

**EXPATRIATE NON-MUSLIM NURSES’  
EXPERIENCES OF WORKING IN A CARDIAC  
INTENSIVE CARE UNIT IN SAUDI ARABIA**

by

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## DEDICATION

To my children; Antonette-Johanne, Marcel-Marco, my mother Hester and my father Frederick Jacobus Smith who are and who have always been my inspiration.

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## **EXPATRIATE NON-MUSLIM NURSES' EXPERIENCES OF WORKING IN A CARDIAC INTENSIVE CARE UNIT IN SAUDI ARABIA**

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### **ABSTRACT**

Nursing Muslim patients in the Kingdom of Saudi Arabia (KSA) poses challenges for expatriate non-Muslim nurses. Caring for Muslim patients in a cardiac intensive care unit, catering for patients who underwent open heart surgery, poses unique challenges to non-Muslim nurses.

Semi-structured interviews were conducted with 63 non-Muslim nurses who cared for Muslim patients who had undergone cardiac surgery. Factors that influenced non-Muslim nurses' experiences of working with Muslim patients in the KSA, included culture shock, language barriers and a lack of understanding of Islam as a religion. In-service education sessions, addressing these issues, could enhance non-Muslim nurses' abilities to render culture competent care to Muslim patients in a cardiac intensive care unit in the KSA. Arabic-English translators could facilitate communication between the expatriate nurses and the Muslim patients.

**Keywords:** cultural competent nursing care, cultural congruent nursing care, critical care nursing, Leininger's Sunrise Model, Muslim culture and traditions, transcultural nursing,

## DECLARATION

I declare that **EXPATRIATE NON-MUSLIM NURSES' EXPERIENCES OF WORKING IN A CARDIAC INTENSIVE CARE UNIT IN SAUDI ARABIA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



Michelle van Bommel

5<sup>th</sup> November 2010

ST no: 30791308

## CHAPTER 1

## ORIENTATION TO THE STUDY

1.1	INTRODUCTION.....	2
1.2	BACKGROUND INFORMATION ABOUT THE KINGDOM OF SAUDI ARABIA.....	1
1.3	HEALTHCARE SYSTEMS AND HEALTH ISSUES IN THE KSA .....	3
1.4	HEALTHCARE HUMAN RESOURCES OF THE.....	4
1.5	THEORETICAL FOUNDATIONS UNDERLYING THE STUDY.....	6
1.5.1	Leininger's Sunrise Model.....	6
1.5.2.	Application of Leininger's Sunrise Model to this study: expatriate non-Muslim nurses' experiences of working in a critical care (cardiac surgery) environment in Saudi Arabia: a cultural perspective.....	8
1.6	RESEARCH PROBLEM	
1.6.1	Source of the problem.....	10
1.6.2	Background information.....	12
1.6.3	Statement of the research problem.....	14
1.7	AIM OF THE STUDY	
1.7.1	Research purpose.....	14
1.7.2	Research objectives.....	14
1.7.3	Significance of the study.....	14
1.8	DEFINITIONS OF KEY CONCEPTS.....	15
1.8.1	Biculturalism.....	15
1.8.2	Care.....	15
1.8.3	Caring.....	15
1.8.4	Culture.....	15
1.8.5	Cultural congruent care.....	15
1.8.6	Cultural safety .....	16
1.8.7	Ethnocentrism.....	16
1.8.8	Transcultural nursing.....	16
1.9	RESEARCH METHODOLOGY.....	16
1.9.1	Population.....	17

1.9.2	Research setting .....	17
1.9.3	Research instrument.....	17
1.9.4	Data collection.....	18
1.9.5	Data analysis.....	18
1.10	ETHICAL CONSIDERATIONS.....	18
1.10.1	Confidentiality.....	19
1.10.2	Justice .....	19
1.10.3	Trustworthiness.....	19
1.11	SCOPE AND LIMITATIONS OF THE STUDY.....	20
1.12	OUTLINE OF THE STUDY.....	20
1.13	SUMMARY.....	20

## **CHAPTER TWO**

### **LITERATURE REVIEW**

2.1	HISTORICAL BACKGROUND.....	22
2.2	THE ISLAMIC FAITH FOUNDATION WITHIN THE KINGDOM OF SAUDI ARABIA.....	22
2.2.1	Religion and spirituality .....	24
2.3	THE RELIGION OF ISLAM.....	26
2.3.1	The Western (biomedical) model versus the Eastern (Islamic) care-giving approach.....	31
2.3.2	The biomedical health perspective.....	36
2.3.3	Worldview.....	37
2.3.4	Traditional clothing in the KSA.....	37
2.4	CULTURE.....	37
2.5	CULTURAL LIBERTY.....	39
2.6	CULTURAL DIFFERENCES.....	39
2.7	CULTURAL COMPETENCE.....	41
2.8	CULTURAL COMPETENT CARE.....	43
2.9	THE ART OF (EXPATRIATE) NURSING.....	44
2.10	CARING FOR THE MUSLIM PATIENT.....	45
2.10.1	Nursing and related experiences within the KSA .....	47
2.10.2	Coronary artery disease (CAD) in Saudi Arabia.....	49
2.10.2	Intensive cardiac surgery nursing.....	50

2.11	SUMMARY.....	55
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### **CHAPTER THREE**

#### **RESEARCH DESIGN AND METHODOLOGY**

3.1	INTRODUCTION .....	57
3.2	RESEARCH DESIGN AND METHODOLOGY.....	57
3.3	RESEARCH METHODOLOGY.....	59
3.3.1	Population.....	59
3.3.2	Research setting.....	59
3.3.3	Procedure followed to collect data.....	60
3.3.4	Research instrument: semi-structured interview guide .....	61
3.3.4.1	Organisation of the semi-structured interview guide.....	62
3.4	DATA COLLECTION.....	62
3.5	ETHICAL CONSIDERATIONS DURING DATA COLLECTION.....	65
3.5.1	Informed consent.....	65
3.5.2	Anonymity.....	66
3.5.2	Confidentiality.....	66
3.6	TRUSTWORTHINESS.....	66
3.7	DATA ANALYSIS.....	69
3.8	Scope and limitations of this study.....	70
3.9	SUMMARY.....	70

### **CHAPTER FOUR**

#### **DATA ANALYS**

4.1	INTRODUCTION.....	71
4.2	DATA ANALYSIS.....	73
4.2.1	Data collection, entry, coding and analysis.....	73
4.2.2	Transcribing.....	75
4.3	DATA PRESENTATION.....	75
4.3.1	Personal and geographical data analysis.....	75
4.4	EXPERIENCES RELATED TO NURSING MUSLIM PATIENTS.....	78
4.4.1.1	Culture shock.....	83
4.4.1.2	Language challenges.....	88
4.4.1.4	Islam as religion.....	92



4.5	CULTURAL FACTORS THAT INFLUENCE NURSING CARE.....	92
4.5.1	Improved understanding of Islam as a religion.....	99
4.5.2	Improved communication skills.....	100
4.5.3	Reduced workloads .....	101
4.6	SUMMARY.....	106

## CHAPTER 5

### LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1	INTRODUCTION.....	108
5.2	RESEARCH DESIGN.....	108
5.3	LIMITATIONS OF THIS STUDY.....	108
5.4	CONCLUSIONS.....	109
5.5	RECOMMENDATIONS.....	110
5.6	CONCLUDING REMARKS .....	111

LIST OF REFERENCES.....	112
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### LIST OF TABLES

Table 2.3.1.1 Differences between Eastern and Western countries....	33
Table 4.1 Distribution of participants' socio-demographic characteristics.....	79
Table 4.4 Data presentation: experiences related to nursing Muslim patients	82

### LIST OF FIGURES

Figure1: Map of Saudi Arabia.....	2
Figure 1.1: Leininger's Sunrise Model.....	9
Figure 2.1: The holy mosque in Mekkah.....	27
Figure 2.2.: Traditional tasbih made of wood.....	30
Figure 4.1: Participants' age groups (n=63).....	78
Figure 4.2: Participants' years experience in the CICU (n=63).....	80

### LIST OF DATA DISPLAYS

4.4.1 Culture shock .....	79
4.4.2 Lifestyle: values and traditions .....	81
4.4.3 Muslim patients' hygienic habits and practices.....	82

4.4.4	Clothing style in the KSA .....	83
4.4.5	Strict male and female segregation .....	84
4.4.6	Image of nurses in the KSA .....	85
4.4.7	Level of education within the KSA .....	86
4.4.8	Contributing factors to heart disease .....	87
4.4.9	Patient management in the CICU .....	88
4.4.10	Language challenges .....	89
4.4.11	Islam as a religion .....	92
4.5.1	Factors that could improve nursing care .....	99

## **LIST OF ANNEXURES**

APPENDIX A:	SEMI-STRUCTURED INTERVIEW GUIDE
APPENDIX B:	ETHICAL CLEARANCE
APPENDIX C:	RESEARCH APPROVAL
APPENDIX D:	INFORMATION LETTER TO PARTICIPANTS (EXAMPLE)

# **CHAPTER 1**

## **INTRODUCTION AND BACKGROUND INFORMATION**

### **1.1 INTRODUCTION**

Living and working with Muslim patients in the Kingdom of Saudi Arabia (KSA) can be both an exciting and challenging experience for non-Muslim nurses. Particular challenges are posed by religious and language differences between patients and nurses. Caring for Muslim patients by non-Muslim nurses, in a critical care open heart surgery unit could be different from nursing in other hospital sectors. Cardiac surgery practices became more cost effective with limited hospitalisation days over time. The critical care nurse became instrumental in overseeing the critical care protocols, medications and treatment time from the completion of the cardiac surgery until discharge. Communication of acute clinical changes is an essential skill that maximises efficiency and compassion during the quality care delivery process. The critical care nurse can be described as the link of healthcare extenders for the patient who underwent cardiac surgery by applying necessary knowledge and skills to the patient's care in the critical care setting.

The expatriate non-Muslim nurses working in the KSA should have sound knowledge about the Islamic culture and traditions in order to deliver culturally sensitive care and to respect the patients' beliefs. Providing cultural competent nursing care requires time, expertise and experience to refine, develop and expand awareness and abilities to provide such care. Nurses must continuously strive to become more attentive towards diverse languages, habits, beliefs and behaviours (Benkert, Tanner, Guthrie, Oakley & Pohl 2005:225).

## 1.2 Background information about the Kingdom of Saudi Arabia (KSA)

The KSA is one of the largest countries in the Middle East, and consists of 95% desert (World Atlas: 2010). Large oil reserves were first discovered in 1937, and the KSA remains the largest producer and exporter of oil in the world. Oil profits are spent on the people and improvements of the country's infrastructure. Over the past 40 years there have been dramatic changes in the economy and lifestyle of the people living in the KSA. Prior to the discovery of oil, the Islamic faith and the Muslim people living in the KSA were protected from the 'Western' world. However, post-oil affluence and trading exposed them to modern ideas and technology (Stegl & Baten 2009:146).



**Figure 1: Map of Saudi Arabia**

(Source: <http://www.worldatlas.com>)

It is a strict Muslim country and home to the two holy cities, Mekkah and Medinah. Jeddah is situated on the Western coast of the KSA, and has traditionally been the staging post for millions of Muslims to perform their Hajj (holy pilgrimage) each year.

The two holy cities are protected and non-Muslims are not allowed to enter these cities. The importance of religion, as an integral part of everyday life, means that many Muslim patients would view the world, including health, illness and care from a religious (supernatural) perspective.

### **1.3 Healthcare systems of and health issues in KSA**

Healthcare in the KSA can be classified as a national health system (Wikipedia 2010). The government provides healthcare to all its inhabitants. The Ministry of Health (MOH) was created in 1954 and is the health regulating agency in the KSA (Aboul-Enein 2002:229). Other health bodies include the Ministry of Defence and Aviation (MODA) and the Saudi Aviation National Guard (SANG). Rural to urban living increased from 49% in 1970 to 78% in 1991, and to 82% in 2008. The KSA is divided into 18 health regions which are all answerable to the MOH (Aboul-Enein 2002:229). The 1973-1974 rise in oil prices stimulated government expenditure on improvement of the infrastructure which increased demands for both skilled and unskilled workers in Saudi Arabia (Maben, Al-Thowini, West & Rafferty 2010:392).

Saudi Arabia's population growth rate is the highest and life expectancy is the lowest for the Middle Eastern countries with a male life expectancy of 74 years and a female life expectancy of 78 years. The population in KSA (24 573 000 with 10 690 000 under the age of 18 years) is characterised by a rapid growth rate of 2.7% during 2008 and a 2.49 death rate per 1 000 during 2008. More than 97% of the KSA's people have access to clean water and sanitation (CIA World Factbook 2010).

Lifestyle diseases like obesity and diabetes are prevalent in the KSA and the increasing complexity of health needs are facing future challenges. Obesity, lack of exercise and smoking are factors contributing to heart disease (Syed 2003:1). More than 38% of the KSA's population is under the age of 14 years (CIA World Factbook:2010). Obesity could be prevented by moderate eating, fasting and health education. Smoking is forbidden in Islam by adhering to the principles of avoiding the bad (Quran: surah Al-'Araf 7:157) and knowing that the prophet himself never smoked. Because of the later

invention of cigarettes (after the revealing of the Qur'an), there are no direct references to smoking in the Qur'an. Sterilisation is allowed in case of certain health conditions like uncontrolled diabetes and heart disease and is permitted by the following phrase: "going by the principle of 'necessity' permits the forbidden" (Sheikh & Gatrad 2001:159).

#### **1.4 Healthcare human resources of the KSA**

During the early Islamic era of the eighth century hospitals were established with the first hospital in Islam in Damascus, Syria in 706 AD. The crescent (symbol) in Islam has no religious significance, but is used as a marker or calculator for occasions like Ramadan and is used on all healthcare facilities (Rassool 2000:1479).

In the KSA, the total number of hospitals increased from 74 with 9 039 beds in 1970 to 338 with 28 522 beds in 2005. The number of nurses (3261) during 1970 increased to 42 628 during 2005 (Maben et al 2010:294). The Bachelor's degree in the Science of Nursing (BSN) course was introduced in the KSA during 1976, and then followed by an established Masters program in 1987 (Mebrouk 2008:150). The number of Saudi nurses increased from 9% in 1996 to 22% in 2008, and it is estimated that another 25 years will be needed to fulfil the required healthcare workforce needs of the KSA's citizens (Aldossary, While & Barriball 2008:127).

The global shortage of nurses led to international migration often from low income countries like Africa, India and the Philippines. Social and religious factors create challenges for these nurses working in the KSA. With increased trends in globalisation acute care settings are becoming more culturally diverse. Nurses migrate either to improve their learning experiences, or to improve their quality of life, or to improve their personal safety and end up working in culturally unfamiliar environments (Van Rooyen, Telford-Smith & Strümpher 2010:1). Globalisation generated the need for reflective practice to deliver culturally competent care to any patient from diverse areas of the world (Torsvik & Hedlund 2008: 389). According to Baker (2007:304): "globalisation does not necessarily blur the distinction between culturally safe and culturally unsafe groups", but might put local minority groups at cultural risks. International nurses are encouraged to think about cultural safety and their own cultural practices when caring for culturally diverse patients.

All healthcare providers are expected to view patients holistically and objectively by not being affected by the patient's socio-demographic characteristics and "to use only biomedical information to develop a diagnosis and treatment plan" (Grunau, Ratner, Galdas & Hossain 2009:181). Ethnicity could influence the patient's diagnosis and treatment recommendations of acute coronary syndrome (ACS). Women might be less likely to discuss their risks and management of heart disease based upon their ideas of modesty. Therefore the treatment approach is less aggressive in women when compared to men. The man's image in the Islamic world is seen as sole keeper and provider, and to be moderate in all aspects including health. Illness may be experienced as a trial or cleansing from Allah (Daar & Al Khitamy 2001:60).

Giger and Davidhizar (2008:3) state: "It is believed that demography is destiny, demographic change is reality, and demographic sensitivity is imperative." Transnational migration creates complex healthcare challenges. Improved nursing education approaches might prepare the multicultural workforce to respond to the diverse needs of people of diverse backgrounds and worldviews (Campesino 2006:298). Integrative nursing combines the medical profession and the biomedical understanding with caring behaviours and treatment that have been part of nursing practices throughout history. More meaningful descriptions between nursing and health (from the Western worldview) would include explanations of health, society, mental illness, social pathologies and spirituality (Laird 2007:2434).

Caring for people from different ethnic backgrounds demands intercultural communication, occurring when there are two sided attempts to understand the cultural frame of reference. Consideration of individual value systems and lifestyles should be included in the planning of nursing care for each client. Nursing (Leininger & McFarland 2002:46) "is a learned, humanistic and scientific profession/discipline that focuses on human care and caring activities to assist, support or facilitate individuals or groups to maintain/regain their health/wellbeing". The definition reinforces the idea of care as the essence of nursing and transcultural nursing.

The transition into the international milieu can be eased by encouraging nurses to engage in educational activities. Professional growth and development start with compassion, patience and support (Douglas & Lipson 2008:163). Leininger introduced transcultural nursing into the curriculum of nurse education programmes during the

1960s, and recommended that nurses working with clients from diverse cultures need to increase their own cultural views on health (Leininger 2007:9).

## **1.5 THEORETICAL FOUNDATIONS UNDERLYING THE STUDY**

### **1.5.1 Leininger's Sunrise Model**

Madeleine Leininger is the founder and leader of transcultural nursing, and a theorist who described the influence of culture on caring (McFarland & Eipperle 2008:50; Campesino 2006:298; Luna & Miller 2008:1).

The central focus of Leininger's Sunrise Model is to explain some of the multiple factors that influence care from both an insider (emic) and outsider (etic) view. The goal of the cultural care theory is to provide cultural congruent care, and assumptive premises of the theory include that:

- Care is the core/essence of nursing and the central unifying focus around nursing
- Caring is essential for wellbeing, growing or facing death.
- There can be no curing without caring.
- There are cultural care similarities and differences within every culture worldwide (Leininger & McFarland 2002:76).

Human care and caring (Leininger & McFarland 2006:10-11) refer to all assistive, supportive and any other facilitating ways to help others with needs or to improve health, life ways or the dying in need. Some unique features of the Sunrise Model include that it focuses on discovering holistic comprehensive cultural care, and can be used in Western and non Western cultures. The purpose of cultural care assessment is to discover the clients' cultural care and health patterns, to obtain holistic culture care information for nursing actions, to discover new or specific culture care patterns, to identify potential cultural conflicts or specific dominant themes, to identify similarities or differences among clients and to use theoretical ideas and research approaches for transcultural discipline users (Leininger & McFarland 2002:119). Transcultural knowledge obtained "could guide nurses employed in different global contexts" (Leininger 2007:10).



Culture (in the nursing literature) can be viewed from the cognitive framework, including beliefs and values or from the structural framework focussing on the person's social position, wellbeing and health (Williamson & Harrison 2010:767). Many cultural constructs exist within the estimated existing 4 000 cultures of the world (Leininger 2007:11). Culture care knowledge is the sound basis to establish nursing as a distinct and scientific discipline (Leininger 2007:10). Cultural knowledge is needed to care for culturally diverse populations in safe and beneficial ways. Healthcare is rapidly growing in a multicultural world and cultural care factors should not be overlooked. The nurses' role is to be aware of his/her own culture before attempting to understand and interpret the patient's illness and treatment (Williamson & Harrison 2010:762). Assistance of the patient and family exists within the technical and physiological contexts.

The central purpose of the Sunrise Model is to discover/explain diverse and universal culturally based factors that influence health, wellbeing and illness. Religion strongly affects the way people attempt to prevent illness, and dictates social, moral and dietary practices. The Sunrise Model indicates some potential influences that may explain care phenomena related to the world view, social and environmental factors. Social structure factors include cultural values and beliefs, religious and spiritual beliefs, economic factors, educational beliefs, technology views, kinship, political or legal factors. Gender and age are usually related to social structures such as religion (McFarland & Eipperle 2008:52).

Leininger's three modes of care are defined (in McFarland & Eipperle 2008:51) as:

- Culture care preservation/maintenance – any assistive or supportive acts that help maintain or preserve cultural beliefs.
- Culture care accommodation/negotiation – any assistive, supportive or enabling acts that cultures adopt or negotiate with others in order to care for health and wellbeing.
- Culture care restructuring/repatterning – any assistive, supportive or enabling nursing acts that help people change, modify or restructure their lifeways in order to improve healthcare.

### **1.5.2 LEININGER'S SUNRISE MODEL APPLIED TO THE STUDY ON EXPATRIATE NON MUSLIM NURSES' EXPERIENCES OF WORKING IN A CARDIAC CRITICAL CARE UNIT IN SAUDI ARABIA**

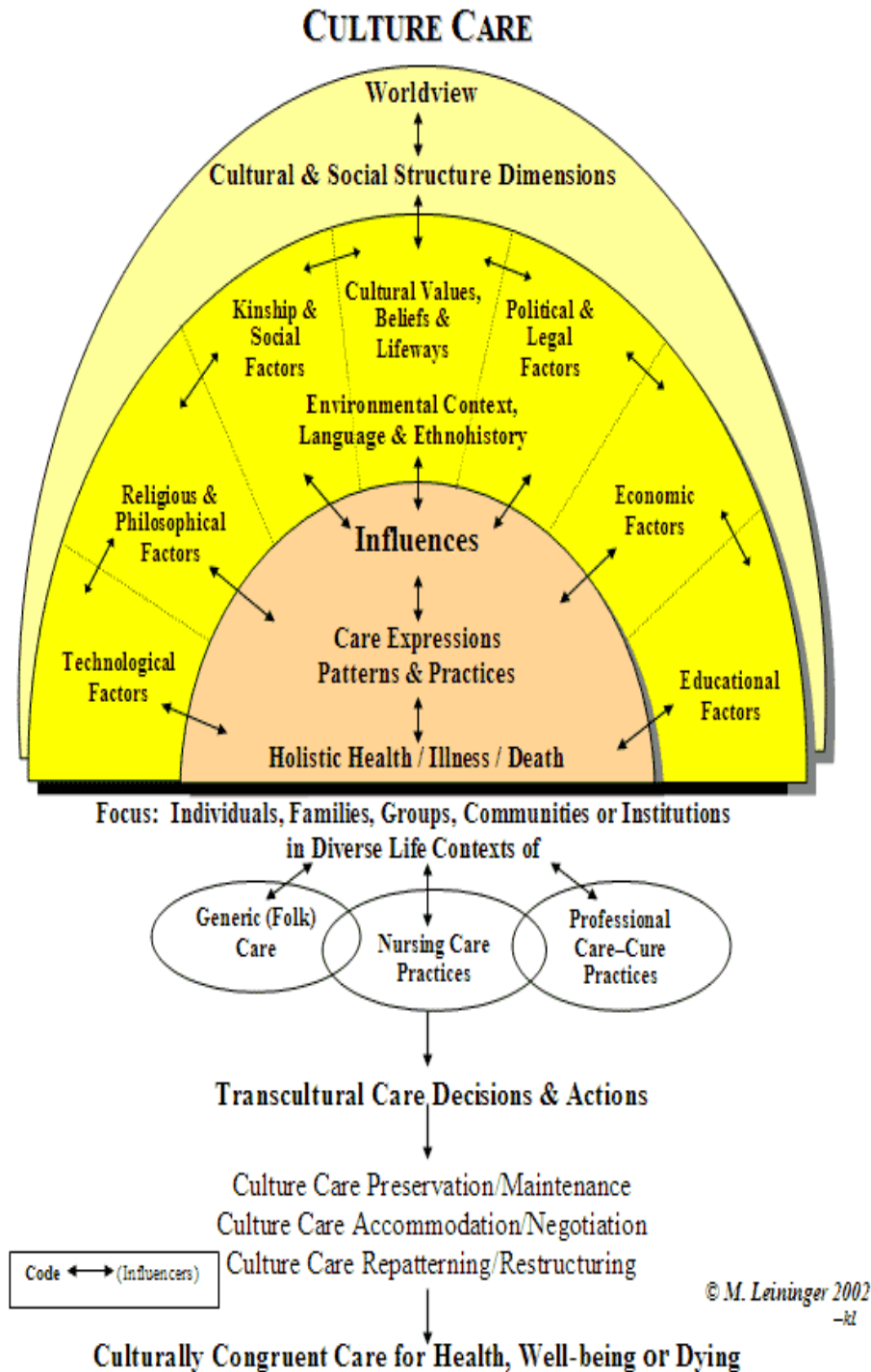
Gender, age and race data are embedded in family ties. Caring decisions within the Islamic world are male related and embedded in family ties. When rendering holistic culturally congruent care to the intensive care patient all relevant cultural factors have to be assessed and implemented into the care plan. The nurse has to set aside his/her previously biomedically dominant knowledge and focus her care on individualism that fits the patients' basic needs within his/her cultural context. Transcultural nurses, as explained by Leininger (in McFarland & Eipperle 2008:54), are "often asked to protect clients from non-Western cultures who are unfamiliar with Western medicines and treatments". Cultural safety includes "actions and respect towards the cultural identities of others", and displays nurses' power in order to support healing (Anderson, Perry, Blue, Browne, Henderson, Khan, Reimer Kirkham, Lynam, Semeniuk & Smye 2003:198). Cross cultural sensitivity is apparent in the global context when the world as viewed is becoming more flat with reference to people and communication. Through the process of traditional view transformation "Western healthcare beliefs are not translated into other cultures" (De Leon Siantz & Meleis 2007:88).

Culturally congruent care, as defined by Leininger (in McFarland & Eipperle 2008:49), refers to: "knowledge, acts, and decisions used in sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways of clients for their health and wellbeing...". The Sunrise Model is used by nurses to reflect on patients' situations and conditions such as diabetes, weight management and mental health. Nurses are guided by the culture care theory to use nursing care, folk care and professional practices in order to deliver culturally congruent care for health and wellbeing (McFarland & Eipperle 2008:52). Being in the presence of people dissimilar from oneself, provides the opportunity to learn from these persons (De Leon Siantz & Meleis 2007:86).

The Sunrise Model illustrates religious and philosophical factors that affect care expressions and practices of a culture. Dimensions like kinship, cultural values and lifeways are all interrelated. Faith is only one influencing factor in the Muslim's life, and openness to professional care is different (Lawrence & Rozmus 2001:229). Nurses can

rely on their knowledge of Muslim generic beliefs while using the Sunrise Model to bridge the gap between the emic and etic practices.

*Leininger's Sunrise Enabler for the  
Theory of Culture Care Diversity and Universality*



<http://www.Leininger/sunrisemodel>

**Figure 1.1**    *Leininger's Sunrise Model*

Culture care preservation can be obtained by allowing patients to consume home cooked meals that are prepared according to the Islamic laws, to avoid male eye contact, and unnecessary touch or body exposure, or to offer food and drinks with the right hand.

Culture care accommodation can be achieved by providing clean areas for prayer times, to offer Qur'an recitations, or to be more flexible with visiting hours. Culture care repatterning can be achieved when the nurse reports any possible harmful practices observed, like when a diabetic patient is refusing to eat or drink during Ramadan and running the risk of becoming comatosed (Wehbe-Alamah 2008:93).

## **1.6 RESEARCH PROBLEM**

### **1.6.1 Source of the problem**

When people become ill, they pray or use their religious/spiritual beliefs. It is important to know what spiritual factors need to be incorporated into care. Caring for the patient from an Islamic denomination, in his/her own environment is very different from caring for patients from the Western countries. This is where conflict between the biomedical and spiritual models and beliefs about Christianity and Islam could develop. Without understanding and appreciating self-being, and without space for acceptance of different cultural beliefs there can be no caring. Care encompasses cultural and symbolic meanings, such as care, respect and protection. Cultural caring is essential to healing (curing), for there can be no curing without caring (McFarland & Eipperle 2008:49).

Research conducted within the KSA, with regards to the critical care patient in the cardiac surgery setting has not been well described. The consequences of heart disease can affect the person's total performance due to uncertain future perspectives and decreased wellbeing. The demographic lay-out of the KSA, especially the smaller "Bedouin" areas, does not allow easy access to hospitals or preventive healthcare settings which could impact on these people's knowledge about and utilisation of medical services.

The success of cardiac surgery is well established compared to the postoperative risks which are threatening in nature including infections, thrombo-embolisms, renal failure, dysrhythmias, heart failure, endocarditis and death (Shih, Meleis, Yu, Hu, Lou & Huang 1998:83). Pre-operative concerns, related to cardiac surgery, include the waiting periods before the surgery, postoperative pain, anger and fear due to mourning the loss of previous good health, helplessness and fear of death, knowledge deficits regarding medication as well as the length of hospital stay and increased costs. People who face uncertain futures or illness tend to elevate their trust in their own religion, and Muslims tend to increase their trust in Allah (Pesut & Reimer-Kirkham 2010:817).

The low levels of knowledge about heart diseases and risk factors contributing to heart disease, among Muslim patients in the KSA, highlight the need for patient education (Netto, McCloughan & Bhatnagar 2007:178). Some culturally relevant educational activities could include group discussions, liaising with minority ethnic groups and using bilingual workers. Health education and promotion programmes should be built on attitudes, beliefs and behaviours that exist within the cultural group to improve lifestyle or quality of life. Patients need to make sense of their health threats through the use of cognitive processes that represent their illnesses' influences of cultural and psychological factors (Darr, Astin & Atkin 2008:92). Illness perceptions influence dietary change, hospital recovery, functional status and health seeking behaviours.

Cardiovascular disease remains the main contributor to adverse health effects among indigenous people worldwide (Brown, Brieger, Tonkin, White, Walsh, Riddell, Zeitz, Jeremy & Kritharides 2010:300). Advances in heart disease treatment continue to improve patients' outcomes. Early recognition of cardiac-related symptoms and lifestyle modifications contribute to the success of essential treatment (Noureddine, Froelicher, Sibai & Dakik 2010:334). Younger and more educated people are more likely to respond to or to distinguish between cardiac related symptoms. Religiousness can reduce exposure to stressful events like legal and interpersonal or family problems which might contribute to ACS episodes (Burazeri, Goda & Kark 2008:941) and consequently heart surgery. Improved secondary prevention of cardiac disease includes lifestyle changes and enhanced understanding of cardiac illnesses.

### **1.6.2 Background information**

During the 1950s, partly due to the availability of Penicillin to treat illnesses, cardiovascular diseases like myocardial infarctions and heart failure became the leading cause of death globally (Wikipedia:2010). Mortality rates ranged from 30-40%, and half of the deaths were due to cardiac arrhythmias.

The cardiovascular system is responsible for the delivery of oxygen and nutrients to the body and for removal of waste products resulting from metabolism (Bassett & Makin 2000:7). Heart rate is the key factor to determine cardiac output, and the two situations of most concern are when the heart rate is too slow or too fast (Bassett & Makin 2000:24).

Patients undergoing cardiac surgery might experience post operative complications like wound infections and respiratory failure. Patients and families should receive a more expansive idea of the proposed treatment for life threatening conditions.

More than 1.5 million cardiac surgeries could be performed globally each year including 10% coronary artery bypass grafts (CABG) or valve replacements (Agren, Hollman-Frisman, Berg, Svedjeholm & Strömberg 2009:284). Co-morbidities like diabetes associated with increased post surgery mortalities, are increasing each year in the KSA, possibly due to lifestyle changes. Early discharge post cardiac surgery reduces the risk of postoperative complications like hospital acquired infections, but puts an additional burden on the spouse to provide support and care at home. Cardiac surgery is both demanding on the nurses, and the spouse when the patient becomes seriously ill at home (with no or limited social support). According to Islamic law, a man is permitted to have four wives. These social arrangements could be difficult when one or more wife, or even the husband is scheduled to undergo heart surgery because the social arrangements include a fair distribution of time between the husband and all his wives.

Coping after cardiac surgery is more problem-focused for men compared to emotion-focused for women (Tung, Hunter, Wei & Chang 2009:470). Anxiety has been identified as the most common concern both pre and post cardiac surgery, and mediates the effects of psychological and physical health problems. Older patients could experience more difficulties during and post cardiac surgery, including longer hospital stay,

psychosocial factors like depression or social isolation (Sorensen & Wang 2009:306). Social support includes interpersonal assistance, and may be tangible in the form of money or intangible in the form of emotional support by family members. Effective social support fosters benefits like reduction in stress and anxiety levels, as well as a more rapid post operative recovery phase. Patients who live alone or isolated (like in the Western countries) might experience three times higher anxiety levels than people who live in close-knit communities (Sorensen & Wang 2009:207). Depression and functional status impairment (inability/difficulty to perform daily activities) could occur after cardiac surgery and require referrals to other healthcare team members.

Responsibilities regarding daily life and financial burdens might complicate the care delivery after discharge. The post cardiac surgery patient as well as the spouse might experience feelings of emotional stress, loneliness, social isolation, decreased personal freedom and insecurity during the recovering phase. The spouses and families of the patients are often referred to as 'hidden patients' because of their emotional feelings and changes during the patient's hospitalisation phase (Cioffi 2005:82).

After cardiac surgery patients need effective education and counseling regarding lifestyle changes or modifications. One aspect of illness representation is the patients' beliefs about the causal attributions in the development of their illnesses. Patients commonly believe that stress; tension, diet, smoking and/or worries caused their cardiac disease (Warren-Findlow & Issel 2010:45). People rate their risks for heart disease development by controlling their health behaviours, and their perceptions could be influenced by their experiences of any cardiac events. There is a direct link between a person's health seeking behaviours after the witness of a cardiac event, and between the perception of cardiac symptoms and the time lapse to seek healthcare. The primary focus of the research problem is to understand the experiences of the nurses and to equip them with certain strategies and abilities to render high quality care in culturally diverse settings. This is a complex situation and the secondary purpose of the research is to determine how the nurses experience these cultural differences during the care delivery process, and to use the findings of the study during in-service education sessions.

### **1.6.3 Statement of the research problem**

The following research questions were formulated to be answered by this study:

- What is the nature of expatriate non Muslim nurses' experiences (biomedical perspective), when caring for Muslim patients in a critical care unit in Saudi Arabia?
- How does the biomedically orientated nurses' experiences influence their therapeutic relationships with their Muslim patients?

## **1.7 AIM OF THE STUDY**

### **1.7.1 Research purpose**

The purpose of the study was to explore and describe the expatriate non Muslim nurses' experiences of working in a critical care environment (cardiac surgery) in Saudi Arabia; where different cultural perspectives, past experiences and occupational strategies are utilised to deal with health and illness interactions.

### **1.7.2 Research objectives**

The objectives were to identify and describe the non-Muslim nurses' experiences of caring for Muslim patients in a cardiac ICU in the KSA. The data obtained would be used to design in-service education sessions to enhance non-Muslim nurses' abilities to render cultural competent care to Muslim cardiac surgery patients.

### **1.7.3 Significance of the study**

The goal of transcultural nursing is to meet patients' needs which are consistent with their cultural beliefs (Gustafson 2005:2). Nurses need knowledge on which to base their decisions and actions to provide culturally competent, holistic and comprehensive nursing care. The findings of this study could be used to enhance non-Muslim nurses' cultural knowledge and skills and enable them to render more cultural congruent care to Muslim patients in the cardiac ICU.



## **1.8 DEFINITIONS OF KEY CONCEPTS**

### **1.8.1 Biculturalism**

Biculturalism refers to the interaction of two cultures and is established during the nurse-patient relationship (Richardson 2004:36). In this study biculturalism refers to the non-Muslim nurses' interactions with Muslim patients in one CICU in the KSA.

### **1.8.2 Care**

Care is an essential basic human need which is required for full development, health and survival (Leininger & McFarland 2002:46). In this study care refers to non-Muslim nurses who meet the needs of Muslim patients in one CICU in the KSA.

### **1.8.3 Caring**

Caring includes all actions and activities utilised in individuals or groups with needs to ease, heal or improve life expectations, death or disabilities (Leininger & McFarland 2002:47). In this study these activities are limited to all these interactions between non-Muslim nurses and Muslim patients in one CICU in the KSA.

### **1.8.4 Culture**

Culture refers to a particular group's learned, shared or transmitted knowledge, values and beliefs that will influence thinking, decisions and actions in patterned ways (Leininger & McFarland 2002:47). Cultural responses develop over time as a result of social and religious structures that shape peoples' daily thinking processes (Giger & Davidhizar 2008:2). This study focuses on the non-Muslim nurses' cultural interactions with the Muslim CICU's patients.

### **1.8.5 Cultural congruent care**

Cultural congruent care involves the use of sensitive and meaningful practices that are appropriate to the general values and beliefs of a patient, that are beneficial or satisfying to them when dealing with health issues, disabilities or death (Leininger &

McFarland 2002:12). In this study cultural congruent care implies that non-Muslim nurses provided culturally appropriate and acceptable nursing care to patients in the participating CICU in the KSA.

#### **1.8.6 Cultural safety**

Cultural safety focuses on the interactions between clients and healthcare providers, emphasising the attitudes of these practitioners (Hart, Hall & Henwood 2003:480). In this study cultural safety implies that the care rendered by non-Muslim nurses to Muslim patients in the participating CICU should be congruent with Muslim expectations and that the healthcare givers should be knowledgeable about the Muslim culture.

#### **1.8.7 Ethnocentrism**

Ethnocentrism is defined as judgements of other cultures in reference to one's own culture (Cundiff, Nadler & Swan 2009:99), possibly judging one's own culture to be superior to other cultures. Nurses who are ethnocentric might not interpret their patients' behaviours appropriately but might judge these patients' beliefs and actions according to the nurses' own cultural expectations.

#### **1.8.8 Transcultural nursing**

Transcultural nursing is defined as the study of diverse cultures, cultural beliefs and values and applying this knowledge in nursing to provide culture specific care to the individual patient (Leininger in Narayanasamy & White 2005:103). Nursing care that is sensitive to the needs of individual patients in diverse populations therefore refers to transcultural nursing. The identification of nurses' experiences of caring for culturally diverse patients in acute care settings contributes to transcultural nursing knowledge (Cioffi 2005:78). In this study transcultural nursing refers to non-Muslim nurses who render care to Muslim patients in the participating CICU in the KSA.

### **1.9 RESEARCH METHODOLOGY**

The research design is the plan of how the research will be conducted, and it specifies the observations to make, as well as the how and when to make them. The design

specifies which variables will be manipulated and how the target population will be selected. Therefore the research design is a set of “blueprints, or system of rules, to be followed in the conduct of a study” (Stommel & Willis 2004:34).

In this study the cultural attitudes of the non Muslim nurses in the KSA are described and explored.

### **1.9.1 Population**

The population in a study as defined by Burns and Grove (2005:746) is “all elements (individuals, objects, events, or substances) that meet the sample criteria for inclusion in a study; sometimes referred to as a target population”. In this study the accessible population comprised all non-Muslim nurses working in the participating CICU in the KSA, for a period of more than six months. A total of 87 non-Muslim nurses were working in the CICU in the participating hospital, but 18 had not worked there for at least six months and were excluded from the study population. As six nurses refused to participate, 63 interviews were conducted ( $87 - (18 + 6)$ ).

### **1.9.2 Research setting**

The research setting was a well established cardiac ICU in the KSA. More details will be provided in chapter 3 about the setting.

### **1.9.3 Research instrument**

The research instrument describes the procedure used during data gathering (Brink 2006:52). In this study a semi-structured interview guide was used. Data generated were non numerical, except for biographic data which were analysed quantitatively. The semi-structured interview's items explored the Non-Muslim nurses' experiences of caring for Muslim patients in a specific CICU in the KSA.

### 1.9.4 Data collection

Semi-structured interviews with open-ended questions (supported with specific probing questions) allow for flexible data collection. Standard questions were asked in the same predetermined sequence from all participants (Stommel & Willis 2004:282). The goal of semi-structured interviews was to explore or describe phenomena which were not yet well defined. Individual interviews were conducted in a private room to ensure each participant's comfort. Probes were used to clarify certain aspects or to obtain additional information and to ensure that each participant attended to similar issues, while retaining the possibility of narrating their unique lived experiences.

### 1.9.5 Data analysis

Qualitative data analysis involved moving from the collected raw verbatim recorded data, through the systematisation to a form of explanation and understanding. The semi-structured interview data attempted to explain individuals' views. Data analysis involved the writing and identification of themes; and themes involved coding. Labelling or coding enabled the retrieval of data associated with the thematic idea (Lewins, Taylor & Gibbs 2005:1).

## 1.10 ETHICAL CONSIDERATIONS

**Table 1.1 Basic ethical principles to be adhered to while conducting research**

	<b>BASIC ETHICAL PRINCIPLES</b>			
	<b>Autonomy</b>	<b>Justice</b>	<b>Beneficence</b>	<b>Non-maleficance</b>
<b>Participants</b>	Informed consent from each participant	Right to privacy and fair treatment; no name of participant nor of hospital would be disclosed	Freedom from harm, no exploitation of participants	Willing participation, freedom to withdraw at any time
<b>Institutions</b>	Right to privacy protected	Anonymous data collection and consent for publication	No known conflict of interest	Institutional review board
<b>Researcher</b>	Full	Confidential data	Use of	Free from bias

	disclosure of factual data	collection procedures; no names would be made available; data of every interview would be numbered	appropriate research methods	and submission of own ideas
<b>Ethics pertinent to the research topic</b>	Protecting the rights of the participants by publishing factual events	Fairness towards participants in relation to care delivery standards – non exploitation	Use of appropriate study designs, non exploitation of vulnerable population groups	Completing true, factual research design

(Stommel & Willis 2004:377-383)

### 1.10.1 Confidentiality

In this study the participants' right to privacy was protected by not sharing personal information like names and dates that could be directly linked to any individual.

### 1.10.2 Justice

In this study the participants received fair treatment during the semi-structured interviews because they were allowed to decide independently whether or not to participate in the study. No name could be linked to any interview.

### 1.10.3 Trustworthiness

Trustworthiness in qualitative research refers to "a matter of persuasion whereby the scientist is viewed as having made those practices visible and, therefore, auditable" (Rolfe 2006:305). Qualitative research is the study of the "empirical world from the viewpoint of the persons under study", and the findings are reviewed by peers and readers (Krefting 1991:215). Participants' behaviours might be influenced by their environments (Orb, Eisenhauer & Wynaden 2001:93). Subjective meanings from the participants are crucial in this study. Trustworthiness, as applied to this study, will be discussed in more detail in chapter 3.

### **1.11 SCOPE AND LIMITATIONS OF THE STUDY**

The study was conducted in one CICU unit in the KSA. The hospital does not allow any research on patients. The patients' perspectives on transcultural nursing are valuable but remained unattainable.

Cultural differences between the researcher and the participants might have influenced the respondents' answers. However, all possible steps were taken to ensure that the researcher's perceptions remained bracketed and that the data would be trustworthy.

### **1.12 OUTLINE OF THE STUDY**

Chapter 1 introduced the topic and discussed the purpose of the study.

Chapter 2 discusses the literature review conducted to understand themes related to the non-Muslim nurses' experience of working in a CICU environment in the KSA.

Chapter 3 describes the research design and methodology, including data collection and population. The scope and limitations of the study, as well as the ethical considerations are also addressed.

Chapter 4 deals with the data analysis and discusses the research findings.

Chapter 5 concludes the study addressing the conclusions, recommendations and limitations of the study.

### **1.13 SUMMARY**

This chapter introduced the study topic and field and provided background information contextualising the importance of conducting research on non-Muslim nurses' experiences in providing care to Muslim patients in one participating CICU. Leininger's Sunrise Model of Transcultural Nursing provided the theoretical foundation for this study.

The research objectives, questions, purpose and significance were explained. Key concepts were defined. The research methodology section addressed the accessible population, research instrument, data collection and data analysis procedures.

The next chapter will present an overview of the literature studied concerning non-Muslim nurses' experiences of working in ICUs in Saudi Arabia.

## **CHAPTER 2**

# **LITERATURE REVIEW**

### **2.1 HISTORICAL BACKGROUND**

There are about 1.6 billion Muslims around the world, with the largest minority Muslim community in India (about 140 million) (Hasan 2010). Muslims originated from Spain and Sicily from the 8<sup>th</sup> to the 15<sup>th</sup> century, and the Ottoman Empire expansion in the 15<sup>th</sup> and 16<sup>th</sup> century brought Muslims to Western Europe (Worldatlas 2010). Muslims in the European (Western) countries might encounter problems related to social, legal status, language, values or customs (Husain 2007:114). Muslims are believed to be worse than other religious groups to report poor health and illness or disabilities (Sheikh & Gatrad 2000:8) which is possibly due to their belief that only Allah will cure them.

### **2.2 THE ISLAMIC FAITH FOUNDATION WITHIN THE KINGDOM OF SAUDI ARABIA**

The Kingdom of Saudi Arabia adheres to conservative Islamic leadership and Islam is regarded as the encompassing ethos of the country. The Qur'an (holy book of the Islamic faith) and accepted "hadeeths" (sayings of the prophet Mohammed) are the basis for politico-religious authority. The Muslim people vary in their expressions and religious beliefs, and range from liberal to extreme fundamentalists (Wehbe-Alamah 2008:85). Within Islam, there are two main sects. The Sunni sect, who are the majority of Muslims worldwide and in the KSA, are strict adherers of the Qur'an and hadeeths. The Shi'a Muslims are followers of the Qur'an, some aspects of the hadeeths and the traditions of Imam Ali and his descendants.

The inspirational knowledge for Muslim patients is the holy Qur'an and Sunnah (life ways of the prophet Mohammed) which provide a balance between the human and the spiritual



worlds. Some of the principles of the Qur'an and "Sunnah" explain the disturbances that can occur in the heart and blood vessels (Targut, Yalta & Tandogan 2009:1). Some disturbances in the heart (spiritual sickness) according to the Qur'an, include love of the world and wealth (Qur'an 10:7-8), greed (Qur'an 20:131), treachery (Qur'an 4:107), taunting or disputing (Qur'an 22:3), and could be prevented by practising fortitude (sabr) (Qur'an 21:37).

Cardiovascular disease, according to the Qur'an and hadeeth, can be decreased through moderate eating, engaging in spiritual activities, reduction of anger or jealousy, physical labour and elimination of greediness. The verses in the Qur'an and hadeeth related to the cardiovascular system are both spiritual, scientific and influence medical anatomical texts (Loukas, Saad, Tubbs & Shoja 2010:20). The heart is described as an organ of intelligence, psyche, emotion and a vehicle for life.

The Qur'an and hadeeth both explain physical and spiritual healing. Divine healing of the heart occurs via the teachings of the Qur'an when God removes "rage from the heart" (Qur'an 42:37). Hidden ailments according to the Qur'an include impurity, disbelief, falsehood, doubt and hypocrisy attributed to diseases of the heart. Muslims believe that faith and loyalty to God will cure illness. Other treatment options, for ailments like fever, (according to the hadeeth) include honey (used for curative interventions), cupping (blood letting), cauterising and "zam-zam" (drinking water from a miraculously generated source in Mecca) (Mebrouk 2008:154).

The Qur'an describes the intimate relationship between man and God, which is closer to him than his jugular vein (Quran: surah Qaf:16). The jugular vein is connected to the heart which is the maintenance of life. The repetitive use of the word "heart" in the Qur'an embodies the spiritual beliefs of Muslims and demonstrates three groups of people related to the heart. First are the believers (mu'minoon), second the rejecters of faith (kafiroon) and third the people or hypocrites whose hearts are diseased (manafiqoon) (Qur'an 17:23; 23:117).

Positive characteristics of the human being according to the Qur'an include being

- given dominance over the universe (Surah 45:12-13)
- given mind and power of thought (Surah 29:20)
- given the privilege of spiritual elements (Surah 38:71-72)
- created in order to worship Allah (Surah 51-56).

Negative characteristics of the human being, according to the Qur'an, include:

- weakness (Surah 4,28)
- hastiness (Surah 21,37)
- tyranny (Surah 96:6-8)
- fearfulness (Surah 12:53).

The three major monotheistic religions in the world include Judaism, Christianity and Islam (New World Encyclopedia 2010). Islam, as a religion, recognises submission to Allah, recognises Muhammad as the last prophet of Allah, the holy book is the Qur'an and it influences all actions of a person's daily life including the way of worshipping and praying.

### **2.2.1 Religion and spirituality**

Religion and medicine are both seen as an important way to meet human needs. Modern medicine believes that no treatment must be applied before evidence of safety. Patients admitted to a cardiac unit, and who had been prayed for prior to admission, could encounter fewer complications (10%) compared to patients who had no prayers said for them before admission (Cohen, Wheeler, Scott, Edwards & Lusk 2000).

There is no single definition that can encompass all religions. Some possible definitions include a set of beliefs, especially believing in God or gods; an organised system of belief; or something one follows devotedly. All mentioned definitions could be viewed as incomplete and inadequate with possible Western bias. Robinson (2010:1) defines religion as "human transformation in response to perceived ultimacy". Most people around the world are perceived as being religious, because religion helps people cope by meeting social and psychological needs. Abdel-Hady in Husain (2007:259) stated that "religion is

an instinctive thing in man, deeply rooted in his nature. Man might have led part of his life, whether short or long, without sciences, arts or industries. But history has never known a human group that lived without religion".

Religion is the foundation of individual life, and is the most common shared source of values. Some people believe that there is no relationship between science and religion, or between religion and spirituality. Islam (as religion) is described by Abdel-Hady (in Husain 2007:251) "as not a mere ideological vision".

Religious and spiritual diversity is associated with global migration, and "the popularity of personalised spiritualities is challenging theories of secularisation that are based on observations of modernising countries" (Pesut & Reimer-Kirkham 2010:816). Spirituality is often defined according to Christian or Jewish models which are presumed universal, which might be perceived as being insensitive towards minority cultural groups with fewer familiar traditions. Religion and spirituality play an important role in nursing care delivery, and a person's own cultural, spiritual and professional identity might affect the religious and spiritual care-giving (Pesut & Reimer-Kirkham 2010:819). The application and use of spirituality could be high amongst patients with heart diseases (Warren-Findlow & Issel 2010:51).

Spirituality (Rassool 2000:1479) in the nursing literature could be defined as "the summation of values and determines how we interact with the world". Religion, on the contrary, is the pathway of practices appropriate to a God or gods. Florence Nightingale described the spiritual dimension of nursing, and regarded these principles essential for rendering quality patient care. Spirituality has a vertical (the person's relationship with God or supreme beings) and a horizontal (relationship with 'self' and other people) dimension. Islam, according to the Qur'an and sayings of the Holy Prophet, maintains that religion is embedded in spirituality and there is no distinction between religion and spirituality.

Sellers (2001:240) defined spirituality as "the provision of unifying human energy that will influence both health and healing" and argued that nurses might lack the underlying theoretical knowledge regarding spirituality. Spiritual care provision is part of ethical

obligations during nursing care delivery, and not treating a patient in totality could be considered as being unethical. Spirituality is culturally bound and depends on each person's interpretations embodying the values of the heart, intellect and performance. Transcultural nursing provides theoretical guides for assimilating spirituality into nursing practices.

Health is a complex phenomenon that balances all aspects of the body, mind and spirit. Body aspects include physical aspects such as gender, age, genetic inheritance and body chemistry while the mind consists of cognitive processes such as memories, knowledge, emotions and feelings. The spiritual aspect includes spiritual practices, intuition, grace, protecting forces and dreams. All of these forces are in constant change over time and are 'self' referenced, and refer to the holistic context of a person (Specter 2002:197). Religion and coping converge; and involve beliefs, practices and feelings which set the foundation of how a person will view and deal with the world. Patients tend to be more involved in the spiritual dimension during stressful circumstances (Ai, Seymour, Tice, Kronfol & Bolling 2009:115).

Spiritual struggles involve the understanding of the psychology of spirituality, religion and human reactions during crisis. Religion cannot be reduced to morality, but combines feelings and perceptions, directed towards the supernatural features.

### **2.3 THE RELIGION OF ISLAM**

The three major monotheistic religions in the world include Judaism, Christianity and Islam. Islam means 'peace, submission and obedience' and recognises Muhammed as the last prophet of God (Allah). The holy book is the Qur'an which guides conduct in daily life, worshipping and praying.

Prayer is performed five times a day at certain prescribed times, and Islam (the faith) is built on five pillars including the declaration of faith, daily prayers, fasting during the holy month of Ramadan, giving alms to the poor or needy and performing one holy pilgrimage (Hajj) to Mecca (Holy city) once in a lifetime. The Qur'anic version differs from the Biblical version regarding the wiping out of original sin. Muslims believe that all children are born

without sin. Health and disease originate from cultural factors that include language, norms, values and religion. Before the scheduled prayers the hands, face, mouth, nose, forearms and feet have to be washed with water. Sand can be used if water is unavailable (Pennachio 2005:50).

During the early Islamic days the Muslims used to face Jerusalem when praying, but this was changed during the January 624 prayers by prophet Muhammed. This change was to prove the distinction between Christianity, Judaism and Muslims. Muslims believe that the ka'bah in Mecca is the first shrine built by prophet Abraham to offer his son to God. "... so turn your face in the direction of al-masjid Al-Haraam (at Mekkah). And where so ever you people are, turn your faces (in prayer) in that direction..." (Qu'ran, Al-Baqarah 2:144).



<http://www.greatmosqueinmeccatoday>

Figure 2.1: The holy mosque in Mekkah

The five obligatory prayers correlate with the time of eating, and the physical movements performed during prayers (like standing and prostrating) might help prevent deep vein thrombi. No eating or talking is allowed during prayers. Foods such as white meat and

whole grains are encouraged while pork is forbidden (Qur'an 16:115; 2:173) due to the high fat content and potential diseases (Trachinella and Teniasis) which it could transmit.

The month of Ramadan is considered the holy month in the Islamic calendar. This month lasts 29-30 days, depending on the sighting of the moon to indicate a new month. It is during the month of Ramadan that the Qur'an was revealed to the prophet Muhammad, and this revelation resulted in more than one billion Muslims fasting worldwide. Fasting means abstention, and fasting Muslims eat only two meals each day – one before sunrise and one after sunset. Fasting is a significant form of worship, and is one of the pillars of Islam (Yusuf 2004:6).

Fasting is not obligatory for children, chronically ill patients, pregnant women, menstruating women, senile patients or people who are travelling (Yusuf 2004:8-9). Hospitalised patients often choose to participate in the fasting, but this could affect cardiac patients. Fasting could lead to altered circadian rhythms because of the increased nightly worship, decreased medicine compliance and changes in dietary patterns. These changes could also affect the diabetic patients' health. Diabetic patients might alter their prescribed treatment and eating habits according to the prescribed worshipping and fasting hours of Ramadan.

Even hospitalised patients obtain their daily calorie intake in only two meals instead of scheduled five smaller meals (Al Suwaidi, Bener, Hajar & Numan 2004:217). Although fasting is not compulsory for critically ill patients (or patients in the cardiac ICU) (Qur'an, surah Al-Bakarah:183-185), most patients prefer to fast in order to obtain the rewards associated with the fasting period in the after- life (Yusuf 2004:8). Rewards in the after- life include a special entrance gate in heaven for those who fasted and obeyed the fasting command of Allah, and that the fasting period is a purification from this life and enjoins moral elevation and spiritual development (Qur'an, surah Al-Nisa v103; Al-Hubaiti {s.a.}:45). Fasting during the month of Ramadan involves total fasting from sunrise to sunset, with the idea to focus on the spiritual and to be detached from the material (Galanti 2004: 65).

According to Laird, De Marais and Barnes (2007:2432): “Islam is a problem for biomedical healthcare delivery”. Nurses should respect their patients’ cultural and religious values even when these values conflict with challenges of the modern/biomedical healthcare system. Islamic religious scripts prohibit pork products and some gelatine capsule encasings contain pork products. These might create a dilemma for physicians’ prescriptions. Muslim diabetic patients might refuse to take their insulin because of the pork-based content. The usage of non-pork based or synthetic insulin should be used wherever possible (Qureshi 2002:489). Food is always eaten with the right hand because the left hand is used for cleaning after toilet usage. Nurses might experience the Muslims patients’ refusal to treatment as noncompliance with their treatment plans.

Other problems might occur during the nursing care delivery process such as the female patients’ refusal to undergo physical examinations and tests like breast cancer screening if conducted by male physicians (Al-Hashimi 2005:80-81). However, “being Muslim may promote good health” (Laird et al 2007: 2433). Many Islamic traditions or ideas like female modesty and fasting could help prevent illnesses like obesity, but economic growth and modernisation had significant impacts on health-related issues stemming from excess dietary consumption (Aldossary et al 2008:125). Cardiovascular disease accounts for 22% of deaths in the KSA each year (Saudigazette 2010). Although the Arabian population, most of whom are Muslims, is one of the fastest growing populations (Marrone 2008:8), the image of the Muslim seems to remain largely negative (Shore 2005:477).

Prayer is performed in a clean area, preferably on a prayer mat known as a *musla* but the use of prayer beads (tasbih) is not compulsory in Islam. The 99 beads in the tasbih symbolises the 99 names contributed towards God (Allah). Tasbih can be made of wood, ivory, pearls or plastic and can be used to recite the scheduled prayers to God. The first 33 beads signify ‘praise be to God’, the following 33 beads ‘thanks be to God’ and the final 33 beads ‘God is great’. During prophet Muhammed’s time date stones were used to make the tasbih and its use remains part of Islamic traditions. The use of tasbih is not exclusive to Islam, and can also be found in Christianity (rosary) as well as Hinduism.



<http://en.wikipedia.org/wiki>

**Figure 2.2: Traditional tasbeih made of wood**

Muslims view the human heart as indicator of good or disease as depicted in the following saying from prophet Muhammed (in Sheikh & Gatrad 2000: 36) “ There is in the body a piece of flesh, and if it is good the entire body is good. However, if it is diseased, the entire body is diseased; and know, it is the heart.” Some signs of a diseased heart include disbelief in Allah, hypocrisy, arrogance, dissatisfaction as well as material and temporal love.

Healing of the heart is explained by prophet Muhammed in Sheikh and Gatrad (2000: 39) as “Allah did not send down a sickness except that He sent down its cure”. Certain rights of the human body include respect in life and death, and the adherence to sacred laws like hygiene, intake of *halaal* (lawful) food as well as enough exercise and rest periods.

Understanding of the Islamic faith is needed when caring for the Muslim patient, and privacy times are needed during prayer periods. Conflicts can arise when a nurse interrupts the prayer periods, or misinterprets a Muslim patient’s kneeling on a mat while praying aloud and performing strange behaviours (Galanti 2004:53), to be symptoms of a psychiatric condition, such as schizophrenia.

Conflicting beliefs can be sources of frustration and misunderstanding but can be dealt with successfully by understanding the person’s beliefs rather than trying to work against them.



Farooqui in Husain (2007:241) stated that "love for our fellows is not limited to physical appearance, it is love for being human". The West and the East have a "history of hatred, fight and confrontation which still control an important part of the collective unconscious self esteem of the West. East is East and West is West. And never shall the two meet" (Husain 2007:109).

### ***2.3.1 The Western (biomedical) versus the Eastern (Islamic) care-giving approach***

There are differences between the care giving of patients from the Western (biomedical) and the Eastern countries. Living in another country for a period of time might enable international nurses to explore new cultures and broaden life experiences through foreign cultural exposures (Myburgh, Niehaus & Poggenpoel 2006:107). Culture plays an important role in individuals' perceptions of daily issues.

Nurses are culturally diverse. They were socialised into the biomedical perspective (especially with their ICU training), and now they have to work in a culturally "strange" environment where the patients view the world according to a religious perspective (biomedical versus spiritual and Islamic perspectives). Spirituality is difficult to define, and is believed to be about experiences and meanings in daily life, or it is related to the presence of "spirit or one's creator, a sense of transcendence, and becoming" (Tse, Lloyd, Petchkovsky & Manaia 2005:182). Spirituality affects individual functioning and wellbeing, and includes features like meaning, connecting, transcendence, value and becoming (Tse et al 2005:182).

Nurses need specific skills and knowledge to care for culturally diverse individuals, without limitations. Cultural competence requires knowledge of transcultural nursing theories and knowledge related to human behaviour, problem solving skills and management. Assessment skills are essential when asking patients about their health beliefs or asking other culturally sensitive questions (Douglas, Pierce, Rosenkoetter, Callister, Hattar-Pollara, Lauderdale, Miller, Milstead, Nardi & Pacquiao 2009:261).

Halligan (2006:1565) stated that the concept of family and the meaning of religion is central in the provision of care, and that nurses should reflect on their own clinical practice to understand the impact of religion during their encounters with Islamic patients. There are stronger family ties between people from the Middle East (although weaker than 100 years ago) than people from the Western countries (Al-Omari 2008:118). Caring for patients from Middle Eastern origin with the tighter family ties could initially be more challenging or difficult for the biomedical/Western orientated critical care nurse (Aboul-Enein 2002:229).

There are strong supportive relationships between critical care nurses' races, attitudes and past exposures to transcultural nursing knowledge (Marrone 2008:13). Critical care nurses' attitudes towards Muslims have significant influences on the provision of culturally congruent care, and the development of culture specific learning opportunities has to be implemented in critical care nursing programmes. Western orientated nursing schools must adopt culturally congruent models of teaching. The provision of culturally congruent care requires a clear understanding of factors that influence nurses' decisions to provide care which is congruent with a patient's values and beliefs.

Cultural competence (Giger & Davidhizar 2008:6) is a dynamic continuous process which healthcare agencies find to be useful care delivery strategies based on cultural beliefs, attitudes, behaviour and heritage to render comprehensive care. Nurses need to apply their skills and knowledge in creative ways during actions in order to provide culturally competent care (McFarland & Eipperle 2008:50). Cultural competence is a journey, not only a process. Nurses should work towards achieving cultural competence that consists of cultural awareness, cultural sensitivity, cultural knowledge and cultural skills which are required to provide culturally congruent care (Mixer 2008:25). Major differences between the Western and the Eastern countries are depicted in table 2.1 (Bibikova & Kotelnikov 2001):

**Table 2.1 Differences between Eastern and Western countries**

<b>Value</b>	<b>East</b>	<b>West</b>
Main schools	Islam	Christianity
Religious relationship	Integrated	Oppositional
Search for the “truth”	All aspects in the universe are interconnected	Focuses on individual roles and functions
Future perspectives	Future is shaped by daily good or bad deeds	Truth aspects must be proven
Beliefs and values	All that is perceived as true is within the person	True success is happiness.
Implementation	Spiritual	Emotional
Principles	Virtues	Ethics

Caring for a Muslim patient can thus be defined as holistic, integrated and spiritual in contrast when caring for a non Muslim patient as individual, oppositional and emotional. The purpose of knowing/understanding each patient's religion includes the idea that all basic human needs are the same but the way we meet those needs is influenced by culture. Through heightened spiritual awareness, resources for encounters with others who suffer from illnesses are provided, and commitment towards the suffering person is strengthened. The value of the family supercedes the value of an individual, and family members can provide social, economic and nurturing support to the patient.

Children are only cared for by family members, and only on rare occasions by unrelated persons. Family members live in close proximity and therefore the extended family can provide support to the nuclear family. Divorce is permitted in Islam, and infertility is an acceptable justification for divorce. The husband is also allowed to get married to another wife to bear children.

“The Western biomedical model is the most dominant model, but to assume that caregivers from different cultures accept the biomedical model can be deleterious to health expectations and outcomes” (Leininger & McFarland 2002:266).

The framework proposed for the provision of culturally competent care (Clark- Callister 2001:210) includes:

- Understanding the dimensions of the culture. Commence the nursing assessment by trying to determine the patient's cultural heritage, including health beliefs and remedies. Stereotyping ethnic groups can lead to mistaken assumptions about clients. Assessment enables the nurse to gather relevant cultural data. Culture is the essence of daily living.
- Moving beyond the biophysical. Assessment skills should include biological and physical knowledge and variations among racial groups, including risk factors like diabetes and hypertension. Culture must be seen as unique, dynamic and significant and must reflect daily experiences. Evaluate personal attitudes towards ethnic nursing, and acknowledge cultural differences in order to deliver individualised holistic care. During the process of self evaluation the nurse might become more comfortable when dealing with cultural differences. Religious health and spirituality are correlated with a higher quality of life.
- Seeking to increase knowledge, change attitudes, and hone clinical skills. Cultural competence combines feeling, thinking and acting in ways that acknowledge and respect diversity while understanding that culture is the sum total of traditions, beliefs, ways in which people function and human thoughts. Socio economic influences play a major role in seeking health and wellness.

The “incompatibility between Muslims and biomedical care is sometimes based on inaccurate assumptions” (Laird, De Marrais & Barnes 2007:2434). When caring for a patient (according to nursing ethics) aspects like colour, race and religion are not determining factors for the quality of care the patient should receive. Cultural essentialism “makes the categorisation of people by race hazardous to the wellbeing of those who are labelled” (Getty 2010:6). Nurses have to get used to the cultural differences between themselves and their patients. Furthermore, nurses function according to the biomedical perspective using scientific principles in the ICU. Expatriate non-Muslim nurses working in the KSA either get used to the cultural behaviours and accept the culture or constantly question the health behaviours and beliefs of the Muslim patients. The longer the nurses are exposed to the cultural differences the more acceptable the healthcare beliefs and

practices might become. Communication between and across cultures is a critical issue for effective cultural understanding (Papadopoulos & Omeri 2008:45). Cultural tradition is the key factor that prohibits aspects like cross sexual communication that could lead to the initiation of friendships. Direct 'male' eye contact in the KSA could be perceived as being impolite.

All patients should be well informed regarding healthcare options and to be actively involved in their healthcare decisions (involving effective communication skills) (Rodriquez, Appelt, Switzer, Sonel & Arnold 2008:258). Good communication skills encourage adherence to treatment regimes, reduce stress and anxiety and reduce psychological effects related to treatment. Medical decision making within the KSA involves the patient's immediate family. "The disclosure issue can present a potentially serious legal dilemma" (Pennachio 2005:48). At first a heart attack patient could be told that he or she has just fainted. Expatriate nurses working in the KSA should have some understanding of the Arabic language or expressions to enhance communication skills with patients. Variations in patient outcomes (in the ICU setting) might be based on the specialist nurses' backgrounds (Braun & Spies 2010:409). There are supposedly no differences between Muslim and Christian nurses' education (Hajj & Panizza 2008:337). Communication is the key for providing sensitive nursing care. Culture involves observable behaviours, and gives a sense of who a person is. When people communicate they share words and ideas that explain who they are (Burnard & Naiyapatana 2004:755).

When rendering high quality care for diverse populations the nurse must have implementable strategies to render culturally congruent care. Nursing, defined according to the Western perspective, focuses on the individual with autonomy and self care. Family members and especially the role of the mother is critical from the Islamic perspective (Aboul-Enein 2002:230). Social support for Muslim patients is extended because family members prefer to live in close proximity to each other (Giger & Davidhizar 2008:95). Problems relating to one individual also concern the whole family. The increased complicated patient populations raised the healthcare consumers' expectations from the healthcare professionals.

### **2.3.2        *The biomedical health perspective***

During the 1800s, biomedicine started to dominate the healthcare scenes, based upon the concept of the body as a machine as described by Descartes, who defined the dualism between body and mind (Wikipedia 2010). Biomedicine was shaped by two sets of observations, namely that specific entities or bacteria were disease causing and that antitoxins or vaccines could ward off these pathogens like typhoid and tetanus. Louis Pasteur demonstrated the correlation between disease and illness and the biomedical perspective still applies his theories (Wikipedia 2010).

One shortcoming of the biomedical perspective could be that it does not incorporate psychological, psychosocial or spiritual factors that are associated with disease causing. During mental illness efforts could be coined to find organic causes like infections and nutritional deficiencies (Wikipedia 2010). Modern medicine, by reducing the human body to that of a machine or mechanical function, could lose the insight that the patient is a total human being and that healing processes should consider this 'wholeness' (Wikipedia 2010). The WHO defines health as follows: "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" could be useful when incorporating healing into theory and nursing practices (Wikipedia 2010).

Integrative nursing combines nursing practice through history with the biomedical understanding of diseases that the whole is greater than the sum of its parts. Western health is known for its biotechnology, drugs and use of surgeries (Wikipedia 2010). Critical care nurses' ability "towards effective hemodynamic decision making immediately post cardiac surgery is crucial and requires complex skill application and understanding in order to consider numerous parameters and attributes within a limited time frame" (Currey & Botti 2006:194).

Patients who undergo cardiac surgery could experience haemodynamic instability for at least two hours post-op because of the physiological changes associated with the cardiopulmonary bypass. Effective nursing decision making could affect patient outcomes and are affected by the level of cardiac surgery nursing experience, technical advances and nursing colleagues' support. Nurses' knowledge and experience in the ICU setting

might enhance critical decision making. Experience alone could not guarantee effective decision making during hemodynamic decision application

### **2.3.3 Worldview**

A person's worldview consists of basic assumptions about reality, which become foundational for all actions/interpretations. Worldview has an important influence on health, and culture affects how a person perceives things. Religion defines a worldview about health and illness (Galanti 2004: 10).

Spiritual beliefs form an integral part of people's lives, and become more important during illness. There is a difference between Western and Eastern medicinal worldviews, seeing that Eastern medicine is based on faith and beliefs while Western medicine is subjected to experimental research and testing (Wikipedia 2010). Muslim patients and their relatives "turn to religion for comfort during times of crisis, such as critical illness and impending death" (Sutherland & Morris 1995:508).

### **2.3.4 Traditional clothing in the KSA**

Modest styles of women's clothing are evident in the KSA. Culturally all women are expected to wear an *abaya* (black dress) that covers the neck line, the arms up to hands and the legs up to the ankles and a *hijab* to cover half or the entire face. Mens' traditional clothing consists of a *thobe* (white dress), *taqiyah* (skull cap), *ghutra* (head scarf made of silk or cotton) and an *aqal* (double, thick black cord to keep the ghutra in place). The significance of the *thobe* (loose garment, ankle length and usually made of cotton) is to be suitably dressed in the hot climates of the KSA as well as to express equality amongst all people (Smith 2005).

## **2.4 CULTURE**

Culture can be defined as "patterned behaviour, and develops over time, is formed as a result of social and religious practices as well as intellectual manifestations and is shaped

by beliefs, values, norms and practices shared by the members of the culture” (Giger & Davidhizar 2000:2). According to Schim, Doorenbos, Benkert and Miller (2007:104) culture is “the integrated pattern of human beliefs, knowledge and behaviours, and depends on the capacity for learning and transmitting knowledge, beliefs, social forms and traits related to race and religion through succeeding generations”.

Cultural values guide actions and decisions and are those unique expressions that have been accepted as being appropriate. People are separated from one another through ethnicity, culture, language and race.

Cultural values determine a person’s beliefs and values and conflict can arise when there are conflicting values or beliefs between the nurse and the patient (Walsh & Crumbie 2007:23). Each patient should be assessed individually to determine cultural preferences rather than applying ethnic stereotyping (making assumptions about a person because of his or her ethnic descent). Muslim men traditionally wear long beards. Shaving of the beard could be “interpreted as a sign of shame or dishonour” (McKennis 1999:1191).

Cultural competence (Gustafson 2005:2) represents a set of individual attitudes, communication and practical skills that enable the caregiver to work within the cultural context of the patient from diverse backgrounds. Cultural customs originated for practical reasons, but people sometimes do not act in a practical manner. The stronger the custom; the “stronger the reminder of ethnic or religious identity” will be (Galanti 2004: 19). “Muslims do not wish or plan for death” (McKennis 1999:1189). The dying patient should only be handled by close relatives. Nurses should be encouraged to wear gloves when touching the body because it is believed that the body belongs to Allah (McKennis 1999:1189).

Culture care knowledge (Leininger 2007:10) is the sound basis to establish nursing as a distinct and scientific discipline. Cultural knowledge is needed to care for culturally diverse populations in a safe and beneficial way. Healthcare is rapidly growing in a multicultural world and cultural care factors could not be overlooked. Culture includes a range of social behaviours, attitudes, values and shared symbols that most cultures take for granted for the most part of their lives. “Culture is shared, learned, dynamic and evolutionary” (Schim



et al 2007:104). Cultures are constantly changing and evolving in response to ever changing physical, social and political realities. Conflict is generated through circumstances when cultural norms and institutions are being modified. Culture also implies a dynamic system perspective that includes diverse subcultures and communities of interest. Culture complexity pervades all aspects of healthcare and life itself.

## **2.5 Cultural liberty**

Cultural liberty implies that all people have to maintain their religious identities, ethnicity as well as linguistic identities, also referred to as cultural rights (Johnstone & Kanitsaki 2009:408). Respect towards individual cultural rights does not mean that healthcare workers must accept all cultural traditions blindly, especially those that have been proven to be harmful. Culture is constantly recreated as people change their practices and realities. Cultural liberty is “to give people adequate opportunities to consider all available options while living – and to be what they choose” (Johnstone & Kanitsaki 2009:408). Patient autonomy relates to the concept of individualism, uniqueness and dignity.

## **2.6 Cultural differences**

Cultural diversity is a fact of life. Language can be seen as a small subset in all universal concepts. What is experienced as normal or deviance is universal in all cultures. Human awareness of mortality, hunger, water and shelter, sexual desires distinguish human life from other life forms. All humans have reasoning and practical capacities, perceive and imagine with feelings (Reed, Crawford Shearer & Nicoll 2003:396). Lane and Rubinstein (in Reed et al 2003:396) suggest that there must be recognition of another’s priorities to bridge the gap between cultural relativism and universalism.

Culture must be viewed within its total social context to understand culture specific behaviour and holism requires that the human behaviour is interpreted within context of occurrence. The components of culture include aspects like religion, politics, economics and health systems and are meshed to form meaningful and operating wholes (Giger & Davidhizar 2008:68).

Ethnic stereotyping (Watson 2007:31) can be avoided by treating patients as individuals and not making assumptions about ethnic groups. Ethnocentrism (Gustafson 2005:11) is the “belief that one’s own culture is superior to that of others”.

Cultural sensitivity is composed of certain attributes like knowledge, understanding, consideration, respect and tailoring (Foronda 2008:208). Cultural knowledge can only be acquired through experience within a culture within a specified context, or through training and education; while consideration can be achieved through fostering and caring for others. Consideration and caring are prominent in healthcare settings when caring for diverse population groups. Understanding the significance of cultural meanings implies understanding one’s own values and experiences first, and then comprehending the perspectives of others.

Ethnicity can be defined as the “social organisation of cultural diversity”, and in order to fully understand ethnicity, one must understand culture (Hoye & Severinsson 2008:339). Culture is a dynamic system which encompasses values and beliefs that will shape interactive processes throughout the lifespan. Increased global mobility established ethnically diverse populations in all countries. Multicultural patients and family members could experience additional stress during hospitalisation because of language barriers.

Nurses’ work in the ICU setting is connected to advanced technology, and therefore emphasises that technology is connected to patient welfare. Cross cultural communication is often a barrier in the ICU when caring for diverse patients, and sometimes nurses tend to stereotype patients according to their cultural groups. Caring for the culturally diverse patient is complex and challenging, and stressors are identified as lack of knowledge about cultural behaviours, language barriers, cultural flexibility and acceptance. Patients in the ICU setting experience loss of power and time, and the family members could be seen as the lifeline to orientate them to time and place in order to enhance recovery (Dhami & Sheikh 2000:352).

## 2.7 Cultural competence

Cultural competence's attributes include cultural awareness, cultural understanding, cultural knowledge, cultural sensitivity and cultural skills (Cowan & Norman 2006:83). Cultural competence is defined as the development of skills and knowledge during human interaction. Nursing is a holistic process and cultural competence is a prerequisite during the caring process. Cultural competence is therefore engaged in sensitivity and also includes consideration towards issues like gender or sexual orientation.

Culturally competent healthcare professionals display cross cultural negotiation skills in ways that are acceptable to the care recipient. Cultural competence "is a never-ending process of becoming rather than a state of accomplishment" (Ogilvie, Burgess-Pinto & Caufield 2008:65), and could occur on the individual, systematic and organisational level.

The earth contains about 6.5 billion people and the closer people come into contact with each other a higher rate of interaction will develop which requires a higher degree of knowledge and experience to raise cultural awareness (Wordatlas 2010). "Globalisation is the contemporary human condition which the forces for global cultural uniformity, with the attendant risk of endangering forces to maintain or even strengthen cultural distinctiveness and diversity, resulting in a volatile mix of potentially creative tension towards a new world order and a downward spiral towards cultural extinctions and conflicts (Kashima 2007:129).

Globalisation brought about changes and people demand nursing care that is culturally appropriate (Williamson & Harrison 2010:763). The reality of globalisation is becoming more evident. The inhabitants of the KSA could be classified as global citizens. Humanity and social justice is imperative when rendering healthcare (Douglas & Lipson 2008:162). Cultural competent nursing care is committed to the protection of fundamental human rights. Nurse professionals need to develop world cultural skills through understanding their own lifestyles, appreciating cultural differences and respecting human rights (Pacquiao 2008:196).

Globalisation generated the need for reflective practice to deliver culturally competent care to any patient from diverse areas of the world (Torsvik & Hedlund 2008: 389). Globalisation according to Baker (2006:304) “does not necessarily blur the distinction between culturally safe and culturally unsafe groups”, but might put local minority groups at cultural risks. International nurses are encouraged to think about cultural safety and their own cultural practices when caring for patients within a defined cultural group.

Globalisation is advantageous to the Western world (Narayanasamy et al 2005:105) because of the dependency upon foreign money. Globalisation pervades cultural identities and individual respect and humanity prevails in factors like ethnicity, colour and religion. The globalised reality of the post 9/11 attacks in the United States of America (USA) where many people were killed had a negative impacts on the social identity, wellbeing and cultural safety of many Muslims in the Western world (Baker 2007:297). After the terrorist attacks “hate crimes against Muslims” increased 160% between 2001 and 2002 and mistrust of all Muslims from the Middle East increased (Baker 2007:298). “For Muslims, whether political dissidents or actual Islamists, the world is evidently engaged in a culture war, a war of faiths...” (Jenkins 2010:24).

Changes in work force resulting from globalisation made multicultural workforces a reality (Thomas 1999:242). The migration of nurses around the world created importance in knowledge possession regarding cultural differences and the effect on healthcare. Increasing cultural diversity in both healthcare providers’ population and recipients of healthcare, challenge cultural sensitivity environments (Cowan & Norman 2006:85). Nurses should continuously update their cultural approaches in order to provide culturally congruent care in the 21<sup>st</sup> century. With the changing times it is not only the client who lives outside his familiar culture, but also the nurse who must learn how to adjust to life within a culture different from her own.

Cultural competence from a nursing perspective is the competence to understand cultural differences, to be sensitive to culture related issues like race and gender or sexual orientation; and to provide quality care to diverse patients (Maier-Lorentz 2008: 38).

Cultural competence is an ongoing practice and the goal is to achieve effective work relations with culturally diverse patients.

Cultural behaviour is a result of adaptation between the physical and social environment which results in the formulation of norms, values and behaviour which are not easily changeable (Galanti 2004:187). Assumptions that all people view the world in the same way could lead to misunderstandings and misdiagnoses of illnesses.

## **2.8 Culturally competent care**

Some guidelines for the delivery of culturally competent care as described in Galanti et al (2004: 219) include:

- Information related to people from a cultural group are just guidelines, and stereotyping must be avoided
- Do not make assumptions about eye contact related to lack of interest. Most of the Eastern and therefore Muslim patients avoid direct eye contact with people from the opposite sex as a sign of modesty and respect
- Traditional health practices and beliefs cannot be confused with signs of abuse, like 'coining' or burning practices
- Food preparations in healthcare settings might violate the patient's healthcare beliefs, and the loss of appetite might not be a sign of illness but rather of the patient's belief system
- Fatal diagnosis and prognosis is not always shared with the patient, but rather with the family members. Incorporate the patient's values into the behavioural pattern to understand the reactions
- Respect the female's request for modesty by keeping her covered, and not by assigning opposite sex healthcare workers to her where possible
- Develop a tolerant, culturally acceptable attitude about different views, and allow visitors as much as requested

During cross cultural communication it is important that nurses have a sound knowledge of their own values, beliefs, attitudes and practices before attempting to learn other cultural

ways in order to gain insight into their personal prejudices. Language can be an obstacle when caring for patients from diverse cultures, and non verbal communication might be beneficial for providing nursing care. Nonverbal communication techniques include aspects like touch, silence, space and distance (Maier-Lorentz 2008:38). Personal growth towards understanding cultural competence is an ongoing process (Gustafson 2005:11).

## **2.9 THE ART OF (EXPATRIATE) NURSING**

Florence Nightingale supported the idea of nursing as a moral art, while Fenwick demonstrated that nursing was both a science and technology (Reed et al 2003:495). Nursing as an art could refer to qualities of caring and skills performed with excellence. When nurses understand and live this art it might improve their practice and teaching. Dewey (in Reed 2003:500) describes human experiences as being essentially related to the aesthetic form. Experience is not a passive reception of sensory data, but rather structured and nameable, and refers to 'that experience'. Illness can be negotiated as a powerful experience, and it is often then that patients stop to reflect during moments of illness and become aware of the meaning of life and new experiences. Nursing practice includes care provision that is holistic, and addresses physical, psychological, social, emotional and spiritual needs of patients (Maier-Lorentz 2008:37). Holistic care also implies culturally competent care to meet the basic needs while accommodating cultural differences.

Narayan (2003:611) stated that "culturally competent care adapts care to the patient's cultural needs and preferences and begins with a cultural assessment that forms the care plan's foundation". Expatriate nurses might face adaptation issues which could lead to early release (due to morale, work attitudes and performance) from their host country translating to significant organisational costs (Boziolenos 2009:113). Nursing jobs do not allow any suboptimal performance and malpractice can be disastrous. Expatriate nurses do not have unlimited time to adapt to the host culture and new expectations before being required to perform consistently according to the set standards.

There remains a worldwide shortage of professional nurses. Some countries, including the

KSA, are forced to recruit qualified nurses from abroad, and to retain the expatriate nurses for extended periods of time. Expatriate nurses who leave their home countries do not always have the formal benefits and resources in the foreign countries.

## **2.10 Caring for the Muslim patient**

Care for the seriously ill patient requires highly skilled nurses to provide close monitoring and early intervention in cases of adverse changes (Bassett & Makin 2000: 1). Caring (Watson 2007:28) is defined as “a deliberate and intentional process that depends upon a relationship being established and maintained between nurse and patient, not a collection of jobs to be performed in a shift.”

In order to deliver care to a patient the nurse has to understand the interrelationship of complexities in that person and understand that the patient cannot be viewed as separate entities but rather as a complex whole. Caring is multidimensional combining social and biological sciences into practical nursing care.

Care of patients with cardiovascular disorders requires skilled nurses because cardiovascular disorders remain a major cause of mortality worldwide. There could be misunderstandings between the concepts and practices of Islam and Western healthcare or nursing practice. These misunderstandings could arise from nurses trained to apply the Western paradigm, but treating patients who foster the significance of spirituality towards healing (Rassool 2000:1476).

Common Muslim phrases include:

*In sha' allah* – God willing

*Al'hamdu'allah* – Thanks be to God

*Assalamu-Alaikum* – greeting of peace

*Salim* – one sound and healthy

Nurses relate to clients during an interview setting, and cultural issues can lead to different interpretations from a unique perspective. There are some guidelines to follow which might enhance nurse-client relationships (Giger & Davidhizar 2008:34-39). Some of these guidelines include:

- Assess the person's personal cultural belief system

The nurse needs to be aware of his or her own personal belief system when relating to patients from different cultures and determine conscious or unconscious attitudes. Personal values, ideas and attitudes have to be set aside because it will influence the care negatively.

- Communication variables must be assessed from the cultural perspective

In order for communication to be effective the client has to be assessed from the cultural perspective which includes the ethnic identity of the patient, to use the patient as a source of information and to assess other cultural factors that might influence or affect the nursing care.

- Plan care delivery according to communicated needs

The patient need to be encouraged to communicate cultural interpretations of health, illness and expected treatment. Cultural beliefs and customs need to be treated with sensitivity because of the patient's uniqueness.

- Communication approaches must meet the cultural needs

Communication modifications to meet cultural needs are essential when caring for culturally diverse patients, and special attention must be given to signs of fear or anxiety and how to communicate with whom concerning the patient (some cultures might find it offensive if the patient's condition is discussed with specific family members).

- The central focus of the therapeutic relationship is respect for the patient and his/her communicated needs



It is important for nurses to understand how to listen to the patient's culture and how to communicate respect to help bridge cultural barriers. Communication should be non-threatening, and validating techniques should be applied to confirm interpreted meanings. Communication should be two way, and eye contact should be avoided with people from the opposite gender as a sign of respect and modesty. Sexual matters are not open for discussion in some cultures, and the use of culturally sensitive interpreters can be used to translate messages or to confirm understanding when caring for patients from different cultures.

For learning in the intercultural domain to be effective, it is important to “remove cultural blinders which may interfere with the counsellor's ability to perceive and make use of cultural information while working with diverse populations” (Canfield, Low & Hovestadt 2009:319). Nurses must be encouraged to consider their own cultural context in reference to attitudes, beliefs and behaviours and consider how these factors could impact on their roles as culturally competent professional nurses.

### **2.10.1 Nursing and related experiences within the KSA**

The KSA's healthcare is staffed by mostly non Saudi nurse professionals from around the world, “which results in inadequate cultural awareness and is more challenging than joyful” (Al-Shahri 2002:133).

Rufaidah Al-Asalmiya practised as a nurse during the 7<sup>th</sup> century when the Holy War was ongoing. She established the first nursing school, the first ethical code of conduct and advocated preventive health care. The word Al-Assiyah is derived from the verb *assaa*, which means curing of wounds. Rufaidah laid the foundation for the Muslim nurses' practice and identity, by volunteering her service during the Holy War (Jihad) in the Badr invasion (January 624G). She provided water for the injured soldiers and dressed their wounds and was allowed to set up a tent in the mosque to serve as a medical centre (Lovering 2008).

The Jeddah region in the KSA hosts 4 539 nurses (2 202 national and 2 337 non- national nurses), have 13 established hospitals and 76 primary healthcare centers. The goals of nursing in Jeddah include:

- Saudiasation, implying that citizens of the KSA should be trained to provide services in the KSA
- Monthly reports regarding quality care and development/education
- Achievement of strategic plans every five years
- Regulation of nursing programmes and registration through guidelines set by the Saudi Health Council for Healthcare Specialities (SHC).

There are ten compulsory student nurse programmes offered in Jeddah:

- basic nursing skills programme
- nursing ethics programme
- nursing management
- ward management
- infection control
- patient education
- disaster management
- “Code Blue” (resuscitation programme)
- nursing care plans
- medication and intravenous administrations

(General Directorate of Nursing, MOH – see first nursing forum 2010)

“Non-ministry healthcare organisations had greater resources than did the governmental facilities, and they employed more Western nurses and nurse managers” (Tumulty 2001:287). The continued development of healthcare in the KSA would be unthinkable without foreign nurses. Nursing programmes in the KSA have low enrolment figures because of the possible “poor image of nursing compared to other professions, strict admission criteria and the five year duration” (of training) (Tumulty 2001:287). Gender separation is respected by all healthcare institutions. There are only 25% male Saudi nurses available to care for male patients and foreign nurses are recruited to fill the gaps (Tumulty 2001:288). “The strict segregation of men and women and restricted freedom of

movement of women in Saudi Arabia is a new and unwelcome experience for most expatriate nurses” (Tumulty 2001:288). Restricted movement refers to the fact that women in the KSA are not allowed to drive vehicles. Barriers to nursing in the KSA could include the social image of a working female, the long working hours over weekends or night duties, low salary compared to the workload and limited professional developmental opportunities.

Madeleine Leininger introduced transcultural nursing in order to explain cultural competency and explained that nurses have to have in-depth knowledge of the different cultures in order to provide optimal holistic care (Maier-Lorentz 2008:38). The transcultural nursing theory “stresses focus on the individual, freedom, individual rights, action and responsibilities” (Gustafson 2005:5). When patient diversity is overlooked or viewed as a static problem nursing care will become marginalised and maligned. Nurses care with sensitivity, but need to be equipped with skills and knowledge to deal with diversity (Kavanagh 2003:6). Nursing as a discipline needs to move beyond the diversity continuum towards a universality model (including diversity and commonalities). The nurse is often viewed as a buffer (between the patient and the healthcare system) rather than a facilitator (who enables the patient to retain his integrity). Recognition of cultural diversity and universality are global phenomena. Nurses might find it easier to avoid comparisons between similarities and disparities between cultures than to make it explicit. International boundaries could be seen as artificial and social networks are constantly re-negotiated. Race does not determine a persons’ intellect, but only reflects physical characteristics and learned behaviour.

### **2.10.2      *Coronary artery disease (CAD) in Saudi Arabia***

Heart diseases and strokes claim 17.5 million lives per year and are therefore classified as the world’s most serious killer disease. In Saudi Arabia cardiovascular disease accounts for 22% of deaths each year. The situation will become increasingly serious because in 20 years’ time a large proportion of the population will be 60 years of age and older (Saudigazette 2010).

Before modern medicine, local traditional healers specialised in herbal remedies and cauterisation. Cauterisation involves heating either a stick or a nail until it is red hot and then applying it to the affected area and this technique is still used to date, and can cause abscesses or other complications (Mebrouk 2008:154). Congenital heart disease is common in the KSA among children as a result of marriage between relatives.

Coronary artery disease occurs when the coronary arteries are being clogged with fatty deposits (plaque) preventing the heart from obtaining enough blood and oxygen resulting in a heart attack (myocardial infarction). Saudi Arabia's Ministry of Health (2004) reported 84 895 heart attacks compared to 91 866 and 12 200 coronary artery bypass graft (CABG) surgeries during 2005. Coronary artery disease can be managed with CABG as a treatment option.

Patients who undergo CABG surgery encounter technical dimensions of the proposed surgery and these highly mechanistic aspects could overlook the 'human dimension'. Failure of holistic patient interactions can influence the expected outcomes. Healthcare providers and nurses must communicate complex healthcare issues related to experiences and health expectations clearly so that it could be understood by the patient (Lindsay, Smith, Hanlon & Wheatley 2000: 1413).

There are nine identified modifiable risk factors that account for 90% of coronary heart disease in men and 94% in women. Psychological factors like anxiety, stress, depression and hostility are regarded as risk factors and contribute to patient morbidity and mortality. Optimal social support is a buffer for stress and hostility. Diet reduces psychological distress, and it is believed that a carbohydrate diet reduces depression (Pischke, Scherwitz, Weidner & Ornish 2008:586-592). Psychological wellbeing and exercise could improve the sense of self efficacy.

### **2.10.3      *Intensive cardiac surgery nursing***

Dr Daniel Hale Williams from Chicago operated on a 24 year old man who sustained a stab wound in the heart on July 10, 1893. Dr Williams tied off the vein and artery that was

injured and closed a tear in the pericardium (Cohn & Edmunds 2003:3). Surgical procedures were experimental in the KSA, with the first open-heart surgery completed in Jeddah in the mid 1970s. Cardiac units experienced a 70% success rate, and the first heart transplant was successfully performed in Riyadh during 1986 (Health magazine 2002).

Coronary artery bypass grafting (CABG) was first introduced during the early 1960s and is a treatment option for coronary artery disease. This procedure involves the transplantation of the patient's blood vessel, by creating a bypass of the blocked artery and ultimately improving oxygen and blood supply to the heart. Single, double, triple or quadruple bypass grafts may be indicated with the use of either conventional surgery (on-pump) or beating heart (off-pump) CABG (Gao, Yao, Tsai & Wang 2009:183). Cardiac surgery remains an advanced and expensive surgical technique (Wake & Cheng 2001:41), irrespective of the duration of hospital stay and irrespective whether the 'on pump' or 'off pump' surgical procedures had been performed.

Living standards, dietary habits and lack of exercise increased patient numbers diagnosed with coronary disease. Demands for post-operative cardiac surgery nursing services continue to increase due to the increased number of cardiac surgical procedures performed each year. Some of the concerns of the post-operative cardiac surgical patient include early extubation and early discharge from the hospital. Symptoms, often encountered after discharge from hospital, could include fatigue, nausea, insomnia, weight loss, abdominal distension, arrhythmia, weakness and limb swelling in combination with psychological changes like depression and anxiety. Complication post CABG could include pleural effusion, infection and acute heart failure (Gao et al 2009:182). The recovery period of patients who undergo conventional CABG is at least three months, with full system restoration after one year of the surgery (Gao et al 2009:183).

The critical care nurses work in an increasingly complex environment and are expected to care for patients with various medical and surgical conditions. Critical skills required in order to deliver optimal patient care could include (Swinny 2010:2):

- Knowledge of advanced pathology

- The ability to define and change priorities according to the patients' changing condition
- Good communication skills
- Advanced clinical knowledge to recognise any deviation from normal values or occurrences
- The ability to work in and cope with a stressful environment
- Frequent assessment of medications, treatment, procedures, wounds, hygiene and nutrition.

Patients' experiences could be regarded as an important indicator of quality of care during the intensive care period. Nurses and relatives must empower the critically ill patient in accordance with their health beliefs. The patient could experience communication difficulties and therefore the nurses and relatives might be responsible for meeting the patient's needs. "Joy of life, the will to survive, humour, teamwork and spiritual experiences are experiences shared by the patient, nurses as well as the relatives" (Wahlin, Ek & Idvall 2009:33). Patient specific experiences in the intensive care unit include mechanical ventilation, confusion, communication and the transfer to the general ward. Poor or insufficient communication ultimately could lead to the non-fulfillment of patients' needs or wishes (Agren et al 2009:285).

Nursing workload in the ICU setting could be linked to patient safety. Larger patient ratios "result in higher death risk and higher failure to rescue or complication identification rates" (Padilha, de Sousa, Garcia, Bento, Finardi & Hatarashi 2010:109). Curative care became more futile and complicated due to the technological advances. Conditions and illnesses that were considered fatal are now manageable and curable, and it is even believed that "death can be avoided" (Calvin, Lindy & Clingon 2009:215). Patients and families in the ICU are challenged to understand the link between modern advanced technology and the patients' risk or implications due to the applied technology. The nurse encompasses the role of both educator and advocate when providing health education to the patient and family when curative care is no longer suitable to sustain quality of life.

Nurses could feel frustrated when decisions regarding end of life is made. Providing

aggressive treatment to patients who are not expected to survive is stressful and influences personal moral values. When a patient in the ICU dies the nurse grieves, but these feelings are suppressed due to the “unacknowledged right of the nurse to grieve” (Calvin et al 2009:215). Suppression of emotions in the ICU could lead to higher stress levels amongst nurses.

Moral distress levels amongst nurses increase when the family wishes to interfere with what is considered to be in the best interest of the patient, like when life support is continued or to perform tests without specific values or outcomes. Moral distress could lead to emotional exhaustion in the ICU. Communication among nurses, patients and family members is vital to achieve optimal care. ICU hospitalisation could “trigger a variety of emotional responses to both the patient and the family that manifest in the form of anxiety, shock or despair” (El-Masri & Fox-Wasylyshyn 2007:43). Emotional responses can impede family members’ coping strategies and ultimately lead to family dysfunction. The nurse must attend to the family’s needs in order to cope with stressors and to maintain a sense of wellbeing. Plasma cytokines increase during medical illness, and the cytokine IL-6 is elevated during heart disease and depression. Patients scheduled for cardiac surgery have elevated IL-6 levels because of the underlying heart disease, and these levels might remain high during the postoperative phase (Ai et al 2009:116). Obese patients with a body mass index higher than 30 have lower respiratory muscle strength and enhanced IL-6 productions which might be an predictor of the outcome after CABG (Lida, Yamada, Nishida & Nakamura 2010:172.e2)

When a patient is awaiting cardiac surgery he receives care from several healthcare providers and it is believed that the information is “varied and not well synchronised” (Ivarsson, Larsson, Johnsson, Lühns & Sjöberg 2008:243). Patients and family members often experience a lack in information regarding their disease and intended surgery, partly due to limited personal contact from the healthcare delivery attendees. Written information brochures which are available before the intended surgery can possibly be helpful regarding concerns and complication management. Relatives could experience shock when they hear that a family member must undergo cardiac surgery, partly due to the risk and the limited understanding about the seriousness of the underlying cardiac condition.

Recovery from CABG involves physical, psychological and social recuperation (Rantanen, Kaunonen, Tarkka, Sintonen, Koivisto, Astedt-Kurki & Tarkka 2009:319). Spousal support is important during the early recovery phase, and friends or extended family support could become more important during the progress of recovery. Patients who receive less or limited support from family members tend to experience more depression, anxiety and cardiac symptoms like shortness of breath.

Pain post cardiac surgery consists of both sensory (type and intensity), and reactive (emotional properties) components. The type and degree of pain experienced post CABG is affected by various psychological factors (Ferguson 1992:155).

There are three classifications of pain according to anatomical structure (Roediger, Larbuisson & Lamy 2006:540):

- Cutaneous pain - involves the skin, and is caused by invasive lines, pacing wires and chest tubes. The pain is sharp, and prolonged pain results in a burning sensation.
- Visceral pain – results from internal tissue damage or organ handling, and the pleura or pericardium can be experienced as painful due to possible inflammation.
- Deep somatic pain – involves the ligaments, fasciae and muscles. The pain experience varies from sharp to dull aches in cases where the saphenous vein had been harvested.

Vital signs can be a suggestive indicator of discomfort or pain due to autonomic nervous system activation. Mean arterial pressure (MAP) and heart rate (HR) could increase during endotracheal suctioning. Post cardiac surgery patients are sedated and self reports of pain are not available. Haemodynamic parameters like blood pressure (BP) and HR increase with pain experiences, even when the patient is sedated. Stable vital signs should not be considered as an absence of pain (Arbour & Gélinas 2010:84).

Advancements have been made since the late 1980s regarding pain management and assessment in critical care (G'elinas 2007:298). Pain resulting from surgery, invasive



equipment, nursing interventions and immobility could be regarded as important stressors in intensive care. Position changes (turning) and endotracheal suctioning could be identified as two of the most painful experiences in the ICU, but the residual effects of sedatives and analgesia may suppress the patient's memories of the pain experienced. Other contributors to pain experienced in the cardiac ICU include breathing when the sternal incision is stretched, lower back pain due to prolonged positioning during the surgery, throat pain due to the endotracheal tube and the removal of chest tubes. Pain is subjective and can only be described by the person who experiences it. Frequent pain assessment must be performed because the sources of pain are numerous.

Mechanical ventilation modes evolved over the past 15 years from 'volume control' to 'patient regulated volume control' which changed the patient's experiences of ventilation and sedation. "Predictors of weaning patients successfully from the mechanical ventilator are done extensively, including physiological and technological perspectives as well as the patient experience" (Schou & Egerod 2008:172).

Patients who experienced prolonged ventilation may develop post traumatic stress disorder when anxiety memories are provoked. Normal speech is not possible while ventilated, and it might contribute to stress, anxiety, insecurity, possible hallucinations, panic and discomfort. Nurses must inform their patients about the nature of their illnesses and treatments in order to reduce the patients' anxiety levels. Patients who recover from sedatives could experience feelings of chaos which might lead to prolonged fear. Co-morbid factors that lead to prolonged ventilation post CABG could be identified as smoking, heart failure and unstable angina (Yende & Wunderink 2002:240).

## **2.11 SUMMARY**

This chapter presented an overview of the literature reviewed pertaining to nursing, nursing care, transcultural nursing, and intensive care nursing after cardiac surgery.

Aspects addressed include the Islamic faith foundation within the KSA, religion and spirituality, the religion of Islam, the Western versus the Eastern care-giving approach,

cultural aspects (cultural liberty, differences, competence, competent care), the art of expatriate nursing, caring for the Muslim patient, CICU experiences within the KSA.

The next chapter will address the research methodology adopted to conduct this study.

## **CHAPTER 3**

# **RESEARCH DESIGN AND METHODOLOGY**

### **3.1 INTRODUCTION**

Qualitative research could be considered to be time consuming and difficult to analyse. Technologies, like the Internet and computer software programs, simplify the coding and analysis processes (Blank 2004:187). The qualitative research process could be explained as systematic, well documented, spontaneous and flexible. Systematic refers to “order and structure with non impulsive analysis” (Blank 2004:188). Qualitative research could offer rich and detailed results and attempts to understand phenomena in their entirety (Brink 2007:11).

### **3.2 RESEARCH DESIGN**

The research design could be explained as being the blueprint of the study or the “entire strategy followed from identification of the problem to final plans for data collection” (Burns & Grove 2005:211).

Qualitative research consists of an investigation that seeks answers, collects evidence and produces findings. Understanding of the research questions is obtained from the perspectives or worldviews of the local population involved. It could be effective in obtaining culture related information like values and behaviours (Wikipedia 2010). Qualitative research is used to “explore a topic or idea, to gain insight into the lifestyle of cultures or to provide deeper understanding from quantitative research results through the provision of complex textual descriptions” (Mack, Woodsong, MacQueen, Guest & Namey 2006:11). This method could be utilised to provide a deeper

understanding of complex realities like social norms, ethnicity and religion. The findings obtained during qualitative research could be “extended to people with characteristics similar to those in the study population” (Mack et al 2005:12).

Qualitative research as defined by Burns and Grove (2005:747), is “a systematic, interactive, subjective approach used to describe life experiences and to give them meaning”. Qualitative research is also referred to as non numerical data collection. Research participants could be selected purposefully and the researcher should maintain a neutral position. It is different from quantitative research in reference to language, signs and meanings. Data analyses are done holistically and should be contextually accurate (Wikipedia 2010).

Qualitative research according to Brink (2006:11):

- Has only a few preconceived ideas
- Information collection occurs without formally structured instruments
- The context of the research is not controlled
- The context of the research is captured in totality
- Subjectivity is seen as being essential for capturing and understanding human experiences
- Information is analysed and organised by intuitive fashion
- Sustained interaction with people (participants) occur
- Both inductive and dialectic reasoning are applied

The research design was qualitative and descriptive in nature. Attempts were made to identify and describe the experiences of non-Muslim nurses working with Muslim patients in one CICU in the KSA. Descriptive research, according to Burns and Grove (2005:734), “provides an accurate portrayal or account of the characteristics of a particular individual, event, or group in real-life situations for the purpose of discovering new meaning, describing what exists...”. This study aimed to describe the non-Muslim nurses’ experiences of working in a CICU in the KSA. The lived experiences of the participants were described within the research setting.

### **3.3 RESEARCH METHODOLOGY**

The following aspects will be covered in this section: population, sampling, inclusion and exclusion criteria, research setting, data collection method and instrument (semi-structured interviews) as well as ethical considerations adhered to during the research process.

#### **3.3.1 *Population***

The population refers to “all elements (individuals, objects, events or substances) that meet the sample criteria for inclusion of the study” (Burns & Grove 2005:746). Population as defined by Stommel and Wills (2004:441) is: “any universe of subjects, cases, units, or observations containing all possible members”.

The accessible population, according to Stommel and Wills (2004:435), is the: “study population defined in terms of geographic location, institutional affiliation, or study unit characteristics to which the researcher has access, given the available resources...” The accessible population in this study comprised the non-Muslim nurses working in the CICU (in the participating hospital) within the KSA. Three Muslim nurses were excluded from participation. All 87 non-Muslim nurses working night and day duty were included in this study. However, six nurses refused to participate and 18 had less than six months’ experience in the participating CICU and were thus excluded from the study. No sampling was done as the population of 87 nurses were approached, but 24 were excluded, implying that 63 interviews were conducted.

#### **3.3.2 Research setting**

The setting refers to the “location for conducting research, such as a natural, partially controlled, or highly controlled setting” (Burns & Grove 2005:751). In qualitative research there is a low level of control over the research setting, and participants are encouraged to respond freely and spontaneously. The research setting was a well established CICU in the KSA. Expatriate non-Muslim nurses’ experiences of working in a CICU intensive care unit in Saudi Arabia were studied.

The participating CICU had 25 beds and 4-5 open heart surgery procedures (such as coronary artery bypass grafts (CABGs), mitral valve replacements, tricuspid valve replacements, aorta valve repairs, double and triple valve repairs and/or replacements, surgical ventricular repairs, aorta aneurysm repairs) were performed daily during 2010. In addition to the cardiac surgeries, 10-15 procedures (including diagnostic catheterisations, parenteral cardiac imaging, stent implants, electrophysiological studies and intra-cardiac defibrillator implants) were done on a daily basis. During 2010 this CICU managed a total of 1 350 cardiac surgical cases (Statistics obtained from the participating CICU. 2010).

### **3.3.3 Procedure followed to collect data**

Research participants were informed about the research topic. Informed and written consent was obtained from each participant. Participants were re-assured about anonymity and confidentiality issues. Each participant was informed about the exact date and time of the interview. The interviews took place in a private office and no disturbances occurred during these interviews. Before the start of the interview each participant was re-assured that no personal information shared during the interview would be disclosed to the participating hospital or in any report in anyway whatsoever. The research report would contain information obtained from all participants, and no one besides the researcher and the data analyst and supervisor would have access to the transcribed information. No name would appear on any transcription and no one would be able to link any transcription to any specific person. Participants were given time to ask questions about the research and also to read the interview questions. The allocation of numbers instead of names on the tape recorder as well as on the field notes re-assured the participants about the anonymity of the interview data. Each signed consent form was sealed and locked away for safe keeping – in a separate container from the transcriptions of the interviews. All audio tapes were kept in a safe dry place and to which only the researcher had access. The audiotapes were transcribed verbatim and these transcriptions were also kept under lock and key. Only the researcher, an independent coder and the supervisor had access to these transcriptions. Subsequent to the acceptance of the research report, these would be destroyed.

Semi-structured interviews are used when the researcher “asks a certain number of specific questions, but can also pose additional probes” (Brink 2007:152). Rapport building during semi-structured interviews could be “established by strategic self disclosure on the part of the interviewer” (Bell, Locke, Condor, Gibson, & Stevenson 2006:221). Participants tend to tell stories in order to answer questions. The results obtained from the semi-structured interviews were reflected as themes and sub-themes.

### **3.3.4 Research instrument: semi-structured interview guide**

A semi-structured interview guide was used to answer questions related to the research topic. Aspects considered during the semi-structured interview (Hoepfl 2009) included:

- The researcher should control his/her reactions
- The researcher should keep the purpose of the interview in mind: to obtain information about individual persons' experiences. This information should be free of bias and not influenced by evaluative responses from the interviewer.
- The environment in which the interviews take place should make the participants feel comfortable and safe. Freedom of speech should be encouraged
- Simple 'yes' or 'no' questions should be avoided, or further responses elicited by asking probing questions.
- The researcher should maintain a flexible approach towards the participants.

The questions asked during the semi-structured interview should be:

- neutral and not leading; participants should be encouraged to speak freely with as little prompting as possible
- open-ended, non-inquisitorial questions should allow neutral but encouraging responses (Rapley 2001:316).

The date and time for the semi-structured interview guide was confirmed with each respondent ahead of time. The environment was quiet and private without any interruptions. Participants' comfort was ensured (De Vos et al 2007:294). During the interview (which was conducted in a private, quiet office with no disturbances) the participants were given time to relax. The office layout provided enough space to be

formal and comfortable. The windows were covered with blinds and the room temperature was cool.

### **3.3.4.1 Organisation of the semi-structured interview guide**

Questions about expatriate non-Muslim nurses' experiences of working in a cardiac intensive care unit in Saudi Arabia included:

Part A of the semi-structured interview included personal data including

- The number assigned to each participant (in order to maintain anonymity)
- Date of interview
- Gender
- Country of birth
- Citizenship
- Age
- Country of training
- Years' experience in the CICU
- Years experience in the KSA CICU
- Religion

Part B of the semi-structured interview included questions related to cultural expressions, namely:

- How do you experience nursing patients in the CICU?
- What cultural aspects impact on the rendering of care to patients in the CICU?

Probing questions which had been prepared for use during the semi-structured interviews included:

- What differences do you encounter in nursing patients in the CICU compared to nursing cardiac patients in your home country?
- What do you know about Muslims' perceptions of the heart, of heart disease and about the prevention of heart disease?
- What does the Qur'an say about heart disease and its treatment?
- How does the nursing care in the CICU differ from, or agree with the Qur'an prescriptions?
- What cultural aspects impact on the rendering of care to patients in the CICU?



Probing questions regarding cultural aspects included:

- How do you think the patients experience the restricted visiting hours in the CICU?
- Do you think these visiting hours should be changed? Please give reasons for your answer.
- How do you understand the role of the extended family in Islam?
- What is the role of the mother in Islam families?
- How should food be served to a Muslim patient?
- What foods are forbidden in the Muslim culture? Can you give reasons why these foods are forbidden?
- How should a female nurse assist a male Muslim patient with ablution; and a female Muslim patient (question will be adjusted if the respondent is a male)
- How should a female nurse bed bath a male Muslim patient; and a female Muslim patient (question will be adjusted if the respondent is a male)
- Please explain how the pillars of Islam can influence a Muslim person's experience of his/her illness.
- Why do Muslims fast during Ramadan?
- How is the nursing care in the CICU adjusted during Ramadan?
- What is the policy if a critically ill CICU patient refuses to eat or drink or take medicines during Ramadan? What do you think this policy should state?
- Is it acceptable to have a 'mixed' male and female CICU for Muslim patients in the KSA?
- Is it acceptable for the female Muslim patient to lie in bed without her abaya targa (head cover) or niqab (face cover)?

### **3.4 DATA COLLECTION**

The researcher and each participant engaged in formal discussions during each semi-structured interview. Semi-structured interviews can provide reliable and comparative qualitative data. The inclusion and application of open ended questions could allow meaningful ways of gaining a deeper understanding of the research topic.

The prepared interview questions ensured that the researcher asked the same open-ended questions from each person in the same sequence and also asked similar probing questions. Participants were encouraged to voice their opinions in their own words and expressions and to narrate their unique experiences.

Semi-structured interviews are useful to discover issues that might be useful, personal or controversial. Questions could range from complex and broad to more specific in order to cover the research topic thoroughly. All questions asked are neutral and not leading, and open-ended questions allow spontaneous responses. It is preferred to hand the interview questions to the participants in order to improve concentration. Deviation from the interview questions is allowed (De Vos, Strydom, Fouché & Delport 2007:297), but the researcher should strive to obtain answers to similar questions to facilitate data analysis. However, unique experiences were recorded because these could reveal persons' lived experiences that could provide meaningful insights into the research topic.

The semi-structured interview questions used in this study were pre-determined. All participants were given the same set of non leading questions, in the same order. Interview responses were recorded and participants' behaviour and expressions were noted. All participants were given enough time to express their feelings and experiences. Participants were encouraged to disclose their true and accurate reflections without feeling threatened.

Interview data could be used as either interview data as a topic or interview data as a resource. Interview data as a topic are seen as 'reflecting a reality jointly constructed by the interviewee and interviewer' while interview data as a resource reflect 'the interviewees' reality outside the interview' (Rapley 2001:304). Some pitfalls during the interview according to Field and Morse (in De Vos et al 2007:290) include interruptions, distractions, jumping awkward questions, superficial attention and confidential information revelations. During the interview periods the researcher encountered limited interruptions and most of them were from the bleeper system. The presence of the voice recorder was an obvious distraction for some participants which kept staring at it or even tried to lower their heads in order to speak 'into' the microphone. The interview was paused for a few seconds and the importance of comfortable seating was

explained, as well as the audio recording. These interviewees were once more assured about the confidentiality of their answers and also about their anonymity.

One participant experienced a hysterical loud laughing outburst and the interview had to be paused until she had regained her balance. The researcher offered her assistance by soft spoken language and offered a drink of water. The reason given by the participant was that nobody ever asked her before about her experiences and feelings.

The researcher had some knowledge regarding the Islamic faith and Muslim traditions and the participants' responses and answers were both emotionally exhausting and time consuming. The interviews lasted from eight to 35 minutes on average.

### **3.5 ETHICAL CONSIDERATIONS DURING DATA COLLECTION**

#### **3.5.1 Informed consent**

Informed consent is defined by Stommel and Wills (2004:439), as the: “disclosure statement to be signed by each participant that contains a clear account of all the risks and benefits involved in the participation in a particular research study”.

Consent was obtained from the Director of Nursing Services and from the management of the participating hospital to conduct this research, after ethical clearance had been granted by the Ethics and Research Committee of Unisa's Department of Health Studies. All participants signed consent willingly to be interviewed by the researcher and for the interviews to be audio-recorded. Each signed consent form was sealed in an envelope and placed into a sealed container where all signed consent forms were kept so that no signed consent form could be linked to any specific recorded and/or transcribed interview.

All participants were ensured that no personal information would be revealed. No names would be mentioned in any report nor attached to the recorded or transcribed interviews. Only numbers were used in an effort to maintain anonymity. The audio-tapes and the transcribed data were kept locked up by the researcher. Only the researcher, a data analyst and the supervisor had access to the raw data. The participants would have access to the completed report.

### **3.5.2      *Anonymity***

“Anonymity means that the participant should not be identifiable at any time by anyone reading the publications of the research” (Holland & Rees 2010:98). All participants were interviewed by way of numbers and no real names were used. Prior to the interviews all participants were requested not to make any reference to colleagues or to the participating hospital. Wherever such references were made, they were deleted during the verbatim transcribing of the data to ensure anonymity of the interviewees, their colleagues and the hospital concerned.

### **3.5.3      *Confidentiality***

“Confidentiality is essential in order to protect people, especially if they are disclosing sensitive information as part of the research” (Holland & Rees 2010:99). During this study all participants were verbally reassured about the confidentiality of the information provided. The signed, informed consent also guaranteed the confidentiality agreement on the side of the researcher. The researcher requested participants not to discuss the content of the interview with colleagues. All consent and recorded data were locked up in a safe dry place and only the researcher had access to the material.

## **3.6          TRUSTWORTHINESS**

The validity of qualitative research according to Hoepfl (2009) includes the following:

- Be a listener and interpret the participant’s responses properly. During this study the researcher remained an active listener. Only observed and verbal data were recorded as true reflections
- Records must be accurate. The researcher kept all notes as well as audiotape recordings (twelve tapes) in a secure area available for audit when needed
- Writing should be initiated early. The researcher completed the writing of the recorded voice tapes at the end of each session which provided the opportunity to clarify any misunderstandings before the start of the next interviews
- Primary data should be included in the final report. Direct quotes and lived experiences from the participants as well as observations from the researcher were recorded and quoted in the final report

- All data should be included in the final report so that the readers could develop their own conclusions
- Being candid – the researcher allowed reflection about her personal feelings. Personal observations and feelings from the researcher were documented and reflected upon in the final report
- The researcher should seek critique “to ensure that information is reported accurately and completely” (Hoepfl 2009)
- Balance could be achieved through the discovery of perceived importance and actual importance clarification
- Accurate writing could be achieved through using correct grammar and by avoiding inconsistencies. The research report was reviewed and critiqued by the researcher and supervisor, as well as by the manager of the participating hospital

Trustworthiness in qualitative research according to De Vos et al (2006:345) refers to:

- The credibility of the study
- The applicability of the study findings in another setting
- Reasonable surety that the research findings will be replicated when repeated under similar conditions
- The research findings are a true reflection of the subjects, and not a mere creation of the researcher
- Freedom from bias and prejudices

Trustworthiness according to Krefting (1991:215) includes:

- The truth value
- Applicability
- Consistency
- Neutrality

The truth value refers to the true reflections of the research findings, and confidence that the findings are based on the research design, informants and context. The research findings will reflect true lived subjective human experiences. People who shared similar experiences will recognise the descriptions of the findings (Orb et al 2001:94).

Applicability refers to the degree to which the findings can be applied in other settings or with other participant groups. The strength of applicability is that the research was conducted in a naturalistic setting with only a few controllable variables. Sufficient collected descriptive data could allow comparisons to other similar situations.

Consistency could be achieved when the inquiry is replicated with the same subjects in a similar context. Variability "is expected in qualitative research, and consistency is defined in terms of dependability" (Krefting 1991:216). Explainable variability might be due to the increased insight from the researcher, informant fatigue or changes in informant lifestyle. In this study a range of non Muslim nurses' experiences in the CICU were explored. Neutrality refers to freedom from bias. The research findings were solely from the informants' lived experiences. Conformability could be considered the criterion for neutrality and is achieved when truth and applicability have been established.

Strategies to increase trustworthiness (Krefting 1991:217) include:

- Identification and documentation of recurrent themes, patterns and values
- Sufficient time spent with all informants in order to identify patterns
- Adequate submersion into the research setting
- Reflexivity - to keep, describe and interpret behavioural and experienced data within the research context

Transferability strategies include the time spent with each participant. The participants were given enough time to express their feelings and lived experiences without a pushed time limit. The characteristics of informants, as well as their demographic data were available. These data were described in detail and available for critique. Dependability strategies refer to the dense descriptions of the research method. Conformability strategies include triangulation, referring to the convergence of multiple perspectives for confirmation of data. All aspects of the phenomenon under investigation were addressed.

- Triangulation of data methods occur when all data collected (semi-structured interviews and observations/field notes) are compared
- Data collection records (field notes, audio records, verbatim transcriptions of interviews and interview schedules) will be available for external auditing

The research was conducted in an area familiar to the researcher and participants were known to the researcher. This familiarity might have contributed to free responses from the participants. However, this familiarity also required repeated assurances about confidentiality and anonymity.

### **3.7 DATA ANALYSIS**

Coding is a technique to organise the research data obtained. The researcher read the verbatim transcriptions of the interviews and “demarcated segments within it” (Wikipedia 2010). All segments were coded and labelled. Relationships between different codes were identified by using the same colour highlighter for comments pertaining to the same issue.

The basic steps involved in data analysis are noticing and coding, collecting and sorting of instances and thinking (Stommel & Willis 2004:369). Noticing involves observations, field notes, recording of interviews or the gathering of documents. Collecting and sorting involve the analysis of the research material into parts or manageable units. The final step in the data analysis is the thinking process to examine the collected data, to make sense of it, to identify patterns of occurrence and to make general discoveries (Stommel & Willis 2004:369).

Interviews were audio-recorded (with the permission of each participant) and transcribed verbatim at a later stage. Field notes kept during the semi-structured interviews contained short remarks from the researcher, as recommended by Stommel and Willis (2004:286):

- Descriptions of each participant in the research setting. Factors such as physical appearance or interaction were addressed. During the interviews the participants were observed regarding appearance and behaviours. All data observed were recorded.
- Short quotes or phrases stated by the participants such as “it is very terrible for me here” were recorded and the participants were requested to give detailed descriptions of statements or events.
- Descriptions of interactive events during the semi-structured interviews (observational notes) such as constant moving in the chair or ticking with hands were recorded.

Field notes are a true reflection of observed events (personal notes), and should be completed immediately after completing each interview, before initiating the next scheduled semi-structured interview. After each interview the researcher reviewed the personal notes drafted during the interview and documented it in detail.

An experienced qualitative researcher acted as an independent coder and analyst. This person compiled themes, categories and subcategories and the researcher did the same independently from each other. Then the independent coder and the researcher compared their analyses and reached consensus after some discussions.

### **3.8 Scope and limitations of this study**

- The research was conducted in a single CICU within the KSA.
- The patients' inputs were not assessed because the hospital's policies did not allow patients to participate in research.
- The sample was small .
- Cultural differences between the researcher and participants could not be left out of consideration.

Although the interviews were conducted in English, some participants experienced difficulties comprehending the open-ended questions and their shared experiences might have been affected thereby.

### **3.9 SUMMARY**

Chapter three discussed the research methodology and addressed the population, sample, data collection (in the form of semi-structured interviews) and data analysis. Chapter four will present the analysis and discussions of the research findings.



## **CHAPTER 4**

### **DATA ANALYSIS AND DISCUSSION**

#### **4.1 INTRODUCTION**

Data analysis comprises the systematic organisation and synthesis of research data (Polit & Beck 2008:751). Data analysis is the process of ordering, structuring and assigning meaning to the extensive amount of collected data. De Vos, Strydom and Delport (2000:339-340) mentioned that the qualitative data analysis process is time consuming, creative and fascinating.

The data collection during this study was done through conducting semi-structured interviews with open ended questions with individual participants, who have worked for at least six months in the participating CICU. The semi-structured interview guide contained the following two sections:

##### **Section A. Demographic information of the participants**

This section included gender, position, qualifications, years of experience in the current CICU, total years of professional nursing experience and religious affiliations. Data derived from these questions were analysed quantitatively and presented in tables and diagrams.

##### **Section B. Information on factors influencing care to Muslim patients**

This section focused on general information regarding non Muslim nurses' experiences when caring for Muslim patients as well as the cultural factors that could influence nursing care. The open ended questions allowed spontaneous responses from the participants.

Questions used during the semi-structured interview included:

- How do you experience nursing Muslim patients in the CICU?
- What cultural aspects impact on the rendering of care to patients in the CICU?

Probing questions prepared and used during the semi-structured interviews included:

- What differences do you encounter in nursing patients in the CICU compared to nursing cardiac patients in your home country?
- What do you know about Muslims' perceptions of the heart, of heart disease and about the prevention of heart disease?
- What does the Qur'an say about heart disease and its treatment?
- How does nursing care in the CICU differ from, or agree with, the Qur'an's prescriptions?
- What cultural aspects impact on the rendering of care to patients in the CICU?

Probing questions regarding cultural aspects included:

- How do you think the patients experience the restricted visiting hours in the CICU?
- Do you think these visiting hours should be changed? Please give reasons for your answer.
- How do you understand the role of the extended family in Islam?
- What is the role of the mother in Islam families?
- How should food be served to a Muslim patient?
- What foods are forbidden in the Muslim culture? Can you give reasons why these foods are forbidden?
- How should a female nurse assist a male Muslim patient with ablution; and a female Muslim patient (question will be adjusted if the respondent is a male)
- How should a female nurse bed bath a male Muslim patient; and a female Muslim patient (question will be adjusted if the respondent is a male)
- Please explain how the pillars of Islam can influence a Muslim person's experience of his/her illness.
- Why do Muslims fast during Ramadan?
- How is the nursing care in the CICU adjusted during Ramadan?
- What is the policy if a critically ill CICU patient refuses to eat or drink or take

medicines during Ramadan? What do you think this policy should state?

- Is it acceptable to have a 'mixed' male and female CICU for Muslim patients in the KSA?
- Is it acceptable for the female Muslim patient to lie in bed without her abaya (loose long black dress), targa, (head cover) or niqab (face cover)?

## **4.2 DATA ANALYSIS**

Data analysis starts at the proposal stage in which the decision is made on the study design (Welman, Kruger & Mitchell 2005:200). The process of data analysis covers a spectrum of techniques including observations, interviewing and documenting (Welman et al 2005:211). During the data analysis, researchers scrutinise their data carefully, reading it over and over again in search for meaning and deeper understanding. Insight only emerges when researchers become completely familiar with their data (Polit & Beck 2008:571). The intention was to reduce data into smaller, more manageable themes. Data analysis commenced during the data collection phase. The revision generates new data that is subjected to new analysis.

Welman et al (2005:219) comment that qualitative data analysis can be presented in a spiral rather than in a fixed linear mode. However, for convenience of description, the researcher has presented the data in a linear form although the steps moved in spirals.

### **4.2.1 Data collection, entry, coding and analysis**

In data collection, the researcher maintained the perspective of open discovery, active listening, and genuine learning in the total context of the informant's world. She was active and curious about the 'why' of whatever was seen, heard, or experienced. She was also appreciative of the information the informants shared with her. She recorded whatever data was shared with her in a careful and conscientious manner in order to perceive the full meaning of each informant's ideas. The interviews were done in English which was not the mother tongue of some respondents.

A semi-structured guide was developed by the researcher to obtain culture-specific data related to the domain of enquiry and open-ended questions were used. De Vos et al (2000:340) also point out that in data collection, the researcher uses interview guides to ensure systematic data collection.

Data obtained from this qualitative study was entered and managed through Digital Voice Recorder. Data entry included a wealth of detailed raw emic data from all the informants that included verbatim statements and field notes. The researcher's insights, theoretical speculations, feelings, and environmental contextual data were also included for a full and detailed account.

The researcher read and re-read the verbatim description many times and also repeatedly listened to the tape recordings. This enabled the researcher to become immersed in the data. When themes, categories and subcategories began to emerge, descriptive codes were assigned to data specific groupings. Codes were continuously compared to identify patterns. Patterns were the researcher's best statements that reflected the meanings and experiences of the participants. Patterns were scrutinised to discover saturation of ideas and to identify similar or different meanings.

The coding of the data that reflected categories and subcategories was done manually. This was done after the researcher had re-visited the data and organised it along the line of the semi-structured questions. A document that included all the informant's data in a single document was produced. After manual coding, the researcher revisited the data, read it many times and also listened to the tape recordings and was able to identify more data that had been missed during the initial coding. Manual coding took many hours to accomplish.

Data can be retrieved as the researcher saved the interviews on tapes (twelve tapes) and saved the transcriptions in 'my documents' (on a USB data stick) that will be available for auditing on request. Notes were kept regarding each participant's behaviour during the interview. These notes are also saved on a USB data stick and saved in a safe place for retrieval on request.

### 4.2.2 Transcribing

Clues about the meaning could get lost when listening to tapes, as the transcriber no longer has access to important clues about the meanings. The researcher noted some non-verbal discomfort from the non-Muslim nurses during the interviews. Facilities and resources were available for crisis intervention if required. The researcher did the transcribing herself. This exercise also helped the researcher to become immersed in the data and to become thoroughly familiar with it.

## 4.3 DATA PRESENTATION

### 4.3.1 Personal and geographical data analysis

Data analysis from personal and geographical information were analysed quantitatively. From the sixty-three (n=63) semi-structured interviews, only 10 (15.9%) participants were males and 53 (84.1%) were females. Most participants originated from the Philippines (76.2%; n=48), followed by the Indian nurses (15.9%; n=10), South African nurses (3.1%; n=2) and Malaysian nurses (4.8%; n=3). Their years of experience in the CICU within the KSA varied from six months to 19 years (mean experience = 2 years and 9 months). Their total nursing experience varied from two to 35 years (mean experience = 10 years and 5 months).

**Table 4.1: Participants' socio-demographic characteristics (n=63)**

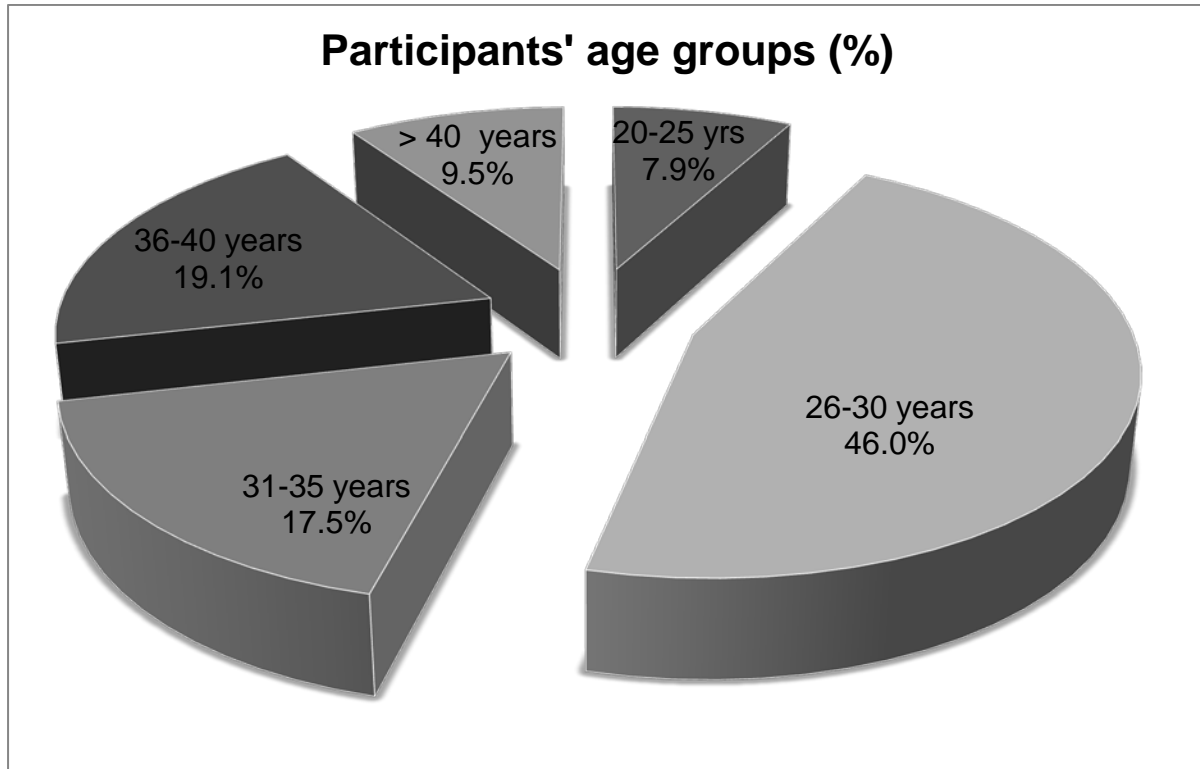
Category	Frequency	Percentage
<b>Gender</b>		
Male	10	15.9
Female	53	84.1
Total	63	100
<b>Country of birth</b>		
India	10	15.9
Malaysia	3	4.8
Philippines	48	76.2
South Africa	2	3.1
Total	63	100
<b>Participants' ages</b>		
20-25 years		
26-30 years	5	7.9
31-35 years	29	46.0

36-40 years	11	17.5
More than 40 years	12	19.1
	6	9.5
Total	63	100
<b>Years of experience in the CICU</b>		
6 months - 1 year	9	14.3
> 1 year	14	22.2
> 2 years	9	14.3
> 3 years	12	19.1
> 4 years	6	9.5
> 5 years	13	20.6
Total	63	100
<b>Total years of professional experience</b>		
Up to 23 months	0	
2 to 5 years	19	30.2
6 or more years	44	69.8
Total	63	100
<b>Country of training/education</b>		
India	10	15.9
Malaysia	3	4.7
Philippines	46	73.0
South Africa	2	3.2
Other (Jordan)	2	3.2
Total	63	100

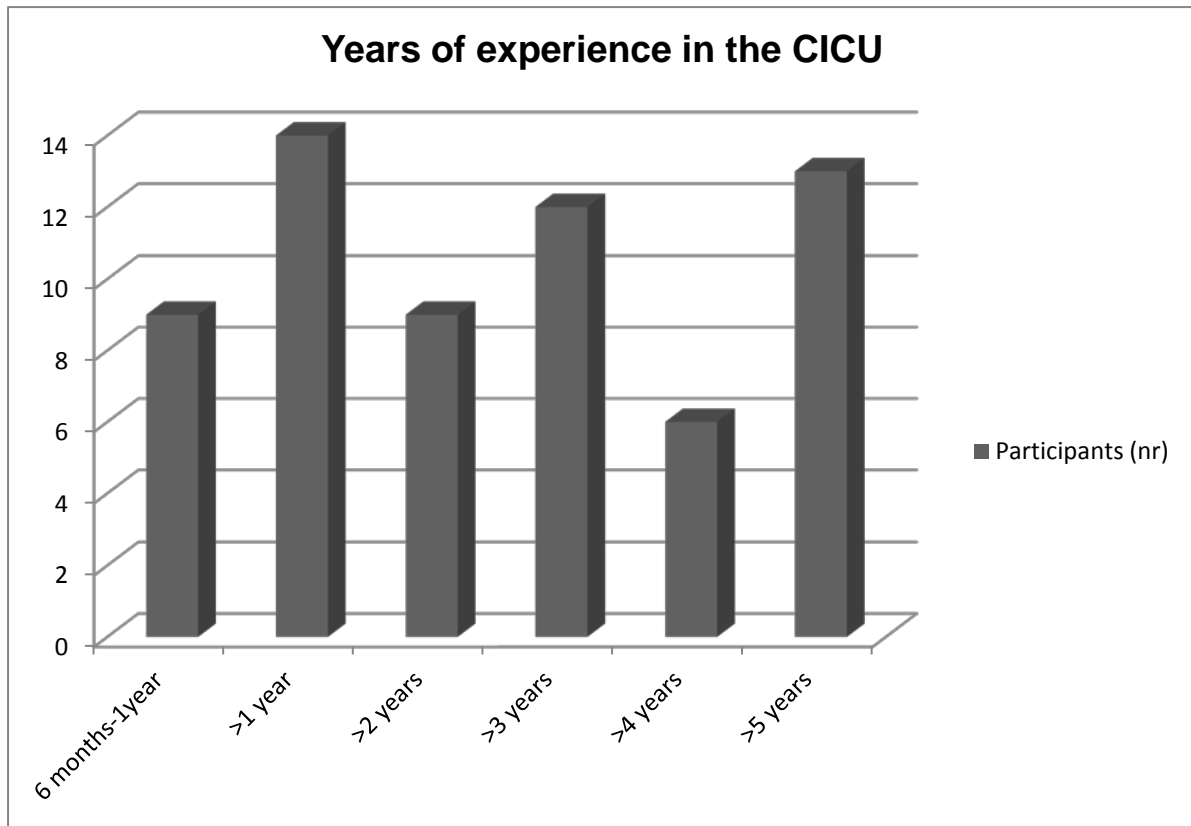
Participants' ages varied between 25 and 57 years. Their average age was 32.2 years and 29 (46.0%) fell within the 26-30 year age group, which was the largest age group.

Religion was classified as Christian (95.2%; n=60) and other religious groups (4.8%; n=3). Christian participants belonged to the Roman Catholic (n=47), Protestant (n=6), Born-again-Christians (n=2), Orthodox (n=2), Baptist (n=1), Methodist (n=1) and Anglican groups (n=1). Other religions included two Hindus and one Buddhist.

Interviews lasted 8-35 minutes, with an average time of 17.5 minutes. The shorter interview times could be attributed to the fact that some participants found formal English conversations difficult, hence the frequent phrases like 'what do you call this one', '*yani* (what is this again)', 'I don't know' and 'I cannot say anything'. This might have impacted negatively on the richness of the data obtained during the interviews.



**Figure 4.2: Participants' age groups (n=63)**



**Figure 4.3: Participants' years of experience in the CICU (n=63)**

#### **4.4 EXPATRIATE NURSES' EXPERIENCES RELATED TO NURSING MUSLIM PATIENTS**

An experienced qualitative researcher acted as an independent coder and analyst. The independent coder and the researcher compiled themes, categories and subcategories independently from each other. Then they compared their independent analyses and reached consensus after some discussions.

The categories identified that could affect the non-Muslim nurses' experiences when caring for Muslim patients included:

- Culture shock
- Language challenges
- Understanding of Islam as a religion

Sub categories that could affect the non-Muslim nurses' experiences when caring for Muslim patients included:



**Culture shock:**

- The Muslim patients' lifestyle, values and traditions
- Muslim patients hygienic habits and practices
- The clothing style in the KSA
- Strict male and female segregation
- Image of nurses within the KSA
- Level of education
- Level of contributing factors to heart disease in the KSA
- Patient management in the CICU

**Language challenges:**

- Understanding of patients' basic requests
- Explanation of procedures to patients
- Explanation of visiting hours
- Explanation of changes in the patients' condition to visitors.

**Islam as religion (understanding):**

- Prayer schedules
- Muslim patients' perceptions of healing
- Religious practices
- Fasting periods
- Role of the mother in Islam

**4.4.1 Culture shock**

<b>DATA DISPLAY 4.4.1</b> <b>CULTURE SHOCK</b>
<ul style="list-style-type: none"> <li>• This is not at all what I expected</li> <li>• I knew there were Muslim people, but I actually never seen one before, also I have never seen a mosque before</li> <li>• It was a total shock for me, it is much different than treating patients in my home country</li> <li>• Even though we had an orientation programme in our home country it still did not prepare me what to expect here...</li> <li>• Everything is so much different than what I am used to</li> <li>• You are not allowed to do the practices what you are used to do</li> <li>• For me it is the same. You are human and you are treating humans</li> </ul>

- For me there is no problem nursing those patients. I understand their culture. Before coming here I read about the religion. I understand them. They are okay
- ...in working with them there are no difference from my own experience...that was when I told myself 'this is way different from my country but I have to respect that'...
- They are like that...but you have to respect that
- Based on my experience, it is the first time to work in a Muslim country. We have Muslim patients in our place and I have friends that are Muslim. Here in Saudi Arabia it was the first time for me to have a culture shock. As the days passed by, you get to understand the culture and get to know the people...
- One thing is their practices. It is like most patients. If they will tell you something they will not listen to you. What they want is what they want, and they will insist...

Some participants mentioned that working in the CICU within the KSA was not what they had expected and that there were differences in nursing the patients from their home countries. They mentioned that there existed big cultural/habitual differences from what they were used to. When it was the first time they worked in a Muslim country they experienced culture shock. It was also explained that it became easier over time to get used to the Muslim people and to understand their behaviours and their culture.

*[During the interviews some participants seemed stressed when sharing these experiences and kept staring in front of them, while others kept on ticking nervously with their pens].* This behaviour from the participants could implicate that they experienced working in this CICU in the KSA as being stressful.

Factors that might have contributed to the participants' experiences included difficulty to understand the Muslim patient's lifestyle/values/traditions, the Muslim patients' hygienic practices/traditions, the clothing style in the KSA, strict male and female segregation, the image of nurses within the KSA, the level of education as well as the low level of the Muslim patients' understanding of contributing factors towards ACS.

Expatriate non-Muslim nurses working in the KSA either get used to the cultural behaviours and accept the culture or constantly question the health behaviours and

beliefs of the Muslim patients. The longer the nurses are exposed to the cultural differences the more acceptable the healthcare beliefs and practices might become.

Cultural liberty implies that all people have to maintain their religious identities, ethnicity as well as linguistic identities, also referred to as cultural rights (Johnstone & Kanitsaki 2009:408). Respect towards individual cultural rights does not mean that healthcare workers must accept all cultural traditions blindly, especially those that have been proven to be harmful.

***-The Muslim patients' lifestyle, values and traditions***

<p style="text-align: center;"><b>DATA DISPLAY 4.4.2</b> <b>LIFESTYLE: VALUES AND TRADITIONS</b></p>
<ul style="list-style-type: none"> <li>• The male relatives are the ones taking all decisions. I feel the females does not have any rights</li> <li>• The people like to eat a lot. They like to fry their food in oil, especially the lamb and chicken. They will refuse to eat the food from the hospital and will insist that the family must bring food from their homes</li> <li>• What I have observed here is that the people like to eat sweets or appetisers before they start the main meal...they will eat the dinner at 22h00 at night</li> <li>• Visiting hours is really a problem in the CICU. The security is not supportive. Relatives are allowed to visit patients throughout the day. There will be no difference if you tried to apply strict visiting hours. It will make no difference...</li> <li>• ...honestly, it is not our country and we have to respect the patients' needs. Sometimes they are demanding and sometimes they are nagging...</li> <li>• First you know, nursing patients is not just about giving medical treatments. It is holistic. So we have to know them and care for their emotional status...and everything which also are still here...their rituals and their beliefs</li> <li>• All of the patients admitted to the CICU suffer from hypercholesterolemia. It is different from my country. Patients eat a lot of fresh fruits. Here they like to eat food prepared in oil... they will eat dinner late at night around 22h00...</li> </ul>

Expatriate non-Muslim nurses working in this participating CICU in the KSA said that it was difficult at first to get used to the Muslim patients' lifestyle, values and traditions. Participants mentioned that they found it very strange that it was only males who were allowed to sign consent for female patients and that all discussions, regarding treatment and progress of the patients, were conducted only with male relatives.

They stated that the Muslim patients enjoyed eating dinner late at night and the food needed to be prepared in oil. Participants mentioned that most of the patients admitted to CICU suffered from hypercholesteremia. All the Muslim patients' traditions were based upon the stipulations in the Qu'ran, like the role of the family, visiting of the sick and care of the elderly. Visiting hours caused disturbances in the CICU because relatives did not adhere to the restrictions of visiting for only two hours per day. Participants felt that the security guards, who were supposed to control the visitors, did not assist the nurses at all. When prompted on how they would like to change these visiting hours they laughed and said that it would not help because the relatives felt that the KSA is their country where they could make the rules. Visitors often came to visit one patient, and then ended up visiting other patients in the CICU, who were strangers to the visitor, as well.

When visiting and greeting patients the visitors will touch and kiss them without washing their hands. The participants felt that this could contribute to infection rates in the CICU. The infection rate in the CICU ranged from 1.8% to 7.2% (Statistics obtained from the participating CICU). Some of the patients were discharged without any signs of infection but were later re-admitted with deep sternal wound infections.

***-Muslim patients' hygienic habits and practices***

<p align="center"><b>DATA DISPLAY 4.4.3</b> <b>HYGIENIC HABITS AND PRACTICES</b></p>
<ul style="list-style-type: none"> <li>• Some of the patients refuse to take a bath, shower or even change their clothes. You are really lucky when you can convince them that it is in their best interest to be cleaned</li> <li>• I don't know if this is included in their culture about hygiene because really, they have very poor hygiene. During night shift you really have to convince the patient and you will be very lucky if he is convinced if you can bath him. Personal hygiene is a cultural aspect and sometimes their practice is really a problem we encounter. Is this their culture?</li> <li>• Hygiene and bathing should be addressed when the patient is admitted. I don't know why, I don't think it has got anything to do with religion itself, but maybe they are just lazy. They don't like to wash</li> <li>• ...actually it is very different. When I came here, I was not expecting things that way. I can handle female patients in the .... When it comes to the private parts I can call another female nurse. There is a big issue to handle female patients (in the KSA). Also here, there are a lot of traditions that I was not aware of before.</li> </ul>

- We were really not orientated. We knew we were going to a Muslim country but I have not seen a Muslim patient before. ...I was really shocked. There are some differences regarding hygiene. They have a different culture here...sometimes I feel better amongst my own people...

Participants mentioned that they found it difficult to understand the Muslim patients' refusal to bath or shower. They could not understand why the patients would wash themselves only before the scheduled prayer times. Patients admitted to the CICU did not bring any personal toiletries like soap, facecloths or towels to the hospital. This created some concern among the participants regarding hygienic practices. Some participants mentioned that some discharged patients had been re-admitted wearing the same clothes they wore when discharged.

#### ***-The clothing style in the KSA***

##### **DATA DISPLAY 4.4.4 CLOTHING STYLE IN THE KSA**

- Here the people are very conservative. It is not allowed to see the body, skin or face of the females
- "...when you walk in the street all you see is black..."
- Because they are Muslim, they have certain cultures that we have to follow for the females. They have to wear a head cover and are not supposed to be seen by males. When we are nursing the patient we are closing the curtain. On some occasions we forget and the females are exposed and then we are not following the culture...That makes it difficult to nurse...

Participants mentioned that they could not understand why the female patients were all covered in black both within and outside of the hospital setting. They mentioned that in their own home countries they had the freedom to choose what to wear. Some of the participants mentioned that they experienced feelings of depression when seeing women wearing black veils with only their eyes being visible.

Females are expected to cover their whole body from the neckline up to their ankles with a black dress (abaya). They are not allowed to show any part of their body or skin. Elder or stricter female patients also covered their hands and feet with gloves and socks. Younger or more liberated females will wear the abaya and face cover

(targa), while the stricter females will cover their faces with a full cover with only their eyes open (hijab). The modest style of women's clothing is evident in the KSA. Some cultural misunderstandings could occur when a female patient refuses to be treated by a male physician or refuses to accept assistance from a male nurse.

Other problems might occur during the nursing care delivery process such as the female patients' refusal to undergo physical examinations and tests like breast cancer screening if conducted by male physicians (Al-Hashimi 2005:80-81). Many Islamic traditions or ideas like female modesty and fasting could help prevent illnesses like obesity, but economic growth and modernisation had significant impacts on health-related issues stemming from excess dietary consumption (Aldossary et al 2008:125). The significance of the *thobe* (loose garment, ankle length and usually made of cotton) is to be suitably dressed in the hot climates of the KSA as well as to express equality amongst all people (Smith 2005).

***-Strict male and female segregation***

<p align="center"><b>DATA DISPLAY 4.4.5</b> <b>STRICT MALE AND FEMALE SEGREGATION</b></p>
<ul style="list-style-type: none"> <li>• Muslim patients differ regarding male to female segregation. There are some issues you have to address and you have to be careful with them. They have different culture and traditional practices. They will pray 5 times a day and you have to respect that. Regarding female patients you have to be sensitive. They are covering their body and face. You need extra time and patience to take care of them compared to other patients</li> <li>• In the CICU we are handling Muslim patients and of course they are having their own cultures and we must respect that. The privacy is very important with the female patients. So instead of arguing we have to respect them</li> <li>• In the beginning I found some difficulties in dealing with them because I am new and still adjusting, but now so far it is okay. Especially here in our unit we have to segregate the male and female patients and the curtains are closed. That is very difficult because of the cardiac monitors. Especially if you are alone in that area and you cannot see the other patients. You have to cover them every now and then. That is very difficult because you cannot work so fast...that is the difficulties in dealing with them</li> <li>• There is really a big difference. For example when it comes to patients, it is very difficult to deal with Muslim people...we are very careful during our nursing care. Specific to the culture in the ..... they are more liberated and here they are more...conservative</li> <li>• It seems like the only difference between the Muslim and non-Muslim is the</li> </ul>

segregation between male and females who are very conscious of showing their face and skin. That is the difference... that is all...

Participants mentioned that they found the strict male and female segregation strange. They mentioned that in their own home countries they did not have this strict segregation and even male nurses would be allowed to take care of female patients. Culturally it is not allowed for male nurses to handle female patients. Female patients could refuse assistance from male nurses. Male patients requested the assistance of male nurses only, but this was not always possible, because of the shortage of male nurses. “The strict segregation of men and women and restricted freedom of movement of women in Saudi Arabia is a new and unwelcome experience for most expatriate nurses” (Tumulty 2001:288).

The CICU consisted of open areas with 6 beds in each. The critical or post open heart surgery area accommodated both male and female patients. This created some conflict when the patients insisted on drawing the curtains between the beds. Nurses had to observe the cardiac monitors for any vital changes. Drawing the curtains between beds made such continuous observations impossible and could be dangerous for the patients concerned. There was no centralised monitor display system in the CICU. All participating nurses agreed that it would be to the patients’ advantage to have separate male and female CICUs within the KSA.

### ***-Image of nurses in the KSA***

#### **DATA DISPLAY 4.4.6 IMAGE OF NURSES IN THE KSA**

- ...this is the Muslim culture. Some people when we came here, tried to convince us to be Muslim also. They are telling us to repeat the words (*shihada* –confession of faith). For me, personally I have to believe in my belief. I have to be on my own religion. You can change, but that is from your own mind. Nobody can change us. If somebody is telling me to be Muslim, sometimes I am uncomfortable because I believe in Christ and Jesus. Some of the patients keep telling me I have to convert now. I feel sad and I am escaping...
- I feel that the patients here are not respecting us. Unlike in the ... we are respected and treated kindly...
- ...all they want us to do is work, work and work...

Participants felt that they were possibly undermined as nurses in the KSA because of their cultural heritage. They mentioned that the patients, if given a choice would want to be taken care of by Muslim and Arabic speaking nurses. Some of the participants felt that the Muslim patients tried to convince them to embrace Islam.

Some participants stated that they experienced Muslim patients as being very short tempered. These short tempered periods could be linked to the Muslim patients insisting on treatment or nursing actions before the scheduled prayer times. Narayan (2003:613) stated that: “nurses who assess their patients’ cultural beliefs, values and practices are better able to individualise care and achieve positive outcomes”.

Nursing programmes in the KSA have low enrolment figures because of the possible “poor image of nursing compared to other professions, strict admission criteria and the five year duration” (of training) (Tumulty 2001:287). There are only 25% male Saudi nurses available to care for male patients and foreign nurses are recruited to fill the gaps (Tumulty 2001:288). Barriers to nursing in the KSA could include the social image of a working female, the long working hours over weekends or night duties, low salary compared to the workload and limited professional developmental opportunities (Nursing4all 2010).

#### ***-Level of education***

<p style="text-align: center;"><b>DATA DISPLAY 4.4.7</b> <b>LEVEL OF EDUCATION WITHIN THE KSA</b></p>
<ul style="list-style-type: none"> <li>• Most of the patients don't understand the surgery and what it involves. When you try to educate them they will tell you we leave it in God's hands. If we can educate them...Some understand that diet, exercise and good eating habits will help them...</li> <li>• Almost all of them have low education, especially the elderly. The young patients are educated but they don't know about heart disease prevention. They are eating a lot of oil and eating a lot of junk food</li> <li>• Here they are more demanding when it comes to work. They feel, I get the feeling sometimes, that there is real discrimination on the part of the Saudi against...</li> <li>• It is very good to research about the culture and how it is being practiced so</li> </ul>



that you will have no difficulty when dealing with patients within that culture...

- Cultural aspects for me personally – people with higher level of education is more patient with regards to the nurses. Patients coming from low socio economic status are more demanding probably because they don't understand what is going on compared to the more educated people...

Participants mentioned that they perceived some Muslim patients' educational levels to be low. When prompted they explained that especially the elderly patients were unable to speak English and had no education while the younger and more liberated generation were better educated. The nurses reportedly perceived many female patients to be uneducated and explained that although some female patients had acquired formal education they chose to stay at home and take care of their husbands and children.

The low levels of knowledge about heart diseases and risk factors contributing to heart disease, among Muslim patients in the KSA, highlight the need for patient education (Netto, McCloughan & Bhatnagar 2007:178). Younger and more educated people are more likely to respond to or to distinguish between cardiac related symptoms. Religiousness can reduce exposure to stressful events like legal and interpersonal or family problems which might contribute to ACS episodes (Burazeri, Goda & Kark 2008:941) and consequently heart surgery.

#### ***-Contributing factors to heart disease in the KSA***

##### **DATA DISPLAY 4.4.8 CONTRIBUTING FACTORS TO HEART DISEASE**

- Most of the patients admitted are heavy smokers for more than 20 or 30 years
- Actually I think it is not about Muslim or non Muslim. I think it is the same regarding their diet and exercise. People from a young age start to smoke. It is not directly through heart disease but indirectly through control of cholesterol levels. They are saying some Chinese herbs will control the cholesterol levels so that will prevent heart disease...
- I think Muslims don't have any idea about heart disease, but I am not sure about it. Here are a lot of congenital heart diseases...

Reportedly most patients admitted to the CICU were heavy smokers for more than 20 or 30 years. Younger children admitted to the CICU with congenital heart diseases were the result of inter family marriages. In the KSA 'consanguinity' is

practised where cousins are encouraged to marry each other in order to keep beauty and money within the same families (El-Mouzan, Al-Salloum, Al-Herbish, Qurachi & Al-Omar 2007:1881-1882). “Many Arab countries display some of the highest rates of consanguineous marriages in the world, and specifically first cousin marriages which may reach 25-30% of all marriages” (Tadmouri, Nair, Obeid, Al Ali, Al Khaja & Hamamy 2009:2).

Participants mentioned that some patients with high cholesterol levels and diabetes refused to eat the prepared hospital food. The patients opted to eat family meals or fast foods from home. The participating nurses mentioned that the patients admitted to the CICU were more obese than patients from their respective home countries. They explained that it could be due to the poor dietary habits and lack of exercise.

Heart diseases and strokes claim 17.5 million lives per year and are therefore classified as the world’s most serious killer disease (Saudigazette 2010). In the KSA, cardiovascular diseases account for 22% of deaths each year. The situation will become increasingly serious because in 20 years’ time a large proportion of the population will be 60 years of age and older (Saudigazette 2010).

Obesity, lack of exercise and smoking are factors contributing to heart disease (Syed 2003:1). More than 38% of the KSA’s population is under the age of 14 years (CIA World Factbook:2010). Obesity could be prevented by moderate eating, fasting and health education. Smoking is forbidden in Islam by adhering to the principles of avoiding the bad (Quran: surah Al-‘Araf 7:157) and knowing that the prophet himself never smoked.

#### ***-Patient management in the CICU***

<p style="text-align: center;"><b>DATA DISPLAY 4.4.9</b> <b>PATIENT MANAGEMENT IN THE CICU</b></p>
<ul style="list-style-type: none"> <li>• Oh, totally in the management of the patients... It is really fast track here...</li> <li>• Actually it is not that much difference. It is only the culture because the equipment is different. In the ... we don't have this much ventilators and nurses are expected to ambu-bag patients twenty-four hours. They don't have much money to pay for ventilation. It is totally different...</li> </ul>

Factors identified by the participants that could influence nursing care and contribute to culture shock included the faster rates of patients' admissions and discharges, as well as the availability of more modern medical equipment in the KSA compared to their home countries. Healthcare facilities are available and free to all individuals in the KSA. The CICU of this participating hospital was a tertiary referral unit for all inhabitants of the KSA and neighbouring countries. All participants mentioned that the way of dealing with the patients, especially after surgery, was very different from their home countries.

Equipment was always available and the patients spent minimal time in the CICU post extubation in order to prepare available bed space for other pending admissions. Within this 24 bed CICU there were an average of 4 to 5 cardiac surgeries and 10 to 15 intervention cardiology procedures performed each day. Some participants mentioned that in their home countries one hospital might have only one defibrillator for the whole hospital and possibly 2 to 3 ventilators for all the ICUs. Expatriate nurses recruited to work in the KSA might need more time to get orientated to technological advances.

Cardiac surgery remains an advanced and expensive surgical technique (Wake & Cheng 2001:41), irrespective of the duration of hospital stay and irrespective whether the 'on pump' or 'off pump' surgical procedures had been performed. Critical care nurses' ability "towards effective hemodynamic decision making immediately post cardiac surgery is crucial and requires complex skill application and understanding in order to consider numerous parameters and attributes within a limited time frame" (Currey & Botti 2006:194).

#### **4.4.1.2 Language challenges**

<b>DATA DISPLAY 4.4.10 LANGUAGE CHALLENGES</b>
<ul style="list-style-type: none"> <li>• Nursing assessment is compromised because of the language barrier</li> <li>• Even when the patient is discharged, you want to give health education but you cannot because of the language barrier</li> <li>• It is the responsibility of the doctor to explain to the patient the proposed procedures and interventions but that does not always happen. Some of the patients are scheduled for surgery the following day and then they will ask what is going to happen to them...</li> </ul>

- For me the most important is that most of the people here are not so educated and when you talk a lot it seems that they don't understand. The level of education is different
- Language is very important. First it is important to learn their language so that you can assess them properly. You can inform them of what to do. You can instruct them of what is happening...
- It is not quite easy because of the language barrier. Sometimes when we understand the language it is easy. They are very appreciative when we use their phrases like 'Alhamdul Allah' (thanks to God)
- Nurses that are hired must be knowledgeable enough to be exposed in the CICU and they must also try their best to speak the patients' language
- Number one is the communication barrier. It is difficult to assess them, And they don't understand so I have to look for someone to interpret...and also when they ask they still don't understand. Not all Muslims understand English...
- It is very difficult to deal with the Saudi language...
- The language is a problem. When you try to explain, they don't understand English
- Number one is the communication barrier. It is difficult to assess them and they don't understand so I have to look for someone to interpret...not all Muslims understand English. Their temper is very short...,
- Since we are in cultural diversity rendering care to patients, so far, I could not see anything that could cause conflict. It is only the language barrier
- It is very difficult language wise. Their culture and communication with them is so difficult. The females don't have any rights. The males are the ones to sign consent for them. They don't have the right to say no. Also concerning hygiene...it is very poor. Covering is also another shock for me, you only see their eyes.
- For me it is very difficult. For me it is the first time to work here and I don't know how to speak Arabic. As time passes by you adopt to their culture. In the ... nursing communication is very important. Here there is a barrier on communication, so when they are telling you something you cannot understand them. It is not the same. Some people have different dialects, especially the ones from the mountains (Bedouin).

Participants identified the language barrier as an obstruction in caring for Muslim patients in the CICU. The language barriers include the inability to explain procedures to the patients, misunderstanding of patients' basic requests, inability to explain visiting hours as well as difficulty in explaining changes in the patients' conditions to visitors. Simple instructions before scheduled interventions or surgery, discharge planning and health education might have been neglected because of the language barrier. Some participants mentioned that they used basic Arabic terminology but were uncertain about the patients' levels of understanding.

Although it was the primary responsibility of the physicians to explain admission, procedures and interventions to the patients there were identified gaps in communication. Some patients admitted to the hospital were from the mountain areas (Bedouin) and these patients spoke a different Arabic dialect. Bernard, Whitaker, Ray, Rockich, Barton-Baxter, Barnes, Boulanger, Tsuei and Kearney (2008:355) stated that "...acute care hospital medical professionals perceive language as an impediment to quality care delivery and as a source of workplace stress". The Arabic language derives from the Semitic language group and consists of "classical or Qur'anical Arabic, formal or modern standard Arabic and spoken or colloquial Arabic" (Arabiclanguage 2011).

Participants mentioned that they could not understand why all health-related discussions involved male relatives. The role of the extended family in Islam is support and guidance. Some conflict or misunderstandings could arise if the family is not included in the nursing process or the treatment plan. There are stronger family ties between people from the Middle East (although weaker than 100 years ago) than among people from the Western countries (Al-Omari 2008:118). Caring for patients from Middle Eastern origin with the tighter family ties could initially be more challenging or difficult for the biomedical/Western orientated critical care nurse (Aboul-Enein 2002:229). The man's image in the Islamic world is seen as sole keeper and provider, and to be moderate in all aspects including health. Illness might be experienced as a trial or cleansing from Allah (Daar & Al Khitamy 2001:60).

Aboul-Enein and Ahmed (2006:168) stated that "poor patient outcomes...increased use of expensive diagnostic tests...increased use of emergency room services...poor patient satisfaction and poor or no patient follow-up, when follow-up is indicated, resulted from a language barrier between patients and healthcare providers".

"In nursing communication is essential to treating and caring for individuals to avoid issues that arise with a language barrier. It is recommended that all healthcare providers use trained interpreters with regard to patient care" (Aboul-Enein & Ahmed 2006:169). In this participating CICU within the KSA there were no appointed translators and only three Muslim Arabic speaking nurses working in this unit at the time of data collection. Their duty schedules included both day and night duties,

which implied that there was not always an Arabic speaking person available in the CICU.

#### 4.4.1.3 Islam as religion

##### DATA DISPLAY 4.4.11 ISLAM AS RELIGION

- The patients will be scheduled for surgery but they will insist on praying first
- Patients from cardiac interventions, who are supposed to be on bed rest will insist on getting up to take ablution and to pray
- Before taking medication the patient will tell you that they have to pray first
- When it is lunch or dinner time the patient will tell you that they have to pray first
- "I do not know why Muslims fast during Ramadan. I think it is because Allah fasted so they feel they must also do the same..."
- "Fasting in Ramadan is because Mohammed also did the same"
- Most of the patients do not refuse to take their medications during Ramadan. Some of the elder and stricter religious patients will totally refuse any treatment even they know they need it. They will tell you it is from Allah...whatever happens to them
- I do not know what their food preferences are... The only thing I know is that they don't like the pork...maybe because they don't like this animal
- All Muslims pray five times a day
- I don't know about the pillars (pillars) of Islam...
- The role of the mother is just to stay at home and to take care of the children
- Actually here in Saudi Arabia the nursing care is designed for Muslim patients. Everything is regarding Islam. All thinking in the work is based on the religion
- There are some patients who are very cooperative and very strict when it comes to their Islam beliefs. They are very conservative. Their Muslim beliefs carry heavy on their health beliefs
- We have difficulties because it involves understanding of the religion. Sometimes I cannot implement total nursing care because I always think of the religion. It is quite difficult in the medical treatment and the religion...
- It is just the Islamic culture. Not the religion, the culture. It goes hand in hand. Their culture is Islam
- Especially for Muslims, they are very particular about blood. For them blood is really sacred. Even though you are extracting little blood they will tell you that are too much. Also about their praying times... sometimes you will tell patients not to move but they will insist to pray. They should be on complete bed rest but they will insist that they are fine and they will get up to wash and pray
- They are lacked when it comes to treatment related to heart problems. Sometimes maybe because of the religion they are not trying to understand. We have difficulties implementing our treatment
- ...of course you have to respect the religion of the Kingdom. Sometimes you want to take the vital signs but they are making salah (prayer). You have to respect that...

- Well, what I experienced here is quite different from the other patients since they are more private and religious also...
- Having in mind that I am in a Muslim country, I have to respect whatever necessary things I have to give to them based on their religion. Like, for example when there is a female patient a female nurse should take care of her and that is it. Privacy is of high regard here.
- The religion, practices, customs and beliefs are different. As much as possible we have to adjust and respect their customs and traditions, especially their religion...
- I don't have a problem with Muslim patients. Their expectations are the same as any other patients. The religion does not really count, it is the culture...
- ...actually they have many beliefs that we have to put in mind before they are admitted. Before working here we had orientation in our country about the religion. I was really afraid at first and paid a lot of attention. You cannot hold or even touch the Qu'ran, and I am really conscious about that...
- ...what I discovered here is that they have some things. They will burn themselves just to remove the pain. Before they even consult the doctor they will do burning...
- There are big cultural factors I experienced. Some patients believe that they must bring zam-zam to drink. We don't even know if it is sterile or not. They are still insisting that the patients have to drink it. Their cultural beliefs will make them to believe that they will get benefit from it. I will just go with their cultural beliefs and respect that but it is very hard
- It is really much different, especially when you are taking care of the dead. It is really different from my practice in the ... You have to embrace the culture so you will know how to take care of the patients...as far as I know Islam has really close family ties. They are believed to be so caring of the person that is sick. I think we also have to consider the relatives and not only the patients. Sometimes when the patient is agitated, so will be the family. The relatives care for the patients so much and they want to be informed about the patients' condition
- "...for me personally, I feel patients that are sick but insisting to fast should not be admitted and should stay at home"
- Patients admitted to the CICU are sick and they must know they are sick. When they refuse to take their treatment we ask the family to help us to convince the patient...but they still will refuse. They will say it is from Allah...
- Some of the male patients admitted with long beards refuse to shave their beards. This causes a problem post operative when the hair is touching the sternal wound and could cause wound infections
- ...I think they should change the nursing care. Patients that are prepared pre-operatively refuse to shave their beards and that causes problems. Sometimes the beard will touch the sternal wound and you will ask them to cut it but it causes problems. If that could be addressed infection could be diminished somewhat. Having patients with beards touching wounds is not right.

Participants mentioned that they found it very difficult to deal with the Muslim patients' traditional religious practices which included prayers five times a day. Muslim patients' perceptions of healing, religious practices like consumption of zam-zam, fasting during Ramadan and the role of the mother in Islam, posed challenges to the expatriate nurses in the CICU.

Religion could be regarded as a major factor that will influence nursing care rendered to a patient. Islam means peace, submission and obedience. The holy book is the Qur'an which guides conduct in daily life, worshipping and praying. Prayer is performed five times a day at certain prescribed times. The holy month in the Islamic calendar is Ramadan when the Qur'an was revealed to the prophet Mohammed.

Some participants experienced nursing Muslim patients as being very different from nursing patients in their home countries. Muslim people vary in their expressions and religious beliefs, and range from very liberal to extreme fundamentalists (Wehbe-Alamah 2008:85).

### ***-Prayer schedules***

Participants mentioned that they found it very strange that patients would insist on performing their scheduled prayers before any procedures or interventions. Patients who just arrived to the CICU after interventions and who were instructed to adhere to strict bed rest would insist on getting up to perform their prayers. Before the scheduled prayers the hands, face, mouth, nose, forearms and feet have to be washed with water. Sand can be used if water is unavailable (Pennachio 2005:50). Patients who are sick can be allowed to pray while sitting in bed and it is not obligatory for them to perform the actions required during prayer.

Islam, the religion, is built on five pillars and one of them is to perform five prayers per day at certain set times. The prayer could be at the same time of pre-scheduled interventions or nursing actions and this might lead to possible delay in treatment or misunderstandings regarding refusal to comply with medical treatment.



### ***-Muslim patients' perceptions of healing***

Participants also mentioned that the Muslim patients opted to prioritise healing from Allah rather than relying on medication. Healing of the heart is explained by prophet Muhammed in Sheikh and Gatrad (2008:39) as "Allah did not send down a sickness except that He sent down its cure". Muslims are believed to be worse than other religious groups to report poor health and illness or disabilities (Sheikh & Gatrad 2000:8) which is possibly due to their belief that only Allah will cure them.

### ***-Religious practices***

Islamic religious practices refer to prayer times, traditional beards worn by men in Islam, fasting periods and their strict following of the holy scriptures (Qur'an).

Participants mentioned that they had difficulty in understanding the Muslim patients' religious practices. Some of the misunderstandings occurred when the patients insisted on praying before going to surgery or scheduled interventions which caused time delays. Participants mentioned that it frustrated them when patients insisted on praying before taking urgent medications, or refused to take any form of treatment during fasting periods in Ramadan.

Religious practices could make religion unique. Some misunderstandings could happen when there are uncertainties regarding practices like prayer and fasting periods during Ramadan. Religion is based on believing in a higher or supreme being.

Western orientated nurses might not be familiar with certain religious practices related to the religion of Islam. Muslim patients believe that zam-zam and honey has certain healing powers as explained in the Qu'ran. Participants mentioned that they did not understand why the patients would insist on drinking zam-zam because the origin and sterility could not be determined.

The Qur'an and hadeeth both explain physical and spiritual healing. Divine healing of the heart occurs via the teachings of the Qur'an when God removes "rage from

the heart” (Qur’an 42:37). Hidden ailments according to the Qur’an include impurity, disbelief, falsehood, doubt and hypocrisy attributed to diseases of the heart. Muslims believe that faith and loyalty to God will cure illness. Other treatment options, for ailments like fever, (according to the hadeeth) include honey (used for curative interventions), cupping (blood letting), cauterising and “zam-zam” (drinking water from a miraculously generated source in Mecca) (Mebrouk 2008:154).

- ***Traditional beards in Islam***

Participants mentioned that they found it difficult to understand the Muslim males’ refusal to shave their beards and that this could possibly contribute to post operative sternal wound infections. Elderly and more religious patients were admitted to the CICU with long beards which had never been shaved during their life time. Nurses working in the CICU were not permitted to shave these patient’s beards without consent from the patient and relatives. These long beards could pose infection risks in cases of sternal incisions.

Patients should be assessed individually to determine cultural preferences rather than applying ethnic stereotyping. Muslim men traditionally wear long beards. Shaving of the beards could be “interpreted as a sign of shame or dishonour” (McKennis 1999:1191). Some conflict might occur when nurses try to convince patients to shave their beards or even shave them without prior consent from the patient or family.

- ***The Qur’an***

Some of the participants mentioned that they felt uncomfortable when patients or visitors gave them a Qur’an as a gift and one participant mentioned that he/she felt guilty for not reading it. Muslim patients kept the Qur’an at the bedside and even listened to recorded versions in the CICU. Participants mentioned that they did not know if they were allowed to turn the volume lower if it was too loud. Muslim people only touch the Qur’an after ablution is done. They believe that the Qur’an is from Allah and need to be treated with respect and dignity. Some misunderstandings

could occur when nurses touch or move the Qur'an away from the patients without asking permission to do so or without covering it before touching it.

- ***Handling of corpses***

Some participants mentioned that they were unaware of specific religious practices related to Islam. Handling of the body after death has to be done according to strict guidelines. In some cases the washing and preparation of the body was done only by the relatives.

After the death of a patient there are certain rituals about which nurses should be aware. These include turning the body in the direction of the Kiblah (towards Mekkah), and timing the cleaning of the body, not to dress the deceased body in anything but cotton cloth, to wrap the body in cotton sheets and the burial to take place before sunset on the same day (Al-Shahri & Al-Khenaizan 2005:436).

***-Fasting periods***

Participants mentioned that they did not know nor understand why Muslims fasted during the month of Ramadan. Some participants thought this was done because Allah himself fasted and Muslims decided to follow this practice.

The holy month in the Islamic calendar is Ramadan when the Qur'an was revealed to the prophet Mohammed and is celebrated each year with fasting by the Muslims.

Participants mentioned that they found it difficult to understand why patients were admitted to the CICU during Ramadan but then refused to take their treatment. Family members were requested to convince the patients to adhere to the treatment protocols but this was not always successful. The treatment administration times in the CICU were adjusted to fit in with the fasting periods but some emergency admissions refused all treatments.

### ***-Role of the mother in Islam***

Participants mentioned that they perceived the role of the mother in Islam just to stay at home and to take care of the husband and children. They did not feel that she had any importance in the family structure. Some of the participants mentioned that they only saw how caring the family members were towards the mother during visiting periods. One participant shared the experience of how a male relative was caring for his mother because she was so old and too tired to walk.

Family members, and especially the role of the mother, is critical from the Islamic perspective (Aboul-Enein 2002:230). Social support for Muslim patients is extended because family members prefer to live in close proximity to each other (Giger & Davidhizar 2008:95). Problems relating to one individual also concern the whole family.

Nurses trained in the Western/biomedical perspective could find it more challenging to deal with patients from the Islamic/supernatural beliefs. Nurses who are prepared to leave their home countries in order to seek better living standards or financial reimbursement from foreign countries might not be prepared for the challenges that they could encounter. Orientation programmes offered by recruitment agencies might not include all the challenging aspects that the expatriate nurses could encounter. Most people around the world are perceived as being religious, because religion helps people cope by meeting social and psychological needs. Abdel-Hady in Husain (2007:259) stated that "religion is an instinctive thing in man, deeply rooted in his nature. Man might have led part of his life, whether short or long, without sciences, arts or industries. But history has never known a human group that lived without religion".

## **4.5 CULTURAL FACTORS THAT INFLUENCES NURSING CARE**

Participants identified the cultural factors that could improve the care delivery to Muslim patients as:

- Improved communication skills/basic Arabic understanding

- Improved workload/fewer patients allocation in order to provide optimal nursing care
- Improved understanding of the religion of Islam including lessons regarding Muslim beliefs, practices during Ramadan and eating preferences

No participant identified cultural obstacles in the CICU when prompted, but rather commented that they knew they were working in a multi-cultural environment and they needed to respect each other and their patients.

<p style="text-align: center;"><b>DATA DISPLAY 4.5.1</b>  <b>FACTORS THAT COULD IMPROVE NURSING CARE</b></p>
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- |  |
|--|
| <ul style="list-style-type: none"> <li>• I think the bottom-line here is to respect everybody, because we are working together as different nationalities with different cultures...</li> <li>• It is really very important to know the background of the person you are working with. First, when I came here I was really swimming in deep waters without knowing how to swim first. Actually it is my fault because I should have had a view on their culture.</li> <li>• For them here, they are bond to their culture. They are very rigid and not easy to manipulate their customs. What they do is their custom and they can manipulate us</li> <li>• cultural aspects in the CICU are broad and it is so difficult. I think we should adopt their culture and implement it into the medical reign so there can be a good combination between the culture and the medical treatment...</li> <li>• "I think it will be better if they will give us a basic Arabic language course"</li> <li>• "Definitely the nurse patient ratio, especially the post operative patients are very hard to manage"</li> <li>• "This is a cardiac unit and the patients need to be monitored very closely. Anything can happen to them. Sometimes you will handle three patients. One will be confused and agitated..."</li> <li>• "The female patients are very demanding. When they see you spend a lot of time with one patient, even you explain to them that she is <i>taban</i> (tired, sick), they will call you every now and again...this is really very difficult for us..."</li> </ul> |
|--|

#### 4.5.1 Improved understanding of Islam as religion

Some participants mentioned that there were differences from Western countries and thought that Muslims should follow the "Western ways" in order to receive good nursing care... During the interviews the participants seemed very confident and eager to elaborate on some of their statements. When probed the participants mentioned that they encountered difficulties to understand the Muslim patients' views

of their total dependence on Allah for healing. All illnesses were perceived as being trial periods with the knowledge that healing will occur. One participant mentioned that it would be easier to nurse Muslim patients if they could follow the “Western ways”, and be less conservative in their daily practices. When prompted it was explained that the Muslim patients need to see the importance of modern medicine in the healing process.

Nurses are culturally diverse. They were socialised into the biomedical perspective (especially with their ICU training), and now they have to work in a culturally “strange” environment where the patients view the world according to a religious perspective (biomedical versus spiritual and Islamic perspectives). Spirituality affects individual functioning and wellbeing, and includes features like meaning, connecting, transcendence, value and becoming (Tse et al 2005:182). Muslim patients and their relatives “turn to religion for comfort during times of crisis, such as critical illness and impending death” (Sutherland & Morris 1995:508).

#### **4.5.2 Improved communication skills**

Participants mentioned that they might find it easier to deal with Muslim patients and to understand the culture and traditions better if they had learned some Arabic language skills. They suggested that a basic Arabic language programme, including basic terminology, as a prerequisite for employment in the KSA. Some of the participants mentioned that it was very difficult to know and understand the patients’ background because they could not communicate with each other.

Communication among nurses, patients and family members is vital to achieve optimal care. ICU hospitalisation could “trigger a variety of emotional responses to both the patient and the family that manifest in the form of anxiety, shock or despair” (El-Masri & Fox-Wasylyshyn 2007:43). Emotional responses can impede family members’ coping strategies and ultimately lead to family dysfunction. The nurse must attend to the family’s needs in order to cope with stressors and to maintain a sense of wellbeing. Communication is the key for providing sensitive nursing care. When people communicate they share words and ideas that explain who they are (Burnard & Naiyapatana 2004:755).

### **4.6.3 Reduced workloads**

Participants mentioned that the allocated workloads in the CICU were very stressful and the patients were very demanding. They mentioned that if the workload could be improved, they would be delivering better quality nursing care. The nurse patient ratio in the CICU at the time of the study was 1:1 for all critical or ventilated patients and 1:2 or 1:3 for all stable (or long term stable) patients. They explained that when patients became agitated or confused, especially after cardiac surgery, the nurses required additional time to complete their nursing care. Care for the seriously ill patient requires highly skilled nurses to provide close monitoring and early intervention in cases of adverse changes (Bassett & Makin 2000:1).

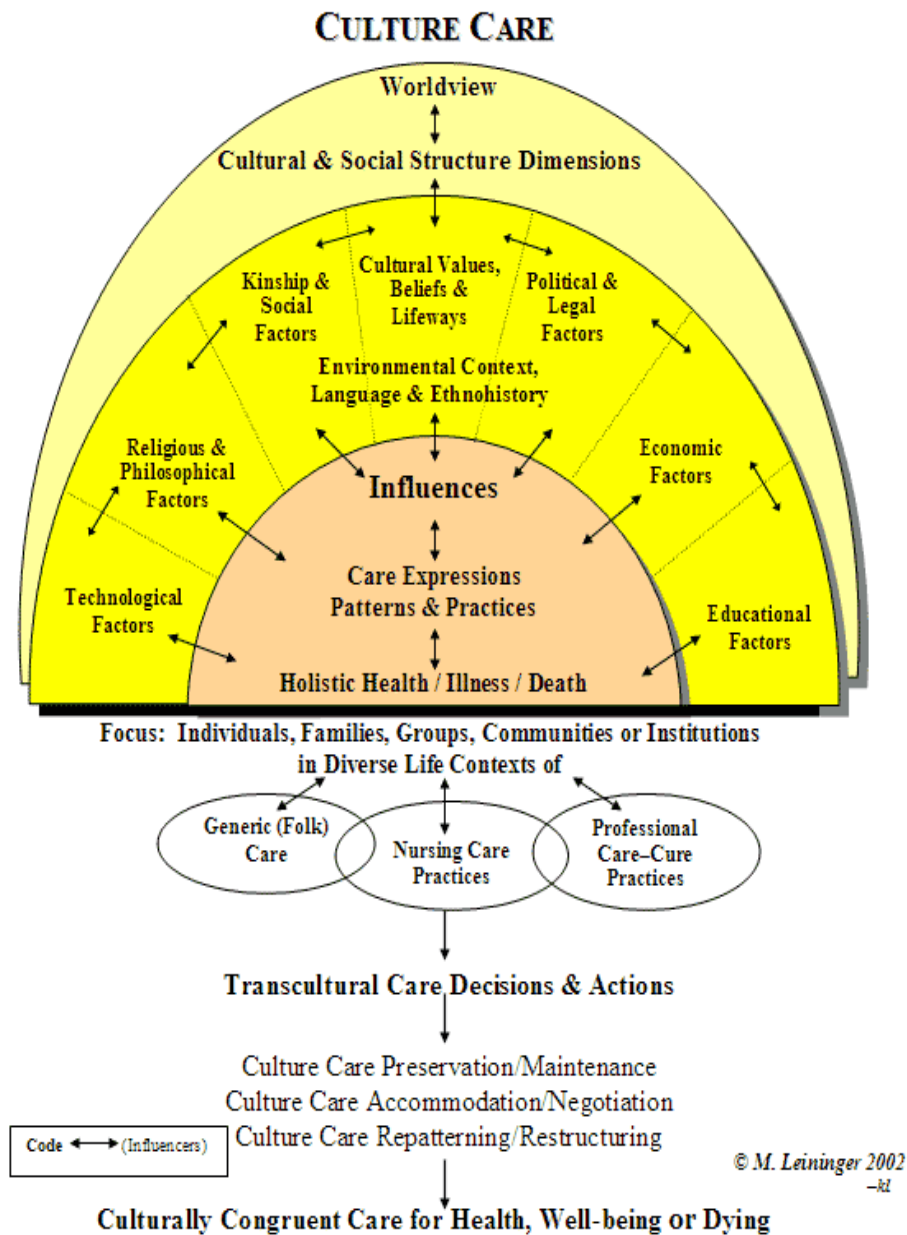
## **4.6 APPLICATION OF LEININGER'S SUNRISE MODEL TO THE STUDY'S FINDINGS**

Non-Muslim nurses working in a CICU within the KSA might experience some cultural and religious practices as strange and/or unfamiliar. Nurses need specific cultural knowledge to provide culturally congruent care to their patients without limitations. Technology, religion/philosophy, kinship/social factors, cultural values, political/legal, economic and education are factors identified in the Sunrise Model that could influence the Muslim patients' perceptions about health, illness and death.

### ***-Religious and philosophical factors***

Expatriate non Muslim nurses working in the KSA are orientated from the Western/biomedical perspective and are now expected to work and care for patients who view the world and thus caring/curing from the supernatural perspective. Nurses might experience the Muslim patients as strange and not adhering to Western treatment options because of their total dependency upon Allah for healing.

*Leininger's Sunrise Enabler for the  
Theory of Culture Care Diversity and Universality*



**Figure 4.4 Leininger's Sunrise Model**

(<http://www.Leininger/sunrisemodel>)

**-Technological factors**

Participants mentioned that the advanced technology available in the KSA is better than those in their home countries. Patients opted to rely only on Allah for healing rather than to seek these medical treatments. Expatriate non Muslim nurses



working in the KSA, might need to develop a deeper understanding of the balance between technology (Western) and religion (Eastern).

### ***-Kinship and social factors***

Muslim patients have very close family ties and the role of the family supersedes the function of individuals. Participants mentioned that they found this fondness very different from what they were used to in their respective countries of origin.

### ***-Educational factors***

Some of the participants mentioned that they found it very difficult to communicate, deliver nursing care or understand some of the patients from the lower socio economic districts. Most of the Muslim patients will only communicate in Arabic with religious references like 'Thank God' and 'God willing'. Education is one aspect in the Sunrise Model that might influence the Muslim patient's worldview.

### ***-Cultural values, beliefs and lifestyles***

Participants mentioned that the strict conservatism in the KSA (and inside the CICU) was very different from what they were used to. This could lead to possible conflicts between the nurses and patients when they unknowingly transgressed the modesty principles. Cultural care knowledge is needed to care for culturally diverse populations in a safe and beneficial way.

Some participants mentioned that they could not understand why some patients practiced cauterizing as a treatment option. Cultural values held by the individual determine beliefs and values and conflicts can arise when there are conflicting values or beliefs between the nurse and the patient (Walsh & Crumbie 2007:23).

Culture care knowledge is the sound basis to establish nursing as a distinct and scientific discipline (Leininger 2007:10). Healthcare is rapidly growing in a multicultural world and cultural care factors should not be overlooked. The nurse's

role is to be aware of his/her own culture before attempting to understand and interpret the patient's illness and treatment (Williamson & Harrison 2010:762).

### **- *Illness and death***

Muslim patients experience illness as a trial period from Allah. It is believed that devotion, prayer and fasting will contribute to healing. Death in this world is viewed as a celebration for believers who will continue living in the after-life.

### **-*Transcultural care decisions/actions***

There are strong supportive relationships between critical care nurses' races, attitudes and past exposures to transcultural nursing knowledge (Marrone 2008:13). Critical care nurses' attitudes towards Muslims have significant influences on the provision of culturally congruent care, and the development of culture specific learning opportunities has to be implemented in critical care nursing programmes. The provision of culturally congruent care requires a clear understanding of factors that influence nurses' decisions to provide care which is congruent with a patient's values and beliefs.

Culture care preservation/maintenance, according to Leininger (in McFarland & Eipperle 2008:51), is explained as any assisting or supportive acts that help maintain or preserve cultural beliefs. Nurses care with sensitivity but need to be equipped with skills and knowledge to deal with cultural diversities (Kavanagh 2003:6).

Culture care accommodation/negotiation (Leininger in McFarland & Eipperle 2008:51) includes any assistive, supportive or enabling acts that cultures adopt or negotiate with others in order to care for health and well-being. Non-Muslim nurses working with Muslim patients might need time and experience to get use to the cultural practices and be supportive of the extended family during the nursing care delivery process.

Culture care restructuring/re-patterning (Leininger in McFarland & Eipperle 2008:51) includes any assistive, supportive or enabling nursing acts that help people change,

modify or restructure their lifestyles in order to improve healthcare. Non-Muslim nurses working with Muslim patients might need to gain more insight into and experience of the religion of Islam and connected religious practices before any reconstruction of cultural behaviour could be attempted.

Human care and caring (Leininger & McFarland 2006: 10-11) refer to all assisting, supportive and any other facilitating ways to help others with needs or to improve health, life ways or the dying in need. Some unique features of the Sunrise Model include that it focuses on discovering holistic comprehensive cultural care, and can be used in Western and non Western cultures.

The Sunrise Model illustrates religious and philosophical factors that affect care expressions, including practices of a culture. Dimensions like kinship, cultural values and lifestyles are all interrelated. Faith is only one influencing factor in the Muslim's life, and openness to professional care is different (Lawrence & Rozmus 2001:229). Nurses can rely on their knowledge of Muslim generic beliefs while using the Sunrise Model to bridge the gap between the emic and etic practices.

#### **4.7 SUMMARY**

Chapter 4 discussed the data analysis and findings. The categories identified that could affect the non-Muslim nurses' experiences when caring for Muslim patients included culture shock, language and understanding of Islam as religion. All categories were explained in detail.

Some answers that could be included in the first research question: what is the nature of expatriate non Muslim nurses' experiences (biomedical perspective), when caring for Muslim patients in a critical care unit in Saudi Arabia are:

- Western-orientated nursing staff might find the culture and related religious practices by the Muslim patients strange
- Western-orientated nurses could find it difficult to understand the Muslim patient's refusal to take treatment or undergo interventional procedures before

prayer as strange

- Western-orientated nurses might find it difficult to understand the traditions and practices connected with Ramadan
- Western-orientated nurses could find the close family ties and non- adherence to limited visiting hours as being unacceptable
- Western-orientated nurses could find the role of the mother in the Muslim family not acceptable in comparison with Western practices
- Western-orientated nurses might not be adequately prepared to face the challenges and expectations when dealing with Muslim patients in the KSA

Some possible answers that could be included in the second research question: how does the biomedically-orientated nurses' experiences influence their therapeutic relationships with their Muslim patients are:

- The biomedically-orientated nurses might focus on medical treatment, strict adherence to treatment plans and the timely execution of physician's orders while the Muslim patients might argue that illness and healing are from Allah
- The Muslim patients might not see the urgency to stick to medical time schedules because the prayer times are seen as being more important which might lead to conflict between the nurse and the patient
- The biomedically-orientated nurses might think that religious practices like the consumption of zam-zam, cauterizing and even fasting could be harmful for Muslim patients
- The biomedically-orientated nurses might feel that the Muslim patients are impatient and demanding, and that might make expatriate nurses feel inferior
- The biomedically-orientated nurses might feel that Muslim patients do not approve of being nursed by non Arabic speaking or Christian nurses which might lead to feelings of negativity
- The biomedically-orientated nurses might find it difficult to render comprehensive nursing care to the Muslim patients because of the language barrier which makes it difficult to explain nursing care, interventions or even health education

Chapter five will present the conclusions of the study, based on the research

findings, and provide recommendations for enhancing non-Muslim nurses' adaptation to providing nursing care for Muslim patients in a CICU. The limitations impacting on the generalisability of the study's findings will also be listed.

## **CHAPTER 5**

# **LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS**

### **5.1 INTRODUCTION**

In this chapter the conclusions, limitations and recommendations are presented. The purpose of this study was to describe the expatriate non Muslim nurses' experiences of working in a CICU within the KSA. The research questions were as follows:

- What is the nature of expatriate non Muslim nurses' experiences (biomedical perspective), when caring for Muslim patients in a critical care unit in Saudi Arabia?
- How does the biomedically orientated nurses' experience influence their therapeutic relationships with their Muslim patients?

### **5.2 RESEARCH DESIGN**

A qualitative descriptive research design using Leininger's Sunrise Model was employed. Data collection was done by conducting individual semi-structured interviews. Data analysis was done manually. The major themes that emerged were culture shock, language barriers, Muslim traditions and practices and the lack of insight into Islam as religion.

### **5.3 LIMITATIONS OF THIS STUDY**

Some of the limitations that could be included in this study are:

- The research was conducted in only one CICU within the KSA

- The patients' inputs were not acquitted as involving patients in research was not allowed in the KSA at the time of conducting this study
- The population sample was small
- Cultural differences between the researcher and participants might have impacted on the quality of data obtained during the interviews
- Although the interviews were conducted in English, some participants might have experienced difficulties to comprehend some questions and their answers might have been affected by their language abilities

#### **5.4 CONCLUSIONS**

The conclusions are offered according to the themes derived from the findings in chapter 4.

Cultural shock was identified by most of the participants. Some of the factors that might contribute to cultural shock include climate, food, language, dress code, social roles, rules or behaviours and values. Signs of cultural shock might include headaches, stomach aches, difficulty in concentration and focus, irritability and changeable emotions (UKCISA 2008). Some of the participants mentioned that they found it easier nursing patients from their own home countries. The mean years of experience from the participants in this CICU was 2 years and 9 months. Possible reasons for this long stay in the CICU could be financial gain and sound working environments.

The language barrier influenced nursing care because the participants felt that they were unable to communicate effectively with patients. Participants mentioned that they used sign language or applied basic Arabic phrases to explain ideas to the patients. The effectiveness of this form of communication could not be assessed because the patients could not participate in this study.

Participants identified the fact that some of the practices and lifestyles of the Muslim patients were not easy to understand and could possibly be harmful to the patients like

over eating, smoking and fasting. Over eating, obesity and smoking are contributing factors to heart diseases. Participants mentioned that patients admitted to the CICU identified that they were heavy smokers for periods longer than 20 to 30 years. Fasting during the month of Ramadan is one of the pillars of Islam and all devoted Muslims will fast during this holy period.

Religious practices connected to the religion of Islam, like praying five times every day was experienced as being strange by the participants. Participants mentioned that patients would insist on praying before medication, interventions or surgery implying delays in performing procedures. The participating nurses reported that Muslim patients believed that illness and healing were from Allah and they entrusted their treatment options to Allah.

## **5.5 RECOMMENDATIONS**

Non Muslim nurses planning on going to work in the KSA should obtain cultural knowledge in the form of an orientation programme that includes:

- Understanding of the Muslim culture and traditional practices in order to deliver culturally sensitive care
- Basic Arabic language knowledge
- Basic knowledge about Islam as a religion, which includes the religious practices based on the five pillars of Islam
- Knowledge regarding different worldviews and the nursing practices related to each view
- Hospitals in the KSA, recruiting non Arabic speaking nurses, should have interpreters available to explain nursing actions, progress and to give health education when needed
- Separate CICUs for men and women should ideally be maintained in the KSA to accommodate the strict cultural separation of men and women
- Serious consideration should be given to installing central observation stations where all patients' monitors could be watched, to enable nurses to



observe patients' vital signs while respecting the principles of modesty and the patients' desires to close the curtains around their beds.

## **5.6 CONCLUDING REMARKS**

The strong socio economic stability in the KSA, as well as the need for trained nurses (because of the shortage of Saudi Arabian nurses) might necessitate recruiting expatriate nurses for a number of years. Nurses interested in working in the KSA might explore this opportunity to gain international experience while earning better salaries than their countries of origin could offer them. The KSA is equipped with advanced medical technological practices and equipment that could be a vast advantage to the nurses.

By offering these nurses basic Arabic programmes, acquainting them with the basic aspects of the Muslim religion and familiarising them some Muslim cultural knowledge, the nurses' adaptation could be facilitated. This would make expatriate nurses' care for Muslim patients more effective and enhance the nurses' levels of job satisfaction. More satisfied nurses could imply reduced rates of staff turnover, reducing recruitment and orientation costs and enhance the quality of care received by the patients in the participating CICU, and possibly in other ICUs and in other hospital departments.

Leininger (1991:41) maintained two decades ago that the time had come "... to prevent cultural imposition practices, cultural care negligence, cultural care conflicts, and many other practice problems... Nurses are now keenly feeling and demanding transcultural care knowledge to help them function in a tense multicultural world". This statement seems to be applicable to the nurses working in the participating CICU. By offering effective orientation programmes, nurses might be able to render more effective culture congruent care to patients from different cultures.

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## APPENDIX A: SEMI STRUCTURED INTERVIEW GUIDE

Research participant number \_\_\_\_\_ and date of interview \_\_\_\_\_

## A. Personal information:

Gender:

- ☐ Male
- ☐ Female

Country of birth:

- ☐ India
- ☐ Malaysia
- ☐ Philippines
- ☐ Saudi Arabia
- ☐ South Africa
- ☐ Other

Your current citizenship as indicated in your current passport

- ☐ India
- ☐ Malaysia
- ☐ Philippines
- ☐ Saudi Arabia
- ☐ South Africa
- ☐ Other

Participant's age

- ☐ 20-25 years
- ☐ 26-30 years
- ☐ 31-35 years
- ☐ 36-40 years
- ☐ more than 40 years

In which country did you complete your education/training as a nurse?

- ☐ India
- ☐ Malaysia
- ☐ Philippines
- ☐ Saudi Arabia
- ☐ South Africa
- ☐ Other

Years experience in the CICU within the KSA

- ☐ 6 months-1year
- ☐ >1 year
- ☐ >2 years
- ☐ >3 years
- ☐ >4 years
- ☐ >5 years

Total years of professional nursing experience (since you have completed your training and become a registered nurse)

- ☐ up to 23 months
- ☐ 2 to 5 years
- ☐ 6 to 10 years
- ☐ more than 10 years (please specify actual number)

What is your religious affiliation?

- ☐ Muslim
- ☐ non Muslim: please specify
- ☐ None

**B. Care expressions and practices**

- ☐ How do you experience nursing patients in the CICU?

Possible probing questions:

- ☐ What differences do you encounter in nursing patients in the CICU compared to



nursing cardiac patients in your home country?

- ☐ What do you know about Muslims' perceptions of the heart, of heart disease and about the prevention of heart disease
- ☐ What does the Qur'an say about heart disease and its treatment?
- ☐ How does the treatment in the CICU differ from or agree with that stated in the Qur'an?
- ☐ What differences do you encounter in nursing patients in the CICU compared to nursing cardiac patients in your home country?
- ☐ What could be done to improve the care rendered to patients in the CICU?

### C. Cultural aspects

What cultural aspects impact on the rendering of care to patients in the CICU?

Probing questions:

- ☐ How do you think the patients experience the restricted visiting hours in the CICU? How do these patients experience the limitations of two visitors per bed?
- ☐ Do you think these visiting hours should be changed? Please give reasons for your answer.
- ☐ How do you understand the role of the extended family in Islam?
- ☐ What is the role of the mother in Islam families?
- ☐ How should food be served to a Muslim patient?
- ☐ What foods are forbidden in the Muslim culture? Can you give reasons why these foods are forbidden?
- ☐ How should a female nurse assist a male Muslim patient with ablution; and a female Muslim patient (question will be adjusted if the respondent is a male)
- ☐ How should a female nurse bed bath a male Muslim patient; and a female Muslim patient (question will be adjusted if the respondent is a male)
- ☐ Please explain how the pillars of Islam can influence a Muslim person's experience of his/her illness.
- ☐ Why do Muslims fast during Ramadan?
- ☐ How is the nursing care in the CICU adjusted during Ramadan?
- ☐ What is the policy if a critically ill CICU patient refuses to eat or drink or

take medicines during Ramadan? What do you think this policy should state?

- ☐ Is it acceptable to have a 'mixed' male and female CICU for Muslim patients in the KSA?
- ☐ Is it acceptable for the female Muslim patient to lie in bed without her abaya targa (head cover) or niqab (face cover)?

## APPENDIX B: ETHICAL CLEARANCE

**UNIVERSITY OF SOUTH AFRICA**  
**Health Studies Research & Ethics Committee**  
**(HSREC)**  
**Faculty of Human Sciences**  
**CLEARANCE CERTIFICATE**

Date of meeting: 2 December 2010

Project No: 3079-130-8

Project Title: Expatriate non Muslim nurses' experiences of working in a cardiac intensive care unit in Saudi Arabia

Researcher: Michelle van Bommel

Supervisor/Promoter: Prof VJ Ehlers

Joint Supervisor/Joint Promoter: N/A

Department: Health Studies

Degree: Masters in Public Health

**DECISION OF COMMITTEE**

Approved



Conditionally Approved



  
**Prof TR Mavundla**  
**RESEARCH COORDINATOR**

  
**Prof MC Bezuidenhout**  
**ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

KING FAHD ARMED FORCES HOSPITAL  
P.O. BOX : 9862 JEDDAH 21159  
KINGDOM OF SAUDI ARABIA



مستشفى الملك فهد للقوات المسلحة  
ص.ب: ٩٨٦٢ جدة ٢١١٥٩  
المملكة العربية السعودية

**To :** University of South Africa  
c/o Proj. V. J Ehlers

**From :** Anya Pelser  
Assistant Director of Nursing

**Date :** 5<sup>th</sup> December 2010

**Subject :** Research Study of Michelle Van Bommel  
Student # 309 913 08

We hereby confirm that Ms. Michelle Van Bommel attained permission to conduct her research project in King Fahad Armed Forces Hospital, Cardiac Intensive Care Unit on the following topic: "Non Muslim nurses experience of working in a CICU within the KSA".

We conclude that patient confidentiality was not breached.

Thank you.

Yours sincerely,

**Anya Pelser**  
Assistant Director of Nursing





**Information letter for the participants and their signed consent form**

Dear registered nurse

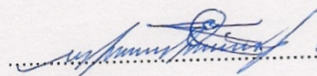
I am Michelle van Bommel, a registered master's student with the University of South Africa. As part of my studies, I am required to collect information and write a research report. The University of South Africa has approved my research proposal and the Director of Nursing Services of this hospital has granted permission for me to interview non-Muslim nurses working in the cardiac intensive care unit.

The purpose of the interviews is to learn about non-Muslim nurses' experiences of nursing Muslim patients in the cardiac intensive care unit. The knowledge and understanding gained from these interviews could be used to design in-service education programmes that would enhance nurses' abilities to care for these patients.

You are under no obligation whatsoever to participate, but I do value your experiences and will appreciate it if you were willing to be interviewed. You may discontinue with the interview at any stage and you may refuse to answer specific questions, without incurring any negative effects whatsoever. The interview will be audio-taped and later transcribed verbatim. Only I, my supervisor and one data analyst will have access to the recorded and transcribed interviews. I will keep this information securely locked up. No names will be mentioned in any research report. All nurses working in the unit will have access to the research report.

If you are willing to participate in this study, kindly sign this form for record purposes only. You can seal the signed consent form in an envelope and place it in this sealed container where all the signed consent forms will be kept. No name will be attached to your interview so that no one can link any interview to any specific person.

I have read the information about Ms M van Bommel's research and I agree to be interviewed by her.

  
Signature

23/12/2010  
Date

## APPENDIX C: RESEARCH APPROVAL

APPENDIX D: LETTER TO THE RESEARCH PARTICIPANTS  
(EXAMPLE)