> </ul>	<p>Organisational Strategy to overcome abuse and bullying:</p> <ul style="list-style-type: none"> <li>• <i>Anti-bullying programme and retention group</i></li> <li>• <i>Magnet hospital (code white) toward harassment and bullying</i></li> </ul> <p>Overcoming patient care jeopardy:</p> <ul style="list-style-type: none"> <li>• <i>Equal treatment for all patients regardless of ethnicity, beliefs, etc.</i></li> </ul> <p>Strategy to overcome violence and aggression:</p> <ul style="list-style-type: none"> <li>• <i>Verbal attention before termination of staff having an attitude problem with patients and colleagues</i></li> <li>• <i>Code white if the nurses are physically or verbally harassed</i></li> </ul>

	<p>Educational status and occupation:</p> <ul style="list-style-type: none"> <li>• <i>Further education</i></li> <li>• <i>Salary discrepancy</i></li> <li>• <i>Lack of hospital support action and staff satisfaction</i></li> </ul> <p>Salary discrepancy:</p> <ul style="list-style-type: none"> <li>• <i>Unfair assignment</i></li> <li>• <i>Animosity between staff</i></li> <li>• <i>Dissatisfaction because of institutional ignorance</i></li> </ul> <p>Skin colour:</p> <ul style="list-style-type: none"> <li>• <i>Discrimination</i></li> <li>• <i>Stereotyping</i></li> </ul> <p>Contract threatened:</p> <p>Ethnocentric:</p> <ul style="list-style-type: none"> <li>• <i>Superiority feeling from Saudi VIP patients and staff toward other ethnicities</i></li> <li>• <i>Own culture feeling toward any other staff trying to speak or criticise</i></li> <li>• <i>White and English privilege</i></li> <li>• <i>Western superiority</i></li> </ul> <p>Workplace violence and aggression:</p> <ul style="list-style-type: none"> <li>• <i>Patient family violence</i></li> <li>• <i>Staff aggressive behaviour</i></li> <li>• <i>Management physical violence toward staff nurse</i></li> </ul>	
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In relation to the cultural knowledge expected of nurses working within this demanding environment, it is unrealistic to presume them to acquire a detailed understanding of all of the cultures with which they come to interact. The collective culture studied here exemplifies more than fourteen nationalities. It is significant to perceive that the term nationality is not equal to, nor synonymous with, the term culture, as multiple ethnicities may occur within people from the same country. The present research highlights those essential elements of culture that nurses should know about as the minimum necessary cultural competence that would facilitate and guide them in working collaboratively a transcultural way. I would argue here that this approach does not reduce the problematic description of culture; but the strategy emphasises those vital cultural differences that suggest the need for cultural awareness and knowledge. Alongside this necessary knowledge, nurses need to recognise that within the one ethnic group, norms and beliefs are not constant – they are modified over time. This understanding corresponds with the anthropological view of culture as a dynamic process that is formed by social transformations, social conflict and migration (Taylor, 2003). Moreover, cultural practices can change within similar ethnic groups; the causes can range from differences in gender, political views, religious beliefs, ethnicity and personalities (Kleinman & Benson, 2006). From this understanding, nurses must be aware that some cultural practices and attitudes can vary, even within people of the same group, and are not attributable to all colleagues.

This study also produces a new consideration of the concept of cultural awareness that is lacking in the original Purnell framework. The findings from the study support the assumption that cultural awareness embraces the consciousness of workplace justice and injustice, including personal prejudices, abuse, bullying, discriminations and stereotypes, as such attitudes may adversely influence interactions with a culturally diverse group (Campinha-Bacote, 1999, 2002, 2003; Jirwe, Gerrish & Emami, 2006). This process of recognition of one's attitudes can go some way to helping nurses to avoid the cultural impositions and ethnocentric viewpoints that cause harm to others (Campinha-Bacote, 2003; Taylor, 2005).

The data moreover reveals that nurses are required to practise cultural awareness from a holistic approach to guarantee balance in general; a point not made by the framework. They must be

aware that cultural diversity can influence the nurses in multiple domains, including the psychological, spiritual, emotional and physical. This study has also illuminated that when nurses develop cultural awareness, they demonstrate it by being sensitive to and appreciative of other cultures. Hence, cultural sensitivity is associated with cultural awareness.

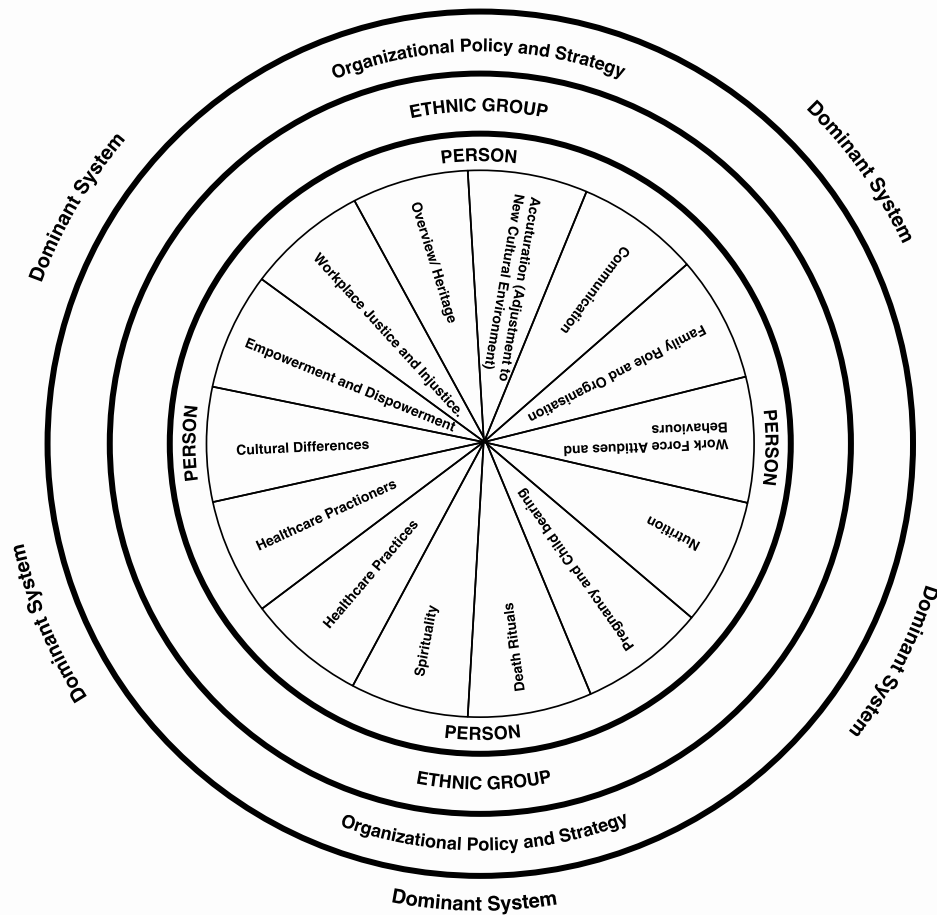
One crucial element evident in this study and not explained by the Purnell Model is the empowerment and disempowerment of this nursing workforce during cultural encounters. Disempowerment was demonstrated through the nurses' experiences, as explained in the interviews. According to Simons, Vázquez and Harris (1993), feelings of fear are generated by cultural diversity, which includes feelings of isolation and unfamiliarity, fear of people who are different, fear of favouritism, and fear of the unknown. There is no evidence from the findings of this study that the organisation provided adequate support to overcome these fears and enhance the collaboration and emotional status of this multicultural nursing workforce. The nurses in this study are of different ethnic groups from the dominant ethnic group within the dominant culture of Saudi Arabia, and the power differential is not culturally or organisationally balanced in their favour. The conceptual framework of cultural competence did not address these issues, which affect the collaboration and emotional status of the nurses, who did not feel empowered and confident enough to challenge or discuss any concerns and issues related to their work together.

In the multicultural nursing workforce context, the meaning of cultural empowerment might, therefore, be related to restoring and enhancing the self-confidence of nurses and feelings of security in order to collaborate effectively. It also implies mitigating the effect of the dominant culture on nurses through apparent organisational support. Redistribution of power associated with cultural competence for a multicultural nursing workforce can result in better collaboration and health outcomes.

This study shows that the difficulties that arise from cultural diversity can be ironed out by way of adequate organisational support and strong policy guidance, which enhances the continuing professional development of individuals practising at the nexus of cultures.

This study, therefore, proposes a modified Extended Model of Cultural Competence (Figure 6) with new themes and subthemes based on the research findings to ensure that the model not only

relates to working with patients in a multicultural environment, but also covers staff working effectively together in a multicultural workforce.



**Figure 7: The Extended Cultural Competence Model for Effective Collaboration in a Multicultural Nursing Workforce**

## 6.4 Conclusion

This chapter has sought to explain the results of the case study which has demonstrated 14 competencies for effective multicultural nursing in KSA.

The Purnell Model of Cultural Competence is a useful means of identifying competencies for working in a multicultural setting, but to ensure that nurses are fully culturally competent to work with each other, the study discussion suggests that additional domains and themes need adding to the model. These include cultural differences, empowerment and disempowerment, workplace justice and injustice

Cultural competence is essential for effective collaboration between nurses from different ethnic groups that can develop through awareness, acknowledgement of cultural differences and similarities and maintaining sensitivity to the needs of people from different cultures. Nurses can draw on their understanding of other cultures to acknowledge cultural differences and use their background to recognise similarities. This acknowledgement is not limited to the differences between cultures; it also extends to the recognition of differences within the same cultural group. In summary, the nurses' experience in this multicultural environment suggests that cultural diversity is risky without appropriate education and support, and can compromise the nurse's ability to collaborate and deliver patient care. In general, the results revealed that nurses were struggling to some extent to collaborate effectively and they also struggled to perform nursing care. This study recommends that there is a need for education about other cultures to overcome the barriers between multicultural nurses regarding cultural awareness, as the nurses in this study were inadequately prepared in this respect.

The findings suggest that the cultural competence of the nursing workforce can lead to effective collaboration and that this can be achieved through continuous education and training programmes at an individual level and embodied or role-modelled at the organisational level. Hence, in a multicultural context, obtaining cultural competence requires a combination of both individual passion and effort, coupled with adequate organisational support and resources. The findings of this study also emphasise the importance of pre-departure cultural preparation for

nurses to mitigate the effect of cultural dissonance, and so eliminate, or reduce, the potential for cultural differences. It can conclude that a multicultural nursing workforce in any context is characterised by diversity in cultural values, beliefs, traditions, race, religious affiliation, language and patterns of behaviour. Cultural conflicts and clashes between the nurses themselves or with the patients are therefore strongly associated with the multicultural workforce, as evident in this study.

There is uncertainty within a multicultural nursing workforce about the effectiveness of working together. Another feature of a multicultural nursing workforce is the risk of misunderstanding both in communication and in interpreting the behaviour of people from other cultures, which also gives rise to collaboration and safety concerns.

Adequate support is required by organisations through policy and continuing professional development to address the implication of collaboration barriers within practice in a multicultural workforce. This study suggests that cultural competence of the nursing workforce needs to be enhanced and maintained through continuous education, training programmes and social activities, because cultural competence can resolve the barriers and conflicts generated by diversity and facilitate understanding and transcultural collaboration.

This study revised a model of cultural competency and highlighted the importance of cultural competence domains, alongside staff empowerment, and workplace justice, as facilitators to overcome barriers that have arisen from multicultural nurses working together to develop transcultural collaborative work. The literature did not report any studies with similar findings in terms of barriers and facilitators between multicultural nursing workforces, thus demonstrating the uniqueness of this research.

In summary, the results demonstrate that the nurses' lack of cultural competence in this multicultural environment is a barrier to effective collaboration. The present study revealed new elements of cultural competence that can be incorporated into a new revised Model of Cultural Competence with the newly emerged themes and subthemes from this research finding that can specifically address the barriers and facilitators among multicultural nursing workforce.



Highlighting these issues between nurses could overcome some obstacles and work as a facilitator for an effective transcultural workforce. This finding can contribute new understanding about the influence of cultural competence between nurses in the perception of collaborative working. No research with similar results was evident and published studies on barriers and facilitators dealt with multicultural nurse groups. Cultural development is at the heart of this research; transforming care from the culture of individual competence to a truly collaborative team environment.

The following chapter will present the study's conclusion and implications for nursing practice as well as recommendations for future research.

# Chapter Seven: Conclusion

## 7.1 Introduction

Throughout the world, effective collaborative working between multicultural nurses is an essential feature for teamwork and patient outcomes. Nurses cannot perform their clinical roles such as delivering patient care, work support and exchanging information with nurses without effective collaboration.

Effective collaboration is of crucial importance in Saudi Arabian hospitals due to the diverse cultural issues the country faces. This collaboration can be affected by gender, language, religious, social, professional and organisational issues that can sometimes pose barriers to working together. Moreover, nurse managers and policy makers in Saudi Arabian hospitals need an in-depth understanding of the complexity of cultural values and beliefs and how these interface with the process of collaboration in the delivery of healthcare.

This study examined barriers and facilitators to effective nursing collaboration that multicultural nurses (including local Saudi nurses) currently face within a Saudi Arabian cultural context. A descriptive approach was used to develop a detailed understanding from which to recommend ways of improving collaboration between staff and ultimately patient care in Saudi hospitals. The findings suggest that effective collaboration was not being achieved due to complex and overlapping personal, ethnic, organisational and dominant system factors.

This chapter outlines the major conclusions and recommendations derived from the findings of this study and explains how the research question has been addressed. Recommendations for clinical services, practices of policymaking, nursing education and future research based on the current study findings are also provided in the following sections.

## 7.2 Overview of the Study and Contributions to Knowledge

In contrast to multicultural working amongst nurses and patients, collaboration between multicultural nurses within the workforce is not well addressed in the literature. The case study described here addresses this gap within the international literature to provide an in-depth understanding of how nurses and nurse managers perceive culture and effective and ineffective collaborative working in a highly multicultural healthcare setting in Saudi Arabia. This study is the first of its kind carried out internationally and specifically in a Saudi Arabian cultural context that has investigated how local nurses and those of different ethnicities interact and work together.

When I began this research, I did not realise how much I would learn. I have learned in particular about the difficulties that nurses encountered due to cultural clashes and conflicts that negatively affect collaboration and the possible positive steps the nurses and organisation can take to overcome these obstacles. I hope the outcome of this research will make a difference to both nurses and patients in the multicultural context, by improving collaboration that will be reflected in health care outcomes.

The nurse's interviews in the current thesis highlighted many challenges to collaboration and possible facilitators in their work environment, in particular, those that arose from cultural and linguistic diversity. As a result, the healthcare outcomes could be argued to be less than optimal if there are no active solutions provided.

According to the Purnell Model of Cultural Competence, understanding cultural knowledge enables optimal nursing care for culturally specific groups across a spectrum of gender, age, culture, ethnicity, background and other factors. The findings of this study are used to modify and enhance the model to ensure its relevance for issues amongst a multicultural workforce as well as providing multicultural nursing care.

The main contributions to knowledge made by this study include:

- Unique in its qualitative examination of barriers and facilitators of nurse-nurse collaboration within a culturally unique, complex Saudi context

- Offer a comprehensive understanding to improving awareness of the cultural values, work experience and benefits of professional education and communication for both Saudi and multicultural nurses employed in Saudi Arabian hospitals.
- An adaptation of the Purnell Model of Cultural Competence which helps to understand how multicultural and local nurses can effectively collaborate in KSA health organisations.
- Cultural diversity in a multicultural nursing workforce can adversely affect the collaboration between nurses and quality of care delivered to the patient

## **7.3 Study Strengths and Limitations**

### **7.3.1 Strength of the Study**

The study provides a critical discussion on the cultural influences on nurses' collaboration status. It points to the need for changes in the current organisation style and is of importance to policymakers implementing new protocols and guidelines to enhance collaboration between nurses and with patients in Saudi Arabia.

### **7.3.2 Limitations of this Study**

Although the research achieved the aim and objectives established in Chapter 1 several obstacles were encountered. It is important to acknowledge the limitations of this study.

□ This study was conducted at a single hospital in Riyadh. Also, although eighteen semi-structured interviews were conducted, they were all held at the same hospital. It would be interesting to compare multiple sites. The lack of generalisability of the results is a limitation of the study as it cannot be assumed that other nurses in other locations would feel the same way about collaboration.

□ In-depth data was obtained only from the semi-structured interview. This research only takes on board the in-depth investigation of the qualitative part. Future work should include data from other methods as well, such as a quantitative survey so a pattern in multiple qualitative and quantitative methods can be profiled.

□ Research is focused on the Saudi context. It will be expected if the research context is expanded to include other countries, more factors contributing to effective collaboration than have been mentioned in this thesis will emerge.

## **7.4 Recommendations**

This section presents the recommendations from the findings of this research project concerning the management of cultural diversity and overcoming the barriers and problems posed by the cultural clashes and conflicts between the multicultural nursing workforce and their patients. The recommendations discussed below have the potential to inform clinical practice, hospital policy, continuing nurse education and future research.

### **7.4.1 Implications for Clinical Practice**

It is recommended that organisations with a multicultural nursing workforce should adopt the revised Cultural Competence Model developed in this study, as means of benchmarking and auditing practice to guide education, induction and continuing development of their multicultural nursing workforce. This model can help the organisation to manage the complexity of a multicultural nursing workforce, in order for international and local nurses to develop and sustain effective collaboration in KSA hospitals. Appropriate application of the model would characterise nurses' competence towards each other, thereby maximising the effectiveness of patient care.

Collaborative efforts across the boundaries of healthcare, between all policymakers, nurses, patients, doctors and hospital stakeholders are needed for the development of effective multicultural nursing collaboration protocols within the Saudi context.

The findings call for the nursing profession to recognise that subcultures, ethnic groups or ethnocultural populations exist; groups who have different experiences from those of the dominant culture with which they identify.

This cultural group may be defined by nationality, language, socioeconomic status, education, sexual orientation or other factors that functionally unify the group and cause each member to have a conscious awareness of these differences. In KSA hospitals, the presence of professional translators with an in-depth knowledge of ethics is essential to secure nurse integrity and patient safety and provide effective communication. Therefore, the current study recommends the utilisation of well-trained translators who could use their skill in Arabic and a foreign language such as English to provide professional services to nurses and patients alike. The person who is acting as a translator should be highly skilled in medical terminology and have a professional attitude to provide competent communication and ensure high-quality healthcare. Hospital translators should also have in-depth knowledge of the Saudi culture of their patients and culture of others.

Translators should rely on reliable and unbiased interpersonal skills with a nurse to facilitate communication and provide optimal care. Moreover, hospital translators must demonstrate a strong commitment to professionalism and the code of ethics. Failure to use a qualified professional translator in medical settings can lead to breaches in nurse's emotional status and can compromise quality patient care.

The identified critical aspects of culture that contribute to workplace justice and empowerment are that:

- The Saudi ministry should review the salary discrepancy among the multicultural workforce.

- Organisational culture needs to be less hierarchical and more flattened to power within nursing management (by ensuring all members of the team are valued, and that this is a definite philosophy that is espoused).
- Directors of nursing and nursing managers' approaches and attitudes to nursing staff on clinical areas deserves attention.
- Awareness of the culture of nursing and the values espoused by staff to staff and staff to patients suggested that a supportive culture needs to promote respect and inclusion.
- An appreciation of new multicultural staff as team members and therefore inclusion into the team (breaks/meals).
- The self-esteem of qualified staff needs to be nurtured through respect and dignity in all communication with all team members.
- A zero tolerance policy should be introduced across the health system to tackle endemic rudeness.
- Respect and dignity policies should be adopted in all wards/organisations through a charter of communication to create an empowering and inclusive environment in which to collaborate.
- Values and attitudes suitable and congruent with nursing ethos need to be reinforced by nursing managers and staff.

#### **7.4.2 Nursing Education and Continuing Professional Development**

The onus is on the healthcare organisations of KSA to provide relevant, accessible educational packages, both orientations as well as ongoing refresher courses, to improve their health workforce and in particular nurses' understanding of collaboration processes, including cultural competence. The current study specifically identified continuing nurse education to increase collaboration with other nurses and maintain patient safety in a multicultural environment. A well-structured continuing education package is recommended for nurses when they commence employment, aiming to increase their competence skills, to enable them to provide high

integrative skills and practise high levels of collaboration, including emotional, psychological, spiritual, cultural, professional and physical abilities. Moreover, these educational packages should utilise and employ optimal learning approaches to ensure participation, comprehension and understanding.

Concerning educational programmes and workshops in a multicultural environment, the study findings recommend the need for effective cross-cultural communication programme; understanding cultural diversity, developing awareness of individual cultures, demanding mutual acceptance, keeping it simple and getting the help of translation services if required.

These can take the form of both online and face-to-face modules. Furthermore, including the norms and values of certain cultures, such as food and religion, would need to be accommodated in the form of workshops as well as online sessions.

The additional recommendation regarding training courses is to offer them to all staff and employees such as doctors, social workers, nursing students and other staff who have contact with nurses or play a role in the delivery of patient care. Also, improving cultural education programmes for health staff working together should involve building a comprehensive database of the cultural education programmes and materials available to service providers. Moreover, it is recommended to develop resources to support self-directed learning that can be easily accessed by staff to meet their changing needs and is regionally specific so as to address specific workplace needs.

Interactive multimedia training materials are a currently under-utilised option that could be accessed on CD/DVDs, smartphones and the internet, as well as through the Ministry of Health in Saudi Arabia's intranet, and are therefore accessible to all public service staff at any time, at no cost. Moreover, an evaluation of current cultural education practices across a range of health services could be productive given the concerns of both users and providers about current inadequacies in cultural education services. Further documentation and research on good practice in cultural education and its consequences could inform future developments in this area.

- The educational audit needs to focus on capturing the values and attitudes that are espoused within a unit/ward culture.



- A culture of excellence needs to be encouraged in all activities and practices.
- Resources to investigate incivility and negativity within nursing culture are needed.
- Further education for preceptors and management on the importance of empowerment in culture is needed.
- Preceptorship education programmes and clinical updates need to emphasise the importance of socialisation (demonstrating the importance of fostering self-worth, inclusion and belonging) in the clinical learning environment to new multicultural staff.
- Inclusion and belonging can be promoted through the provision of an inclusive and warm environment into which to welcome new multicultural staff. Spending time on induction for multicultural nursing is an investment into the new multicultural staff education and time spent with the new multicultural team reinforces the staff feeling of self-worth and belonging.
- Time spent by managers with nursing to reinforce feelings of self-worth and empowerment (provide feedback on progress, point out areas for improvement).
- Creative and critical thinking needs to be encouraged by means of a questioning approach from preceptors. Questioning tools and strategies should be implemented to promote critical and analytical thought processes in multicultural nursing.
- Teaching on dealing with rudeness in the workplace to include negative behaviours and promotion of assertiveness is required in GNO.

### **7.4.3 Health Service Delivery Care and Hospital Policy**

A key finding from the data and subsequent recommendations was that teamwork was needed to improve collaboration. Indeed, developing and implementing a standard set of behaviour policies and procedures is vital.

In KSA, it is of paramount importance that chief nurse directors, principal medical managers and hospital administrations cooperate on a team-based cultural and communication framework to work towards improving relationships between nurses from different ethnicities. Before

implementation, hospital administrations must make sure all employees are familiar with the existence, purpose and intent of the policies and procedures, for instance clear policy and guideline implementation regarding DNR and organ donation to prevent arguing and avoid personal and cultural judgment.

Moreover, training on policies and procedures should be implemented every four months for all hospital staff. Strategies should focus on building team collaboration as well as accentuating the importance of trust and respect as core cultural competents. Central to these teams should be the embedding of the findings on open communication, shared decision-making and feedback.

#### **7.4.4 Future Research**

As this study has created an augmented Model for Cultural Competence within a multicultural nursing workforce, further research to assess and improve the reliability and validity of this model in this and other settings is recommended.

The qualitative components of this study investigated the influence of barriers and facilitators on effective collaboration between multicultural nurses in a Saudi context from the perspective of multicultural and local nurses. One limitation was that only a qualitative interview was utilised to interview the nurses; for this reason

- Future research is recommended to explore quantitative data and policy review as well as patients' perspective on the barriers and facilitators of collaboration in this multicultural environment, where they encounter nurses from different cultural and linguistic backgrounds. The hospital policy is central because it is the first line and guidance for nurses from diverse backgrounds. Also, patients are care recipients and are in a position to judge the quality of care and express their feelings about effective collaboration.
- Future research is recommended to investigate different ethnic groups according to their experience and religion and cultural competence in any given setting, such as in a university faculty team or an educational organisation. The inclusion of the faculty member is essential because educators are dealing with colleagues and students from

different cultural and linguistic backgrounds; their cultural competence is vital to ensure effective education in collaboration skills.

- Further research instruments should be established with subscales designed to accommodate culture, religion and family practices. Moreover, these new inventions should measure and eliminate response bias.
- It also recommended to develop new self-administered competence surveys with critical subscales of gender, religion, culture and language to capture multicultural nurses' perspectives so as to measure nurse-nurse collaboration and explore current collaboration inefficacy across KSA hospitals.

## **7.5 Dissemination Plan**

It is important that the results of this research are widely disseminated. This should include the University of Salford, King Faisal Specialist Hospital and Research Center, King Fahd University Hospital, Imam Abdurrahman University in Dammam, the Saudi MOH, publication in nursing health and community journals, as well as international and national conferences.

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## **Appendices**

### **Appendix 1: Interview Guide**

#### **Demographic information**

Gender

Nationality

Ethnic group

Age

Level of education

Place of work

Experience (Years)

**The following themes from the Literature Review will guide the interviews:**

#### **Multi-cultural issues**

- *Nursing and Patient Care Relationships*

**Example: Could you describe to me what it is like to care for patients from other cultures?**

- *Different Cultural Norms*

**Are there times you notice colleagues doing things in different ways?**

- *Barriers to Communication*

**Could you give an example of where communication has been good, and where it has broken down?**

- *Attitudes towards Nurses and People from Different Cultural Backgrounds*

**For Saudi nurses: How do you feel about non-Saudi nurses working here?**

**For non-Saudi nurses: How do you think Saudi nurses feel about you working here?**

- *Additional questions drawn from Purnell's model for culture competence:*

1. *Overview/heritage*

**To what extent do you think that people's background affects how they behave in practice?**

2. *Communication*

**As literature review Q (see above)**

3. *Workforce issues*

*Are there times you notice colleagues doing things differently?*

4. *Workplace injustice*

**Tell me about times (you believe) ethnicity and racial origins (might have played a role in the way) colleagues' behave towards each other**

5. *High-risk behaviours*

**What type of behaviours do you consider to be high risk and have you had any experience of these when working with colleagues?**

6. *Nutrition*

**Could you tell me about times (you believe) colleagues have shared their own values about food with patients or other colleagues?**

7. *Pregnancy and childbearing practices*

**What type of behaviours do you consider to be taboo practices related to pregnancy, birthing, and postpartum treatment? And have you had any experience of these when working with colleagues?**

8. *Death rituals*

**Could you describe examples of how colleagues might have played a role in the way patients or other colleagues think about death and dying?**

9. *Spirituality*

**Tell me about any times you have noticed colleagues sharing their own values about spirituality with patients or colleagues?**

10. *Health care practices*

**Are there times you notice colleagues view things in different ways toward mental illness, chronicity, organ donation and transplantation, etc?**

*11. Health care practitioners*

**Could you tell me about times when colleagues' own values and experience might have played a role in the care of patients or in the medical practice of other colleagues?**

*12. Family roles and organization*

**Could you describe to me times when colleagues might have shared their own social status and views toward alternative lifestyles such as single parenting, etc. with patients or other colleagues?**

If the initial interviewees do not provide adequate responses, for example due to the sensitivity of the topic, I will reframe the topics in the interview guide as hypothetical scenarios.

## Appendix 2: Participant Consent Form (Interview)

**Title of study:** Working Effectively as Nurses in a Multi-Cultural Setting in Saudi Arabia: Barriers and Solutions.

**Name of Researcher:**

Rasha Alturki

1. 1. I confirm that I have read and understand the study information sheet version 1, 14.12.2015, for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected.
3. If I do decide to withdraw I understand that the information I have  to the point of withdrawal, may be used in the research. The timeframe for withdrawal is within a month of the interview.
4. I agree to participate by interview (and the interview being audio-recorded)
5. I understand that my personal details will be kept confidential and not



revealed to people outside the research team. [However,  
I am aware that if the research reveals illegal or harmful activity the researcher will have  
to share that information  
with the appropriate authorities]

6. I understand that my anonymised data will be used in the researcher's thesis/  
research report and other academic publications and conferences presentations.  Yes/No

7. I agree to take part in the study:  Yes/No

\_\_\_\_\_  
\_\_\_\_\_  
**Name of participant**                      **Date**                      **Signature**

\_\_\_\_\_  
\_\_\_\_\_  
**Name of person taking consent**                      **Date**                      **Signature**

## Appendix 3: Letter of Ethical Approval



Research, Innovation and Academic  
Engagement Ethical Approval Panel

Research Centres Support Team  
G0.3 Joule House  
University of Salford  
M5 4WT

T +44(0)161 295 2280

[www.salford.ac.uk/](http://www.salford.ac.uk/)

17 March 2016

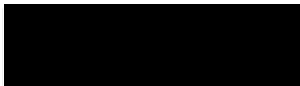
Dear Rasha,

**RE: ETHICS APPLICATION HSCR 15-128 – Working effectively as nurses in a multi-cultural setting in Saudi Arabia: barriers and solutions**

Based on the information you provided, I am pleased to inform you that your request to amend application HSCR15-128 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting [Health-ResearchEthics@salford.ac.uk](mailto:Health-ResearchEthics@salford.ac.uk)

Yours sincerely,



Sue McAndrew  
Chair of the Research Ethics Panel

## Appendix 4: Collaborative Research Agreement

**COLLABORATIVE RESEARCH AGREEMENT  
BETWEEN  
KING FAISAL SPECIALIST HOSPITAL & RESEARCH CENTRE (KFSH&RC)  
AND  
THE UNIVERSITY OF SAIFORD  
In connection with PhD of RASHA AL TURKI**

THIS AGREEMENT is entered into to specify the terms and conditions under which KING FAISAL SPECIALIST HOSPITAL AND RESEARCH CENTRE (hereinafter jointly referred to as 'KFSH&RC'), having an address at P.O. Box 3354, Riyadh, 11211 Saudi Arabia, and THE UNIVERSITY OF SAIFORD (hereinafter referred to as 'UoS'), having an address at The Old Fire Station, The Crescent, Saiford, Manchester, M15 4WT, will participate in the conduct of a PhD project which Rasha Al Turki (a student of UoS) (hereinafter referred to as 'Rasha') is undertaking which is entitled: "Working effectively as nurses in a multi-cultural setting in Saudi Arabia: barriers and solutions" (hereinafter referred to as 'Project').

### I. BACKGROUND:

Rasha wishes to collect data from KFSh&RC's nursing staff, through non-intrusive interviews and questionnaires, for the purpose of her Project. All use and publication of the data which is collected will be anonymised.

### II. STATEMENT OF WORK:

KFSh&RC undertakes to find nursing staff who are willing to participate in interviews and questionnaires and to give Rasha access to them within suitable space at KFSh&RC's premises for data collection purposes (referred to below as "RESEARCH PROGRAM"). Rasha will obtain the informed consent of participants for their data to be collected.

### III. PERIOD OF PERFORMANCE:

The duration of the RESEARCH PROGRAM is expected to be [12] months which will only start following review and approval by UoS' Research Ethics Panel and KFSh&RC's relevant Institutional Research Review Committee.

### IV. TOTAL ESTIMATED COSTS:

No cost or expense is expected to be incurred by KFSh&RC in undertaking the RESEARCH PROGRAM. In the unlikely event that either KFSh&RC or UoS incurs any cost or expense, then this is intended to be and remain its sole responsibility. Rasha is sponsored by the Kingdom of Saudi Arabia for the collection of data.

DATA  
2

REVISED 2010/11/14  
KFSH&RC/University of Saiford

## Appendix 5: Approval Letter to Conduct Research



مستشفى الملك فيصل التخصصي ومركز الأبحاث  
King Faisal Specialist Hospital & Research Centre  
مؤسسة عامة، Gen. Org.

Office of Research Affairs  
☎ 32939 ☎ 27894 ☒ MBC 03  
INTERNAL MEMORANDUM

TO: Rasha AlTurki, PhD candidate  
email: altrurkisha@hotmail.com

DATE: 07 Jumada Al Thani 1437  
16 March 2016

Marinha Sofia Macedo, RN, BSN, PG, MSc IIBHC ©  
Nursing Research Senior Specialist  
Nursing Development Saudization Department

[REDACTED]

FROM: Anmar Al Kawi, MD  
Deputy Chairman, Research Ethics Committee  
Office of Research Affairs

REF: ORA/0601/37

SUBJECT: Project # 2161 041  
Working Effectively as Nurses in a Multi-Cultural Setting in Saudi Arabia: Barriers and Solutions

Further to ORA's email (dated 25 February 2016), your reply/ revised proposal and the participant information sheet (received on 09 March 2016) were reviewed by the Research Ethics Committee (REC) on 13 March 2016. It is my pleasure to inform you that the REC has recommended the revised proposal, questionnaire, participant information sheet and waiver of signed consent form for approval as submitted; and I would like to take this opportunity to congratulate you on behalf of the Research Advisory Council.

However, the committee would like to remind you to keep copy of all the Questionnaires and the participant information sheet (confidential) with you in case needed for outcomes or RAC/ORA review.

Please be informed that in conducting this proposal, the Investigators are required to abide by the rules and regulations of the Government of Saudi Arabia, KFSH&RC, and the RAC. Further, you are required to submit a Progress/ Final Report by 13 February 2017; so it can be reviewed by the REC without lapse of approval. The approval of this proposal will automatically be suspended 13 March 2017, pending the acceptance of the Report. You also need to notify the ORA as soon as possible in the case of any amendments to the project, termination of the study, any event or new information that may affect the benefit/risk ratio of the proposal. Further, the Committee would like to remind you that the process of obtaining the Verbal Consent should be documented in the Investigator file of enrolled subjects. This should clearly specify:

1. The research subject' acceptance to participate in the study;
2. The project's RAC number;
3. The date the verbal consent was obtained;
4. The name and signature of the principal investigator/ delegate.

## **Appendix 6: Letter to Specialist Hospital’s Local Research Supervisor**

Dear xxx,

I am a PhD candidate at the University of Salford in the United Kingdom. The title of my study is “Working Effectively as Nurses in a Multi-Cultural Setting in Saudi Arabia: Barriers and Solutions.” The aim is to better understand the issues contributing to an effective multi-cultural workforce and I plan to collect data through interviews. I have permission to conduct the research at Specialist Hospital. I am writing to you to determine your willingness in helping to select appropriate candidates for interviews: nursing staff, the Head of Nursing, and nurse managers. The research will involve a maximum number of 20 participants for interviews. Participants will be asked to sign a consent form giving their agreement to take part (prior to commencement of the interviews).

Participants will be selected according to the following inclusion criteria:

- Saudi and non-Saudi nurses with one year’s nursing experience or more.
- Nurses of different ages, education levels, positions, ethnicities, faiths, and genders.
- Speaks the English language.

The interviews will be recorded. Information from the participants will be handled confidentially. No names will appear in any place in the study. Anonymity and confidentiality of the participants will be safeguarded at all times.

I hope that the findings of this proposed study will benefit not only practising nurses but also the future nursing workforce.

I have enclosed a copy of a participant information sheet to be distributed (eventually) to the selected candidates.

If you require any further information regarding any aspect of the study, please do not hesitate to contact me as follows:

Rasha Alturki

PhD candidate

School of Nursing, Midwifery, Social Work & Social Sciences

University of Salford, Salford, Greater Manchester, United Kingdom

M6 6PU

UK

[r.a.al-turki@edu.salford.ac.uk](mailto:r.a.al-turki@edu.salford.ac.uk)

Alternatively, you can contact my supervisors:

Nick Hardiker RN PhD FACMI

Professor of Nursing and Health Informatics | Associate Dean (Research & Innovation)

School of Nursing, Midwifery, Social Work & Social Sciences

MS1.12, Mary Seacole Building, University of Salford, Salford M6 6PU

**t:** +44 (0) 161 295 7013

[n.r.hardiker@salford.ac.uk](mailto:n.r.hardiker@salford.ac.uk)

I look forward to hearing from you in the near future.

Yours faithfully,

Rasha Alturki

PhD candidate

School of Nursing, Midwifery, Social Work & Social Sciences

University of Salford, Salford, Greater Manchester, United Kingdom

M6 6PU

UK

r.a.al-turki@edu.salford.ac.uk

## **Appendix 7: Participant Information Sheet**

**Title of study:** Working Effectively as Nurses in a Multi-Cultural Setting in Saudi Arabia: Barriers and Solutions.

**Name of Researcher:** Rasha ALturki

I am currently undertaking a research study for my PhD in Nursing at the University of Salford. I would like to invite you to be part of my research study by participating in individual interviews. Ethical approval has been obtained from the University of Salford. It is important that you understand the purpose of the research and your role as a participant. Please ask any questions if any part of the information seems unclear to you. Finally, it is your decision whether or not to be part of the study.

### **What is the purpose of the study?**

The aim of this study is to identify the factors that promote or impair effective collaborative work in a highly multi-cultural healthcare setting.

### **Why have I been invited to take part?**

The main reason for including you in this research is because you have knowledge and experience about nursing in a multi-cultural environment in Saudi Arabia.



### **Do I have to take part?**

Whether to participate in this study is up to you. This information sheet will provide all the details you need to help you make this decision and you can contact me if you have any questions about this research. You are free to withdraw at any point while taking part in the study without any penalty.

### **What will happen to me if I take part?**

- You will be asked to sign a consent form prior to the face-to-face interview.
- The interview will explore your knowledge and experience about effective and ineffective collaborative work. The purpose of the interview is to investigate the factors (facilitators and barriers) affecting multi-cultural collaborative work in a Saudi hospital.
- The length of the interview will vary depending on the amount of detail you would like to offer in response to the questions asked. However, the interview should take approximately 30-60 minutes.
- The interview will be confidential and will take place in a quiet and private place in Specialist Hospital, during working hours.
- The interview will be audio recorded, transcribed, and stored digitally. The study will have two forms of data: hard copy and soft copy. Hard copy data (papers) will be kept in a locked locker. Only the researcher will have a key. No one will be authorised to use it except by the researcher. The soft copy data (digital data) will be secured on a password protected encrypted external hard disk. It will be connected only to the researcher's private laptop. Only the researcher will be able to access the saved study data.

### **Expenses and payments?**

There will be no expenses or payment for this research.

### **What are the possible disadvantages and risks of taking part?**

There are no personal risks associated with participation in the study.

Any sensitive issues, such as suspected poor practice, will be raised as necessary through appropriate channels.

If an interviewee discloses illegal or harmful practices or a serious concern about another member of staff the researcher in accordance with their professional code of conduct will talk to the participant individually about the issue, encouraging them to report it as necessary. Depending on the severity of the practice, the researcher will contact the Chair of the Nursing Department to draw their attention to the issue and provide sufficient information to enable them to deal with it effectively. Only in severe cases where the Chair of the Nursing Department is unable to deal with the issue without identification will the participant's name be disclosed.

### **What are the possible benefits of taking part?**

We cannot promise the study will help you personally, but the information that we obtain from the study will help identify factors that promote or impair effective collaborative work in a highly multi-cultural healthcare setting.

### **What if there is a problem?**

In the first instance please contact my supervisors: Nick Hardiker RN PhD FACMI  
Professor of Nursing and Health Informatics | Associate Dean (Research & Innovation)  
School of Nursing, Midwifery, Social Work & Social Sciences  
MS1.12, Mary Seacole Building, University of Salford, Salford M6 6PU  
t: +44 (0) 161 295 7013  
n.r.hardiker@salford.ac.uk

If you remain dissatisfied please contact, *Anish Kurien, Research Centres Manager, G.08 Joule House Acton Square, University of Salford, M5 4WT*  
[a.kurien@salford.ac.uk](mailto:a.kurien@salford.ac.uk) 0161 295 5276

### **Will my taking part in the study be kept confidential?**

The information that you provide will be treated as confidential. No names will appear in the study. Your identity and personal contact details will be known only to the researcher, the research assistants, and the research supervisors at the University of Salford. The researcher will use a code to replace your name. No information that could reveal your identity will be used in this or in any future research study, publication, conference, or teaching session. To guarantee confidentiality, all data will be stored in a secure, locked locker or on an external hard disk protected by a password and data encryption at the researcher's office during the study. Storage and destruction of your data will be undertaken in accordance with the University of Salford's data management policy.

### **What will happen if I don't carry on with the study?**

As mentioned previously, you have the right to withdraw from the study at any point without prejudice. This will not affect your employment in any way. If you withdraw from the study, all of the information and data that will have been collected from you will be destroyed.

If you decide to withdraw from the study please contact the researcher within a month of your interview.

### **What will happen to the results of the research study?**

The results of the interviews will be used to develop a questionnaire that will be used in the second part of this study.

### **Who is organising or sponsoring the research?**

The University of Salford, UK.

*Thank you for taking the time to read this leaflet.*

If there are any further questions regarding this study, you can contact me (by phone or email).

**Contact Details****Researcher**

Rasha Alturki

PhD candidate

School of Nursing, Midwifery, Social Work & Social Sciences

University of Salford, Salford, Greater Manchester, United Kingdom

M6 6PU

[r.a.al-turki@edu.salford.ac.uk](mailto:r.a.al-turki@edu.salford.ac.uk)

## Appendix 8: Participants Quotes

<b><i>Theme 1: Overview/heritage</i></b>
<b><i>Reasons for Working in Saudi Arabia and Associated Economic Factors</i></b>
Participant 2 noted the perfect geographic location of the KSA that will attract western nurses to work there:  <i>“Most Western nurses come here because Saudi Arabia is the perfect place to travel from because you're in the middle of all the big places to go.” (Participant 2)</i>
Participant 1 indicated the Saudi system’s financial benefits to expatriate workers:  <i>“I know people, and they came to work here to prepare for their retirement because of the money they can make here” (Participant 1)</i>
Saudi participant highlights Saudi nurses’ passion for working and improving the place, unlike others who came only for money:  <i>“The Saudi nurse they want to improve the place they give to heart, unlike the others who came for money only.” (Participant 17)</i>

### ***Theme 2: Acculturation (Adjustment to the New Cultural Environment)***

<b><i>Adaptation Process</i></b>
One participant explains the adaptation to new culture and self-transformation and gains from these changes:  <i>“I'm different there, and I'm different here. I just change how I transform myself because when I come here, I'm more updated with things.” (Participant 4)</i>
One participant, as part of the adjustment to the new workplace culture in a Saudi hospital, modified her Asian cultural food habit:

*"I like some fishy smelling and all that, and we Asians we love to eat fish. In that part, we have to modify it a bit. You know what? Maybe you don't bring fishy food." (Participant 9)*

It was suggested that moving nurses to other areas that match their skills is needed occasionally for the sake of better integration:

*"If a person is coming for a different reason and they are not able to merge themselves to the work they should not be in the area where they are. We have to find an area matching them because, in the end, they will not be satisfied. Also, they will not satisfy the people around them, and then it will harm the patient." (Participant 6)*

### **Education**

Participant 12 explains the preceptorship programme provided by the hospital for all new staff to facilitate their adjustment to the new work environment:

*"If you're new, we have this preceptorship... she's going to guide you. You're going to buddy with her. ... What do you usually do in the unit on an everyday basis." (Participant 12)*

Participant 3 explains how the preceptors' personality can have a significant influence in orientation:

*"Depends on who you get as a preceptor as well. Who is going to show you around? Who's going to show you how to do this and that? I think that also matters as well." (Participant 3)*

Moreover, participant 3 highlights the lack of management and organisational support behind the inadequate education delivered to new staff:

*"It doesn't come from my colleagues. It comes from the management and the educators, and the ones who are preparing you to be on that unit. They should know that you're able, you're capable of doing this." (Participant 3)*

### **Theme 3: Communication**

#### **Language Barriers**

The participant explains how different accents and the use of unknown and unnecessary abbreviations between different ethnic groups can

provide barriers to communication and impact care:

*"I think with us mostly it's communication, accents, and trying to understand what the person is saying in their accent. Something that will take like 5 minutes drags on to 10 minutes. You cannot accept a patient and say, "Okay. Fine, bring the patient over," and you didn't understand the wording what the other person was saying, people abbreviate a lot here even if it's not necessary" (Participant 7)*

One participant explains that different languages will lead to clashes between nurses from diverse ethnic groups:

*"Sometimes we do have clashes. People talk in their language, and you don't understand" (Participant 7)*

Participant 11 noted that although staff are advised several times to standardise their language, staff from different ethnic groups still insist on using different languages in one unit and are resistant to change:

*"Even though we have discussed it many times that English should be the language spoken on the unit, there is a lot of different languages spoken, so I'm not sure if anything is being said in one language about another" (Participant 11)*

One participant indicated a sense of social isolation resulting from language barriers with colleagues from different ethnic groups:

*"I feel like we are over, outnumbered. Every time people are talking in their different language, and we are sitting there with them, speaking, and it's not like they are rude, I feel left out most of the time. I can't even come here for a break I like to go out because I feel like if I'm here, they're going to have to compromise now and not feel comfortable in speaking English." (Participant 7)*

Participant 14 illustrates the social isolation and personal barriers from learning 'hospital Arabic', as it will not work in a social situation with someone from the Saudi ethnic group:

*"Then when you get into a social situation, it's completely different because I would say [ana atklm mostashfa Arabic]. I speak hospital Arabic." (Participant 14)*

***Expression and Interpretation***



Participant 11 stated that sense of humour differs between different cultures and meaning may be lost in translation and interpretation, which leads to insulting attitudes or feelings:

*“Lost in translation. My sense of humour might not be your sense of humour. You might not have a sense of humour as I understand humour, so you could offend somebody while you're actually just trying to have a bit of fun.”(Participant 11)*

Participant 12 describes how the expression and tone of voice differs between nationalities and affects communication; sometimes they appear rude because of cultural differences in interpretation:

*“In my opinion, for the Filipinos, we speak soft... nicely. We manage the tone. When you hear Saudis speak like males, they sound angry. They are like shouting on you like, “Blah, blah,” but for them, it is normal. I respect that one. Some of them also, they are angry as well, or they are rude. The tone of the voice, for me, is my ear is sensitive with that one like if shouting at me. ” (Participant 12)*

Participant 7 added that cultural knowledge and knowing the background of another ethnic group would make sense of his/her communication style and way of expression so as to overcome misunderstanding:

*“Westerners are more out loud and outspoken. The other countries, India, are much more quieter. You get to know people.” (Participant 7)*

### ***Communication Style***

Here participant 14 appeared to avoid speaking directly as a communication style with Arabs and colleagues from other ethnicities so as to overcome the communication conflict:

*“I would have to stop and instead of just being able to ask them I would think, “Okay, how can I phrase this so that they won't feel threatened and they'll listen to me? Which I found really, really challenging.” (Participant 14)*

Participant 2 noted the resistance to acknowledged changes in practice by Arab men and the need to use a smart communication style to get them on board because they do not like being challenged:

*“Jordanian men are the bane of my existence ... A couple of Lebanese ones as well because they don't like to challenge.*

*They've done these things the way they've always done them, and you come along and say, "Well, actually, you should be doing it this way." ... it's still very hard for them to acknowledge, ... You have to be very smart about how you get them on board. They can be very difficult. Either I intervene and say from a policy, procedure, education point of view, ... or I escalate it to the management, and I say, commander, you need to go down and have a word with [Ameen] or whoever. ...When your management is predominantly Arab men, it's very hard because they don't like to come in and do that." (Participant 2)*

Another concern about the organisations' communication policy style arises from the hospital, as management hierarchy communication is through a chain of command, which is frustrating for staff, as it is not easy to speak to higher management directly:

*"Communication through channels sometimes it's bad and frustrating, for example, if the staff have requested and this request refused by admin, when the staff want to speak direct to them about it they will refuse."(Participant 16)*

### ***Strategies for Good Communication***

Participant 2 explains the communication mechanism with technology:

*"Come out of these negative events ...this patient passing away and other issues with regards to communication. These are the steps that introduced. The idea is when you hand over a patient if you're doing over the phone, both of you can have that record open. ... We call it the SBAR. So we have implemented a paper transfer form between the two areas, which will go live as an electronic form. The nurses will both have to sign. ...That handover has to be done appropriately." (Participant 2)*

There were some organisational policy changes implemented to improve communication between colleagues and patients as well during handover to improve communication:

*"We changed our handover process from doing a roundtable first thing in the morning to doing a one-on-one with the nurse at the bedside, visually seeing the patient that you're discussing. That, I think, was a great example of how that communication is working well. You got to involve the patient as well if they were awake, of course. " (Participant 2)*

Participant 13 noted the importance of meeting with higher administration to listen to them, as these meetings existed before, but were gradually phased out:

*"I also think the higher people, they have to do annual meetings with us, listening to us, if they care about us, to ask us about*

*our needs and us. It happened for a while. I cannot say to lie about it. It happened for a while that some of the higher people come and doing annual meetings with us. Those meetings gradually decreased and decreased until they vanished." (Participant 13)*

**Theme 4: Family Role and Organisation**

**Head of Household**

According to one participant, family usually interfere with the patient care:

*"The patients' relatives. They try to interfere with our practice in that way." (Participant 4)*

Participant 7 explained the organisational strategy for the patient's family and the need to please the family all the time as part of care, lest the nurse be changed:

*"There's much family oriented; we have to please the family most of the time like with the nurses that get changed for just to appease the family." (Participant 7)*

**Alternative Lifestyles**

Participant shared incident with non-Saudi staff having a relationship with one of the non-Saudi doctors, which was considered to be breaking cultural rules, so she stopped her:

*"I saw Filipino staff with a doctor in the isolation room, and there was something between them, I spoke to the doctor I told him you should respect the place, then I talked to the nurse, and she started to cry and say sorry I will not do that again. I did not report this issue, and I told her you could do this outside the hospital" (Participant 17)*

Participant 6 noted that any illegal relations between different peoples are not accepted, and they will not allow them to stay in the hospital:

*"Relation between different people without following the proper way, it's not acceptable here we will not allow them to stay" (Participant 6)*

Participant 1 stated that the risk of an illegal alternative lifestyle provides a reason for the organisation not to re-contract one member of staff because her son was known to be homosexual:

*"She has a son that not only he's gay or he's androgynous, and he has this different way of life, and of course, they're going to associate with her. You know how here, everyone ... you are associated to your tribe that. It's even worse if it's your son. Here, you have to have a reason to be fired, but you don't have to have a reason not to be re-contracted." (Participant 1)*

This participant's statement provides an example of the way in which a lifestyle that is illegal in the Saudi system can threaten the staff member's position within a Saudi hospital. Participant 12 describes how his soft features caused him to be questioned by the Saudi embassy. Being gay is illegal in Saudi Arabia, but the questioning caused him offence, as the participant stated:

*"I have soft features. In my passport, I think have just really red lips because of maybe the picture, so they thought I was gay maybe. That's the reason the agency told me, "The Saudi Embassy wants to see you, talk to you, and ask some questions." I said, "Why? What's the reason?" "Maybe they think you're gay. Based on the picture, you look like actually a girlish." I said ... that's not a compliment." (Participant 12)*

Additionally, participant 14 explained the risk of being arrested by Saudi police if he was reported for being gay:

*"I have a friend who's gay; I don't think he would talk about being gay because it's illegal here. It would get him arrested." (Participant 14)*

### ***Individualistic Versus Collectivistic***

Participant 8 indicated that it is normal to support a person from one's own culture:

*"The issue sometimes with the country, we will support our country custom. I'll give you an example like you are living in England, and you are Saudi. If you travel other Saudi ladies work in the university, you will support each other. That's what ... Not be, like against other people, but people who will be supporting people will support each other, and this is normal."* (Participant 8)

### ***Theme 5: Workforce Attitudes and Behaviours***

#### ***Professional Attitude***

Participant 2 noted that the influence of social values and views of nursing as a career in the UK are high unlike in Saudi Arabia, and that leads to a strong expectation of nurse professionalism:

*" There is an expectation of professionalism that driven high. We're very proud to be nurses in the UK. Society wise held in quite a high place, which is nice. We feel like we make sure we don't do anything to bring a negative aspect onto that. The Saudis are not always the same, but to be honest with you that has changed even over the four-and-a-half years I've been here. The differences in the nurses that come through in comparison to when I arrived to the nurses I work with and see now, especially the girls who are getting more and more which is great"* (Participant 2)

A lack of compassion in work can affect colleagues working together or caring for patients. Participant 14 indicated that some staff lack compassion with patient care:

<p><i>"Well looking after patients but not caring for them. There was a missing piece of compassion with them" (Participant 14)</i></p>
<p>Participant 11 indicated that the lack of compassion from colleagues affects the real meaning of nursing as a job:</p> <p><i>"I think to recognise when people are at the end of their life, and for people to be better nurse advocates. I am not saying that I am a great nurse advocate, but I am just saying from what I see that your job needs to do with a bit more compassion. It is not a job because it is paying a wage. It is a job, and it is a very hard job if you want to do it well." (Participant 11)</i></p>
<p>Participant 3 explain the cultural stereotyping attitude about some is high risk and can affect communication:</p> <p><i>"High-risk behaviour would be failing to communicate because you have misconceptions or you have stereotypes about someone, or you don't want to talk to them because of their nationality may be. That could be high risk. I guess that could be one thing between different cultures." (Participant 3)</i></p>
<p>Participant 14 noted a stereotypical view about western culture with bad values:</p> <p><i>"I remember we had a director of nursing and she became quite close to the guy who used to manage our departments in here. because the view can be skewed, I've heard people say, "Oh, I don't want to take my kids to the west because you know just the values are so bad." (Participant 14)</i></p>
<p>Participant 13 also illustrates the issue of stereotyping the nurse's background in work relations and practice:</p> <p><i>"Like the Filipino people, they are very respectful people. I love them, although a lot of people see them in the lower level from them, just Filipinos. No, they are very respectable people, very neat people, and very clean people, even with the patient. Like if we compare it to another nationality, say India when you see those nationalities with the patients, there's a huge difference between the patient cares, so it's a little bit affecting the culture." (Participant 13)</i></p>

**Theme 6: Nutrition**

<p><b>Meaning of Food</b></p> <p>Participant 7 explains the significance of food in a multicultural environment for celebration and getting to know people:</p> <p><i>"Food plays a big role here we always eat. We always having [ma alsalama] party we always have things. We get to eat and</i></p>
--

*get to enjoy each other's food. It's a nice thing because you get to know people and you get to know their different taste. Some of the food is nice some of it is bad, but we all laugh about it. Food plays a major part. Yes.” (Participant 7)*

### **Common Foods and Food Rituals**

Also, one Saudi participant expressed a lack of sensitivity toward others’ cultural food:

*“Sometimes am telling them to eat away in the cafeteria because their food is smelly” (Participant 17)*

### **Theme 7: Pregnancy and Childbearing Practice**

Participant 1 noted that the Saudi organisation is influenced by cultural beliefs and this may sometimes jeopardise patient care, as the pregnancy test is considered taboo for the non-married woman. This cultural difference can lead to conflicts in the workplace:

*“Of course, there's a lot of safety that it goes on jeopardy here. You might not be married, but the chances you can be pregnant are ... anyone can be. It's a taboo because they don't talk about it. It's a big thing. I've seen people going into trouble being called to their office manager because she's done a pregnancy test into a woman and she wasn't married. The nurse didn't understand that... a big taboo about that.” (Participant 1)*

Moreover, participant 18 showed her respect towards a colleague with an illegal pregnancy, even though it was against her beliefs:

*“We do have pregnancy out of the frame of marriage not much but we came across, and they want to terminate the pregnancy which not accepted in Islam. but still we deal with them in a highly professional way, and everybody treats her with respect, and she went to her country to miscarriage, and till now she is working she got married, and she has four children now.” (Participant 18)*

### **Theme 8: Death Rituals**

#### **Death Rituals and Expectation**

Participant 6 noted the staff acknowledgement to Saudi Muslim culture and the patient's family's cultural and religious needs regarding death and difficult times:

*"If their family they want to give the Quran beside the patient during this difficult time. Someone to pray for them also we allow them to stay with them. Also after the visiting hours to be close to their loved"* (Participant 6)

Also, participant 6 explained the courses provided by the hospital to new staff concerning death and dying and how to deal with the family in Saudi culture:

*"Usually here in the hospital we do specific courses for Death and dying to make the staff is ready how to communicate with the family, how to make the family ready."* (Participant 6)

### ***Responses to Death***

Saudi participant explained the neglect of dying patients without a proper hospital policy:

*"Chronic patients did not attend really just routine care even medication not given on time. Usually, they are dying or something."* (Participant 17)

One participant suggests that the hospital is full of brain-dead patients, but because of the religious and cultural influences on the hospital policy, they do not do anything to them:

*"I mean the hospital itself has lots of patients who are kept alive for years when they are brain dead, but they don't flip the switch because of the whole process of they can't see as doing anything that's going to end somebody's life, culturally or religiously"* (Participant 2)

## ***Theme 9: Spirituality***

### ***Religious Practice and Use of Prayer***



Participant 12 explained the importance of respect and acknowledging Muslim patients' religious practices and values:

*"The patients here are really having their salat (praying) time with their religion and everything. Here, they're more really conscious of their religion, so they have to follow whatever it is that they need to do and all the things like ... Ramadan and everything with the holidays, so that's a big difference, I think. All in general, they're different cultures. You just have to know and respect them. In nursing, we have this respect in religion and different cultures, so I'm used to it already though."* (Participant 12)

Participant 14 noted that Muslim patients' strong faith and belief led them to grieve differently and accept loss. This is different from the home culture and heavily influenced by religion:

*"I think it was the first time I really was impacted by how the strength of your faith can ... I'm so used to grief and the stages of grief. I thought now, will she have the same stages of grief, will there be the anger and the bargaining and the ... Is it because she had time to work through that before this baby was born or is it just because her faith is so strong and her belief is so strong that she truly believes this was God's plan for her and it was God's will that this baby not survive."* (Participant 14)

On the other hand, patients and families impose their religious values on non-Muslim staff:

*"Patients and family do. They do openly tell non-Muslim nurses, "Just get into Islam." My Muslim nurses who don't wear a headscarf, "Why don't you wear a headscarf." Patients and family does."* (Participant 9)

*"I think patients, yes, they have been talking about the spirituality even for non-Muslim they give you a Quran to read and all these things."* (Participant 4)

Participant 14 described that in Saudi culture everything in life is firmly connected to faith, even law and business, unlike in western cultures, and therefore this could make it difficult for Saudis to accept and understand those who have no beliefs:

*"I think they had a hard time with people that have no belief system or have nothing to frame their lives around because of the faith ... Whereas in Canada, church and State separated. You can belong to any faith; these are the rules of the country. What I found when I came here were your faith and your laws and everything so strongly intertwined that your life is about your faith. The way you live, the way you conduct yourself in business, the way you conduct yourself, it's not governed by governmental laws, it's governed by the laws of the faith. And so there is a much stronger link so I would assume, I don't*

*know, that if you asked a westerner and they said, "I don't believe in anything". Where do you get your guidance from? Where does that come from?" (Participant 14)*

Similarly, participants suggested that Muslim nurses use praying as an excuse for long breaks, to avoid working and forget their patients:

*"The only thing maybe is when they go to salat (pray) when they go for their break. Pretty much that's it. Here in critical care, so you need to stay at the bedside, but sometimes they go. They're not going to ... like they go on break, pray; they take longer, and sometimes they forget the patients. It's not really Saudi but Muslims in general. That's the most thing, I think, the most taboo part because if you're in the hospital, the patient first. You're taking care of life I know ... but you cannot subside religion as well." (Participant 12)*

However participant 6 highlighted the importance of non-Muslim groups acknowledging the Islamic cultural and religious needs and practice:

*"They have to respect the culture here. You cannot, for example, meet in a public area. If we are not fasting, we have ... Also mistaking they come in front of Muslim staff not they drink, or they something and mistaking and they have to apologise for that. They not allowed to drink, they are not allowed to eat in front of Muslim people. Also, they have to able Muslim to go for their prayer, also when they go to break their fasting" (Participant 6)*

## ***Theme 10: Healthcare Practices***

### ***Healthcare Practices from the Country of Origin***

One participant indicated that the high tech care in Saudi Arabia is different from back home:

*"They get more technology here. More technology we need to learn. It's different" (Participant 4)*

Furthermore, Participant 1 indicated that the hospital can overcome this discrepancy by having a culture of following the policy regardless of experience and background:

*"It's the feeling of "we know that we learned it this way at home." This is when we decide to have policies, and we are practising on making people comply with it... We have the culture of following the policy here. so, there's not a big room to discuss; we should do it this way or that way because of their nationality or their background because if the policy says it*

*this way, this is how we have to do it regardless where I come from or where you come from.”(Participant 1)*

Another participant explains the different standard of care between this Saudi hospital and the practice back home, and refers to this practice as good:

*“We came from a complicated background. We came from bad practice to reach this good practice. We came from really like daily hard work job to reach this one.” (Participant 5)*

### ***Standards of Care***

Saudi participant suggested that some Asian ethnic groups have an unclean or different standard of care and do not follow the hospital policy:

*“Some nurses like Indian came from the dirty culture they don't wash their hand after cleaning baby stool; some nurses will not do positioning for ICU patients” (Participant 16)*

Moreover, another participant from a different background views standards of care regarding patient safety in this hospital as lacking, and that there is more concern about documentation rather than patient care:

*“We do not pay attention, I have noticed, here. We are not using the sterile technique as much as we should... Just in general, a lot of it had to do with people being on monitors. This patient has so-and-so; they should be on a monitor... everyone is freaking out about the papers...Stuff like that. Just different standards of care, standards in general, were just missed.” (Participant 3)*

### ***Blood Transfusion and Organ Donation***

Saudi participant explains the belief of organ donation as a good Muslim to help others:

*“I believe in organ donation, and I signed the consent, and we have a campaign about that, as Muslim, it is considering the as good point to help others.” (Participant 18)*

The same participant who believed in organ donation explains the conflict with a colleague not believing in organ donation and not following

the hospital policy:

*"Organ donation not all the doctor and nurses believe. there was one case was fit for organ donation, and the doctor did not believe in organ donation he was Muslim non-Saudi, and I told him we have the policy to follow, but he was insisting not to carry on then I contact the unit director who spoke to him and change his mind!" (Participant 18)*

Another participant shows that unclear policy affects the decision of DNR patients because the family does not accept the organ donation, and there is no clear policy about DNR as patients are neglected but medication is still given.

*"DNR patients they will neglect them they will give feeding and medication, but they will not do positioning to them! Still, organ donation not accepted by the family." (Participant 16)*

Also, one participant explains the importance of public education and awareness about organ donation and the hospital role in supporting that:

*"We have a mobile bus that is trying to reach out to the universities. Go to the campuses, Princess Nora, King Saud, and drive donation. These are educated young people, and if you get them now when they understand what we are doing and why we are doing it, then it will proliferate, and they will continue to donate and share that for years and years and years. Then you have more of a sustainable force coming through." (Participant 2)*

### ***Experience & Seniority Practice***

Participant 6 suggests that senior staff are resistant to changes in policy and procedures and this will affect the whole practice:

*"You find those people they are resistant to change their practice. Certain people, they are having a negative response with a bad attitude. They don't implement, and then it harms everyone in the unit. It will not aim to reach the goal that we need in the unit." (Participant 6)*

Moreover, participant 2 explains the lack of organisational action and transparency to deal with incidents:

*"The thing is if they do this and no one finds out then nothing happens. Then if they do this and someone finds out and an SRS, which is our reporting system, SRS goes in, then the management have to follow it up. Still, we don't see what happens to that nurse. I have no idea because this is the thing. It's not then brought up by the management openly to be discussed."*

*(Participant 2)*

Participant 12 explains that practice in this hospital is based on evidence rather than based on staff experience, which is different from the home country:

*Here, it's continuous education." Unlike in the Philippines, you know things; you experience them then they're going to pass it with some other generation of new staff nurses because not every time you experience things. Unlike here, we change now and then. We have like, "Okay, this month, we're going to change like this. From last year, last month, this is how we do it, but from the studied research we had for this, we already pass, and everything so we're going to change it." (Participant 12)*

***Cultural Responses to Health and Illness: Mental Illness***

Participant 2 explained the patient with depression will try to pray instead of seeking treatment, as depression is culturally considered a sign of weakness:

*“Some patients you see a fight in the acknowledgement of depression because they feel it's a sign of weakness and the fact that they need just to try and stay strong. You'll find they'll pray excessively, things like that to try and relieve the fact that they feel depressed. They could turn around and say to you, I'm depressed, but they know that something is wrong or not right. Yeah. I think our biggest stumbling block is getting doctors aware and not being scared to prescribe somebody something or at least to get a psych evaluation done. It's not that you're crazy. It's just that right now you're sad because of what's happening to you.” (Participant 2)*

In their accounts of the patients' suicide events surrounding mental illness issues, the hospital identified a psychological assessment tool for the nurses to implement:

*“We've had a couple of instances of suicides with patients who should have been identified as being at risk. Now we have a psychological assessment tool for the nurses to carry out to try and raise the alarm bells sooner than okay, this behaviour isn't normal.” (Participant 12)*

**Theme 11: Healthcare Practitioners**

**Status of Healthcare Provider**

One participant noted from the base of a dominant male culture that the concept, and environmental interactions with male and female staff, could all lead to conflict between staff and standard of care:

*"Then you add in a Saudi or a Saudi manager or Jordanian assistant manager, a Saudi assistant manager, and you add in ten or twelve Western female nurses, and you will see fireworks. These are Western female nurses who know what they're doing. They know how it needs to do. They know what is right. They know what is wrong. They know the standard at which they should be working too. That often clashes with the fact that maybe the assistant manager, even the manager clinically don't know really what's going on; don't know the standards that should be set." (Participant 2)*

According to participant 11, the relation between western nurses and doctors is different, and doctors usually lessen to westerns opinions because they are more proactive with advocacy, and assertiveness:

*"I don't know if doctors take Westerner's opinions more than non-Westerners, but Westerners do speak up more often. so is that why they listen to Westerners more because we speak up more because I have heard other nationalities speak every now and again, not often, and when they do they're heard, too, because what they say makes sense. "Let's do this for the patient, and why are we not doing that for the patient?" but we need to be more proactive with our advocacy, and our assertiveness." (Participant 11)*

In this regard, participant 11 noted the cultural issue behind the lack of speaking up and the need to improve it, otherwise the doctors would continue expecting nurses to follow them for anything:

*"It's a cultural thing that goes way back. They're afraid to speak up, so that needs to be improved. If that's not improved then, the doctors will continue to sort of say let's do A, B, C, and D, and you might say well she's notable for C and D today because of certain things." (Participant 11)*

Participants noted that forcing others to respect her by virtue of a strong, assertive personality and a standing up attitude toward abusive and bullying physician colleagues and patients caused them to appreciate and stop abusing:

*"There was a shift in our relationship, and I wouldn't say respectful, but he could be pushy and abusive and bullying with the other nurses, but I guess because I stood up to him regarding this issue, I didn't experience that." (Participant 14)*

*"They treat nurses like maids sometimes here. Then, it gets to be a strong Western nurse to say, "You don't treat me like that. This is not the way." (Participant 1)*

Moreover, participant 1 noted the conflict between colleagues if the nurse follows the physician and not the policy:

*"The physician said to the nurse to do something that is not by the policy and then you do it because you would just follow what the physician says. And then your colleague will come, or your charge nurse will come and will get in conflict with you because you shouldn't have done that because that's how it says in the policy." (Participant 1)*

Furthermore, participant 2 explains the hospital's lack of standard system policy as the proper care was led by a doctor's personality, not by policy, which means the nurse's job will be easy or hard depending on the doctor's concept of care management:

*"In Saudi Arabia ... If you get a good doctor who is on board with the good end of life palliative care, good pain control, withdrawing the things that no longer need to be done to the patient, then your life as a nurse and delivering that care becomes a lot easier." (Participant 2)*

According to participant 4, the different cultural views of doctor/nurse relationship are being perceived differently by different cultures, as the system is much better for them compared to back home, where they see them as being at a lower level, while Saudi hospital culture encourages the nurses to speak to the doctor based on evidence, and they are listened to:

*"Here, we have the autonomy. We can talk. We can speak up. If you are right, you can speak up. No such thing like the doctors only can say whatever they want to say. If you have a supporting thing, evidence with you, you can speak up for the patient's safety. I feel like easier, better. Back home we have sometimes the doctor is thinking that nurses are lower level, they're not to the level of we can communicate and all these things, the order. Yeah, you have to follow the order. In this way, the demand is there. Here, we can speak to the doctor what we wanted and actually when we talk they listen to us and many things can be changed" (Participant 4)*



***Theme 12: Cultural Differences***

***Cultural Norms and Values***

This participant indicated that she felt ridiculous toward Saudi people, mainly when she was laughing in public, and some staff members asked her to stop laughing, as it is inappropriate to do so in public:

*"Some staff administrations walked by, and they said, "She can't be excited. She needs to stop laughing." Something ridiculous. I said, "What? I am working. You should be happy that I am happy because usually, I am not happy with this place." I have had other nurses' say, "You're not supposed to be laughing and having fun. That's not allowed." (Participant 3)*

Participant 17 highlights different values between nurses according to the background:

*"Filipino freer they are open everything with doctors even physically touching each other. India has strict religion, and they have a limitation with a male. For Saudi, we don't share social life it is teamwork." (Participant 17)*

Participant 7 explained the uncomfortable feeling because colleagues from a different culture are not used to the different cultural way of hairdressing, and they touch it and comment on it:

*"Things I dislike is when they talk about my hair all the time. "OH my God, I never talked about your hair don't talk about my hair." People think they can touch it and can do things like that. That's the only annoying thing because they're not used to it, the way we do things." (Participant 7)*

***The Positive Aspects about the Multicultural Workforce Environment in Saudi Arabia***

Participant 1 noted that the Saudi nurse group are welcoming and accepting of other ethnicities working with them:

*"I always worked with Saudi nurses. My second boss was Saudi. I have to deal because of the nature of my work with a lot of Saudi people, and I'd be wrong, but until today, I have never felt they were not happy with me being here. I always felt I was welcomed, To be honest with you, I have never felt that someone would say I should be there or she shouldn't be here or that I shouldn't be doing the job that I do. Until today, thank God, I feel welcomed here." (Participant 1)*

Another participant highlights the positivity of Saudi nurses accepting other colleagues from different nationalities:

*"The Saudi nurse who I worked with in the ER was awesome. They were happy to have me or have us" (Participant 3)*

Similarly, participant 2 explains the Saudi people's kindness and generosity in all aspects:

*"I've always found that the Saudi people have been very kind and warm and very generous towards me in all aspects." (Participant 2)*

Participant 8 explained the positive aspects regarding open organisational culture concerning other religions without imposing, which led one staff member to convert to Islam by personal choice:

*"I remember a few years ago we have an American nurse here and she was listening one day to the Quran, but she didn't understand anything. The way was she hear it, and she thinks there is something different. Then one of the staff I remember he had translated properly and she became Muslim and then ... It was 7, eight years ago. This is one of them. The other thing also here in our hospital we should not talk about the difference between the religions unless someone asks. We don't need to put our self in because we, the hospital here employing everyone as we are open culture." (Participant 8)*

### ***Saudi Cultural Beliefs and Saudi System***

participant 14 highlights that Saudi staff are intolerant and take things personally, and don't accept comments from other, and the nurse explains that she felt disturbed and had an uncomfortable feeling and was crying because she was working in isolation without their help:

*"One time I got upset with the Saudi ward clerks because they were all in having tea, and the phone was ringing off the hook. and were having to leave our patients to come answer the phone and after the third time I just come out and said, "One of you has to sit out there and answer the phone, you can't all be in here." They got upset with me, and it was like a*

*wall, they wouldn't do anything for me, they wouldn't help me in any way. It was not a very comfortable feeling. Finally, I just broke down, and I cried because it had affected me that much because it was like working in isolation without their help." (Participant 14)*

Participant 1 noted the values of jobs done by non-Saudi nationalities, which are considered as lower class and humiliating, which is different from back home:

*"Back home. We don't have Filipinos or Bangladeshi people coming to do the labour. We are the labour to ourselves. People they ... my clean lady will be a Portuguese person; the drivers, they are Portuguese. If you go to France, it's the same thing. In the UK, you will find English people being cleaners. The rubbish guys, they will be English. Whereas here, you won't ... and maybe that's one of the biggest differences as well. Know for a fact that a Saudi man will prefer to be jobless than to do a driver job for another Saudi because it's a ...Humiliation for him. A Saudi lady will never go and clean another Saudi lady house, so it's tricky." (Participant 1)*

Also, participant 1 noted the differences between Saudi culture and back home, as sometimes colleagues and patients ask personal questions that make her uncomfortable:

*“They ask me. And sometimes, I feel a bit uncomfortable about it, and I find my way out. It’s different because back home when you meet someone, they will never ask you right away, “Are you married? Do you have children?” It’s like, “Whoa!” Coming here and you meet someone, even your patients they will ask you right away, “Are you married? How old are you? Do you have children?” We were like, “Whoa! Where is this coming from?” But then you have to understand, its part of the culture. They’re not doing it because they want to be nosy in your life, it’s because they expected them to say yes and then they’re going to say, “Mashallah!” and they will greet you for that. But then when you say no, they would be like, “Oh, I’m sorry,” and I’m like, “Why are you sorry? Don’t be sorry.” (Participant 1)*

Moreover, participant 1 explains similar things about skin colour discrimination in Saudi culture and the dark skin associated with a lower class:

*“Unfortunately, I know that probably because I’m white and I look Western, and if I do a nice smile, they will treat me differently than if there is an Indian nurse or a Filipino nurse next to me. It is sad to say it, but I’ve seen it happen. That’s not a problem of the hospital, of nursing. This is the country. That’s the way the country is. Socially, in their culture and Saudi, the beauty is to be white. It’s not to be dark because dark, it’s heavily associated with the lower class. ” (Participant 1)*

### ***Theme 13: Empowerment and Disempowerment***

#### ***Workplace Advocacy and Challenging Policy***

Participant 14 suggests that it is important to adapt behaviour rather than fight about procedures as a means of self-protection, unless it’s an issue of safety:

*“If it’s a safety issue, I’ll raise it, I’ll fight with it. I’ll fight it...If it were something that I felt impacted safety, then I would speak up and put my energy behind it because otherwise, you’re fighting all the time it seems to ... It was self-protective, I had to decide what I needed to do.” (Participant 14)*

Participant 1 noted that empowerment of nurses depends on background, particularly if the background culture is based on best evidence giving them the “power” to advocate firmly and have the leadership skills to stop any procedure that is not following policy or that risks patient safety, nurses from some backgrounds are seen as followers only:

*“The fact that depending on nationalities as well, some nurses were trained with more empowerment than others. How does this affect care? It affects care in a way that I may have a nurse that will advocate strong and if she sees something not being done according to the policy or not according to its best evidence. she may, or he may speak up and say, "I won't allow this to be done because it's not according to best evidence." Whereas we have other nationalities where nursing is still seen as following orders, other than questioning them. From those backgrounds where nurses are not powered to advocate, the physician will just go ahead and do what she wanted to do” (Participant 1)*

Further, participant 1 explained the important role of the nurses not only in notifying the doctor, but in stopping them:

*“It's not just about making the physicians aware or notifying them. It's about really avoiding and stopping them.”*

*(Participant 1)*

Moreover, participant 9 illustrates the organisational support to improve speaking up and recognising speak up campaigns among colleagues:

*“The hospital recognise that, and they're eventually going to a speak-up campaign where everyone has an opportunity to speak out.” (Participant 9)*

Another interviewee argued that organisational support improved communication and identified a speak up campaign to make the same level of communication between colleagues:

*“That's when we have a speak-up campaign where you know what, you just don't listen. This also happens between doctors and nurses as well. It takes a huge amount of effort to make sure everyone is in the same level of communication.” (Participant 9)*

### ***The Use and Abuse of Power (Corruption)***

One participant explains that people with good connections outside work will abuse authority and give the staff empowerment based on social relationships:

*“Even some of the people who are higher than her, they are afraid to speak to her because she is not going to stop talking. She's a friend of some of the executives, so who will dare to speak to her. Especially the western here. Since we have a lot of people here from western, and most of the hired people in the higher position for that same nationality, they go together to sit together, they go and go like it, what do you call it, camping or something. Some picnic time or having party times, though do this connection together.” (Participant 13)*

The same participant illustrates the power of connection and lack of sensitivity, with one nurse challenging authority and during Ramadan, eating in the station in front of everybody without respect to Saudi culture:

*“The non-Muslim people, the non-fasting people, they are not supposed to eat and drink in front of another, especially in front of the patient, who is also supposed to be fasting, for the respect of our holy month. I've been seeing that nurse on the station eating and drinking during the day, and nobody is saying anything to her...she was a western. She didn't care at all about the patient or us. I don't know. People are afraid of her because she's a western, she can do whatever ... She had the connection. She was connected with one of the executives, so if we had to speak with her, she knows very well she's protected, and nothing will happen to her.” (Participant 13)*

Also, participant 2 noted that some Saudi managers lacked qualification or skills and had been pushed for the position simply because they were Saudi:

*“I think sometimes you come up with that as well. You find people who have been pushed forward into posts which they probably shouldn't be in, but because of where they've come from, because they're Saudi, they've been pushed into that direction. It's really not actually what they should be doing. Not everyone's a manager.” (Participant 2)*

Moreover, participant 1 noted that colleagues' way of treating each other was different according to their social status, as some staff have *Wasta*, the ability 'to utilise connections with people, who are both able and prepared to change the course of natural events on that person's behalf':

*“Then if you know that you're working with a colleague that belongs to a really wealthy family, you probably will treat him differently; maybe you're going to be nicer to her or him because they come from a wealthy and important family because you will think that they have connections and they have Wasta ... It's a very interesting network.” (Participant 1)*

#### ***Theme 14: Workplace Justice and Injustice***

##### ***Dominant Culture Abuse and Bullying***

Assignment and overtime issues are strongly linked with dominant culture behaviours, as illustrated by the participant below. One Saudi

participant explains an incident of unfairness toward her from the dominant culture in the assignment of work:

*“When I was junior staff the charge nurse, non-Saudi Filipino gave me heavy infected patient and the staff from same ethnic group light patient, and then they will go to eat together and leave us working” (Participant 17)*

Regarding the dominant culture’s lack of fairness with other ethnicities, one participant said:

*“The charge will give light patients and non-critical to the same nationality staff, and they will give other ethnicities always two pt. and heavy pt.” (Participant 7)*

Participants noted that a dominant culture could lead to inequity and discrimination regarding colleagues’ chances to get overtime:

*“Let’s say for example there is overtime available in a certain unit and the charge nurse or the one responsible to book people for overtime is from Jordan or Philippines or a certain mafia. He or she will do things in a way, and all the crazy things they can do to give priority to the people from their own nationality. This is probably the situation where I have heard, and I have felt in the beginning, some discrimination. There are criteria to people for scheduling themselves for overtime, but somehow they will always try to manipulate it to favour their colleagues.” (Participant 1)*

Participant 2 explains the difficult and non-welcoming work environment created by the dominant culture:

*“The Filipino nurses was running the unit, were horrible to the Indian nurses that came in. Predominantly because before these nurses arrived, we were very short staffed, which meant there was a lot of overtime available. The Filipino nurses would work a lot of overtime, and obviously, that meant they earned a lot more money...Filipino [group or mafia] was running the unit, which made it very difficult for the Indian nurses to come and assimilate and work. If you're in an environment where you know you're not welcome you're not going to want to work or stay.” (Participant 2)*

Additionally, participant 1 noted that the predominant culture is usually not from Europe or western countries, as the number of nurses from there is fewer than from other groups:

*“A mafia is basically you may go to a unit where you have the predominant nationality from the Philippines or Jordan. You will never find a mafia from the Western world because you can never have as many nurses together as from Europe or Australia or the West.” (Participant 1)*



Participant 2 noted that there was significant gender abuse and feeling of intimidation as a result of the dominant male culture:

*"There is big abuse. There really is. Even from different areas, but also between the sexes, between male and female. Because of this male Arab persona that they're always right... a process of intimidation sometimes between some Arab nurses towards the female manager of the department. I've felt intimidated at times as well by them. Yeah. That can be difficult to manage." (Participant 2)*

### **Patient Care**

Participant 5 express his thoughts about most Saudi patients as being less educated than other ethnicities, which indicates provision of additional care:

*"Usually for most Saudi people, you need more explanation for them. I mean, you need to more care for them because the understanding, it's like the level of education is less than any other nationalities" (Participant 5)*

Additionally, participant 14 expresses her view of superiority toward simple Saudi people, and calls them patients from the desert and crazy:

*"I joke and say we thought she was a little bit crazy, but I think she was just that really basic person. She was just lived her life in the desert and really didn't understand all of this. Of course, she couldn't communicate with us very well because her dialect and even some of the physicians had difficulty understanding her Arabic and she was from a remote area." (Participant 14)*

Another staff member noted the patient care was different if the patients had the same ethnicity as the nurse:

*"Some Filipino or Indian staff will give extra care to patients from their nationalities." (Participant 17)*

Also, participant 18 highlights the importance of equal patient care even for enemies, and the self-awareness of staff can overcome the nurse-patient background differences:

*"they used to say the real enemy for Arabs and Muslim are Israel. We don't communicate with anyone from Israel before, during my training outside KSA I have a lot of patients from Israel, and they like me because I treat them like any other patients respecting them, joking with them like any other patients. For me patients are patients. And even if I do assignment, I don't look who they are." (Participant 18)*

### **Ethnocentrism (Own Culture)**

One Saudi participant agrees that Saudi staff have an ethnocentric feeling toward others staff:

*“Saudi staff they have judgment always about other, we are doing this and what you are doing is wrong! Saudi always impose their values on others” (Participant 15)*

Moreover, one participant expresses the ethnocentric feeling when she thought because a person was white and English, he should know better:

*“You’re white. You’re English. You come from a wealthy family. You are educated for that sake. I used to feel so mad at him because you should know better” (Participant 1)*

Furthermore, participants noted the feeling of superiority toward other colleagues from nurses coming to Middle Eastern countries:

*“Sometimes people coming from certain country and certain hospital they though we are the only one knowing everything and no one else know anything else. For some people, they come, and in their mind, we are coming to the Middle East country, those people they understand nothing. We know everything. You find them; their personality has been already negative.” (Participant 6)*

*“Let’s say, for example, I have one European people. She came we gave her orientation, she came for orientation. The 20th days after this orientation, we started to find her, like she’s really aggressive, really doesn’t like anybody to talk to her, doesn’t like anybody to explain her anything ...” (Participant 5)*

Moreover, participant 18 explains that feelings of superiority and inferiority between colleagues are very common, and consequently this will affect the collaboration between them and lead to discrimination:

*“culture very important, some people the background and what in their mind will drive them, it will affect how people will look to each other. some they will have superiority or inferiority, I know a lot of Saudi they have inferiority feeling when they work with western and superiority feeling when they work with Asian, and there is complain about it (I heard a lot of story about Indian nurses abused by Filipino nurses)” (Participant 18)*

### ***Discrimination***

Participant 7 explains that discrimination between colleagues could be by country or by gender:

*“Discrimination would be by country and would be by gender. Males here are very dominant, so it's one of the things you get used to. Different countries, some people stick together, and some people get left behind so those kind of things.” (Participant 7)*

Additionally, participant 7 noted that people judge, listen and respect more according to the person’s ethnicity:

*“People judge you from your country most of the time. Sometimes some people are more they're willing to listen to you if you're from a different country. Some people are, I don't know, respect you more. I think like that. Even though it's not outspoken said out loud, you can see it in their behaviour that they change and they are more accepted, and there are more things from if you are from its own country.” (Participant 7)*

Additionally, participant 16 indicated the discrimination between colleagues is sometimes because of religion and beliefs or ethnicity:

*“Some people think they will treat them badly because they are from another religion, sometimes between Saudi with deferent belief, some non-Saudi like Indian will feel Filipino don't like them.” (Participant 16)*

Moreover, participant 2 illustrates that the Saudi ethnic group views nurses from other ethnicities as being at a lower level and not well trained:

*“Saudi staff very dismissive of some of the other ethnicities, Filipino nurses and Indian nurses. We've had a large influx of Indian nurses last year. The reception to them wasn't necessarily as nice as you would have wanted it to be from that aspect. I think because there's a bit of a situation where they kind of look down on them. They don't realise these nurses are highly trained just the same as I am, just as the nurses in America or Canada would be.” (Participant 2)*

### ***Organisational Opportunities Strategy toward Saudi Staff***

Participant 13 noted that the managers are highlighting other staff more than Saudis, which will cause barriers to staff career development:

*“Because the manager, the direct manager, they are not highlighting that. They are not highlighting them, and they are really good workers. They are highlighting other people to make them shine, and the other Saudi people not shine, and it*

*happens several times with me, several, several times.” (Participant 13)*

Also, participant 13 explained that these differences and organisational favouritism of western staff among others make them behave as if they are better than other staff, which is risky:

*“High risk... People who think they come here and they own the place because they are having a European nationality or America or Canadian nationality. They do have this behaviour. They think they are better than us, and they know they've been treated differently than us, and they're behaving according to that.” (Participant 13)*

As a result of that, participant 13 expresses her feelings of upset about other cultures:

*“A taboo is you are not western, and you are Saudi. This is a big taboo. This is one of the big taboo. I will say it in their face, “You are nothing. We are here better than you.” (Participant 13)*

Talking about this issues of ineffective support, lack of action, and frustration about the Saudisation department’s role in the organisation, one interviewee said:

*“We have the Saudisation department, but it's just the department at ... We tried once upon a time to do a committee, a Saudi nursing committee to reach our voices with higher management, and we arise our issues. I was part of that committee once upon a time, but when I found things is not going anywhere, I just stop attending because nothing is happening. Nothing is changing.” (Participant 13)*

### **Educational Status and Occupations**

Another participant explains the hospital discrepancies in salary and benefits, including education, according to staff nationalities:

*“Here, we are facing the problem like the difference between nationalities. If we compare ourselves to any other nationality, we are working the same. We are on the same level. I mean sometimes we are given more job because we are Arabic speakers, so we understand families, we understand lifestyle, we understand our colleague more, much more than other nationality. We think that we are expecting from our ... I mean our management to give us like little bit ... I mean or the same level. To put us on the same level that American, Canadian, or whatever.” (Participant 5)*

The comment below illustrates the lack of hospital support action and staff satisfaction that causes the staff to leave:

*“This is what we are facing. That's why for example for me, I think I'd like to leave maybe like next year. I spoke many times to our program director, to our officers, to head of the nurses in our Hospital. She didn't give me a good answer. I sent many emails before; I'm an active person. I'm not ... I need some satisfaction.” (Participant 5)*

According to participant 6, this organisational discrimination forces the staff to leave:

*“This is the thing that means they will leave. When they come, and they find those things we do not stay that much.” (Participant 6)*

### **Salary**

Another participant suggests dissatisfaction because of institutional ignorance to the staff needs regarding the salary discrepancy, which will affect patient care:

*“Every nationality has their own ranking. It is very unfortunate. It is a sad thing, because everybody comes here, work the same way, have the same ... You go and buy chicken outside; it is the same price. The patient is the same. The concept is the same. I have paid you, why do I have to pay you more? That kind of ignorance, it does affect patient quality I must say.” (Participant 9)*

Besides, participant 1 explain that salary discrepancy is the main reason for discrimination and affects collaboration between staff:

*“Then the salaries as well. That is a big thing. Discrimination and collaboration in works are affected right from the beginning, which is the passport you hold dictates your salary. "You earn more, so work more." It is tricky. It is a really tricky situation. Sometimes you have managers that earn less or even half of what a newly arrived nurse earns because ... I am a manager from the Philippines, and you are a staff nurse from the U.S. That staff nurse will be earning three times more than the manager.” (Participant 1)*

Moreover, one participant stated that salary discrepancy is business:

*"If they give, they will look at the cost of living, maybe they are telling India may be the lowest cost of living in the world, so they are going to give the similar. Giving them, the one coming from the states, do not care. It's business." (Participant 8)*

Also, one Saudi participant indicated workplace justice toward other ethnic group staff, and they should be thankful:

*"They should be thankful they are here; big salary, safety, housing, transportation and ticket. But they are resigning and moving to Dubai and more free country. Without freedom but still, they are doing everything here! When I travelled to Egypt 2000 SR = 4400 Egyptian pound... So the staff will receive almost 10000 Egyptian pounds in Saudi hospital they will not have this money there!" (Participant 16)*